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The Other Side of the Story
PERPETRATORS IN CHANGE

Country Report: United Kingdom





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Country Report: United Kingdom

The Other Side of the Story: Perpetrators in Change



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Abbreviations

ACEs	Adverse childhood experiences
BU	Bournemouth University
CAFCASS	Children and Family Court Advisory and Support Service
CAN	Child abuse and neglect
CARA	Conditional Cautioning and Relationship Abuse
CBT	Cognitive Behavioural Therapy
CCR	Coordinated Community Response
CDVP	Community Domestic Violence Programme
CJS	Criminal Justice System
CPS	Crime Prosecution Service
CSEW	Crime Survey for England and Wales
DAPP	Domestic Abuse Perpetrator Programmes
DASH	Domestic Abuse, Stalking and Honour Based Violence
DHR	Domestic Homicide Review
DVA	Domestic Abuse and Violence
DVPN	Domestic Violence Protection Notices
DVPO	Domestic Violence Protection Orders
DVPP	Domestic Violence Perpetrator Programme
EVAW	Ending Violence Against Women Coalition
FGM	Female Genital Mutilation
GP	General medical practitioner
HMPPS	Her Majesty's Prison and Probation Service
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisor
IPV	Intimate Partner violence
LGBT+	Lesbian, Gay, Bisexual, Transsexual, plus
MARAC	Multi Agency Risk Assessment Conference
NSPCC	The National Society for the Prevention of Cruelty to Children
NSPCC	National Society for the Prevention of Cruelty to Children
ONS	Office of National Statistics



SDVC	Specialist Domestic Violence Court
SPSS	Statistical Package for the Social Sciences
STADV	Standing Together Against Domestic Violence
VAWG	Violence Against Women and Girls
WHO	World Health Organisation

Terminology

Although the authors acknowledge that there is a lot of discussion around the language used for describing both those who experience abuse and those who abuse others, including the challenges around not seeking to label and define people by the abuse either given or received, in this report victims and survivors will be used interchangeably to refer to those who experience violence and abuse. Those who have been abusive to their partners will be referred to as perpetrators.

Organizational Information

Bournemouth University (BU) has more than 19,000 students and we are ranked as one of the top 200 young universities in the world. Our research shapes and changes the world around us, providing solutions to real-world problems and informing the education we deliver. Our students are a key part of the research we conduct, co-creating knowledge with us and playing a crucial role in everything that we do. In the Research Excellence Framework 2014 96% of our research was defined as internationally recognised or higher, with 72% deemed to have an outstanding or very considerable impact on society. Our vision of Fusion brings together these three key elements of education, research and practice, creating something which is greater than the sum of its parts. Through the impact of our research and education, and the contribution of our staff, students and graduates, we are able to deliver the third aspect of our purpose, to enrich society. It is this focus on Fusion which is reflected within this research project, as we value the interaction between academic research and front-line professional practice.

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Overview of UK Response to DVA

There is a range of legal and voluntary routes to both accountability and support for both survivors and perpetrators of DVA in the UK. These have been underpinned by the UK Governments 'Violence Against Women and Girls Strategy 2016-2020' and the introduction of the Domestic Abuse Bill which is currently going through Parliament. From the British Government's perspective this work is intended to demonstrate their commitment to the majority of requirements outlined in the Istanbul Convention, which was signed in 2012 but still remains to be ratified.

UK Cross-party definitions of domestic violence/abuse

In recent years domestic violence and abuse (DVA) has risen up the political agenda and has become a cross government priority. The UK Home Office published a consultation paper entitled "Safety and Justice" in 2003, which set out the Governments strategic approach to DVA. This consultation paper resulted in the 'Domestic Violence, Crime and Victims Act 2004' (Home Office, 2004). The Act, applicable to all devolved nations of the UK, was the most comprehensive piece of legislation on domestic abuse for over 30 years (British Medical Association Board of Science, 2014, p. 3). The UK Government also first endorsed a cross-party definition of domestic violence in 2005:

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern to black and minority ethnic (BME) communities such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

(HM Government, 2005)

This was followed in 2005 by a Home Office national report which, "provided an overview of its achievements in implementing the proposals outlined in Safety and Justice, as well as setting new objectives for dealing with domestic abuse through early identification, prevention and improved response" (British Medical Association Board of Science, 2014). This approach of early identification and response was criticised by the House of Commons Home Affairs



Committee in 2008 for focusing “disproportionately [...] on criminal justice responses at the expense of effective prevention and early intervention” (House of Commons Home Affairs Committee, 2008).

In 2013 the cross-party definition of DVA was amended to:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological; physical; sexual; financial; emotional.

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

* This definition, which is not a legal definition, includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

(Home Office, no date)

There were several major changes inherent in this definitional adjustment. One was the reduction of the lower age limit for victims of DVA to sixteen years old. This was in response to findings from the Government’s successful Teenage Relationship Abuse Campaigns and British Crime Survey data from 2009/10 which found that 16-19-year-olds were the group most likely to suffer abuse from a partner (Deputy Prime Minister’s Office, 2012). Specifically, it was found that, “12.7 per cent of women and 6.2 per cent of men in this age group suffer abuse, compared to seven per cent of women and five per cent of men in older groups” (Deputy Prime Minister’s Office, 2012). The inclusion of minors in the definition however served to, “muddy the waters further about where the boundaries between child abuse and domestic abuse lie” (British Medical Association Board of Science, 2014). The National Society for the Prevention



of Cruelty to Children (NSPCC) note that whilst different jurisdictions in the UK have their own policies on child protection, “all agree that a child is anyone who has not yet reached their 18th birthday” (British Medical Association Board of Science, 2014). Thus, young people may be covered by both the DVA and child abuse legislation simultaneously.

The second major change that was inherent in this definition amendment was the inclusion of ‘coercive control’. This follows work by Evan Stark (Stark, 2007a, 2012; Stark and Hester, 2019; Barlow *et al.*, 2020) which led to a legal change in the UK where Section 76 of the Serious Crime Act 2015 created a new offence of controlling or coercive behaviour in an intimate or family relationship.

Nationwide Domestic Violence UK Statistics

There is a long-standing data collection from both the Office of National Statistics (ONS) which calculates DVA prevalence, and the Crime Survey for England and Wales (CSEW), which is a nationwide survey that collects data on police recorded crime and crimes reported by members of the public but not necessarily reported to the Police. However, caution must be applied to the interpretation of national statistics as a significant amount of DVA that occurs does not come to the attention of the police. It is estimated that only one in six (17%) victims report their abuse to the police, suggesting that the majority remains hidden (Oliver, Alexander, Roe, & Wlasny, 2019). SafeLives (2015) found that, on average, high-risk victims live with DVA for two to three years before getting help and support, so the official statistics are likely to represent only a small proportion of the extent of DVA. However, using the available data sets together has produced a picture of DVA prevalence in the UK.

Current evidence in the UK reinforces the perception of DVA as a gendered crime. The national data from 2017-2018 found that 24.9% of women and 10% of men aged 16 to 59 have experienced partner abuse at least once since the age of 16, while 6.3% of women and 2.7% of men aged between 16 and 59 have experienced partner abuse once or more in the last year (Office for National Statistics, 2018). The Home Office (2020a) reports that two-thirds of the 2.4 million victims of DVA are women. When victims do access front-line support services, it has been found by SafeLives data that women are far more likely to experience high risk or severe DVA, with women making up 95% of victims who access specialist high risk interventions, such as Multi Agency Risk Assessment Conferences (MARAC) or



Independent Domestic Violence Advisors (IDVA) services (SafeLives, 2015). A further issue that impacts interpretation of the statistical data on DVA prevalence is that DVA is known to be a repeat offence, with a quarter of high-harm perpetrators being repeat offenders, some with at least six different victims (RESPECT, 2019). In the *Violence Against Women and Girls* (VAWG) Strategy 2016-2020 it noted that whilst there are high levels of repeat victimisation, less than 1% of known DVA perpetrators receive a specialist intervention (Home Office, 2016a).

DVA makes up a significant proportion of police work in the UK. It is estimated that more than 10% of offences recorded by the police are related to DVA (Home Office, 2020b). There was a total of 1,316,800 domestic abuse-related incidents and crimes recorded by the police in England and Wales in the year ending March 2019, an increase of 118,706 to the previous year (The Office for National Statistics, 2019). However, 43% of these reports were not subsequently recorded as crimes. Data suggests that the police made 32 arrests per 100 domestic abuse-related crimes in the year ending March 2019, which equated to 214,965 arrests¹ (The Office for National Statistics, 2019). Additionally, the ONS report that only 77% of domestic abuse related prosecutions were successful in securing a conviction in the year ending March 2019 (The Office for National Statistics, 2019). The Home Office also report an downward trend in convictions or offences, which has reduced from 8.9% prevalence in 2005, to 6.3% in 2019 (Home Office, 2020b). However, this downward trajectory has not been necessarily seen by front-line support services. Front-line providers have reported an increase in high risk complex DVA cases, as well as a year-on-year increase in high-risk clients accessing support services (Oliver et al., 2019).

The costs of DVA in the UK are estimated to be £66 billion (74,166,955,104.00 Euro) accounting for the costs of anticipation, consequence, and response (Oliver et al., 2019). In addition, the costs of managing perpetrators individually is high. The Drive (2020) report noted that “without intervention, a high-harm perpetrator costs the system about £63,000 in interventions at each incident. With an intervention these repeat costs can often be avoided”

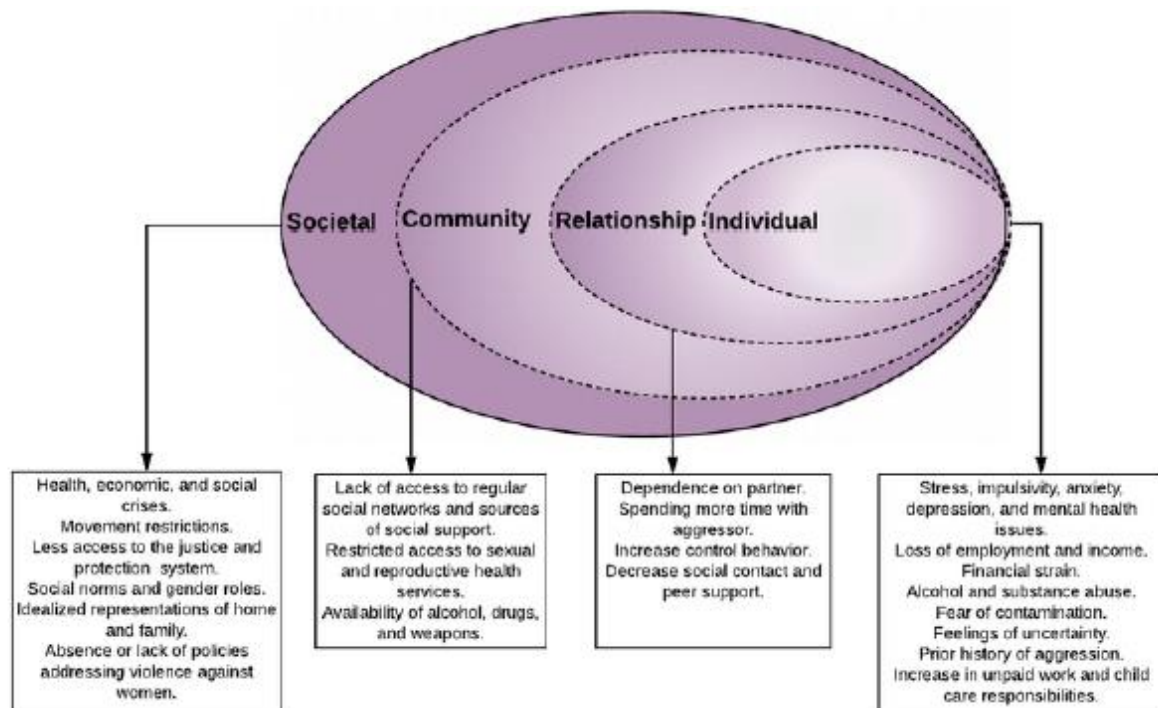
Domestic Violence and COVID-19

¹ In the 39 police forces that supplied data.



The United Nations Population Fund explains how pandemics can amplify existing gender inequalities for women and girls, which can impact upon how they receive treatment and care (UNFPA, 2020). The outbreak of COVID-19 (C-19) has been reported to cause an increase to DVA cases worldwide, which the United Nations have called a “shadow pandemic” (UN Women, 2020). They note that since the outbreak of C-19, emerging data and reports, “have shown that all types of violence against women and girls, particularly domestic violence, has intensified” (ibid). In the UK, EVAW, a strategic umbrella charity for women’s organisations, expressed concern that the isolation caused by governmental policies during C-19, such as enforced domestic lockdowns, has been used as a tool by perpetrators to enhance control and isolation of victims (EVAW, 2020). They also have raised concerns about the potential abuse of the UK’s Cd-19 contact tracing system, enhanced control over child-contact arrangements, and the potential of controlling or distorting information about the virus (EVAW, 2020).

An overview of the impact of lockdowns on DVA survivors is shown below.



(Sánchez *et al.*, 2020)



During the C-19 pandemic the UK has recorded a rise in DVA cases and there has been evidence that suggests that, “incidents are becoming more complex and serious, with higher levels of physical violence and coercive control” (Home Affairs Committee, 2020, p. 4). In the UK reports suggest that there has been an increase in calls to DVA helplines by 25% since the C-19 outbreak (Kelly & Morgan, 2020). The number of third party calls to the Police related to DVA have also increased during the UK lockdowns, which has partly been attributed to the fact that people have been spending more time at home during this period and so were in a position to be more aware of DVA happening around them (Office for National Statistics, 2020). In the UK context, we have seen an increase in DVA homicide with the rate during the first lockdown at the highest it has been for eleven years, and double the expected average (Ingala Smith cited in Home Affairs Committee, 2020). There has also been evidence of an increase in perpetrators trying to access support services. The RESPECT phoneline saw an increase in calls by 26.86%, with its website seeing a 125% increase in visits in the same period compared to the previous week (Home Affairs Committee, 2020).

The UK Government led a targeted awareness campaign during the first lockdown with the slogan #YouAreNotAlone, which aimed to raise awareness that anyone at risk of DVA at home could leave, despite the national lockdown (Home Affairs Committee, 2020). The DVA sector has raised concerns during -19 have largely been calling for an increase in funding to cover both the increased use of DVA services, related to the surge in demand for services that has been seen nationally due to the pandemic (EVAW, 2020). The UK Government delivered an emergency relief package for VAWG services of £37million after the first wave of the pandemic (Home Office, 2020c). Despite this commitment to funding in the early stages of the pandemic, VAWG services reported finding this process complex and laborious to access which resulted in delays to the money reaching front-line services (EVAW, 2020).

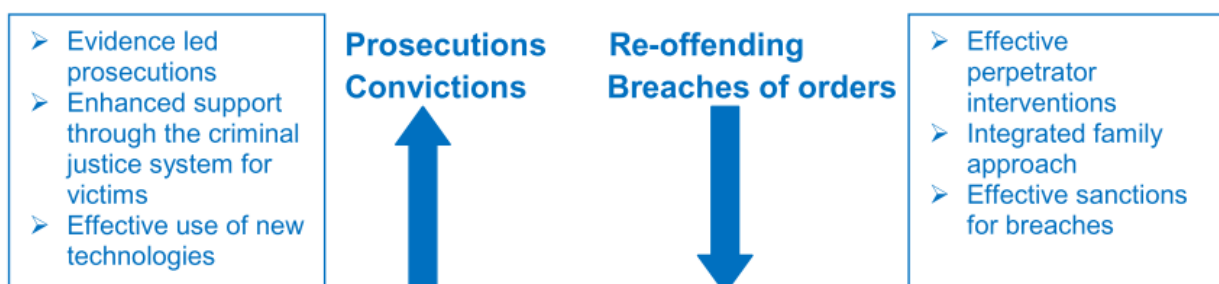
There have also been reports of a dramatic increase in requests for support by those charities that work with victims of stalking, with Paladin (a UK National Stalking Advocacy Service) reporting a, “50–70% increase in initial requests for support via email from both victims and wider services in the 3months from April 2020 compared to the previous 3 months” (Bracewell, Hargreaves and Stanley, 2020, p. 3). They note that victims of stalking have experienced increased vulnerability to their abusers as they have been more easily located during lockdown periods (ibid). With the increase in DVA coinciding with UK-wide lockdowns, there has also been an additional negative impact on other referral pathways that victims are usually able to access. For instance, there was a near closure of dental treatment facilities, which has led to



concerns that DVA victims with facial injuries have had limited access to care (Coulthard *et al.*, 2020). A concern that has been raised by children's services practitioners, is that whilst there has been an increase in referrals to DVA services for adult survivors, there has been a significant decrease in the number of referrals to children's services during lockdown (Donagh, 2020). This has been related to the lack of opportunities that young people have had during the pandemic to access services such as schools, youth clubs, and sports clubs, where they can access a trusted adult to disclose experiences of DVA (ibid).

Current UK Strategy and Legislation

The UK is currently working to the *Violence Against Women and Girls (VAWG) Strategy* which runs between 2016-2020 (Home Office, 2016b). This is an explicitly gendered approach which examines a range of abuses which are disproportionately gendered, including DVA, sexual violence, sexual exploitation, as well as related issues such as Female Genital Mutilation (FGM), honour-based violence, revenge pornography, modern slavery, and trafficking. In terms of perpetrator work in this strategy, the focus is on an enhanced criminal justice response, including targeting repeat offending through a combination of "disruption and support" (Home Office, 2016a).



(Home Office, 2016a)

There has been a recent increase in funding for perpetrator programmes from the Home Office, including £10 million allocated in the 2020-2021 budget outlined for interventions for DVA perpetrators. A large proportion of this (£7.17 million) was delivered to local areas via



allocated to regional Police and Crime Commissioners across England and Wales (Home Office, 2020a).

Domestic Abuse Bill

In the UK the nationwide response to DVA has received an enhanced focus through the development of a 'domestic violence bill' in the UK parliament. This work was solidified in 2019 with the Conservative government manifesto included a commitment to, "support all victims of domestic abuse and pass the Domestic Abuse Bill" (Home Office, 2020b). A public consultation took place in 2018, which was followed by the publication of a draft bill in January 2019. The bill included 123 commitments with both legislative and non-legislative elements which aimed to enhance victim safety, strengthen the justice process around DVA for both victims and perpetrators, and promote consistency across the nationwide DVA response. The Domestic Abuse Bill completed its Commons stages on the 6th July 2020 and will now be debated in the House of Lords before it receives Royal Assent and becomes law.

The aims of the Bill are to:

- Create a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, coercive or controlling, and economic abuse;
- Establish in law the office of Domestic Abuse Commissioner and set out the Commissioner's functions and powers;
- Provide for a new Domestic Abuse Protection Notice and Domestic Abuse Protection Order;
- Place a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation;
- Prohibit perpetrators of abuse from cross-examining their victims in person in the civil and family courts in England and Wales;
- Create a statutory presumption that victims of domestic abuse are eligible for special measures in the criminal, civil and family courts;
- Clarify by restating in statute law the general proposition that a person may not consent to the infliction of serious harm and, by extension, is unable to consent to their own death;



- Extend the extraterritorial jurisdiction of the criminal courts in England and Wales, Scotland and Northern Ireland to further violent and sexual offences;
- Enable domestic abuse offenders to be subject to polygraph testing as a condition of their licence following their release from custody;
- Place the guidance supporting the Domestic Violence Disclosure Scheme (“Clare’s law”) on a statutory footing;
- Provide that all eligible homeless victims of domestic abuse automatically have ‘priority need’ for homelessness assistance;
- Ensure that where a local authority, for reasons connected with domestic abuse, grants a new secure tenancy to a social tenant who had or has a secure lifetime or assured tenancy (other than an assured shorthold tenancy) this must be a secure lifetime tenancy.

(Home Office, 2020b)

As can be seen above, perpetrators are addressed within the bill in terms of increased legal powers to hold them to account. However, it has been criticized for not going far enough in terms of outlining a strategy to prevent, manage, and support DVA perpetrators. A spokesperson for Drive, a consortium of providers of perpetrator work, noted:

“This is why we’re calling for a perpetrator strategy to go alongside the Domestic Abuse Bill. We can’t stop domestic abuse until we invest in prevention. At the moment there is very little on this in the Bill” (Drive, 2020).

In 2020 a consortium of a wide range of organisations including third sector organisations who provide services for DVA victims and/or perpetrators, some police forces and the Mayor’s Office for Police and Crime, as well as experts in the field, collaborated under a campaign organised by RESPECT to put forward a national ‘Call to Action’ for perpetrator work (RESPECT, 2019). This call to action emphasised the need for a nation-wide perpetrator strategy which would ensure consistency in provision across the UK as well as the funding to make this available. A further tenet to the call to action was the introduction of a national quality assurance system. The inclusion of survivors voices here is important, as they note that “80%



of survivors have told us that they think interventions for perpetrators are a good idea – yet such programmes are patchy in their availability, limited in the range of perpetrators they can reach safely, and variable in their quality” (RESPECT, 2019). It is further emphasised in the call that services for victims and perpetrators should be, “funded sustainably, independently of each other. It is not either/or” (RESPECT, 2019). This relates to the postcode lottery of services that we currently see in the UK. The report includes some excellent initiatives that are working across the UK, but we are still not in a place where this is an offer in all areas with easy access to perpetrator support. Funding for perpetrator services is an imperative part of the Istanbul Convention as well as the Domestic Abuse Bill however the situation in the UK is that “suitable and quality-assured interventions are far from universally available – indeed there are perpetrators, for whom there are almost no suitable groups, such as LGBT+ interventions available for when this legislation is enacted” (RESPECT, 2019). Thus, we are in a situation where there is ambition for increased intervention but a lack of sustainable funding source to ensure this occurs.

Findings from Domestic Homicide Reviews (DHRs)

When homicide/femicides are carried out in the UK and it is categorised as “domestic” then this instigates a process of a ‘Domestic Homicide Review’ (DHR). This includes both ‘interpersonal homicide’ as well as ‘adult family homicide’ (Montique, 2019a). The aim of the review is to ascertain the missed opportunities for recognition, risk management, and prevention of the resulting death. In a recent review of DHR files in London by *Standing Together Against Domestic Violence*, the most frequent themes across the 84 DHR’s that were examined were:

- Lack of awareness of DVA and its impacts;
- Lack of information sharing between agencies;
- Missed opportunities to ask about victim’s relationships;
- Lack of consistent DASH risk assessments carried out;
- Lack of focus on perpetrators and risk they pose to others.

(Montique, 2019a)



In terms of the findings from DHR's that specifically focus on gaps in perpetrator work, they found that in 24% of cases there were missed opportunities to hold the perpetrator accountable or offer support to change. They also found a particular overlap between DVA perpetration and unmet mental health needs, with 48% of the perpetrator having mental health issues and 28% of cases had missed opportunities to offer mental health support (Montique, 2019a). They emphasised that there is a need for perpetrator risk assessments to be built into professional practice (Montique, 2019b).

Coercive Control Law

The UK adopted a new law related to DVA in the form of "Section 76 of the Serious Crime Act 2015 - Controlling or Coercive Behaviour in an Intimate or Family Relationship" (Crown Prosecution Service, 2017). This new legislation came into effect on the 29 December 2015 and was a response to the ground-breaking work by Evan Stark to highlight the way in which coercive control is fundamental in DVA perpetration. Stark's theory of coercive control (2007b) focuses on the controlling and abusive behaviours which are distinct from physical injury sustained during DVA. DVA is "interweaving repeated physical abuse with three equally important tactics: intimidation, isolation, and control" (Stark, 2007b). It is the assertion that these other factors are as *equally* important which has been so impactful in DVA policy. Stark has problematised the historical emphasis on physical injury:

"Viewing woman abuse through the prism of the incident-specific and injury-based definition of violence has concealed its major components, dynamics, and effects, including the fact that it is neither "domestic" nor primarily about "violence." (Stark, 2007b)

Indeed, as suggested by Stark, the label "domestic violence" has been a barrier to recognising the victims who experience it apart from the traditional victim stereotype of a bruised and battered woman. This has been pertinent for young people between 16 to 18 years old who have been shown to be at the highest risk of experiencing DVA but due to their age are less likely to be in a 'domestic' cohabiting context. Furthermore, Stark's work also emphasises that



“violence in abusive relationships is ongoing rather than episodic, that its effects are cumulative rather than incident-specific, and that the harms it causes are more readily explained by these factors than by its severity” (Stark, 2007b).

Section 76 of the Serious Crime Act 2015 was a response to this enhanced focus on the elements of DVA which are not associated with physical violence. Prior to the introduction of this new law there had been a difficulty in both proving and prosecuting the elements of DVA, as outlined in the Home Office definition discussed earlier, that are concerned with patterns of behaviour which can amount to harassment within intimate relationships (Crown Prosecution Service, 2017). In order for the coercive control law to be applied there must be proof that the negative behaviour is engaged in 'repeatedly' or 'continuously' which has, “a 'serious effect' on someone and one way of proving this is that it causes someone to fear, on at least two occasions, that violence will be used against them” (Crown Prosecution Service, 2017). Thus, the burden is on the prosecution to show that there was intent in these behaviours to control or coerce someone.

UK Statistics from November 2019 indicate that recorded coercive control offences nearly doubled within the year. The legislation had 9,053 offences recorded in the year ending March 2018, which rose to 17,616 offences by March 2019 (The Office for National Statistics, 2019). Although this shows that there has been a significant uptake in use of this new law, this also coincided with an overall decrease of police referrals to the Crown Prosecution Service as well as a decrease in the proportion of female victims reporting domestic abuse to the police (Women's Aid, 2019). When the new legislation was introduced there was also a general concern that focusing on aspects of DVA which were not physical violence would lead to more female perpetrators being identified, however since its inception the vast majority of individuals charged under this new law have been male.

The Istanbul Convention

The Istanbul Convention is a ground-breaking piece of work which sought to create a legally binding set of guidelines which aim to combat violence against women in a range of forms. It clearly frames all aspects of VAWG as fundamental violations of women's rights and forms of gendered discrimination. The Convention outlines a range of acts which must be criminalised in the member countries, including DVA (both physical and psychological abuse), sexual



violence (including rape) as well as sexual harassment and non-consensual acts of a sexual nature, stalking, forced marriage, female genital mutilation, forced abortion, and forced sterilisation, honour crimes.

The Istanbul Convention was signed by the UK parliament in 2012 however it has still not been ratified. The UK Government notes that, of the 81 articles in the Convention, “the UK already complies with, or goes further than, almost all the Convention’s articles” (Home Office, 2020d, p. 7). They emphasise that the new Domestic Violence Bill which has been introduced (discussed earlier) will also contribute to the enhanced response to DVA as required in the Convention. As is discussed later in this report, the Home Office emphasises the importance of a co-ordinated multi-agency response to VAWG. They note that since signing the convention in 2012, “the UK has continued to put measures in place to encourage agencies to work across boundaries and ensure greater consistency” (Home Office, 2020d). In response to the UK’s delay in ratifying the Istanbul Convention, a campaign group which represents VAWG organisations, some parliamentarians, and supporters has been pressing the need for the ratification (Icchange, 2020). The campaign emphasises that, although the UK Government claim they are doing work which is in excess of that required by the Convention, without ratification there are no legal assurances that hold them to account for this work. This could mean that despite such guarantees being enshrined in law local authorities and other agencies may not have the funds or impetus to put in place the resources needed to tackle gender-based violence.

Dominant Approaches to DVA in the UK

Duluth model of Power and Control

The Duluth model of DVA has been highly influential in providing the pro-feminist framework for both victim and perpetrator work in North America and the UK (Bowen, Brown, & Gilchrist, 2002). A key resource that was created in the Duluth project in Minnesota was the ‘Power and Control Wheel’ (Domestic Abuse Intervention Programme, no date). This approach was developed from accounts given by female victims who attended the Domestic Abuse Intervention Project (DAIP) in Duluth, Minnesota (Barnish, 2004, p. 6). Themes of coercion and threats, intimidation, emotional abuse, isolation, minimising, denying and blaming, using



children, male privilege, economic abuse were ascertained and then placed in a visual format, in a wheel with power and control in the centre and the 'tactics' of abuse around the edge (Dasgputa, 2005, p. 59). The tactics, which can precede or accompany physical and sexual violence, are described as: intimidation, isolation, use of male privilege, coercion and threats, emotional abuse, economic abuse, use of children, and abuse minimisation, denial and victim-blaming (Barnish, 2004). The visual format of the wheel is used to emphasise that, although different tactics and/or violence may be used, power and control is at the heart/centre of the abuse (Domestic Abuse Intervention Programme, 2011). Central to this theory is that DVA is "characterized by the pattern of actions that an individual uses to *intentionally* control or dominate his intimate partner" (author emphasis: Domestic Abuse Intervention Programme, 2011). The power and control wheel emphasises the gendered nature of DVA and has a section of the circle dedicated to abuse through "Using Male Privilege", described as; "Treating her like a servant; Making all the big decisions' acting like the 'master of the castle'; being the one to define men's and women's roles" (Domestic Abuse Intervention Programme, no date). Measures of psychological and physical violence have been derived from this model and have been considered valid and reliable (Barnish, 2004; Shepard & Campbell, 1992).

The Duluth Power and Control Wheel and related resources are used in perpetrator intervention work in order to explore core beliefs of offenders which are related to a patriarchal context (Bowen, Brown and Gilchrist, 2002). This is carried out in a range of ways, utilising cognitive behavioural approaches such as, role-play, rehearsal and self-monitoring which lead to an understanding of the dynamics of DVA (Cunningham et al., 1998). At the core of this approach is a feminist understanding of DVA, and so male perpetrators are faced with the causes and consequences of male privilege within a patriarchal societal structure. Another significant contribution that started within the Duluth project is the Coordinated Community Response approach to DVA (Shepard & Pence, 1999).

The Coordinated Community Response to DVA

The Coordinated Community Response (CCR) to DVA was an approach that was born out of the Duluth model. Based on the work of Ellen Pence (Shepard & Pence, 1999), the CCR seeks to develop and solidify whole community approaches to DVA, which integrate all sectors including criminal justice agencies, local government, health, education, and social services



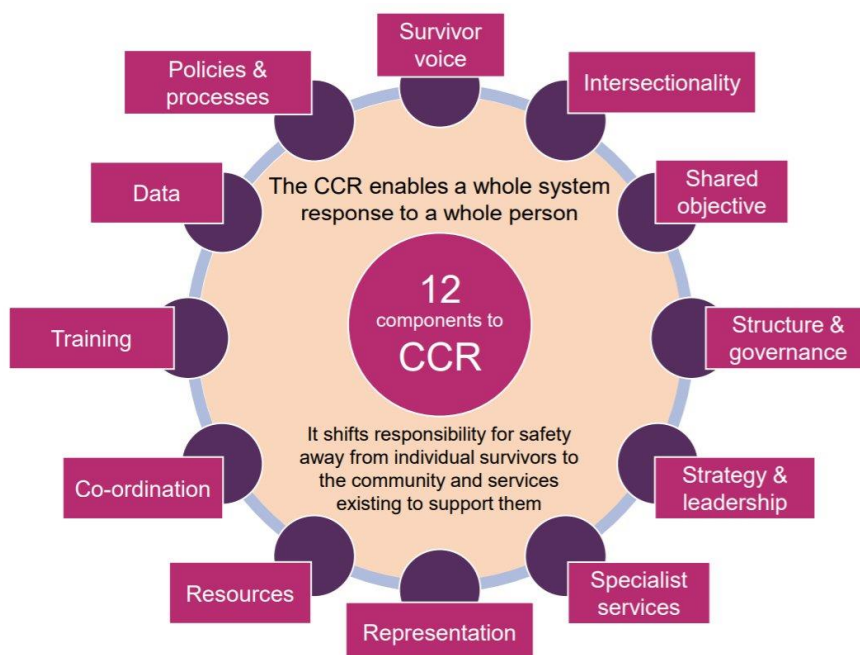
to name a few. The CCR approach was first used in the UK in the London Borough of Hammersmith and Fulham in 1989 (Kelly & Westmarland, 2015). Originally organised as the bringing together of multi-agency groups as part of a wider 'Domestic Violence Forum', it was coordinated by a third sector organisation called *Standing Together Against Domestic Violence (STADV)*. STADV sought (and continues to do so) to provide coordination of the localised response which aimed to provide training and solidify referral pathways so that victims would receive the same supportive response wherever they presented (Wills *et al.*, 2013).

The key principles for developing successful partnerships were outlined as follows:

1. An understanding of domestic violence
2. Domestic Violence as a Historic Concern and Priority
3. An Ethos of Gender Equality
4. Cross-party Political Support
5. History of Multi-agency Working
6. Partnership
7. Developed Partnership Structures
8. Leadership
9. Funding
10. Communication

(Wills *et al.*, 2013)

The aim of this approach to the CCR is the development of non-partisan ways of working which are rooted in a feminist understanding of gender-based-violence. This model has been expanded throughout the UK, where now several hundred domestic violence coordinators work to this same framework (Kelly & Westmarland, 2015). STADV coordinate a network of DVA coordinators nationally, who sit within a range of organisational structures, including in local councils, community safety partnerships, police, and third sector organisations. Unfortunately, despite the widespread adoption of these principles, there is still not national coverage of DVA coordination in all areas of the UK, and this is in a state of constant flux (Kelly & Westmarland, 2015). There are twelve core components to a successful CCR.



(Standing Together Against Domestic Violence, 2020, p. 12)

In this graph we can see that it is the blended combination of the availability of appropriate services as well as coordination and training, with supporting policies, which is key. It aims to create a whole community response rather than focusing on the individual victims. Central to this is hearing the survivor's voice, as STADV noted that less than 50% of survivors they surveyed felt that their local strategic partnership adequately sought the voices of survivors to inform the work (Standing Together Against Domestic Violence, 2020). Intersectionality is also foregrounded here, which moves a step forward from the Duluth model, which focused on gender over other intersecting issues of race, ethnicity, and class which affect the individuals' experiences of the CCR.

In the CCR model, perpetrators fit within the broad concept of 'being held to account'. However STADV note that this feature is, "regularly overlooked area of delivery" (2020, p. 34). They highlight that often in risk management processes including MARACs and DHRs the perpetrator can be invisible, with the predominant focus remaining solely on the victim themselves. They regard this as inadequate as it can result in missed opportunities to manage perpetrator behaviour, a significant point given the prevalence of repeat offending and often multiple victims (Standing Together Against Domestic Violence, 2020). There are several reasons that perpetrator interventions have been side-lined within CCRs; one of the main



reasons is that there has been a focus on the risk management from the perspective of victim safety. MARACs, IDVAs and refuges have all been set up with the focus on the safeguarding of the victim and their children. Domestic Violence Perpetrator Programmes (DVPP) are still somewhat of a 'postcode lottery' across the UK, meaning that their delivery is dependent on resourcing pressures and different local priorities. A focused study on the CCR Model and perpetrator interventions has been carried out by Kelly and Westmarland in 'Project Mirabel' (2015). The aims of this study were to ascertain what DVPPs contribute to effective behaviour change among perpetrators, but also what they add to a coordinated community response (Kelly & Westmarland, 2015). They focused on the ways in which perpetrator programmes increase 'space for action' among other measures (Kelly & Westmarland, 2016).

Key components of the CCR approach to DVA include the provision of a Coordinator (or several) who works to ensure that pathways to support are open, as well as ensure clarity in the pathway to hold perpetrators to account. One of the ways that this is enacted is through Specialist Domestic Violence Courts (SDVCs). In the implementation of an SDVC, there is an assurance that staff are trained and specialised around DVA cases, and specialist victim support is provided. Data is collected by the SDVC Coordinator who monitors the effectiveness of the court in providing victim safety outcomes (Standing Together Against Domestic Violence, 2018). It is this external verification system which is crucial to the regulation and quality control in the court, to ensure the most appropriate criminal justice response for DVA survivors.

MARAC System of Risk Management

Multi-Agency Risk Assessment Conferences (MARAC) were introduced in the UK following the Domestic Violence, Crime and Victims Act (2004). The first one was held in Cardiff in April 2003 (Robinson, 2013) and MARACs have now also been adopted internationally, in Finland, Switzerland, Australia and Canada (Ketwaroo-Green, 2020). Usually held every three to four weeks, they bring together all agencies including local police, probation services, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. The aim is to share information and referrals in order to coordinate community responses to domestic abuse (Cleaver *et al.*, 2019). The underlying assumption is that no single agency can see the complete picture (SafeLives,



2014). Specifically, they share information to increase the safety, health and well-being of victims and their children; determine whether the perpetrator poses a significant risk (to anyone specifically, or the community at large); and construct a risk assessment plan to support everyone, reduce repeat victimisation.

Some have argued the word 'conference' is a misnomer as MARACs are not case conferences but are more geared toward resource allocation (Robbins *et al.*, 2014). The meetings briefly discuss cases, and assess the risk and needs of the victim, but focus upon providing appropriate services for all parties from each agency. So, for example the police may focus upon victim safety by target hardening their property and managing the perpetrator by instigating an investigation (Steel, Blakeborough and Nicholas, 2011). The responses are turned into co-ordinated action plans. IDVAs not only represent the victim at the MARAC meetings but coordinate these plans, bridging the gap between criminal justice and victim needs (Robinson, 2013). They work with victims to assess risk, develop safety measures and advise on court process (Groves, Nicola, Thomas, 2014).

In the 12-month period to 30/06/20 there are currently 291 MARACs operating across the UK, managing more than 105,000 cases a year. Those referred are the highest risk cases in particular geographic areas (Robinson, 2013). Criteria for referring a case to MARAC include high scores on risk assessment tools (such as CAADA-DASH risk indicator checklist); potential escalation in the number of police call outs; or professional judgement where someone may have a serious concern.

Criticisms

The purpose of MARACs is to ensure a co-ordinated response beyond criminal justice agencies (The Home Office, 2007) shifting the focus to the perpetrator (rather than victim) and the community (rather than individuals). However, they were developed to deal with the top 10% of cases of risk of serious harm or homicide (McLaughlin *et al.*, 2014) , and in reality focus on a few, high risk, victims (Kelly, Westmarland and Kelly, 2015). In addition, certain groups (such as LGBT+ victims due to under-reporting generally) may be less likely to be referred (Donovan, 2010), and groups such as disabled, migrants, older females and traveller communities may still be largely excluded from these services (Harne and Radford, 2008; Haguea, Thiarab and Mullenderc, 2011). This is despite some being at increased risk of additional types of abuse (Hassouneh-Phillips and Curry, 2002). Some have criticised the



levels of engagement by some agencies (Peckover, Golding and Cooling, 2013) Whilst there are some 'core' agencies expected at MARACs, other agencies attend more sporadically, and representatives are inconsistent. Attendance from social care agencies has been reported as mixed, and therefore criticised for not optimally safeguarding children (Peckover, Golding and Cooling, 2013). MARAC attendees have also reported feeling unsupported by their employers (McLaughlin *et al.*, 2014) with resource and time limitations a main barrier to MARAC's success (Robinson, 2004). Increasing referrals have also impacted on their utility. Reports have indicated there was nearly a 25% increase in referrals in one area between 2010-2013 with cases having an average of 10 minutes per case (McLaughlin *et al.*, 2014).

MARACs are not currently statutory, despite their value, and some argue such a mandate could enhance agency representation, and improve recognition of the importance of the work from supervisors and agencies more generally (Steel, Blakeborough and Nicholas, 2011). Lack of co-operation from victims has also been identified as another barrier potentially reducing the effectiveness of the MARACs (Robinson, 2004). However victims may not fully understand the process or feel involved (although they should be), instead describing the process as being done 'to' rather than 'with' for example (McLaughlin *et al.*, 2014) and some saying they were not always contacted and informed about decisions (Robinson and Tregidga, 2007). Some wanted to present themselves, and others wanted ongoing support, beyond their immediate crises (McLaughlin *et al.*, 2014). Additional common pitfalls identified in MARAC toolkits include difficulty in identifying victims, untrained or unconfident professionals, lack of standardised risk assessment, unclear referral criteria, lack of relevant information, and actions to address the behaviour of the perpetrator not identified. This latter point is of particular note given holding perpetrators to account has been identified as one of the best ways in keeping victims safe (Robinson, 2004). It has also been noted that there is little opportunity to monitor actions from the meetings in some areas (though this seems to happen in some e.g., Dorset requires each agency to update their actions). A review for the Home Office summarised such challenges in identification (e.g. who are the victims), representation (e.g. who should attend), volume (cases are increasing) and action planning (Steel, Blakeborough and Nicholas, 2011).

Evaluation outcomes and good practice

Evaluation studies have measured success in MARACs in various ways. In terms of recorded incidents, one study found after six months 60% (and after 12 months 40%) of victims had not



been re-victimised (Robinson, 2004, 2013). As noted by Robinson (2004) this is a significant finding given the extensive histories of abuse and high risk of re-victimisation in many cases. Financially, programmes were beneficial with indications that for every investment of £1, £6 would be saved (Robinson, 2013). In relation to more qualitative measures of success, agencies valued MARAC (Robinson, 2004). Victims were aware of them, but highlighted the importance of having advocates (Robinson, 2013).

Robinson (2013) also outlined the factors linked to the effectiveness of MARACs highlighting the important role of the IDVA, the need for good leadership by the chair, agency representation and strong partnerships. Information sharing between agencies is a critical component of MARAC (Robinson, 2006). This has also been endorsed from reviews of intimate partner homicides (Ketwaroo-Green, 2020) and shown to reduce risk in intimate partner violence (Hague and Malos, 1998). It gives a complete picture and developing a more holistic action plan ensures risk assessments are more accurate (Robinson, 2006). A Home Office survey found MARAC meetings achieved good co-ordination and information sharing (The Home Office, 2011).

Ketwaroo-Green (2020) highlights some good practice in information sharing for MARAC including:

- establishing a protocol and engaging victims in order to reduce the ethical burdens of different agencies gaining consent
- providing shared training
- only sharing necessary and relevant information, and
- building inter agency trust

Even seemingly minor issues such as standardising language can prove beneficial; for example, different agencies use labels such as victim, survivor, tenant, client, patient and these can be confusing depending on the agency (Robbins *et al.*, 2014; Ketwaroo-Green, 2020).

Importantly, MARAC meetings have been shown to be mostly successful in identifying (and hopefully acting upon) victim and perpetrator risks (The Home Office, 2011). In summary, Robinson (2004, p. 3) states the “evidence from the evaluation of the MARACs makes it clear that taking a holistic multiagency approach to domestic violence can reduce recidivism, even amongst the population most at risk.” Similarly, in a more recent review, Ketwaroo-Green



(2020, p. 4) highlights how MARACs have proven to “reduce repeat victimization, increase victim safety and connect victims with the support and services they need”.

RESPECT Accreditation

A key tool that promotes the role of the coordinated community response in UK perpetrator work is the oversight of a national third sector organisation, *RESPECT*. *RESPECT* run both services for perpetrators, male victims of DVA, and young people who carry out violence and abuse in their own relationships (*RESPECT*, 2020). *RESPECT* as an umbrella organisation holds great influence over UK DVA perpetrator provision predominantly through its work creating, maintaining, and accrediting organisations who adopt the ‘*RESPECT Standards*’ which have been in operation since 2008. The aim of the standards is to provide a framework to ensure that there is continuity across “risk, need and responsivity principles... ; to ensure survivor confidence; that perpetrators are given an intervention which has a realistic opportunity of success, and that services provide value for money for commissioning agencies” (*RESPECT*, 2017, p. 2). The desire to create uniform principles which underpin DVA perpetrator work promotes a consistency in approaches and services offered nationwide, though is dependent on local funding constraints.

The *RESPECT Principles* which underpin the standards are as follows:

- 1) **Do no harm.** Organisations take all reasonable steps to ensure that their services do not create additional risks for survivors of domestic violence and abuse.
- 2) **Gender matters.** Organisations work in a way that is gender informed, recognising the gender asymmetry that exists in the degree, frequency and impact of domestic violence and abuse. They understand that men’s violence against women and girls is an effect of the structural inequality between men and women and that its consequences are amplified by this. A gender analysis includes violence and abuse perpetrated by women against men and abuse in same-sex relationships, and these also require a gender informed response.
- 3) **Safety first.** The primary aim of work with perpetrators is to increase the safety and wellbeing of survivors and their children. The provision of an Integrated Support Service for survivors alongside the intervention for perpetrators is essential. When working with



perpetrators it is important to recognise the need for behaviour change, but risk reduction should always be prioritised.

4) **Sustainable change.** Organisations offer interventions that are an appropriate match to the perpetrator, considering the risks they pose, the needs they have and their willingness and ability to engage with the service offered. This will ensure that they are offered a realistic opportunity of achieving sustainable change.

5) **Fulfilling lives.** Organisations are committed to supporting all service users to have healthy, respectful relationships and to lead fulfilling lives.

6) **The system counts.** Domestic violence and abuse cannot be addressed by one agency alone and work with perpetrators should never take place in isolation. Organisations are committed to working with partners to improve responses as part of their local multiagency arrangements.

7) **Services for all.** Organisations recognise and respect the diversity of their local community and take steps to respond to everyone according to their needs.

8) **Respectful communities.** Organisations recognise that the environment their service users live in has an impact on their lives. They will make the links between individual change and the development of respectful communities.

9) **Competent staff.** Organisations deliver a safe, effective service by developing the skills, well-being and knowledge of their staff through training, supervision and case work support.

10) **Measurably effective services.** Organisations employ clear and proportionate measurement tools, which demonstrate both the individual benefits and the impact of interventions.

(RESPECT, 2017)

Existing Perpetrator Work in the UK

There have been a number of evaluations of interventions with perpetrators of DVA (Skyner and Waters, 1999; Morgan, McCausland and Parkes, 2019) that note that it is often not as simple as a set period of intervention, but instead that interventions need to take place over



as significant period of time (Morran, 2013) and include support for the partners (Skyner and Waters, 1999) and children (Morgan, McCausland and Parkes, 2019).

Voluntary Community Options

DVPPs or Domestic Abuse Perpetrator Programmes (DAPPs) are the predominant interventions that are available to perpetrators in the community across the UK. The format of intervention varies, but is typically a weekly group programme of around two hours, over the course of six months (CAFCASS, 2020). The aim of such programmes is both to hold perpetrators accountable for their behaviour and offer strategies to reduce abusive behaviours. There is a UK wide helpline number which is available to all individuals who are concerned about their abusive behaviours. It provides a single point of contact for individuals (of all genders) who are concerned about their abusive behaviours as well as offering advice to people around them. In addition to self-referral, the first point of contact for many perpetrators to support services is via services related to children. In Project Mirabel research, as discussed earlier, the majority of referrals to DVPPs were from Children's Services, CAFCASS, and self-referrals (Kelly & Westmarland, 2015). This reflects the importance of children's safeguarding as referral motivation. They also noted the comparable lack of referrals from police, general practice medical services and mental health services. This reflects the concern about broken referral pathways among health and DVA services in the homicide reviews as outlined earlier.

Criminal Justice Interventions

CARA Conditional Cautions

Since the 1990's the Home Office has encouraged 'positive action' in relation to DVA arrests, and since 2000 police have had to justify any decision not to arrest in a DVA case where there is sufficient evidence. Although this resulted in an increase of arrests, the majority were dealt with via a caution. As a result of enquiries into the victim outcomes whose partners experience a caution, the development of a 'conditional caution' was proposed by The Hampton Trust,



Hampshire Police, and Cambridge University. This was initially developed as a randomized control trial in Hampshire in 2011 (Strang *et al.*, 2017) and given the acronym CARA (Conditional Cautioning and Relationship Abuse). Perpetrators who were eligible to access CARA included those who would have previously received simple cautions, who admitted the offence, who had no record of violence in the previous two years, and who were assessed as being 'standard' or 'medium' risk on the DASH² risk assessment. This risk assessment has been used across the Police and voluntary sector services since 2009 in the UK. Victim agreement was also sought before referral to CARA. Men who are referred to CARA attend two sessions, provided on two weekend days several weeks apart, based on principles of motivational interviewing (Miller and Rollnick, 2013).. The approach in these sessions was, “a collaborative conversational style for strengthening a person’s own motivation and commitment to change...in which [offenders] were more likely to be persuaded by what they hear themselves say” (Strang *et al.*, 2017).

The approach was shown to be largely successful in the control trial, with 35% fewer men reoffended compared with a control group. Additionally, re-offenders causing 27% less harm than the men who did not attend sessions, which was calculated using a novel method of ascertaining the cost of crime to both victims and society. Importantly, the approach also provides an opportunity for perpetrators to change, which is important to victims who want the violence to cease in a relationship, rather than being solely based on a relationship ending. Providing a brief and technically early intervention (related to previous arrests for violence at least) it also offers an opportunity for reflection and behaviour change before the abuse becomes more embedded. The CARA programme currently only operates in eight counties across England³.

Drive Project for High-Risk Perpetrators

The Drive Project is focussed upon high-risk perpetrators of DVA. Most interventions require victims to move away or change their lifestyle, however this focuses on perpetrator rehabilitation. It was launched in April 2016. After a successful three-year pilot involving three

² Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model. See <https://www.dashriskchecklist.co.uk/>

³ Hampshire, Dorset, Avon & Somerset, West Midlands, Leicester, Cambridge, Norfolk, West Yorkshire



areas (Hester *et al.*, 2020) four more areas have now adopted, and seen the successes of its implementation (Geoghegan-fittall, Keeble and Wunsch, 2020). Its main aim is to reduce future and repeat victims of DVA by deterring perpetrator behaviour i.e. to reduce harm by early intervention. It involves disruption of abusive behaviour, and supporting perpetrators via behaviour change interventions (Hester *et al.*, 2020). This support involves mainly indirect work such as multi-agency information sharing and co-ordination (Hester *et al.*, 2020). It also however should include direct, bespoke, one to one work with the perpetrator. It includes looking at areas such as relationships, impulse control, emotional regulation, trauma and acknowledging impact of abuse (Hester *et al.*, 2020).

Drive works with high-harm, high-risk, repeat (with the same victim) and serial (with different victims) perpetrators of domestic abuse who are typically identified by police risk assessments or by cases being heard at MARACs. Drive clients are usually men in heterosexual relationships, and around 1 in 10 are still living with the victim and have links with children (Hester *et al.*, 2020). The initial pilot review of the Drive project found 84% of the work is indirect disruption and victim work, with only 16% directly involving the perpetrator (Hester *et al.*, 2020). It appears there needs to be some 'lever' for perpetrator engagement otherwise engaging them is challenging. Statutory involvement e.g. from police, probation or social services appears key, although those with additional needs and with something to gain; such as financial difficulties, mental or physical health problems, also benefit (Hester *et al.*, 2020). In a more recent review of four additional areas adopting Drive, it was found direct contact had improved, now occurring in almost a half of cases (Geoghegan-fittall, Keeble and Wunsch, 2020).

Other difficulties have been encountered such as under-resourcing, training, access to (e.g., police) systems particularly when cross border information sharing was required. In addition, it has not yet been possible to estimate financial savings from the data available (Geoghegan-fittall, Keeble and Wunsch, 2020; Hester *et al.*, 2020), yet success seems to require longer term engagement, and was considered expensive and time consuming by some participants (Geoghegan-fittall, Keeble and Wunsch, 2020). However, it was felt to be worthwhile (Geoghegan-fittall, Keeble and Wunsch, 2020).

A three-year independent evaluation of a pilot study involving 506 perpetrators, concluded Drive reduced abusive behaviour (Hester *et al.*, 2019) and did so, "to a greater degree than in cases where only support to the victim is being provided [and]....shows a more sustainable impact on [victim] safety" (Hester and Newman, 2020). Findings highlight how the those



demonstrating the most severe abuse changed the most, and this desistence was sustained after a year (Hester *et al.*, 2019)). The use of high-risk sexual abuse reduced by 88%; physical abuse by 82%; harassment and stalking by 75%; and jealousy and controlling behaviours by 73% (ibid). Behaviour change sessions by cases managers were associated with a reduction in all four areas, however even when direct contact did not occur, significant risk-reductions still occurred (Hester *et al.*, 2020). It is of note however than in more recent evaluations most interventions (73%) included a combination of both direct support and indirect disrupt, with progress in the number of cases receiving behavioural change support (Geoghegan-fittall, Keeble and Wunsch, 2020).

Hester *et al.*'s (2019) study also highlighted IDVAs perceived at least a moderate reduction in risk in over three quarters of cases, and assessed risk was permanently eliminated in almost three times as many cases for those involved in Drive. MARAC data also shows us Drive helped to reduce risk of serial perpetrators, which was sustained a year after the case was closed. Police data showed perpetration of domestic abuse offending reduced by 30% in the 6 months after intervention (compared to 6 months before). Victims stated they feel safer, however there was an underlying scepticism from them (and some practitioners) of permanent change, once attention had moved away from them (Geoghegan-fittall, Keeble and Wunsch, 2020; Hester *et al.*, 2020). For perpetrators,

“key to the difference was the degree to which they felt like their case manager cared and really listened without judgement. There was indication that building trust was necessary to them take the service user through more challenging and discomfort-producing activities.” (Hester *et al.*, 2020, p. 8).

Probation and Prison Based Perpetrator Programmes

Since the mid-1990's there has been provision of perpetrator programmes which have been court mandated and delivered by prisons and probation services (Kelly & Westmarland, 2015). These have changed from being Duluth approaches to psycho-social approaches. The Integrated Domestic Abuse Programme (IDAP) course was the first programme available, which was targeted at heterosexual male DVA offenders who posed a medium to high risk of harm towards their partner (National Offender Management Service *et al.*, 2015). Subsequently, the Community Domestic Violence Programme (CDVP) was introduced. The



main difference between these programmes was that IDAP was based on the Duluth model of DVA (as outlined earlier), whereas the CDVP was based on cognitive behavioural techniques. Both these programmes were evaluated against each other by the National Offender Management Service in 2015 and, as shown below, both showed a significant improvement in terms of reduced reoffending rates, with the rates of the non-Duluth model, the CDVP, showing slightly higher rates of effectiveness.

Table 2: Reoffending rates by programme

Type of Reoffending	Programme	Reoffending rate (2 yr %)		
		Treatment Group	Control group	Observed Difference
Any Offence	IDAP	31.0	44.3	13.3* ^a
	CDVP	37.1	49.7	12.7* ^a
	Both	32.3	45.5	13.2* ^a
Core Violence Offence	IDAP	14.7	21.8	7.1* ^a
	CDVP	17.6	20.2	2.6
	Both	15.3	21.8	6.5* ^a
Domestic Violence Offence	IDAP	22.0	33.0	11.0* ^a
	CDVP	25.5	34.9	9.6* ^a
	Both	22.8	33.7	10.9* ^a

* Significant difference observed ($p < 0.05$)

^a Small effect size observed using odds ratio

(National Offender Management Service *et al.*, 2015)

There are currently four distinct programmes which are offered by *Her Majesty Prison and Probation Service*, for convicted offenders either in the community through probation services, or those who are incarcerated. The four options that are available are based on CBT, a BioPsychoSocial (biological, psychological, and social factors) change model, and desistance theory (Her Majesty's Prison and Probation Service, 2019). They are:

- Building Better Relationships is for men assessed as moderate risk in custody and for men assessed as either moderate or high risk in the community
- New Me Strengths is for men assessed as moderate risk who have been identified as having Learning Disabilities and Challenges
- Kaizen is for men assessed as high risk and high need in custody
- Becoming New Me plus is for men assessed as high risk and need who have LDC in custody



(Her Majesty's Prison and Probation Service, 2019)

What is notable about these variety of programmes that are offered by the criminal justice system (CJS) is that they have made a deliberate departure from perpetrator programmes with a feminist underpinning.

This speaks to a growth in evidence that increasingly views DVA perpetration as a medicalised and individual issue rather than as a structural one (Hester & Newman, 2020). In the Duluth model, as discussed previously, DVA is situated as a cause and consequence of gender inequality, with patriarchal power structures centralised. This is in contrast to the psycho-social focus in the state provided interventions discussed herein. Hester and Newman (2020, p. 143) noted the discernible shift towards the focus on the mental state of the perpetrators: "The uptake of psycho-medicalised discourses in relation to offenders, exemplified by use of terms such as 'treatment' rather than punishment". This led them to conclude that, "we have ended up with programmes that may be more tailored to individual men's needs, but that perhaps may ignore the wider contexts of gendered inequality and power over women that sit at the root of IPV" (Hester & Newman, 2020, p. 151).

Children and DVA

Domestic Violence as a child protection issue

DVA has become a central issue for child protection, given it has been a present factor in two-thirds of the serious case reviews where a child has died (Radford *et al.*, 2011). Children who witness DVA are considered under statutory guidelines to suffer emotional and psychological maltreatment, related to Section 31 of the Children Act 1989: impairment suffered from seeing or hearing the ill treatment of another (LSCB, 2016, I. 28.4.2). Thus, seeing or overhearing DVA is recognised as detrimental to children's welfare (Radford *et al.*, 2011). DVA is a complex issue within families as its presence can overlap with a range of other social issues such as substance abuse and mental ill health (Stanley and Humphreys, 2014).



In addition, research has shown that children are more likely to be abused or neglected in homes where DVA is happening. One study found 34.4% of under-18's who had lived with DVA had been abused or neglected, in comparison with 7% of the general child population (Radford *et al.*, 2011). Thus, DVA cannot be seen as an isolated problem for children where it is occurring. In Mullender *et al.*'s (2002) research into children who witness DVA they concluded that the process had culminated in a wider view of DVA as both a child protection issue was also a complex community problem with far reaching consequences. This displays the far-reaching nature of the issue within a home environment.

Child Protection interventions have historically been focused on the mother, "regardless of who is the alleged perpetrator" (Daniel and Taylor, 1999, p. 210). Statutory safeguarding guidance explicitly notes that experiencing domestic violence "may diminish a mother's capacity to protect her child/ren" (LSCB, 2016). The invisibility of fathers/perpetrators in child protection interventions has been labelled a "form of mother-blaming" (Katz, 2015, p. 73). This is because the onus to protect the child is placed on the abused mother, who is then held responsible for "failure to protect" if children are then harmed (Lapierre, 2008; Katz, 2015). Holding an abuse victim responsible for their abuser is problematic as being abused can impact on their parenting capacity (LSCB, 2016) and "space for action" (Kelly, 2003).

Social Work Perspectives on DVA Perpetrator Work

Social work is grounded in evidence-based practice, and DVA now comes under the umbrella term 'adverse childhood experiences' known as ACEs, and have an increased likelihood of negatively impacting a child's development and increasing their risks of experiencing such issues as mental health and substance use problems in later life (Kitzmann *et al.*, 2003; Chapman *et al.*, 2004; Bellis *et al.*, 2014). Social services are expected to adhere to the NICE quality standard for DVA which specifies that "services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway. A person-centred, integrated approach to providing services is fundamental to delivering high-quality care to people experiencing or perpetrating domestic violence and abuse" (National Institute for Health and Care Excellence, 2016, p. 8). However, one study that investigated 184 families notified by the police to children's services in two English authorities found that due to the nature of work, and limited time period for completing initial assessments, social workers do



not often have much engagement with perpetrators of DVA (Stanley *et al.*, 2011). The same study found that safeguarding teams had more interaction with perpetrators, but that interactions varied widely across cases. The reasons for this lack of engagement included concerns about staff safety, time limitations, the extent of their involvement with the children and the lack of available services for them (Stanley *et al.*, 2011).

Some studies have shown that female victims of DVA see social workers as a threat (Robbins and Cook, 2018), rather than someone they can trust. In this study a number of participants stated that social workers were more focussed on victim blaming and the victim/survivors parenting skills than they were on the actions of the perpetrator, particularly if they are not engaging with services. The pressure is put on the mother to keep the children 'safe' rather than from the 'father' to stop being abusive. This indicates there is an enduring societal culture that practised mother-child relationships and suggested this would also impact social work practice (Philip, Clifton and Brandon, 2019). In their questionnaire several participants noted that a change they would like to see was for the perpetrator to be the one who had to leave the situation, as often they felt it was the mother's responsibility to leave. Another recent study showed that the need for the focus to be on child protection, and the lack of resources to support perpetrators, meant that although social workers were often left with the only option of asking the mother to leave their abusive partner, and that many found this a frustration as it went against inherent social work values (Witt and Diaz, 2019). Although it is understandable that social workers should focus on a child's safety in such situations, such fixation can have a negative impact on the mother's willingness to engage with services, and absolves the perpetrator from having to change their actions.

Whole Family Interventions- The example of the 'For Baby's Sake' Programme

'For Baby's Sake' was a pilot voluntary programme working within a whole family DVA intervention. The aim of the project was to reach pregnant women and parents of children aged under two years. The programme was novel in its approach as it worked explicitly with the "entire cycle and history of domestic violence and abuse, identifying and directly addressing the trauma or traumas that lie at the heart of the problem" (Kings College London & The Stefanou Foundation, 2019, p. 1). The programme named this the 'inner child model' which looks at the adults' childhood experiences and the impact that they have on current



relationships. The 'For Baby's Sake' programme is similar to the *Her Majesty's Prison and Probation Service* (HMPPS) discussed earlier which has deliberately departed from the Duluth model with a focus on feminist practice, but rather adopts an individualised psycho-social approach to DVA. Facilitators reject the terminology of 'victim' and 'perpetrator' as fathers find this 'blaming' (Kings College London & The Stefanou Foundation, 2019). Instead, they focus on the role of the parents in relation to their child and each other.

Conclusion

In the review of current strategic directions with policy and legislation in the UK there is evidence of a growing momentum within perpetrator programmes, with recent increase in funding for perpetrator interventions, and with the raft of both legal and supportive measures included in the Domestic Abuse Bill. However, as shown in RESPECT's 'Call to Action' there is a sense within the perpetrator sector that there is an enduring 'postcode lottery' in terms of both funding and provision across the UK. The Istanbul Convention has still not been ratified and so although the UK Government claims that proposed measures in the Bill will meet and go beyond their obligations to the Convention, there remains a reticence to sign up to the full legal responsibility of the terms in the Convention.

Another theme that has arisen in the analysis of current interventions is that there is a varied take up of feminist interventions. Some of these are based on the Duluth model, advocated by proponents of the CCR Model including RESPECT, the national perpetrator organisation. However, as was also evidenced above, there has been a growing move to more individualised and psycho-social models, particularly by HMPPS, as well as some whole family interventions. This demonstrates that there remains a disconnect between focusing on patriarchal structures as a core tenet of DVA in opposition to a medicalised model. This is a theme which will be returned to in the fieldwork findings.



Methodology

Ethics Procedure

Prior to any fieldwork being carried out the fieldwork methods and associated documents (see appendices) went through the rigorous BU's ethics procedures. The fieldwork protocol in the UK was repeated in the data collection processes in the partner countries (Greece, Cyprus, Italy, and Romania) and which will be reported on in more detail as a collective in *the OSSPC Time to Change Report* (Forthcoming).

The following data collection methods were conducted:

- Interviews with perpetrator of DVA
- Focus groups with professionals working in the field of DVA
- Online survey with survivors of DVA
- Analysis of available national crime data

Sampling

Before considering the findings, it is important to consider how the sampling strategy impacted on the results. The victims survey was distributed by social media, in particular Twitter, as a result of the C-19 pandemic. The impact that this had on our findings was that we disproportionately accessed respondents who had not received services when they experienced DVA. Perpetrator interviews were facilitated through negotiation with our local partners: The Hampton Trust, and so these were men who had accessed a significant group work programme. Our focus groups were populated by a wide range of professionals, including health workers (midwives), Social Workers, specialist DVA professionals (both victim and perpetrator services), and DVA Coordinators.

Qualitative Data Analysis Process

The fieldwork consisted of a blend of both qualitative and quantitative data. The qualitative data was coded thematically according to the project outcomes and dominant themes that



occurred (See Appendix 4). This was coded using CATMA, a textual data analysis tool developed by the University of Hamburg which enabled joint coding by the research team, with oversight by the Principal Investigator (Levell).

Quantitative Data Analysis Process

Descriptive statistical analysis was used for quantitative data. The questionnaire data was exported from the JISC Online System and imported into SPSS for analysis. SPSS allows for transparency in the analysis process whilst providing a clear audit trail. Data cleaning was used to edit the raw research data to identify and clear out any data points that could hamper the accuracy of the results. Descriptive analysis was undertaken to summarize the data and find patterns and inferential analysis conducted to identify any potential multiple relationships between variables, with a specific focus on factors that might influence or indicate types of support desired. Tests to identify if the data is parametric or nonparametric were used to ascertain which tests need to be used for the inferential analysis. As it had been decided not to mandate some questions it was assumed that some people may have chosen not to answer a number of questions, therefore the data analysis would not be a whole case analysis, but the findings would be presented with the 'n' given when there was missing data.

The research was conducted between June and October 2020. There were a number of limitations for the data collection, as it the researchers chose not to seek participants for the perpetrator interviews via social media, as it was assumed that this participant group would be unlikely to self-identify and therefore sought participants via the Hampton Trust. This meant that those who participated had already started some sort of intervention.

Findings and Data Analysis

Victim Survey

A questionnaire was devised to seek out survivors' perspectives on their own experiences of interacting with support services, and their views on and experiences of the support offered to



the abuser. The questionnaire consisted of both quantitative and qualitative questions. The questionnaire was promoted online and completed by 24 UK participants (**Error! Reference source not found.** Ethnicity).

Table 0-1 Ethnicity of questionnaire participants

Ethnicity	Frequency
White British	13
British	2
White	7
British Indian	1
White Irish	1
Total	24

Of the 24 participants who filled in the questionnaire, two were male and 22 were female. In 22 cases the 'abusers' for the female survivors were male. Both male survivors experienced abuse from female perpetrators. The range of ages for participants was from 27 – 66 (Mean age 41, Median 39.5, Mode 38).

Barriers to Accessing Support

'I never accessed help. Hid the abuse as I was too scared/ashamed' (Trixie)

Participants reported a range of experiences when accessing support, but the consensus in our sample was that survivors had spent a significant amount of time in the abusive relationship. Several participants commented on the support that was most effective for them. The range of services that provided effective support was quite diverse and included: police, counselling services, social services, community health visitors and friends. Types of support that helped included target hardening assessments, legal advice, cognitive behavioural therapy, being believed, DVA workshops, and having a personal alarm.

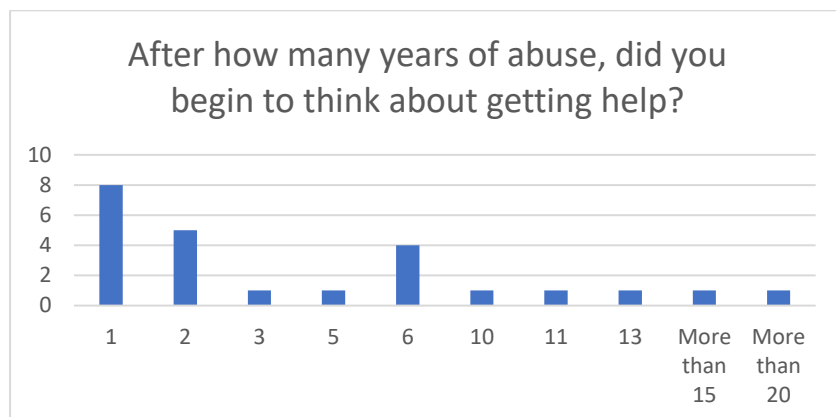


Figure 0-1 Years before accessing help

As can be seen in the graph above, the majority of the victims that took part in the survey had spent a year or more within the abusive relationship, with several spending in excess of a decade. The majority of participants (n=13) sought support in the first two years of experiencing abuse. When reflecting on the barriers that kept them from accessing support a variety of reasons were identified. The majority of participants said they were unable to access DVA support when they needed it (n = 15), they did not know where to get help (n = 13), and they did not feel it was offered at the right time (n= 13). Just over half (n = 13) indicated they did not feel there was a 'good general awareness' of DVA as a social problem in their community. As can be seen, the majority of the people who took part in the survey did not have an easy pathway to support for DVA, which possibly contributed to the length of time they experienced DVA.

Some participants who reached out for support found that the immediate support was ineffective in a variety of ways. Some reported that it did not take into account any domestic abuse and/or violence or coercive control. Other responses included victim blaming, inaccessible or unhelpful responses, being listened to but offered no further support, and not being believed. One participant describes a negative experience of a DVA specialist helpline;

"I called a DVA helpline - it was horrific and caused me a lot of emotional distress. The person on the phone line tried to relate to my experience and justify the behaviour of my partner. She told me "there was nothing I could do" - if he wanted to turn up and take the children he could. She made me feel guilty for not understanding my husband's own needs. Worst experience I had through this process - stopped me getting further help for another 6 months." (Joyce)



This exemplifies the importance of a positive and helpful response to the victim's initial disclosure. For this victim-survivor, they experienced another six months in the abusive relationship after this initial negative experience as a result of the outcome of the call.

Ineffective Health Responses

'The locum doc recorded it as marital issues' (Constance)

One issue raised was that non-specialist services, such as support sought from general medical practitioners (GPs), failed to recognise the abuse being reported to them:

'I told my GP. We got couples counselling but the coercive control and threats of violence were not revealed.' (Rhianna)

'I went through 5 years of therapy, referrals to psychiatrists, being diagnosed with severe mental illness which affected my studies, work, health, was put on anti-psychotics and at no point did anyone investigate more or ask more about the relationship I was in. GPs dealt with my huge weight loss, followed by weight gain, my physical health and mental health issues and again, at no point questioned the relationship or investigate, leading to an explanation of coercive control. I could have been helped. I could have had the lightbulb moment years before I did.' (Carol)

'I also spoke to my GP, who prescribed me with antidepressants, which were not helpful.' (Sheila)

Such experiences mean that unsurprisingly one participant focussed on a need to train GPs to understand DVA:

'Medical students should be told of the seriousness of abuse in marriage and how to respond appropriately.' (Joyce)

For some participants, although they knew and potentially had accessed to services, they could not access peer group support services, either because services were only available during working hours only, or because of a lack of social housing, or housing restrictions around having pets. Another noted that the services themselves were also under resourced:



'I was shattered and it took ages to ring up places and be told they couldn't help - mostly because they were already too overwhelmed.' (Charlotte)

The two male victims had similar experiences in that there was no support available for them. One stated that he was believed by all the services he contacted but there was no service to support him, the other stated that all support was offered to his female partner.

A number of participants stated that they were not believed when they reached out for support. For example:

'Social work had no clue about it and were patronising & judgemental, sheriff in court couldn't see I was being coerced into dropping bail etc (no one asked me what I wanted), lack of understanding by male police who could be patronising and supportive of abuser' (Felicity)

Victim blaming

This process of victim blaming was not just experienced by those accessing statutory support, one participant noted that their counsellor sided with the perpetrator:

'Early in our relationship we had couples counselling - the 'counsellor' sided with my abusive partner. He completely charmed her' (Constance)

Another point raised was that the focus often seemed to be on the women, whether that was blaming them for being a poor mother or expecting them to make significant life changes to leave their own home and the situation, and therefore not addressing the actual problem, but instead allowing the perpetrator to move on and continue to perpetrate:

'More needs to be done, the pressure is always put on the victim to do stuff to change their lives whilst the abuser moves on to the next' (Felicity)

Patriarchal Value Judgements

A further theme that arose from the data was linked to the impact and values underpinning a patriarchal structure and system. Support services such as GPs offered marriage guidance



counselling; religious leaders and family and friends supported the maintenance of the marriage and support services failed to believe that the perpetrator would have behaved in such a way or placed the responsibility on the mother to protect the children. The participants emphasised that societal, religious and cultural beliefs and values pertaining to traditional roles of men and women were often at the root of the ineffective support, victim blaming and stigma as the following examples highlight:

'Stereotypes, misogyny and sexism and racism by police meant my abuser never arrested, despite him threatening my and my child's life.' (Reena)

'She made me feel guilty for not understanding my husbands own needs...needed to get a divorce but was scared to because of my faith. And lastly the estate agent initially told me I couldn't end the joint tenancy without his approval and made it obvious they felt sorry for him when I said I was leaving him without his consent.' (Joyce)

This stereotyping also negatively impacted upon male victims, as one participant reported that speaking out made other people uncomfortable due to his gender:

'People get very uncomfortable when I say that I was abused; that I was beaten; I was attacked with scissors; I was belittled and treated as a slave. They think I should keep quiet, because she was a woman and I'm a man.' (Frank)

The structures within a patriarchal society also impacted on him as even though he was believed by services, those services appeared unable to offer support to men:

'Social Services believed me that I was being abused; Children's Services believed me that I was being abused; my GP believed me that I was being abused; and the police believed me that I was being abused. But despite believing me, they didn't believe they should do anything about it...' (Frank)

One participant felt that media representation of men and women in social media impacted not just on women, but also on the willingness of a perpetrator wanting to seek support, due to the stigma and judgement received:

'On social media if someone has been perpetrating violence against a woman, there, there a wife beater, and they're not ever going to want to stick their hand forward and say, Actually, that was me too mate, and ... have a conversation...I can't see anyone ever receiving a self-referral from a perpetrator into a service at this moment in time. I



think without an agency referral perhaps first because of because of the media.'
(Rachel)

These findings presented from the questionnaire are in line with existing academic and policy literature, including victim-survivors difficulties with accessing support services, experiences with professionals, stigma and pressure from families, friend and religious community leaders and not being believed (Bostock, Plumpton and Pratt, 2009; Cerulli *et al.*, 2012; Brem *et al.*, 2019; Laskey, Bates and Taylor, 2019; Idriss, 2020; Ragavan *et al.*, 2020). As such, they contribute to the existing knowledge database in this field of research and policy. However, a crucial outcome from this data was that half of the participants said that if the abuse had ended, they would have stayed in the relationship (see Figure 0-1 Years before accessing help). This highlights the complexity of the issues and experiences of victim-survivors and perpetrators.

Criminal Justice System Interventions

Of our sample 10 out of the 24 participants contacted the police. Of those that did, one person stated they had called more than 25 times, and a further two people said they called too many times to count. Just over half of the participants had experience of involvement with criminal justice services (n =13). Eleven participants reported that did not find the criminal justice services helpful, effective (n = 10) or vital to their safety (n =12), and only four participants stated it was vital to their safety. 20 participants stated that their abusive partner was not held accountable for their actions through the criminal justice response.

A number of participants reported that the support from the police was unhelpful or lacked knowledge:

'Police didn't take a statement from me at any time. They listened to my abuser, even when I called them out to plead for help as abuser was threatening to throw my baby down the stairs. No follow up ever. And they wouldn't give me access to my 999 calls for me to use as evidence in courts.' (Victoria)

'Police had no knowledge about DA housing had no knowledge of DA and I felt very alone and like my only option was to stay' (Pearl)



A number of survivors reported that they felt they were being blamed rather than the actions for the perpetrator. For some that was linked to being accused of poor parenting or of antagonising their perpetrator, as the following quotes illustrate:

'One particular officer asked me...what do I think I did to antagonise him to the point of physical assault' (Kylie)

'Nothing, police weren't helpful, social services repeatedly threatened to remove my children despite continuous attempts to remove my abuser from our lives. Police charged me with malicious communications after texting him to fuck off and leave us alone, but refused to help when I was being physically, emotionally and financially abused!' (Mary)

The findings highlighted that the physical violence did not encompass the whole experience of what it was to be a survivor of DVA, as many participants also noted the impact of controlling behaviours. UK law has recently changed to enshrine within it the concept of coercive control (Section 76 of the Serious Crime Act 2015). However, this does raise the question how well prepared the CJS is to be able to prosecute for coercive control or whether the system remains focussed on physical violence. Moreover, it could be that those living within an abusive relationship also do not recognise or do not have the language to describe coercive control and this is borne out through some of the statements below.

Effective Support

A number of the survivors reported that change only happened for them after they had either realised, either by themselves, or with the support from friends and family, that they were in an abusive relationship and experiencing coercive control:

'The discovery of just how abusive the relationship was. I suddenly had a lightbulb moment of no longer feeling confused. The community nurse immediately referring me to women's aid 6 months after the relationship ended. She asked direct questions which meant I opened up to her. The arts helped me understand, recognise and empathise what coercive control was.' (Carol)



'Support from blue light charity to make my home safe and had a personal alarm direct to the police. Social Services gave me 1-2-1 DVA workshop. My employer made arrangements for parking closer to the building and escorts in and out.' (Pearl)

Attitudes to Perpetrator Interventions

'Offer help but if they don't take it, lock them up.' (Pearl)

All the participants strongly agreed that for an abuser to accept help, they needed to realise there is a problem with their behaviour. Half the participants felt that their abusive partner could have been helped if the right support had been available and eight felt that such support would have made a difference. The participants were asked for their suggestions on how the perpetrators of abuse were responded to. Of the 22 participants that answered this question, only three suggested that they needed help and that support was linked to the need to change their behaviours. The remaining answers focussed on the perpetrator being penalised, recognising the manipulative behaviour of perpetrators, victims to be taken seriously and believed and addressing underlying societal issues that allows for toxic masculinity and such abuse to continue e.g.

*'Male toxicity ***needs to be addressed from an early age. Entitlement, power, all of it is cultural and societal and it won't change until we start with young people who will make the change.'* (Reena)

When it came to support for perpetrators, participants agreed that for support to be effective it must include a focus on the need for perpetrators to change their behaviours. In the qualitative comments participants emphasised the need for perpetrators to be brought to justice for their crimes and for society to see DVA as a crime:

'lying and manipulation - has to be recognised by the authorities dealing with them. I would also say that action against abusers should be swift and decisive - or they just carry on.' (Tina)



Although there were also some less punitive suggestions regarding support that should be offered

'abusers offered counselling and advice to manage their anger. They should be removed from home for an appropriate period. There should be zero tolerance of violence.' (Tina)

'There needs to be more focus on changing the behaviour of perpetrators, alongside programmes which help' (Sheila)

Moreover, one participant also felt that for the issue to be addressed effectively it needed a deeper societal solution, which aligned to the theme of the impact of patriarchy:

'Entitlement, power, all of it is cultural and societal and it won't change until we start with young people who will make the change.' (Reena)

Half the participants stated that if the abuse had stopped, they would have stayed in the relationship (Figure 0-2).

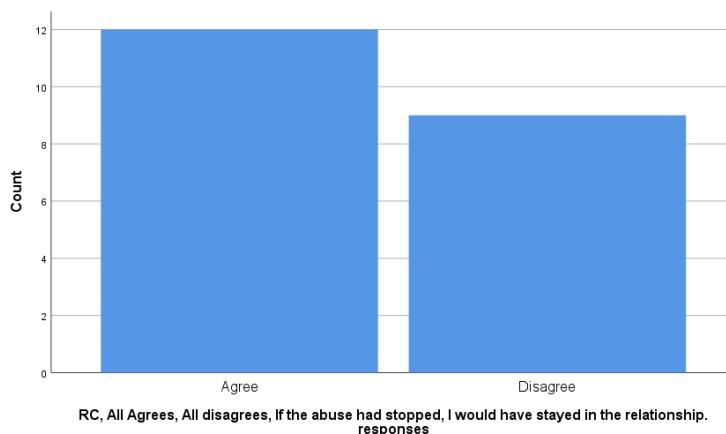


Figure 0-2 Stayed if the abuse had stopped

Only two participants stated that their abusive partner had been offered any support to change their behaviour. Three quarters of the participants said they would have preferred to have accessed support for themselves, their abusive partner, and (where applicable) children. The majority of the participants did not agree with the statement that if the violence stopped the relationship was fine (Figure 0-3).

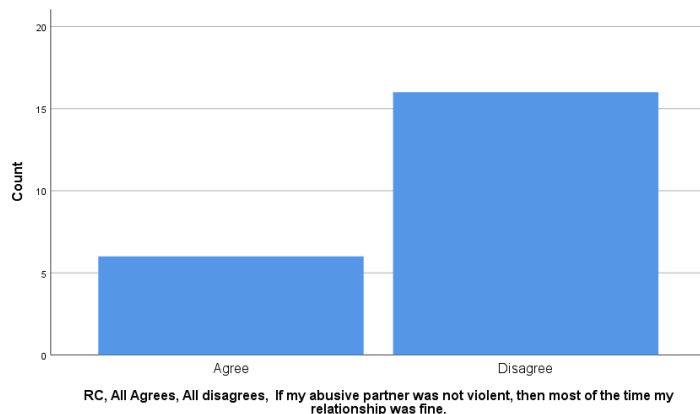


Figure 0-3 Violence in the relationship

Conclusion: Victim Surveys

In the sample of respondents to the victims survey the majority had not had a positive or supportive intervention when they experienced DVA. This was reflected in the length of time that they remained in the abusive relationship, as well as the varied testimonies of inappropriate and ineffective responses to their initial disclosures. The threads that ran through these experiences were those of receiving responses to disclosure about DVA which showed patriarchal and traditional gendered assumptions about the roles of men and women in relationships and marriage. This was raised by some religious leaders and family/friends support networks, but also in some less expected places such as GPs who offered 'marriage guidance counselling'. The participants highlighted that societal, religious and cultural beliefs and values pertaining to traditional roles of men and women often were at the root of the ineffective support, victim blaming and stigma. This suggests there is a double bind, where victims are having the same structural gender inequality reinforced when they sought help. It raises concerns about how permeable and ubiquitous sexism is within wider society.

When victims were asked about their views of perpetrator interventions, this was a sensitive area. Not least because as outlined initially, the majority of respondents had not received effective support themselves. Half of the participants thought there would have been potential for the perpetrator to change if they had been offered effective support, however most sought an effective CJS response which would have made the violence stop. It appears the reality though is that, even when the police are called to intervene, this seldom results in a significant CJS intervention. Key messages from the victims' perspective urged for the perpetrator to be penalised, recognising the manipulative behaviour of perpetrators, victims to be taken

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seriously and believed and addressing underlying societal issues that allows for toxic masculinity and such abuse to continue.



Professional Focus Groups

“There’s a lot of people who didn’t treat coronavirus sensible, and seriously until they started losing people as a result... People do not take domestic violence seriously because it doesn’t affect them”

Focus group is a method of interview that involves several participants instead of one, with an emphasis on interaction, discussion and how participants respond to and interact with each other. They often result in more open discussion on sensitive issues because of their communal setting, (Madriz, 2003). Focus groups are designed to reflect the processes through which meaning and interpretation are constructed in everyday life, and the researcher acts as facilitator to guide the group discussion, encourage responses and elicit a range of views (Tombs, 2000; Bryman, 2004).

Methodology

The aim of the focus groups was to engage with stakeholder and key informant professional participants to gauge their opinions on best practice and challenges in addressing DVA in their respective fields. Eight focus groups were conducted in the UK study, which included 36 participants with backgrounds in social work, police, local authority, midwifery, statutory and voluntary agencies. All participants had experience in supporting either survivors or perpetrators of DVA. Each focus group was facilitated by two research team members on Teams or Zoom, recorded and transcribed, with detailed notes also taken in case of malfunctioning software. Transcriptions were then checked by the Research Assistant and data was analysed using CATMA data analysis software.

The focus groups ranged from between 50-60 minutes and were designed to be semi-structured, with a clear but open-ended topic guide and vignettes. Three vignettes were introduced in the first part of the session, followed by scoping questions designed to probe participants’ awareness of current best practice as well as gaps in service provision. Vignettes describe hypothetical scenarios designed to solicit participants’ professional views and



opinions and encourage discussion and debate. They were distributed to focus group participants in advance of the session, to enable greater reflection, and also presented within the 'Chat' function in the sessions themselves.

As with all forms of data collection, participants were provided with an information sheet and consent form in advance of the focus groups, which were also discussed in the sessions. Written consent was obtained from all participants and they were reminded of their right to withdraw from the project at any time. Focus groups were analysed by two members of the research team independently and then checked by another team member to ensure intra-coder and inter-coder reliability. Any disagreement between research team members was discussed until agreement was reached. Analysis was conducted in line with the key aims of the project and categorising these into key thematic areas. Pseudonyms have been used to maintain participant's anonymity.

Findings

As stated above, participants come from a range of professional backgrounds and geographical locations and as such described what happens in their own areas of expertise. There is an array of good practice interventions currently in use, but below is a summary of participants' views on what is currently being offered to DVA perpetrators and victim survivors. However, what is on offer is piecemeal as some regions have multiple pathway programmes, whereas other participants report having little or no provision at all for perpetrators. There is no "blanket approach" to programmes nationally and extensive gaps in funding that exacerbate this issue (see also Barriers below). The main messages from the participants included the need for early, tailored interventions and education programmes to support children and adults.

Successful interventions and programmes

A number of successful criminal justice initiatives were discussed, including Domestic Violence Protection Notices (DVPN) and Domestic Violence Protection Orders (DVPO) which provide protection for victim-survivors. One of the consequences of these can be the removal



of the perpetrator from their home accommodation. Whilst this provides immediate refuge for victim-survivors, accommodating adult men is not a priority for social housing services and male perpetrators are therefore likely to be homeless or roofless to accommodate these orders. As discussed in the Barriers section below, the loss of home environment because of this can lead perpetrators to move elsewhere, or to return to their homes, putting victim-survivors at greater risk.

The CARA programme is another initiative that many participants highlighted as a successful diversion programme, for “low level” offenders. This provides a conditional caution but does require perpetrators to admit to their wrongdoing. Participants highlight how this can be an area “where we struggle sometimes”. Participants were keen to advocate for a roll out of this programme nationally. One participant runs a programme that they describe as “more CBT based” and as a result is goal oriented and “taps into the reasoning skills and thinking skills that most people have” (FG6). They suggest that a CBT approach enables perpetrators to open up quicker and find it easier to “build up a sort of more collaborative approach and communicate respect” through this medium.

Other programmes cited were the “Up to You” programme for perpetrators and “Change for You” which is a behaviour change programme for both men and women who “display abusive behaviour in intimate relationships”. Up to You is about creating healthy relationships and is delivered across Portsmouth, Hampshire, West Sussex, Dorset and Poole, Rotherham and five areas in Scotland. These programmes can take between 10 weeks to a year in terms of delivery. The ICON programme was mentioned by those working in maternity and post-maternity care, to reduce the risk of harm to babies, as well as the “You, Me and Baby” programme. The Reach programme addresses drug addiction, although participants highlight how with some of these programmes there is a “three strikes” rule which means some perpetrators risk being removed from programmes; there needs to be an acknowledgement that perpetrators often have a chaotic background and adhering to programmes can be challenging. “Community living rooms” are in operation in Bridport and other areas as a safe space for support and ‘chat’.

One participant describes the Change for You programme as follows:

“Our programmes sort of last anywhere between six months to a year and we deliver 25 topics across five different themes of everything from respect to intimidation and coercion. We also provide support to children [who] have been exposed to domestic



abuse as well as women and men who have been abused themselves. Within Change for You we also provide support to partners who are on the... programme” (FG5)

For some participants however interventions are limited to resources within probation services, after a perpetrator has served their sentence. Examples include the ‘Building Better Relationships’ in a region where there are no other programmes on offer. As such, participants describe a ‘postcode lottery’ when it comes to buy in from local service providers, particularly around awareness about issues such as coercive control, with one participant describing their area as “like a desert” because of the lack of support.

STARS is a programme in Dorset that provides support to victim-survivors of sexual violence, and one participant notes that often referrals to them include violence of both sexual and domestic nature. However, STARS is a victim-survivor programme and many participants were quick to point out that there are far greater resources awarded to victim programmes rather than perpetrator ones (discussed further below). For many though, the single point of contact and referral to services is through a police report, which can result in notification to social services if children are involved. One participant describes their work in the police as follows:

“I would say 95% of the time in relation to domestic abuses, the person who’s reported [as having] committed the offence gets arrested” (FG2a)

However, they are only gathering part of the picture as others note there are cultural and social class factors that mean some victim-survivors and perpetrators are not referred to police or other services. One participant notes that there is a gap in provision in terms of ‘middle’ risk:

“We have CARA for low level offenders, I think we do, we do refer in to Up to You... but we seem to be missing this kind of middle range... we obviously have MARAC and everything that we do for the high risk offenders... And I think that just highlights to me how much of that middle, middle gap really that we’re sort of missing in terms of perpetrator programmes in Dorset” (FG5)

Thus, there is a need for innovative approaches to perpetrator programmes, ideally within a holistic environment, as these comments show:

“I think we need to have better responses for perpetrators... more of a CBT type response to perpetrators rather than the Duluth model, which is that generally nationally the preferred model... I think we need to acknowledge that some



perpetrators are – their brains are quite traumatised from their childhood experiences, maybe there's co-dependency because of substance misuse and all these other kinds of layers... we need to look at alternative options for perpetrators, whether it be programmes that [name] offering, whether it be accommodation options that provide holistic support for perpetrators” (FG6)

“a holistic approach... we will see individuals when actually we need to change the system around people, so working with a perpetrator without working with the rest of the family is not much use in many aspects... taking much more family systems, systemic approach to the way we work would be useful... the notion of having a joined up service for families, rather than having a patchy, patchwork service” (FG4)

These points relate directly to the next section on inter-agency cooperation.

Inter-agency collaboration

Working collaboratively inter-agency is a priority for participants. Oftentimes cases are not raised until they are 'high risk' and participants advocate for much earlier interventions wherever possible. Many highlight the 'excellent' work done by multi-agency safeguarding hubs but again this is often within a victim-focussed framework. The MARAC and 'Claire's Law' were similarly mentioned as positive interventions that can be the “starting point to sort of alert them to their partner's previous history” (FG7). However, as participants point out, without a 'cohesive' or 'sequential' response, perpetrators, victim-survivors and their families can fall through the gaps although some cited “colocation” of services as of particular help with inter-agency working. Participants acknowledge that there are limited resources available for perpetrator work, with the majority of funding going to support victim-survivors and admit that “our hands very much tied by what we can be financed to do” (FG4). Nevertheless, there were numerous examples of successful interventions shared within the focus groups.

Good practice included the example of the Hampton Trust working jointly with probation services to provide community based “ADAPT” programmes. Good practice was also noted in Surrey in the collaborative work of a domestic abuse team placed within the police who are available to respond to concerns and call outs. Another participant highlighted how in Hampshire, Portsmouth, Southampton and the Isle of Wight there are health pathways “which run alongside our domestic abuse pathways”, providing therapeutic support for victim-survivors, perpetrators and their children.



Others mention the work that can be done collaboratively in communities, for example, having local Imams helping with training of staff. As one participant stated:

“I think it can be a really difficult kind of cobweb of puzzle pieces to try to get all agencies on the same page, understanding the same kind of terminology, the rationale for why we do what we do in certain remits and what they’ve done...in certain remits” (FG3).

Regardless of where perpetrators are signposted or referred to, many participants highlight a disjointed approach to and between programmes and advocate for a more holistic pathway for perpetrators and their families. Successful programmes work on changing behaviours and reducing re-offending “for all people involved... rather than just focussing on the victim or survivor” (FG4). They also advocate for an incentive or motivation for perpetrators to engage:

“there is often a carrot in some way, shape or form, whether it’s a self-referral to say to, because they want to save their relationship, whether it’s children’s services, they want to maintain contact with their children and have a relationship with their children... because they don’t want to be the same as their dad” (FG3)

“we’ve got ultimatums in place, because we know that that’s – that’s a less appropriate way of movement, which we know we also work with, with a lot of other services – putting those ultimatums in place, particularly if it’s children related, and we spend a lot of time in the initial instances of working with our clients to build up some level of internal motivation” (FG3)

Some participants were working on perpetrator programmes run through the Hampton Trust. Working collaboratively with perpetrators is more likely to succeed, say participants, if that motivation exists internally and is not mandated. They highlight how there is an extensive amount of time spent on ‘conversational work’ to explain what programmes will involve. Their programmes focus on developing awareness of “emotional literacy and start to unpack that kind of thing and try to explore that with him” (FG7). Participants were also keen to stress that those who self-refer are also more motivated than those coming via social care referrals.

Some examples include:

“There has to be some buy in from them, there has to be some agreement that something bad has happened” (FG1)



“it’s very much about sequencing and you’ve got to have the people in the right place at the right time, as much as you possibly can... We’ve got a limited time frame to work with them, but you’ve got to up, you have got to sort of put that in place” (FG4)

As discussed above, many of these programmes are voluntary and could therefore be perceived to be an attractive alternative to a custodial sentence, but there exists a risk that this element of choice may be perceived as less punitive for victim-survivors. Voluntary programmes need to be conscious that they are offering a strong rationale for engagement because of the avoidance of custodial or other sentences and consider the underlying motivations for perpetrators.

Less successful interventions are those which fail to address underlying motivations for certain behaviours and consequently many participants advocate for more focussed engagement with the perpetrator, before events escalate. As one put it, instead of looking at perpetrator actions: “we respond to react to the crisis that comes up” (FG7). Another example is from a participant who describes their social work practice in children’s services as limited to the child alone, meaning:

“we are not continuing to work with the survivor or the person actually at the receiving end of the domestic abuse because actually, we’ve been offering a service to the child, that case” (FG4).

To achieve successful outcomes, participants spoke of engendering trust, honesty, praise, transparency, pro-social modelling and respect. Many perpetrators are described as having little trust in other agencies and work was needed on self-reflection, relationship building and self-realisation. Group work was found to be particularly successful, once clear boundaries and rules were in place, with early intervention a priority. Some participants however talk of the “potential damage” that has been done by previous services and programmes and having to ‘un-do’ harm, and the need to acknowledge that perpetrators may need “as much support as the victim” at times. This was highlighted in the following passage from a perpetrator support worker who explained their model:

“We get to see and work with the whole person... They’re not a perpetrator through and through. They can choose to change that if they want but they, they often [have] never had praise, half of them... quite a lot of them don’t, haven’t had great relationships... So I think that element of prosocial modelling, the – the ability to model those kind of relationships they don’t get from other services... I think that would open



a lot more doors and potentially allow that light bulb moment to come out and come on, a little earlier (FG3)

What is evident from the discussions is the length of time and resources needed to ensure high quality, successful programmes that produce lasting change. When one practitioner leaves, this can result in no one being in a position to carry on that programme and successful interventions are left to 'falter'. Participants repeatedly refer to working with service users for long hours, from those who start with "heckles up" and the input needed to break down barriers. This bespoke work is resource intensive and yet has the potential to produce long-term effects that could consequently reduce state expenditure on long term criminal justice interventions and reduce the likelihood of future victimisation. As one participant states, there is an urgent need "to break that cycle to work with perpetrators, because if you've not got any perpetrators, you don't have any victims" (FG4)

Alternative pathways to referrals

One participant spoke about the IRIS GP training programme which is available to assist GPs to recognise signs and symptoms of DVA. Another referred to a domestic abuse programme they run which takes place over 12 instead of 30 weeks, but which was advertised through doctors' surgeries. Perpetrators could then self-refer to the programme and undergo a screening process before joining. This participant, working in Surrey, describes the programme as "really successful, to the point where we've got additional funding from local councils" to run more groups (FG4). GP referrals were mentioned by a number of participants as a source of early intervention and referral:

"doctors absolutely play a really key part in being, you know, being alert to these factors" (FG5)

Participants advocate for extra training for GPs so they can use the right techniques to identify and refer patients on to other services.

Educational interventions



Many participants called for earlier intervention, involving positive role-modelling, mentoring and education of healthy relationships. Part of this can be done in schools, with some advocating for primary school-aged programmes; others suggesting age 11 upwards. Regardless of age, participants advocated for embedding this practice within the curriculum. One participant highlighted the good practice of an organisation called the Good Lads Initiative which works with schools and colleges, and another talked about the 'Pantosaurus' campaign for younger children.

"it's got to be education. You know about healthy relationships, I think it's got to start there. Because if everybody knows what a good relationship should look like it is much more likely that people will search those good relationships" (FG4)

Funding

There are evident gaps in service provision depending on location. Participants were rightly concerned in some areas that as a result only "extreme cases" were accepted for assessment and noted that the point of intervention was becoming later and later. Partly this is due to limited resources but has an implication in terms of successful outcomes. As discussed previously, all participants advocate for a holistic, early intervention model, when perpetrator actions are less likely to be at the 'extreme' end. They also note the limited funds for perpetrator work generally and a desire to do more with more resources and one participant explains some of the reasons for this:

"I think perpetrator work is not palatable, people do not like giving perpetrator work air time. Victim-survivor work is massive, gets a lot more funding compared to what we get, we get an eight of the funding that is granted in [county]... we'll get a little snippet of the end because it's not a palatable, not seen as a reputable arena to funnel financing... because they don't want to talk about it because it's all taboo" (FG3)

Without these interventions rolled out on a national level, they caution however that "perpetrating behaviour just continues". Participants note that CARA is currently only available in eight forces across the country. Given the gaps in services across regions, participants are keen to see this evaluated and extended.



Barriers to Accessing Services

Participants presented with a wide array of barriers to accessing services, from both the perpetrator and victim-survivor perspectives. Some of these are structural, others within a more individualised or cultural framework. They are summarised below:

- a) **Perpetrators presenting with addiction issues:** A significant barrier that cannot be overcome is that many intervention programmes will not engage with service users who are still using drugs and/or alcohol and are therefore unable to enter onto their programme. As one participant puts it:

“what we say is that we won’t work with anybody who presents as under the influence”
(FG4)

This results in a delay to service provision and the exclusion of potentially vulnerable perpetrators who may have committed to undergoing particularly hard to access intervention programmes.

- b) **Lack of engagement by perpetrators within programmes or services themselves:** At times, this can be because perpetrators are not ready to access support services but there are wider structural issues within this arena. Additionally, it is acknowledged that it is easier to work with victim-survivors than with perpetrators, or that some early intervention programmes are not accessible for all unless for example someone has come to the attention of youth offending teams. Participants point to the value of goal-oriented intervention work but caution that care needs to be taken with this approach as their own perceptions of progress (or lack of) can become a barrier for stability and commitment to the programme, described by one as:

“often a barrier to that sort of progress is their own levels of patience or wish to solve a problem in its entirety, which means that they are setting themselves up to fail” (FG6)

Aligned with this is concern that some programmes could provide ‘better responses’ for perpetrators, rather than the preferred Duluth model, and would be better focused on trauma and the intersections of multiple behavioural, relational and personal factors, perhaps through a ‘CBT’ based approach. One participant suggests: *“maybe*



there's co-dependency because of substance misuse and... it isn't all about gender inequality". This links to the point below:

- c) **Language and terminology surrounding DVA:** Some participants were concerned about the extent that the conceptualisation of the term 'perpetrators' was a barrier in and of itself, associating it with stigma, labelling and stereotyping of individuals. Participants likened it to sex offender terminology and warn that perpetrators are less willing to engage if they are so-labelled, although were clear to state that this is not an excuse for any behaviour. As these participants put it:

"Sometimes it means that people end up actually either absorbing the label or reputation of that area, that it possesses, and it instils within them, the values and attitudes and to some degree the stereotypes that go with it... it's like osmosis, it's seeped into that person's very being" (FG6)

"I'm kind of wondering if the word perpetrator causes an issue as well... it's kind of reinforcing that you've done wrong" (FG2)

"There's a hierarchy isn't there of offences and behaviours of what's acceptable and what's not acceptable, and men more so than women, in my experience, and so sex offending and paedophiles they're bottom... that's the worst of the worst in their mind, and then domestic violence is or abuse to children, or where children have been impacted is above that... so it's got a lot of connotations with it and I think as practitioners, we would all say we have to break that down when meeting these guys" (FG3)

The participants highlight how this 'taboo' contributes to a lack of awareness as to the extent and impact of DVA (see also h) below). There is an understandable reticence in their view about identifying as a DVA perpetrator and some participants would like to see programmes akin to 'cocaine anonymous' or similar, for those who want to engage but don't want to risk being identified and stigmatised. Consequently, some perpetrators prefer to frame their experiences and behaviour in terms of 'mental health problems' and 'anger issues' rather than admitting to perpetrating DVA. By removing



the stigma or taboo associated with DVA, participants felt strongly that will likewise remove the barrier into accessing services.

- d) **Lack of accommodation for perpetrators** means that unless they choose to become homeless, they have no choice but to return to their family home and are potentially at risk of further offending. The provision of accommodation for those on programmes would provide a more holistic avenue for engaging with perpetrators but is constricted by financial barriers (below).
- e) **Financial barriers and gaps in funding** are an inherent problem for practitioners. Aligned to a lack of funding generally are the resulting implications that available spaces on programmes are limited, those that exist have long waiting times and many programmes lack longevity due to financial restrictions. One participant spoke of the 'threshold' of services being raised as a result of lack of funding leading to 'crisis level' before action or support is offered. Another stated, "*we have no services or anything really unless you've got a serious mental illness*", highlighting the extent to which our support services are experiencing extreme financial hardship.
- f) **Translation services:** aligned to the previous point, many participants pointed out that a lack of resources has meant inadequate translation services. The impact of this cannot be under-estimated as one participant highlights how "*without good communication you can't get anywhere*". Another described the current situation with translators as 'really dire' and "*an absolute barrier to getting anybody to do any domestic abuse work*" and emphasised the unaffordability of specialist translation services, resulting in having to avail of services from people who have no training in dealing with DVA issues.
- g) **Inter-agency barriers:** again, linked to financial restrictions are concerns that shared services and inter-agency working are being hampered by insufficient funds. Timely and holistic services need funding to continue to work collaboratively.
- h) **Lack of awareness generally as to the extent of DVA.** This is aligned to perceptions of what 'violence' means, and social constructions of anger, as exemplified in the following example:



“A conversation earlier about how fairly innocuous behaviours can build up to something more extreme over a period of time and then all of a sudden the lines become a bit blurred” (FG3).

Additionally, wider structural class systems mean that certain members of society are less likely to engage in DVA support services or a denial of the problem. One participant speaks of a lack of engagement by ‘high earners’ that refuse to accept they are experiencing or perpetrating DVA and are consequently unaware of how to get access to support. Another participant acknowledges that many people have a fear of social services and see it as a resource to be avoided rather than approached.

Another highlights the lack of engagement at GP/doctor surgery level, suggesting that there should be a shift in promoting support for victim-survivors and their families, and that language could be re-framed to promote the message that support is available. GP services have an opportunity to signpost victim-survivors and perpetrators if they focussed more on identifying underlying causes rather than treating symptoms.

One participant compared DVA to both cancer and C-19, in saying that until it happens to someone known to you, individuals are not taking it seriously. There needs to be greater awareness of the extent of DVA in order for people to be more aware:

“There’s a lot of people who didn’t treat coronavirus sensible, and seriously until they started losing people as a result... People do not take domestic violence seriously because it doesn’t affect them” (FG2a).

Typology of Perpetrators

Perpetrators of DVA were typically described as male, although there was some acknowledgement that female perpetrators also exist. On the whole however the majority of focus group respondents were talking about male perpetrators, including motivations associated with toxic or hegemonic masculinities and issues of power and control. Male perpetrators fall into two categories: serial high-risk offenders who are described as being unable or unwilling to stop, and those who are less high risk and are more likely to be committed to change. Being able to distinguish between the two has implications for funding



and policy making. With regards to motivations for offending, participants cite a history of drug and alcohol misuse and mental ill-health. They highlight how often a 'trigger' or life event such as a loss of a job can lead to depression, addiction or a lack of self-worth. Loss of a job or a family as a result of drug and alcohol misuse or the birth of children can lead to a reaction driven by frustration at their circumstances, which are often conceived of as being out of their control. Participants believe that these events can "make things bubble up to the surface" and provide a trigger for violent outbursts and behaviour where perpetrators are unable to control their anger.

One participant stated that the "vast majority" of perpetrators are serial offenders, with one participant stating that only 14% of perpetrators are first time offenders (although we have not been able to verify this claim). Many participants describe a pattern of repeat violence targeted at different women over a number of years, with one participant stating:

"we look at the perpetrator and his children and he could have from one to ten previous relationships where there's a history of him having a relationship with the first person and there's been DV and then he goes to the next persons, there's DV... and it's really concerning and you're thinking how do we stop this pattern" (FG1)

Perpetrators are conceptualised through dominant hegemonic masculinities framed within wider patriarchal social structures that result in those who lose jobs or homes feeling a sense of injustice that entrenches violent behaviour. Wider social structures that position women as inferior or which does not "recognise equality between genders" are contributing factors for this gendered division of male on female DVA. Participants reflected upon how younger men are exhibiting entrenched attitudes and behaviours as a result of a lack of positive male role model in their early life, socialisation and an inability to construct a reasonable argument without resulting to violence. Some cite gang culture and status as motivating factors in this, others racial or religious values and cultures, as evidenced from the following examples:

"they may have experienced very strong gender roles about what's permissible and not permissible, what people are allowed to do, or hierarchy within relationships" (FG2).



“we live in a society that is anti-women and [we need] to make sure that there’s some education around that” (FG4)

“I’ve worked with cases whereby the man is being pressured by the family to control the woman and actually he’s really upset about it and he’s really uncomfortable, but he’s doing what he perceives is his culture” (FG5)

Perpetrators have different motivations for taking part in intervention programmes; there are those who do it to “get social services off my back” and those who are motivated to change. Participants report that the latter are more likely to achieve successful outcomes. Conversely, participants note that “domestic abuse perpetrators are very, very, very good at manipulating people” (FG4), therefore caution and expertise is required in order to distinguish between the two. One participant, discussing coercive control within DVA, also emphasises the need to identify the motivation underlying the behaviour itself, without which perpetrators may be routed into inappropriate intervention programmes:

“his behaviour is controlling... But from an intervention perspective, I would say this guy’s probably got a ridiculously insecure attachment so he thinks that every time his girlfriend disappears... he’s like, she’s going to leave me... So actually his motivation isn’t to control, his behaviour is controlling” (FG5)

Repeated reference to the triumvirate of drug/alcohol misuse, unemployment and poor mental health underline the importance for early intervention to stop repeat patterns of behaviour. Combined with an inability to control anger issues constructed around an ‘alpha male’ ideology within wider patriarchal social and cultural structures presents a challenge for successful perpetrator intervention programmes. However, those interventions that are well informed, holistic and directed towards the underlying motivations for the behaviour in the first instance, and the motivations behind their commitment to change, are most likely to succeed. Participants advocate for improved early education as a key factor in reducing the likelihood of later offending in terms of anger management, developing good relationships and positive sense of self-worth.

Typology of Victims



Victim-survivors were, in the main, conceptualised and stereotyped as women and mothers. There was an acknowledgement by some participants that DVA can be perpetrated towards both men and women, as one participant states: *"it's never been black and white, you know, there's no such thing as victim and perpetrator as separate people, victim and perpetrator are the same person"* (FG1). For the majority of contributors however there were references to women and children as victim-survivors.

Participants identified patterns of higher risk for potential victims of DVA, particularly for those who are young and feeling constrained by parental control, and for pregnant women. Other factors included drug or alcohol misuse and a family background or upbringing of DVA. Patterns of violence included isolation, control of mobile phones and contacts associated with the concept of coercive control. Participants also acknowledged that for some victim-survivors it can take considerable time to report their experiences and they can be fearful of the first point of contact with support services, particularly if they feel they might end up being criminalised in some way as a result. Aligned to this are media representations of 'victim blaming' and that some victim-survivors are not ready to leave their relationship. Participants acknowledge and admonish the role of media and social media in constructions of victims of DVA. As one suggests *"we're all still victim blaming in mainstream media. Even young people."* (FG6) Another makes reference to a recent high-profile case where a serving police officer was found not guilty of murdering his lover: in the media coverage of the case body cam footage of the officer shows him crying in an ambulance after he's arrested at the scene. As one participant notes: *"what's the relevance of that, what message is that sending out?"*.

One focus group participants' views were at odds with other responses. One participant describes victim-survivors as *'a bit weak'* and a *'bit needy'* and distinguishes between 'genuine' and 'other' victims of DVA. He also describes what he calls *'serial victims of domestic abuse'* who experience decades of victimisation at the hands of multiple perpetrators. This participant's language is indicative of victim blaming, which is of concern given he is working within the CJS.

In contrast, many participants presented a nuanced and holistic approach to victim-survivors, constructing tailored support and a recognition of the difficulty of leaving relationships and support systems. Seeing the victim-survivors beyond a 'one dimensional' construction was



particularly important for those working in victim services, though there was criticism of social services also:

“I can say this because I’ve worked for them [they] can be really punitive and see the victims in a really one-dimensional way... they’re not seeing this person with all the other potential” (FG4)

The participant adds that identifying and achieving small goals enables a sense of respect, achievement and validation beyond their experiences at the hands of their perpetrator. This in turn conceptualises the victim-survivor in a more holistic framework and beyond ‘focusing on them as a victim’.

Rural DVA Issues and Experiences

Focus group participants reported ‘significant’ and ‘incredible’ regional differences in the distribution and availability of resources for victim-survivors and perpetrators of DVA. They highlighted, for example, how in one region there was just a single social worker who had to make referrals and identify funding for support. Of particular concern were rural areas where participants acknowledged that victim-survivors were likely to encounter greater difficulty in leaving relationships as not only are they leaving their partner or spouse they were likely to have to leave their own town or village to do so, therefore removing themselves from the additional emotional support they had in their own communities. Additionally, they report that victim-survivors are less likely to report their experiences and are at greater risk because of their isolated environment. This can be compounded by limited access to local support services in more rural locations because of lack of regional funding. Victim-survivors in rural locations are therefore experiencing a compounded disadvantage when compared to more urban areas. Aligned to their increased risk are issues of poverty, education and austerity which are affecting many locations in the region.

The Impact of COVID-19 on DVA and DVA Services

Focus group participants acknowledged the difficulty with providing services during and following the C-19 lockdowns. Practitioners and service providers moved quickly to providing



services online or over the phone but encountered challenges in doing so. It became more difficult to engage with perpetrators, alongside an awareness of increased numbers of DVA. At the time of the focus group, some participants were moving back to re-starting face-to-face programmes and say they have had a good level of engagement. One example shared was of a DVA perpetrator whose move to assessment via phone resulted in his decision to withdraw from the programme because the contract had been amended as a result of adjustments in response to C-19. Another participant emphasised how the lockdown itself resulted in increased DVA because individuals were being forced to spend more time inside homes together:

“Why is domestic abuse happening more, because they’re spending more time together... That is the reason that [it] increased during lockdown”. (FG2A)

There was also an awareness that those they were working with needed greater support during the pandemic:

“it’s quite different talking to somebody on the phone than it is in a group room so building up those personal relationships and that sort of genuine interest our facilitators had with our perpetrators in their lives, generally, and what’s been going on has really helped their engagement side of things” (FG4)

Conclusion: Focus Groups

The focus groups with professionals were a rich source of information, possibly due to the wide range of sectors that the participants came from. There was a consistent message across the focus groups which was concerned with the lack of consistent funding and provision across all regions in the UK. Some participants felt their area was well served, whereas others did not have any specialist perpetrator programme in their county. This is clearly a concern, as there needs to be the existence of a referral pathway to provide an intervention to those in need. It was noted that inter-agency collaborations worked well in some cases and there was an acknowledgment that a successful referral needs multi-agency collaboration (hinting at an effective CCR).



In reflecting on interventions participants emphasised the importance of early interventions around gender equality, particularly at primary school age, focusing on positive relationships and role modelling. In terms of the qualities in a perpetrator programme that were desired, there were several participants who noted the importance of holistic approaches, which acknowledge that victim-survivors do not always want to relationship to end but want support to address the behaviour within. There was also lots of discussion around how to mitigate the stigma of attending perpetrator programmes, as well as controversies within the language itself, and whether 'perpetrator' is a suitable or desirable term for support workers to use. This revealed a tension between holding the perpetrator to account for their abusive behaviour and reconciling a desire to break down barriers, stigma and negative labelling. However, alarmingly we did detect some victim blaming discourses that were at times tied up in this desire to empathise with the perpetrator, this was particularly the case from some criminal justice practitioners who showed a predominant focus on physical injury of DVA, and some reticence with labelling someone a perpetrator when they had caused 'minor' injuries.



Perpetrator interviews

Two perpetrators were interviewed in the UK. Access to others was attempted, though this proved unsuccessful despite extensive efforts. Nevertheless, some interesting insights were gleaned, and findings were in line with what has been described in previous research. Participants were asked about their knowledge and experiences of support, and how potentially it could be improved. Thematic analysis identified common themes. These mainly considered the 'current organisational response', 'gaps in provision' and 'barriers to accessing or engaging with services'. There was also consideration of a 'typical presentation'; that is to say, the common features of perpetrators, and finally what was useful to the participant and could be considered areas for potential good future practice – i.e. 'what works'. Each will be discussed in turn.

The Journey to Understanding DVA

Both of the interviewees spoke about their perceptions of the patterns of behaviour that led to their abusive relationships. Given there were only two, they are referred to as P1 and P2 below. As can be seen in the excerpts, they were very much focused on their own behaviour rather than on that of their partners. They brought forward a range of explanations, including experiencing DVA themselves in childhood, stress, bereavement, and alcohol use as ways to understand what led them to their own abusive behaviour. Reflecting on the reasons they gave, it was clear that the participants were not locating the blame or source of the abuse in their partners, however they were still seeking to externalise the behaviour through outside justifications. In an attempt to distance himself from responsibility, P1 refers to perpetrators as 'they' (meaning 'others'):

"I don't think they necessarily want to be violent; I don't think they want to be" (P1)

Interviewees discussed how the arguments they had with their partners reflected what they witnessed between their parents. This brought back negative feelings, as well as guilt that they could be doing the same to their children. One described his mum shaking him so

"I didn't see what I was doing as perhaps as bad as I should have done" (P2)



The other explained

*“if you’ve been raised in – around domestic violence it becomes normal behaviour”
(P1)*

A key, repeated theme in P2 was stress as a trigger – from a demanding job, driving long distances, stressful situations, things not going to plan or generally having lack of control. However rather than merely ‘letting off steam’, P2 learnt that such projection led to his family dreading him coming home. Now he states *“I don’t try and have the last word all the time”*. Externalisation of blame was articulated in different guises – blaming alcohol, loss (of a parent) and other forms of victimisation – with vocabulary such as having been ‘targeted’ ‘heartbroken’, ‘dumbstruck’ or ‘stonewalled’ described as explaining their behaviour.

“I was drinking every day...I might have said things I didn’t mean to say” (P2).

The use of the term ‘might’ here indicates a tentative connection with responsibility, remaining non-committal about past behaviours without fully owning that he saw his past behaviour as unacceptable. Identification as being a perpetrator of domestic abuse brings negative associations, and effects how they may be perceived by others as *“it’s a horrible, horrible title”*. Both the participants talked about how the negative connotations of the term ‘perpetrator’ had impacted on them not wanting to be associated with it. One participant suggested the word ‘perpetrator’ programme could be;

“worded in a different way maybe ‘protecting each other from domestic violence’”(P1)

However, this alternative language seeks to frame DVA as an issue which was bidirectional, which was not the reality that was described in the interview. However, specialist support services were praised for not being judgemental when the participant disclosed their circumstances.

*“it’s nice to know people are aware that they are not going to necessarily be judged”
(P1)*

The participants recalled how discussing it made them feel when they initially started reaching out to services. One participant talked about feeling “nervous” when he started engaging with support services. Indeed, when the participant had attempted to disclose at a GP surgery previously, he had found himself seeking more challenge and recognition for the disclosure that he was trying to make;



“it was quite hard for me to actually say that [about how low he was when speaking to the GP]...he just made it easy for me to leave...he wasn't really interested” (P)

This comment suggests that when going to the GP to discuss abusive behaviours there was a desire to be recognised and possibly challenged. In ‘making it easy to leave’ it suggests that the disclosure did not have the impact and onward referral to support services that he had sought when making the appointment. Missed opportunities with GPs for perpetrators is a theme that was picked up the review of Domestic Homicide Reviews, discussed earlier in the report.

Linked to the passages above, where external justifications were sought for past violence, there were also discussions about the process of coming to recognise their own behaviours as abusive:

“it's very hard to justify yourself as a domestic abuser...I appreciate you can put a scale to it...but what I did was unacceptable” (P2)

Perpetrators indicated the initial difficulty of seeing themselves as domestic abusers:

“I denied the fact there was anything wrong in my life, because I thought to myself, ‘I haven't hit people’...I had come to the conclusion I was completely in the right...it's only actually when you start listening” (P1)

“I didn't think I had a problem. But now I fully realise, in this whole thing, the only person to blame is me” (P2)

“there must be a good percentage like me that didn't even realise what they were doing was wrong” (P2)

As shown in the testimonies above, the participants highlighted their own victimisation, linking back to theories of social learning – whereby violence becomes a ‘learnt’ and ‘normalised’ response from witnessing or experiencing abuse (Bandura, 1971). In addition, there was a tendency by one participant to repeatedly reflect how his abusive behaviour this was a ‘one off’ minor incident which had resulted in devastating consequences and the loss of his relationship. The difficulty in analysing such information is that the ‘ground (absolute) truth’ is not known. It is known most people are victimised many times before the initial police report (Satyen, L., Supol, M., Ranganathan, A. and Toumbourou, 2020), however it is also known



that police often have a zero tolerance policy and may prosecute on the basis of a lone incident. Previous research has also highlighted perpetrators discussion of ‘one off’ incidents (Kelly and Westmarland, 2016),– however whether this is minimisation of offending (Lea, Auburn and Kibblewhite, 1999) or a reflection of the truth, is unclear. What is important is that this is the perception of perpetrators hence should be considered in any future prevention programmes. In addition, research suggests very early interventions (such as CARA) for those with no prior offences who have committed minor domestic abuse, suggests offenders are less likely to reoffend therefore may elicit change (Cleaver *et al.*, 2019).

What works

Once support is found, perpetrators highlighted its usefulness and described how they used the knowledge to understand what may lead to abuse and utilise tools in order to recognise and change future behaviour. Such reference by perpetrators of the usefulness of practical tools learnt has also been found in other research e.g. (Kelly, Westmarland and Kelly, 2015). This is particularly of note when we recognise helping individual perpetrators is likely to assist and prevent multiple (Donovan, 2010).

Supportive Networks

Accessing support from others was also shown to be an important feature in the participants’ journeys. Both discussed the ways in which their parental roles and social networks were a prominent motivational feature in their journey through the perpetrator programme:

“I have my son with me and that is a massive thing in my life” (P1)

“I’ve been very lucky I have some good friends” (P2)

One participant also noted that their friends were noticing the changes that they were making through taking part in the perpetrator programme. They said, *“lots of my friends regard me now as being a lot calmer”*. A support network was also found through the group programme itself:



“I thought... everyone would be arguing and quite judgemental of each other and things but it actually worked very well [in a group setting]” (P1)

“they [mentors] supported me through” (P1)

“give each other a pat on the back and it all actually works really well” (P1)

Self-awareness and behaviour change

“you can use the tools so that you can actually reply in a non-domestic violence way” (P1)

It is important to consider that, in the small sample of men we spoke to, they had both successfully engaged with a DVA perpetrator programme. One of the most significant changes that they discussed was the importance of development of awareness about their own abusive behaviours. As one participant noted, he found “self-realisation”:

“It’s actually self-realisation which is the best thing. You don’t get told, you realise yourself. And when you can do that you can then change it, which is the best bit of all” (P1)

“a real opportunity to understand me a bit more” (P2)

One of the ways in which the participants talked about the programme working was through positive reinforcement of non-abusive behaviours. They noted that they were offered ‘praise and respect’ for showing a willingness to change their behaviour.

“providing you...integrate to show you are willing to change, you get nothing but praise and respect...it’s not as though you’re...treated below somebody else...you learn to change rather than being told you are rubbish” (P1)

A key area of this work that was discussed in the interviews was the strategies that they had developed in order to manage their own behaviour, in particular when they became agitated. This included self-regulation and awareness of how to change usual reactions:

“I’ve tried to learn how to control myself because it was something I didn’t realise” (P2)

“it’s not easy, I can remind myself the right way to behave” (P1)



*“you cannot change other peoples’ behaviour, you can only change your responses”
(P1)*

*“if you’re not on edge, or nervous, or angry...you can remove yourself from the
situation” (P1)*

“understand that that’s someone’s core belief and that’s okay, they can think that” (P1)

*“it changes your behaviour by the way you think so it just becomes second nature, you
don’t even realise you’re doing it” (P?)*

However, there was also recognition by the participants that changing patterns of behaviour was not easy and: *“it’s not a magic wand....it’s about understanding that life is still full of stresses, you’re still going to feel grumpy sometimes”. (P1)*

“find myself slipping towards...now I do rein myself in” (P2)

Such barriers are examples of how perpetrators often present in similar ways:

“in today’s modern society an app would be really good...it’s time for a timeout, don’t go to the gym because you’re going to generate some adrenalin; don’t drive your car because you might kill someone, go somewhere you know” (P2)

Accessing support from others was also shown to be an important feature in the participants’ journeys. Both discussed the ways in which their parental roles and social networks were a prominent motivational feature in their journey through the perpetrator programme:

“I have my son with me and that is a massive thing in my life” (P1)

“I’ve been very lucky I have some good friends” (P2)

Support was particularly valued from support groups.

“I thought... everyone would be arguing and quite judgemental of each other and things but it actually worked very well [in a group setting]” (P1)

“they [mentors] supported me through” (P1)

“give each other a pat on the back and it all actually works really well” (P1)



Future relationships

There was acknowledgement that many perpetrators were repeat offenders and were violent with more than one partner, as such recognition of future prevention was recognised:

“the course was important because I can take everything that I’ve learnt into my new relationship and I can make sure that that is positive from day one” (P1)

“I wasn’t going to be going somewhere to [consider] maybe how in future I should conduct myself in a relationship” (P2)

“you helped me with my entire life” (P1)

Gaps in Service Provision

In an attempt to compare work in different Countries, and potentially improve services, it was necessary to understand the current organisational response from different viewpoints, including from the perspective of the perpetrator. Whilst there were some phenomenal accolades to support provided by some, other agencies fell short. It was felt that some criminal justice measures were unrealistic, for example never being able to re-enter one’s home. Whilst some initiatives have included re-housing and supporting perpetrators, there have been tensions in giving such resources to perpetrators (Clarke and Wydall, 2013). In addition, contact with health professionals (GPs were cited) appeared missed opportunities at engagement despite research suggesting community co-ordinated response programmes can improve safety (Gondolf, 2002). However, one participant stated as a patient he felt his GP was not interested and merely given medication and a lecture on how to behave. Moreover, these appeared to miss opportunities of referral. Yet when some agencies (such as child services) did refer, identifying and gaining access to relevant services was problematic.

There were obvious gaps in provision presumably due to a lack of resources as outlined in previous research (Coy et al., 2009 in Kelly, Westmarland and Kelly, 2015). Geographically they may not be available, or there may be long waits. The benefits of ongoing support and aftercare were also discussed. Other barriers to getting assistance were identified including



perpetrators initially not recognising their behaviour was wrong. Interviewees highlighted the difficulties in labelling oneself as an abuser. Kelly and Westmarland (2016, p. 20) discuss the importance of self-awareness and recognition it is not just extreme acts of physical violence which are unacceptable and explain that part of the importance of DVPPs is to “change men’s understanding of what violence is”.

Access

Difficulties and geographic differentiation in gaining access to services was highlighted. Comment was made that whilst children’s services may suggest individuals require help, this may not always be available, and if it is, people may not know where to look for it. Ultimately this is due to a lack of resources.

“the main thing I’d change is having more of these courses available....like many things” (P1)

“it’s all down to funding” (P1)

“I found it very hard to find the [Perpetrator Service]. I also found I had to go through a long period before I could actually start my course...six or seven months to start doing the course and it was only by luck I found it” (P2)

“[DVA Perpetrator Service], they are very very good...I can’t help but think it should be mandatory” (P2)

Overall, there were some negative comments in relation to the response from some agencies which indicated a lack of overall support. For example, stipulations of the CJS such as not letting people back into their homes were viewed as unrealistic, and others such as restraining orders daunting, when

“you haven’t done anything to correct me” (P2)

Health and other services were also criticised. For example, a GP prescribed anti-depressants and merely

*“gave me a lecture as to how I shouldn’t have been trying to control my wife”
(P2)*



Timing

Both participants highlighted their wish for ongoing support. P1 noted it would be useful to be able to maintain contact with course providers or group members, and P2 stated he didn't have ongoing support unless he felt he was going to slip up, even though *"I haven't really moved on"*.

In addition

"it feels like it's more of a reactive than a preventative way" (P1)

"If maybe something was done to try and stem...um, domestic violence in the first place, we wouldn't need the money poured into victim support and, more importantly, we wouldn't have the victims" (P1)

Conclusion: Perpetrator Interviews

As can be seen in the interviews with perpetrators, we spoke to a niche sample who had both accessed and successfully engaged in a perpetrator programme. Finding the help initially was discussed by both men as difficult and they described having negative responses from initial disclosures with GPs for instance. Although they offered some suggestions for what could work better, in terms of early intervention, easier access, and shorter waiting lists. Overall, they were very positive about the group work programme that they received and in particular the mentoring aspect where they could access a peer supporter who had also gone through the programme. They talked about their experience of behaviour change and managing their own emotions, which had had wider benefits than just in their intimate relationships but with other family members, work colleagues, and friends. Their stories pay homage to what successful perpetrator interventions can look like when they are successful and can create long term change.



Overview of National Statistics

Macro-Data on Domestic Violence and Abuse.

The Office of National Statistics (ONS) is the Government's official statistical organisation, gathering data from across the UK. Before outlining the most recent ONS data on DVA some qualifying methodological issues need to be aired. By definition, DVA behaviour is illegal and therefore perpetrators will seek to avoid discovery, often manipulating their partners to conclude with them (Katz, Nikupeteri and Laitinen, 2020) and usually it is not until the victimised partner involves the authorities that any indication can be made as to the extent of the problem. For example, in the field of child abuse and neglect (CAN), a two-year regional cohort of all CAN referrals to the police in a 3.5 million population, found only 348 convictions, although no further action was taken on more than 100 initial reports which could not be pursued. This lack of pursual was because the complainant, the female adult partner, withdrew the allegation or refused to be a witness. Moreover, two-thirds of the men convicted were Extra-family assailants, strongly indicating that Within-family assailants were under-represented in the cohort of convicted offenders (Pritchard and Bagley, 2001; Pritchard, 2004). (This means that most of the knowledge of the authorities of CAN and possibly, if not probably, DVA, will be an under-representation of the true prevalence and incidence. This is not a charter for free-associating with numbers as there is some possible control when considering what is known about children in adverse circumstances, where children are often victims of both observing parental DVA, and being involved, as well as the tripartite types of child abuse. Considerable evidence suggests that ACEs lead to a range of psycho-social and educational problems, onwards into adulthood, including DVA (Kitzmann *et al.*, 2003; Chapman *et al.*, 2004; Bellis *et al.*, 2014). Therefore, consideration needs to be given that outline levels of DVA as reported by the ONS (ONS, 2020; Stripe and ONS, 2020) may be a significant underestimate of the extent of the problem, as is seen in as the example of CAN figures above.

Domestic Violence and Abuse in England & Wales 2018-19 (ONS Data)



Data is provided in actual numbers and percent of the population for England & Wales (ONS, 2020). The whole cohort related to both men and women aged 16-74; estimates are given as to 'life-time' and the latest year. One important, but to be expected factor, is the highest rate of DVA is from the 16-24 years olds, than the 25-34 age-band. Table 0-2 presents the ONS data on DVA drawn from the National Crime Survey in England & Wales. It looked at estimate of life-time experience of men and women aged 16-74 and then in the last year available 2018/19, all forms of DVA and Threats/Force (ONS, 2020). This latter category reflects possibly the atmosphere of the relationship but not accurately actual 'violence'. All forms of lifetime DVA for men was 13.6 and 28.4 for women, a male to female ratio of 2.09. For the slightly younger group 16-59 the percentages were 14.0 and 30.5 a ratio of 1: 2.18. In terms of life-time incidence Threats/Force is was 9.1 to 19.4% a ratio of 1:2.13.

In terms of victims of all DVA in the last year, the 16-59 age band was 2.9% for men and 7.6% for women a ratio of 1:2.62. In terms of Threats/Force DVA last year was 1.7% for men and 2.3% for women a ratio of 1:1.35. When what was described as partner abuse in five age-bands, the 16-19's rate was 2.5% to 6.4%, a ratio of 1:2.56, which based on the England & Wales female population meant there were 95,424 teenage women victims. In relation to the highest DVA age band 20-24 the incidence was 3.3 to 6.3%. a ratio of 1:1.90, and this indicated there were 205,920 young women victims of partner DVA perpetrators.

These are substantial numbers but are they an under-estimate? What we can be clearly certain of is that women are the most victimised but not exclusively so; indeed, the rate of men experiencing DVA may surprise some. There is also a point to note here, that societal stigma may be a reason for men under-reporting DVA (Hogan *et al.*, 2012), or that female perpetrators may be more likely to use coercive control than actual violence, and in which case until the recent change in UK law (Serious Crime Act, 2015) this was less likely to be recorded on the crime data.

Crucially in seeking to deal with the problem of DVA, we must not be overly narrow in our concerns as the link between CAN and DVA is now very well established (Holt, Buckley and Whelan, 2008) and requires a brief consideration (Brandon and Thoburn, 2008; Lünemann *et al.*, 2019; Houseman and Semien, 2020).



Table 0-2 Domestic Violence and Abuse by Sex England & Wales 2018/9 (ONS, 2020)

Category	All Ever % Male- Female	Last Year % Male- Female
16-74 DVA	13.6 - 28.4	3.5 - 6.8
Threats/Force	5.5 - 18.1	1.4 - 2.0
16-59 DVA	14.0 - 30.5	2.9 - 7.6
Threats/Force	9.1- 19.4	1.7 - 2.3
Partner Abuse 16-19		2.5 – 6.4
20-24		2.6 – 9.9
25-34		3.3 - 6.3
35-54		3.2 – 5.7
55-74		3.5- 6.6

Domestic Homicide

Based upon ONS data for England & Wales in 2019 from reported crimes, Table 0-2 gives the numbers of the extremes of DVA: homicides by gender (Stripe and ONS, 2020). There were 96 male victims of domestic homicide to 270 women, a male to female ratio of 1:2.81 but crucially partner homicide of 3 to 216 men and women yields ratio of 1:72.0, such is the risk that women carry in DVA situations. The under-16 domestic homicides, de facto include all the CAN related deaths and reflect this general finding of a slight male bias (Pritchard, Davey and Williams, 2013).

Table 0-3 includes various sub-categories going through the courts, which highlights one problem of Home Office statistics as a murder charge may be changed to manslaughter verdict, which can produce apparently contradictory rates of homicides. For example, WHO data, which reports on a nation's final mortality categories is usually four to five years behind the current calendar year, so for WHO data published in 2020, the latest year recorded is for 2015 (World Health Organisation, 2020).



Table 0-3 Domestic Homicides (DH) England & Wales 2016-2018.

Category & Victim	Men	Women	Male: Female Ratio
Total Domestic Homicide (DH)	96	270	1:2.81
Under 16	92	79	1:0.86
`Suspects'			
All Domestic	50	260	1:5.20
Partner DH.	3	216	1:72.0
Male Suspect			
Partner	26	21	1:0.81
Other Family	20	21	1:1.05
Female Suspect			
Partner	40	1	1:0.03
Other Family	3	4	1:1.33
Court Verdicts			
Homicide	119	14	1:0.12
Manslaughter	46	14	1:0.30
Decision Pending	83	15	1:0.18
Not Concluded	62	12	1:0.19
Suspect Suicide	45	2	1:0.04

Children: A Missing Dimension in DVA?

It is now recognised that a warning sign that a child/children may be at risk is the presence of DVA in the home (Stanley *et al.*, 2011; McGuigan, Luchette and Atterholt, 2018). Consequently, we note the number of children recently and currently (2019) under the supervision of the Local Authority via a Child Protection Plan in England & Wales (ONS, 2020). In 2019 there were 52,260 children with a Child Protection Plan, which included all forms of child abuse; emotional, physical and sexual. Within this linked data set is an indication of



relatively good outcomes, of the under 16-year-old homicides, 171 in total, gives an extreme outcome, the death of a child 0-16, of 0.32%. Self-evidently the death of one child from abuse is unacceptable but when compared with other countries in the Global North (Pritchard, Williams and Rosenorn-Lanng, 2019). this is a relatively good indication of the `success' of the inter-disciplinary child protection services, including social work, police, paediatrics, community services. This is a good model for the DVA situation, as internationally compared with the 1970's when violent child abuse was recognised around the Western world (Kempe and Kempe, 1978), Britain was fourth highest of 21 Western countries but is now third lowest and CAN related deaths have never been lower since records began (Pritchard, 1992; Pritchard, Williams and Rosenorn-Lanng, 2019).

Table [3] Children on Child Protection Plan England & Wales – Selective Years (ONS 2020)

Category	All	Neglect	Emotional	Physical	Sexual
2013	43190	17930	13640	4670	2030
2016	50310	23150	17770	4200	2370
2019	52260	25330	18460	4170	2230

The above sets the wider context to explore the qualitative results for the UK OSSPC data.

Key Themes from the Fieldwork

1. Resourcing Pressures

It is unsurprising in the context of the Respect 'Call to Action' and the still not ratified Istanbul Convention, that we also found in our fieldwork that resourcing and funding is an ongoing issue for victims, perpetrators, and professionals. From the victim perspective, few found effective support themselves and even fewer perpetrators experienced an intervention. The perpetrators that we spoke to also noted how difficult it had been to access support, having to wait a significant period of time on a waiting list before they were able to access a group programme. The professionals spoke about frustrations that in some areas there were few pathways to support at all, whereas others were time limited. It is fair to say that the UK context is a 'postcode lottery', whereby the interventions offered rely on the localised contexts of local



commissioning and political will. It also was clear that perpetrator services did not always operate as part of a wider CCR. In fact, two of the Domestic Violence Coordinators who took part in our study noted that their roles were being altered; with one having their role being made redundant and the other having their remit widened away from a specialist VAWG focus. This suggests that even in the context of the new Domestic Violence Bill coming into place soon with the promise of greater political and strategic support behind a national approach, there is wavering localised support for this agenda. We were fortunate to hear in our sample of lots of good work that is occurring, but with the increased demand heightened by C-19 this is likely to be further stretched.

2. The Important Role of Health Services

Health services were discussed in all of our fieldwork streams. More often than not, participants disclosed that victims and perpetrators often present to health services first and often do not receive a good response. From the perspective of the DVA survivors, several discussed going to GP surgeries, disclosing, and then either receiving marriage advice, marriage guidance counselling, or a prescription of antidepressants. This is significant not only due to the missed opportunity for identification of DVA and appropriate onward referral to specialist support, but also because it reveals the blurred lines between recognising DVA as a form of abuse, instead perceiving it as regular marriage troubles. Lack of positive health response was also mentioned in the perpetrator interviews, with one noting 'they made it easy for me to leave [the appointment]', which suggests there was a desire for challenge and recognition of the abuse that was being disclosed. This is not necessarily an easy distinction to make for health professionals as the disclosure itself may have been shrouded in minimising and normalising language, but this emphasised the need for specialist training on this issue. It is important to note here that there are UK based initiatives which provide such training, such as IRIS (<https://irisi.org/>) which provides specialist training and co-located support for health. However, linked to the previous point made, this is again dependent on location and priorities and is not available to all health practitioners. A further health related barrier discussed was the lack of perpetrator services which would work with people who had a substance abuse issue alongside the DVA. This is an ongoing conundrum for both mental health services as well as DVA specialist services, as although the refusal to take a dual



diagnosis referral can make sense from an intervention perspective, it also means that many who need intervention are not able to access it.

3. *Patriarchal and Sexist Attitudes around DVA*

The third finding that ran across all of our data streams was that there is still an on-going presence of patriarchal and sexist attitudes about DVA, which indicate that there is still a widespread understanding of the issue as; (1) private, (2) an extension of generalized marital issues, and (3) a physical injury model whereby if the injuries are not seen as severe then it is an indication that the DVA is thus not severe. It is important to note here that the perpetrators we spoke talked about DVA in a framework that they had learnt on their intervention programs- they both accepted responsibility and did not blame the victim for their behavior. Rather, these sentiments were found in the victim's surveys, where women had found it difficult to be taken seriously when disclosing, which was reflected in the significant amount of time our respondents had spent in the abusive relationship. They talked about receiving advice from professionals which related to traditional gendered heterosexual roles. It was clear that survivors' intersectional identities impacted on their experiences of help-seeking. One survivor talked about the intersectional "*Stereotypes, misogyny and sexism and racism*" which impacted on the police's response to her disclosure. Another talked about the intersection between her religion and not being granted a divorce, instead showing pity on her abuser. Another mentioned that she was made to feel guilty for not attending to her husband's needs, suggesting that she was to blame for the abusive behaviour. We also had a male survivor who took part in the study, who noted that traditional gendered assumptions meant that he was also not recognized as a victim himself.

Concerningly, we also found evidence of sexist and victim blaming attitudes among some of the professionals that we spoke to. This was not the majority, however that this was present at all is concerning. The distinction was made between 'genuine' victims and others, as well as expressions which suggested that minor physical injuries did not constitute 'real' DVA. In the context of the legal change in the UK to account for coercive control, this suggests that this legislation has not had impact, or is taken seriously, by all front-line practitioners on the ground. This highlights a training need, which links to the previous points on inappropriate health responses. We need to reach a point where DVA is mandatory in training for statutory



front line professionals, including health workers, social workers, and the police. This ideally sits within a CCR approach, however as outlined in the first point, without uniform national funding for such local coordination this will continue to be piecemeal and a postcode lottery.

4. *Discomfort in language around 'perpetrators'*

A core theme that emerged across the professional focus groups was a tension between the negative associations with the label 'perpetrator' and the potential impact that may have on people who use abuse in their relationships accessing support. Indeed, many professionals that took part in the focus groups discussed frustrations at the ways in which stigma and negativity brought about by the term 'perpetrator' could inhibit those in need of a service from accessing it. Suggestions ranged from enabling service users to frame their issues as 'mental health problems' or 'anger issues', that would speak in the language that clients used to describe their own issues.

It is important to note that there are similarities here though in the negative ways some survivors spoke about their own disclosures not being taken seriously, or being minimised as marriage issues, as discussed above. There is a risk of professionals seeking to minimise abuse in order to gain the perpetrators trust, which may put into question the effectiveness of the later intervention. It is worth noting here that we also heard rejections of this concern, which broadly became a split between those who were satisfied with a feminist framework around DVA and perpetrator work accepting the term 'perpetrator' and those who framed DVA as an individualised psycho-social issue who rejected the label. The perpetrators who we interviewed noted discomfort at this label being a "*a horrible, horrible title*" and there was the suggestion that it could instead be worded as, "*protecting each other from domestic violence*". As shown in the literature review earlier, there are some programmes which are using a whole family approach where there is not an identified primary client as you see in mainstream perpetrator programmes. However, widening the focus to a relationship dysfunction rather than identifying a core abuser/victim is problematic in terms of the potential for victim blaming, as discussed in the previous point.

This presents an ideological conundrum, which links to the final theme from the fieldwork, discussed next, that there is a tension both within the DVA and wider sectors of whether to frame DVA as a wider structural issue which is related to gender inequality, or whether it is an



individualised issue among those who use violence. This is summarized in this quote from a professional in the focus group;

“I’m kind of wondering if the word perpetrator causes an issue as well... it’s kind of reinforcing that you’ve done wrong” (FG2)

So perhaps the key question is, is it of fundamental importance to a successful perpetrator intervention that the abusive behaviour is labelled as inherently wrong from the outset, or is the successful engagement of the individual with problematic behaviour the priority focus? This is far from a simple question, although it may appear so, as evidenced in the wider literature we are in a situation in the UK where the majority of perpetrators are serial offenders who are seldom held to account through the CJS. Thus, we are in a position of either needing to rely on an increase in self-referrals to support, or a more robust criminal justice response.

5. Focus on Individual over Structural causes and consequences of DVA

It is clear from the earlier review of current UK legislation and dominant support options that there is an increasing movement to offer therapeutic style interventions, in the form of group work programmes, as alternatives to traditional criminal justice sanctions. This can be seen in our local area, where conditional cautions are becoming preferred over simple cautions. Simply speaking, this is a divergence from either no further action from the police on a first offence, or a brief group intervention. As can be seen in the evaluation of CARA, this has shown to be much more effective than the traditional caution was in future violence prevention. It is important to also reflect on the positive testimonies of the men who had accessed perpetrator services. They presented themselves as having realised their wrongdoing, changed their behaviour, and having made positive steps to denounce DVA and their past lifestyles. However, the survivors who took part in our study in the most part expressed a preference for an enhanced criminal justice response. 83% of the survivors who took part felt that the perpetrator had not been held accountable for the abuse through the CJS. 45% did not find the CJS response helpful or vital to their safety. In fact, of our small sample only 16% felt that the CJS has helped in keeping them safe. We heard reports of victim blaming by police officers who had asked what the victim had done to provoke their partner, and another was charged with *‘malicious communications’* herself. There was a general reticence around the perpetrator being offered supportive interventions as an alternative to traditional CJS routes,



however in this context it is also of note that few of the survivors had even been offered support from services themselves.

So where does this leave us if victims seek more of the 'punishment' aspect of the CJS, which is seldom forthcoming (and we can again note here that we heard victim blaming sentiments from some of our criminal justice professional focus group respondents), yet the political drive is to increase supportive community interventions as alternatives? As evidenced in the literature, there is an increasing move to individualised, medicalised, psycho-social interventions for perpetrators rather than the framing of DVA perpetrators within a framework of structural inequality. In the Duluth model, as discussed previously, DVA is situated as a cause and consequence of gender inequality, with patriarchal power structures centralised. This is in contrast to the psycho-social focus in the state provided interventions discussed herein. Hester and Newman (2020, p. 151) noted the discernible shift towards the focus on the mental state of the perpetrators has occurred concurrent with a lens of 'treatment' rather than punishment. This led them to conclude that, "we have ended up with programmes that may be more tailored to individual men's needs, but that perhaps may ignore the wider contexts of gendered inequality and power over women that sit at the root of IPV".

Conclusion

We are at a point in the UK, in terms of prevalence, where we know that the majority of perpetrators are not held to account through the CJS, nor are offered timely supportive interventions. This happens for many reasons as outlined in this report, including lack of consistent funding, lack of a widespread coordinated community response approach, and a lack of specialist knowledge both within the wider community (including health and social work) and even within the criminal justice practitioner themselves at times. We are also in a situation where the Istanbul Convention has still not been ratified and so there is not the legal obligation to provide perpetrator services, and UK wide charities have created a 'Call to Action' to complain that the Domestic Violence Bill does not go far enough in ensuring comprehensive perpetrator provision.

What we do have is a complex network of third sector and criminal justice agencies who are delivering perpetrator work. However as outlined in the literature review, there is an ideological split between those who are RESPECT accredited and operate within a feminist framework and those who use a psycho-social and individualised approach. This was poignant in the



move from HMPPS to depart from using the Duluth model and instead opting for a CBT approach. This tension was reflected in our findings, where the professionals in our focus groups tussled over whether a feminist approach was integral to the work, or whether negative labelling and the use of the Duluth model was limiting both for encouraging service users to sign up, as well as opening up honestly when they accessed the service. The survivors who took part were clear that it was an enhanced criminal justice response and a reduction in victim blaming that was needed, however it seems that the UK trend is not moving towards enhanced punitive sanctions but an enhanced wrap around support package as the ideal solution. As discussed throughout, this is a complex issue. We know that DVA perpetrators are often repeat offenders and so breaking the cycle of abuse is paramount to ceasing DVA altogether, however underlying this is an ideological paradox, as well as a competition over scarce resources. Ideally it would not be a one-or-the-other situation, however the enduring lack of awareness about DVA, and confidence among front-line community, health, and social care practitioners, means that DVA will go on being undetected and neglected and neither victims nor perpetrators will be offered effective and timely help.



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Appendices



Appendix 1: Focus Group Vignettes

Three Vignettes for use with Focus Groups:

Vignette 1: Maria and Tony

Maria and Tony are in their thirties and have been married for four years. Tony is currently taking a break from a job that he said had caused him mental health issues and a persistent back injury, for which he received welfare benefits and self-medicated using cannabis and medicinal painkillers. Maria has post-graduate qualifications and was working in a well-paid position but has just gone on maternity leave as she is pregnant with her first baby.

Since experiencing mental health problems Tony has had several appointments at his local doctors' surgery, where he discussed his concerns with stress and his own anger at home. The doctor prescribed antidepressants. Maria asked Tony and his friends not to smoke cannabis near her. Tony refused. Currently, Tony is also refusing to make any contribution to rent or other living expenses and, when asked, gets angry, yells and throw things, including a computer on one occasion. This scared Maria so she spoke to the midwife, mentioning that she was afraid but trying not to react, trying not to hurt Tony's pride or impact his mental health. The midwife talked with Maria about a referral to social services early support team. Maria agreed and was allocated a keyworker (Jessie).

As there were concerns about the risks of Tony's behaviour concerning the unborn child, the case worker also talked to Tony. At first Tony was not happy to talk about the situation and wanted Maria to stop seeing Jessie, but after a couple of weeks, when he realised that Maria was not going to do this, he agree to talk with the keyworker again, and said he would try to keep his temper under control. A few weeks later, Maria told Jessie that Tony's behaviour had initially improved but shortly after the baby was born Tony became frustrated with the baby's crying and tried to take the baby from Maria. Maria spoke to Jessie and together they were able to convince Tony to access a local support perpetrator programme. Maria gives regular reports to the perpetrator programme facilitators on Tony's progress, and also to Jessie. Six months on and Maria is reporting a marked improvement in Tony's behaviour towards her and the baby.



Vignette 2: Jason and Amy

Jason is twenty-two years old and Amy is seventeen. They have been dating for 6 months. Amy lives with her parents, whereas Jason lives independently.

Amy was very studious when at school, however since starting college and becoming involved with Jason she has shown less interest in her work. She stays out late and her parents are concerned that she has started drinking and possibly using drugs. Amy's parents are not aware that she has asked her doctor for contraception, and Amy knows they would not approve. They have threatened to throw her out of their house if she continues spending time with Jason. If this happens Amy said she will live with Jason.

Jason is a likeable guy who is popular with his peers. As he has a car and lives on his own he often has young people around him and they regularly stay over. He is known for being able to access drugs and is developing a drug dependency. The police were called out to a DVA incident at Tony's home as neighbours reported hearing Amy screaming and shouting. No charges were brought. On another occasion Jason had been seen with his arms around Amy's neck aggressively down an alley way in town late at night. Amy has since told her college health worker that she has experienced sexual violence but wouldn't say with whom.

Amy's college tutor has noticed that she has become very anxious. Jason is constantly calling her and takes notes of her movements when she is away from him, including at the beginning and end of her classes. Her tutor noticed some bruising on her wrists and also on her face but when asked Amy would not talk about it.

Jason has tried to access substance misuse support from his local doctor. A referral was made to a support service who have been in touch with him to offer support. In the meeting with his counsellor he told them that he gets angry when intoxicated and it has sometimes got out of hand. They referred him to a local domestic violence and abuse perpetrator service however they won't work with him whilst he is taking illegal substances. He feels that he is in an impossible situation.



Vignette 3: Lucy and Amil

Lucy and Amil are in a relationship for around 13 years and had four children together. Amil was born in Iraq but moved to the [UK](#) 18 years ago and runs a small business. Amil is committed to his faith and spiritual beliefs, following a rigorous daily worship practice and requiring that their children strictly comply. Lucy works full-time now all the children are at school. She does not want more children but Amil is opposed to contraception on religious grounds. When Lucy raised suggested a vasectomy, Amil refused to consider this option as he said it would make him feel less like a man.

Lucy sought help from her doctor who offered contraception, which she received but never disclosed to Amil because she knew he would object. Recently, Lucy feels a great deal of tension around multiple issues that Amil had strong views about and that Lucy has been unable to discuss with him without it resulting in him shouting and a friend suggested she contact a local women's support service. Lucy did so and explained to the keyworker that Amil exercised a high level of control over her life and also her children's.

The children do hours of prayers in the mornings and evenings, which makes them late for school and behind with their homework. Amil dictates how prayers should be performed, and then often changes the rules without explanation. If the children perform incorrectly, Amil hits them across the face, or swings them around on one arm. While Lucy experiences some physical violence, she says the children were frequent victims and subjected to the constant threat of more severe harm. Lucy told her keyworker (Candy) about a number of specific incidents where Amil had hurt her.

Lucy told Candy, that she feels as if she is always walking on eggshells. She does not have any friends, rarely leaves the house, and does not have her own bank account. Lucy says she loves Amir and wants to stay in the relationship, she just feels Amir needs to be a bit more understanding about her needs. Candy suggested to Lucy that she needed to talk with social services as Lucy had mentioned that her children were experiencing physical harm. Lucy said she understood but was not prepared to talk to them herself. Social services contacted Lucy, who said there was no issue and that she had made up the stories about Amil because they had a row. Amil and the children also said there was no issues when asked. The school and doctor did not have concerns regarding the children. No further action was taken.



Appendix 2: Key Worker Focus Group Questions

Length of Focus group: 45 minutes - 1 hour (maximum)

Focus Group Introductions:

- Remind participants the session is recorded, and they can participate via audio only (i.e. turn their cameras off) if they wish.
- Start recording.
- Confirm that the participants have all read the information sheet and signed the consent form.
- Ask if they have any questions at this stage?

Please ask each participant to introduce themselves by first name, length of time working in this field, who they support, and job title

First half of the focus group: Choose 2 of the vignettes which outline a case. You should allow 15-20 minutes per case for discussion. Vignettes should be sent out in advance, alongside these question prompts:

Vignette Topic Prompts: Questions:

- How does this story compare to types of cases you experience in your professional role?
- At which points could an intervention have been offered?
(Criminal justice system and voluntary options)
- If you could imagine your ideal intervention in this context, to end the DVA and offer support to both the victim and perpetrator, what would it include?

Supplementary questions (for last 20 minutes)

Scoping Question- Views on existing DVA support provision

I want to ask your views about current perpetrator work:



- In your opinion, are there gaps in the current provision of perpetrator work in your community? If yes, what are they?
- In your opinion, are there barriers faced for perpetrators accessing timely and effective support? If yes, what are they?
- If you could change one thing about the situation for perpetrator intervention in your community, what would it be?

End of focus group

- Thank the participants for taking part.
- Let them know you will be sending out an email and asking if, on reflection they have any further information they wish to share.
- Remind them of their local support services should this focus group raised any sensitive issues for them.
- *Stop the recording and save it as per the guidelines on the focus group guidance sheet.*



Appendix 3: Victim Surveys

Participant Information Sheet – Research Questionnaire

My name is [Orlanda Harvey](#) and I work in a research team from [Bournemouth University](#). As part of a European project we are conducting research into Domestic Violence and Abuse (DVA), so that we can better understand how to develop programmes to support survivors and support and potentially change the behaviours of perpetrators.

All details and information collected through the research will be completely confidential and anonymised, and no individual will be identifiable. Before you decide whether to answer the questionnaire, please take time to read the following information and discuss with others, should you wish. You can also contact me directly should you have any questions.

Participants: To take part in the study, **you must be 18 years or older**, and currently be experiencing DVA or have experienced DVA within the last 10 years.

Purpose: The aim of the project is to prevent further DVA and change abusive behavioural patterns to increase the capacity of frontline workers to support and further teach perpetrators of DVA to adopt nonviolent behaviour in interpersonal relationships .

The questionnaire will take approximately 15 minutes to complete and features several questions where the answers are 'free text' boxes, to give you the opportunity to share your thoughts and opinions. Please be as open and detailed as you can when answering any question. The more honest you are the more helpful and meaningful the data will be.

Benefits: Whilst there are no immediate benefits for those people participating in the project, your participation in this research study will make a valuable contribution to our understanding of DVA and the potential for future support for survivors.

Confidentiality: Only the research team will be able to access the study data. Anonymised data collected in this study may be used in future reports. However, all details are anonymous, and no individual will be identifiable through such publication of data. For the protection of yourself and the researchers conducting this study, this research has been reviewed and



approved in line with Bournemouth University's research ethics code of practice. BU's [Research Participant Privacy Notice](#) sets out more information about how we fulfil our responsibilities as a data controller and about your rights as an individual under the data protection legislation.

Withdrawal: You can withdraw from the questionnaire at any time. Please note that to withdraw you would only need to close the browser page (if completing online) or not return the questionnaire to the researcher. However, once you have completed and submitted the questionnaire, we are not able to remove your anonymised responses from the study.

Thank you for taking the time to read this. **If you have any questions regarding this research, please feel free to contact me using the information below.**

Contact Information: *Researchers: Orlanda Harvey: harveyo@bournemouth.ac.uk; and J. Levell, Email: jLevell@bournemouth.ac.uk . If you have a concern about any aspect of this study and wish to complain, please contact: Prof V. Hundley, Deputy Dean for Research & Professional Practice: Faculty of Health and Social Care, Bournemouth University by email to researchgovernance@bournemouth.ac.uk*



Experiences of Domestic Violence and Abuse (DVA): Questionnaire

By completing this questionnaire, it is assumed that you have given full informed consent.

Thank you so much for taking part. We hope to learn from you to help other people in future.

We stress there are no right or wrong answers, it is your opinion that matters.

SECTION 1: To what extent do you agree or disagree with the following statements - please tick one box?

	Strongly Agree	Agree	Don't agree/ Disagree	Disagree	Strongly Disagree
There is a good general awareness of DVA as a social problem in my community.					
I knew where to go to get help.					
I was able to access DVA support when I needed it.					
The help was offered at the right time for me.					
When I experienced DVA criminal justice agencies were involved (Police, courts, legal support).					
The criminal justice responses were effective					
The criminal justice responses were helpful					



	Strongly Agree	Agree	Don't agree/ Disagree	Disagree	Strongly Disagree
The criminal justice response was vital to my safety.					
My abuser was held accountable through criminal justice responses					
If my abuser was not violent, then most of the time my relationship was fine.					
If the abuse had stopped, I would have stayed in the relationship.					
The abuser was offered support by the services to change their behaviour.					
For an abuser to accept help, they need to realise there is a problem with their behaviour.					
If there had been help for my abusive partner, things might have been different.					
I would have preferred to have accessed support for myself, my abusive partner, and (if applicable) children.					
My abuser could have been helped if the right help had been available.					

SECTION 2:

From Your Experience:-



I began to think about getting help, _____ years of abuse

Did you call the police? Yes/No

If yes,

How many times did you call the police? _____

Please, explain, in your own words:

i) What, if anything, were the **best** three things about **the help you received** for DVA?

ii) What, if anything, were the **worst** three things about the help you received for DVA?

iii) If you could change one thing about how abusers are responded to, what would you change and why?

Please tell us a little bit about yourself:-

How old are you (in years)?	
What is your ethnicity?	



Are you male or female, prefer to self-describe?	
If you are working, what is your job?	
My abusive partner was/is male/female? <i>If you have had more than one abusive partner, please tell us how many in the box below, and what gender(s) they were/are?</i>	
Do you have children?	

If you have any further comments to make about this topic, please add them here:

Would you like us to send you some information about the results of this project?
If yes, please enter your email address* here:

*This email address will only be used for the purpose of sending you a copy of the research summary, and will not be stored as part of the research data. All personal data relating to this study will be held for 30 months from the date of publication of the research. BU will hold the information we collect about you in a secure location and on a BU password protected secure network where held electronically. Access to your personal data will be restricted to members of the research team and for the purpose of the research project only, in line with data protection guidelines. [BU's Research Participant Privacy Notice](#) sets out more information



about how we fulfil our responsibilities as a data controller and about your rights as an individual under the data protection legislation.

Thank you for completing this questionnaire. *Should you have any further questions, please do not hesitate to contact me (Orlanda Harvey) at: harveyo@bournemouth.ac.uk*

Should you wish to find out further information on DVA the following websites provide useful information, advice, and support: *In the UK:*

- *Government Guidance: Domestic abuse how to get help: <https://www.gov.uk/guidance/domestic-abuse-how-to-get-help>*
- *Refuge: <https://www.nationaldahelpline.org.uk/> Call us, 24-hours a day, for free and in confidence: [0808 2000 247](tel:08082000247) and live online chat service*
- *Women's Aid: <https://www.womensaid.org.uk/information-support/> includes and live online chat service*
- *Citizen's Advice: <https://www.citizensadvice.org.uk/family/gender-violence/domestic-violence-and-abuse-getting-help/>*

Confidentiality Confirmation: The collected data will only be accessible by researcher and her supervisory team. Anonymised data collected in this study may be used in future reports such as academic journal and conference presentations. No individual will be identifiable through such publication of data.

For further information about the overall project please contact: Jade Levell, Project Manager for BU, UK: jlevell@bournemouth.ac.uk



This project is funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)



Appendix 4: Coding Frame

Thematic Data Analysis- OSSPC Work Package 2

Thematic Codes Part 1- Key themes as specified in the funding bid

- TC1A- What currently happens: Organisational response and referral pathways
- TC1B- Negatives: Barriers for perpetrators accessing services
 - o Why don't people engage?
- TC1C- Positives: Good Practice/What works
 - o Motivational factors for engagement
- TC1D- Needs: Gaps in provision
- TC1E- Typologies of Perpetrators: Typical presentation/issues
- TC1F- Typologies of Victims: Typical presentation/issues
- TC1G- Victims perspectives- Misc

Thematic Codes Part 2- Important thematic areas to explore for further exploration/future publications

- TC2A- Rural DVA: Localised issues specific to regional/rural DVA
- TC2B- Masculinities: I.e. the perceived gender specific ways men cope/perpetrate/relate to DVA.
- TC2C- Controversies: Pro-feminist vs. gender neutral discourse
- TC2D- COVID-19



Thematic Codes Part 3- All team members are welcome to highlight key points which touch areas of their own interest, for wider discussion by the team.

- TC3A- Noteworthy: Misc areas which are important to note



Appendix 5: Participants Data Graphs

Did you call the police?	Frequency	If yes, how many times?	Frequency
Yes	10	1	1
No	14	2	1
		3	2
		4	2
		7	1
		25+	1
		Multiple	2

Frequencies (n = 24)	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Disagree Strongly
I would have preferred to have accessed support for myself, my abusive partner, and (if applicable) children.	7	11	4	1	1
My abusive partner could have been helped if the right help had been available.	2	7	3	8	4
If there had been help for my abusive partner, things might have been different.	2	3	11	5	3
For an abuser to accept help, they need to realise there is a problem with their behaviour.	24				
My abusive partner was offered support by the services to change their behaviour.	0	2	5	3	14
If the abuse had stopped, I would have stayed in the relationship.	4	8	3	3	6
If my abusive partner was not violent, then most of the time my relationship was fine.	1	5	2	5	11



My abusive partner was held accountable through criminal justice responses	0	1	3	3	17
The criminal justice response was vital to my safety	1	3	8	1	11
The criminal justice responses were helpful	1	4	8	2	9
The criminal justice responses were effective	1	3	10	3	7
When I experienced DVA criminal justice agencies were involved (Police, courts, legal support).	3	7	1	2	11
The help was offered at the right time for me.	0	3	8	2	11
I knew where to go to get help.	2	5	4	9	4
I was able to access DVA support when I needed it.	2	5	2	6	9
There is a good general awareness of DVA as a social problem in my community.	1	2	8	10	3