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The Other Side of the Story
PERPETRATORS IN CHANGE

Time for Change: Evidence Based Research for New Practice Approaches

Co-funded by the European Union's
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This report is the result of the 2nd work package "Time for Change: Evidence Bases research for new practice approaches" of the European project " The Other Side of the Story: Perpetrators in Change" (REC-RDAP-GBV-AG-2019 - 881684)

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Time for Change: Evidence base for new practice approaches.

The Other Side of the Story: Perpetrators in Change

A partnership project between:

BOURNEMOUTH UNIVERSITY (BU) United Kingdom

ASSOCIATION FOR THE PREVENTION AND HANDLING OF VIOLENCE IN THE FAMILY APHVF/SPAVO Cyprus

C.A.M CENTRO DI ASCOLTO UOMINI MALTRATTANTI ONLUS C.A.M Italy

Union of Women Associations of Herakleion Prefect, Greece

EKS Greece

European Knowledge Spot, Greece

DIRECTIA DE ASISTENTA SOCIALA SI MEDICALA DASM Romania

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We would like to thank everyone who has been involved in the wider OSSPC partnership who contributed to data collection throughout this work package. This involved many DVA victims, perpetrators, and professionals who work in the DVA sector who came together and shared their knowledge and experiences.

Country Reports

Each country involved in the project completed an individual report and these can be found on the OSSPC official website: https://www.osspc.eu/app/

Information about the OSSPC Research Partnership

Aims of the OSSPC Consortium

The aim of the OSSPC project is to prevent further domestic violence and abuse (DVA) and to change violent behavioural patterns by increasing the capacity of Frontline workers who will support perpetrators of domestic violence to adopt nonviolent behaviour in interpersonal relationships and understand the impact of DVA on them, their family and their community. OSSPC will achieve the abovementioned aims through the following activities:

- Investigate, map, and comparatively analyse the current work with perpetrators in Cyprus, UK, Italy Greece, and Romania; estimate the scale of the problem; provide a needs assessment and recommended perpetrator programme for professionals in the form of non-criminal justice intervention
- Formulate policy recommendations on the needs and importance of developing perpetrator programmes in the form of non-criminal justice intervention; highlighting the need to undertake systemic change to embed new practice
- Develop and deliver a joint capacity building programme targeting Frontline workers dealing with victims of DVA and increase their capacity and understanding of the dynamics of why perpetrators use violence and abuse
- Prepare regional strategies for an integrated response to incidents of DVA as a tool to foster multiagency responses to incidents of DVA
- Develop Protocols of collaboration between governmental and community-based agencies with a focus on collaborative and consistent service response that increases safety, reduces risks, and helps to prevent further assaults in the community.
- Increase awareness and understanding among relevant policy makers, professionals and the general public of the importance of developing DVPPs in the form of non-criminal justice intervention in order to reduce domestic violence.

This report is part of a wider European partnership study into the effectiveness of DVA perpetrator interventions. The Council of Europe Convention ('Istanbul Convention') highlights the importance of necessary measures to promote changes in the social and cultural patterns of behaviour by men with a view to eradicating prejudices, customs, traditions and all other practices which are based on the concepts of the inferiority of women or on gender stereotyped roles for women and men. It also encourages strengthening appropriate training for the relevant professionals dealing with victims or perpetrators of all acts of violence as well as preventive intervention and treatment programmes. However, the focus of the domestic-violence interventions has predominantly been on victims[1i]. While the growth of victim advocacy and support services is to be lauded, intervention with the perpetrators of DVA has received comparatively little attention from governmental, non-governmental and academic organizations and has not been an integral part of the system of combating violence. Although Domestic Violence Perpetrator Programmes (DVPPs) remain a crucial part of victim safety and coordinated community responses, they have received less financial support and less attention by authorities than other parts of the domestic violence system and the preferred route in most of EU countries has been holding perpetrators to account through the criminal justice system. The success of DVPPs has previously been evidenced in programmes such as the German project "Standards for work with perpetrators", implemented during 2007- 2014 and promoted by EIGE.

Thus it is of paramount importance for the participating countries to develop and/or improve the capacity of frontline workers to provide interventions programmes to male perpetrators of gender-based violence through the development of capacity building methodology and training material and strengthen multi-agency cooperation to increase exchange of information and tools among European/national/ regional/local levels on gender-based violence to develop protocols of cooperation in DVA and perpetrator intervention programmes. This project builds on the results made available from the national reports regarding the provision of interventions for perpetrators of DVA across the EU and the recommendations provided on the website Daphne II Work with Perpetrators (WWP) Project.

[1] [1] Throughout this report the authors will use the terms victims and survivors interchangeably dependent on context. The authors acknowledge that labels should not be used to define people, and each individual has the right to self-define.

Aims of Work Package 2

WP2 aimed to: map and comparatively analyse the current work with perpetrators in each of the participating countries; estimate the scale of the problem; provide a needs assessment, identify potential referral routes, and suggest good practice for voluntary perpetrator interventions. Policy recommendations will assist national authorities in formulating or re– formulating action plans for better and more effective responses to DVA. In particular WP2 was committed to delivering rigorous, innovative and relevant research in the areas of intervention programmes for men. The ultimate aim of the Time for change research will be to provide an evidence base for intervening and engaging with perpetrators who use DVA, in order to enhance support for women and highlight the need for governmental and community-based organizations to undertake systemic change to embed new practice approaches.

Overview of DVA Prevalence across the OSSPC Partnership Countries

EU Gender Equality Index

Data on gender equality across the EU has been collected in the form of the EU Gender Equality Index since 2013. There is a wide range of data which is collected as part of the index, which aims to capture the progress made across legislature, policy and experiences aligned to gender equality. Scores are created across the sectors of; work, health, money, power, time, knowledge, violence, as well as intersecting inequalities. The index was acknowledged as a reliable measurement tool in a 2020 audit carried out by the European Commission's Joint Research Centre. A high score in the Gender Equality Index means a country is close to achieving a gender-equal society.

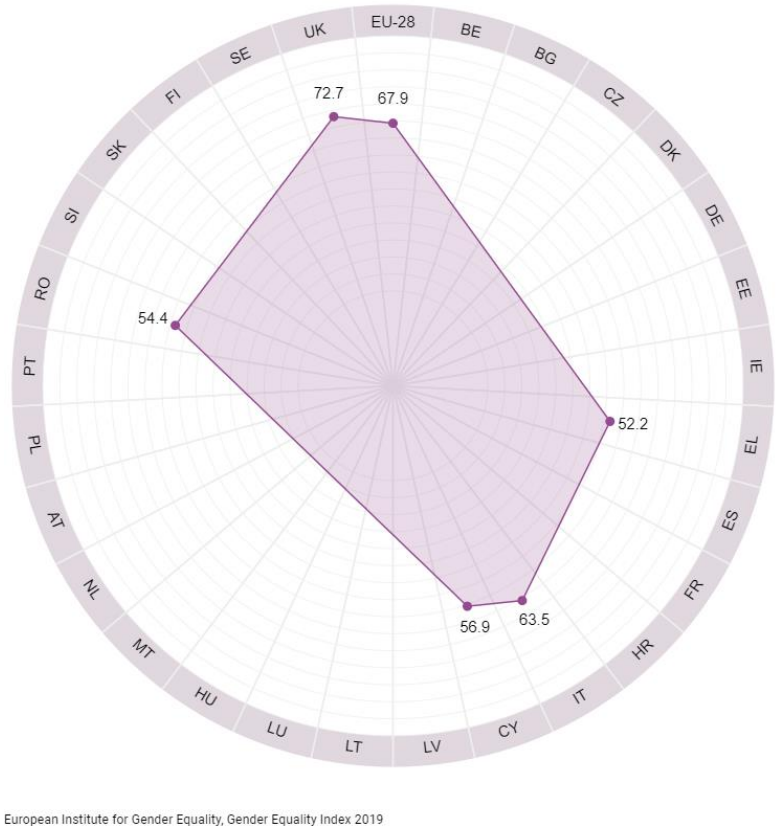

Figure 1 Comparative Country Data: EU Gender Equality Index Scores 2019

This figure suggests that the UK is scoring above the EU-28 combined score for gender equality. The Gender Equality Index score for Violence is calculated from highest to lowest, in that the higher the score, the more serious the phenomenon of violence against women in the country is. On a scale

of 1 to 100, 1 represents a situation where violence is non-existent and 100 represents a situation where violence against women is extremely common, highly severe, and not disclosed. The best-performing countries are therefore those with the lowest scores (European Institute for Gender Equality, 2020). Figure 1 shows that the UK has the highest score for overall gender equality compared to the partner countries, however Table 1 also shows that the UK the highest prevalence of violence on the Index score for Violence. Greece, on the other hand, has the lowest Gender Equality score of the consortium (therefore scoring lowest in terms of achieving a gender-equal society), however, has the lowest result for prevalence of violence. The Gender Equality Index is therefore a useful tool in that it provides an indicator of the broader context of gender equality in the partner countries, beyond a sole focus on violence.

DVA Prevalence Statistics across the OSSPC partnership Countries

The main source of contextual data around the prevalence of different aspects of gender violence across the partner countries has come from the FRA survey (2014). We have drawn on the findings of this survey here, in relation to the countries in the OSSPC partnership consortium. However, it is important to note that this survey focused on the experiences of victim-survivors of different forms of gender-based-violence, and there is no equivalent survey asking about perpetration of violence and abuse.

Table 1: Women who have experienced physical and/or sexual violence by current and/or previous partner, or by any other person since the age of 15 (%). Source: (FRA, 2014)

%	Current Partner	Previous Partner	Non-partner	Any partner and/or non-partner
UK	5	34	30	44
RO	14	30	14	30
IT	9	25	17	27
CY	6	24	12	22
EL (Greece)	10	17	10	25

Table 2: Women who have experienced physical and/or sexual violence in the 12 months before the interview, by type of perpetrator and EU Member State (%)

%	Current Partner	Previous Partner	Any partner (current and/or previous)	Non-partner	Any partner and/or non-partner
UK	2	4	5	5	8
RO	6	3	6	2	7
IT	5	5	6	4	7
CY	2	2	3	2	5
EL (Greece)	5	3	6	2	7

As can be seen in Table 2, the UK has the highest figures for women who have experienced physical and/or sexual violence by current and/or previous partner or by any other person since the age of 15, and this is double Romania's figures. However, when considering the last 12 months (Table 3), although the UK tops the table, Romania's figures are more equitable. There are multiple potential reasons why this could be the case: Romania may have developed better reporting and recording measurements in recent years or may have seen an increase in reporting experiences as a result of a direct increase in violence against women. There is also a question here of understanding and defining 'violence', as Fugate et al. (2005), suggest that some women will only report violence if it is deemed to be over a certain threshold. Consequently, it's hard to draw any substantive conclusions here as there could be multiple reasons for the differences in figures, both over time and comparatively.

Table 3: Women who indicate that the most serious incident of violence came to the attention of the police, by type of perpetrator (%)

%	Partner Violence	Non-partner violence
UK	25	26
RO	23	23
IT	19	18
CY	27	9
EL (Greece)	14	17

Table 4 presents data on the numbers of cases of violence that were reported to the police (REF?? where is it from? FRA?) and suggests that in most violent incidences are not referred to the police. The results across the in-country tend to show that there is a similar likelihood of police involvement across partner and non-partner violence, with the exception of Cyprus where it appears much more likely for police to become involved in partner violence as opposed to non-partner violence. When looking across countries the UK and Cyprus have the highest likelihood of incidents reporting to the

police is Cyprus and the UK, but even this is only around a quarter of serious incidents of partner violence experienced.

Table 4: Women who have experienced psychological violence during the relationship, by type of perpetrator and EU Member State (%)

%	Current Partner	Previous Partner	Any partner (current and/or previous)
UK	15	52	46
RO	30	45	39
IT	25	46	38
CY	27	50	39
EL (Greece)	21	30	33

Table 5 presents data on psychological, rather than physical, violence towards women and shows how, with the exception of Greece, about half of women in the survey had experienced psychological violence and/or abuse from a previous partner. Questions remain as to the extent women identify and recognise psychological violence, which may explain some of the disparity across the consortium, suffice to say that psychological violence is a significant concern for women.

Table 5: Having seen or heard campaigns against violence against women (%)

%	Yes	No	Don't know
UK	48	50	2
RO	55	40	5
IT	66	32	2
CY	60	35	5
EL (Greece)	70	25	5

As can be seen in Table 6, there was evidence of a disparity in awareness of violence against women campaigns across the consortium. The UK scored lowest with just under half of the population aware of VAW campaigns, with the respondents from the other partner countries showing increased awareness, and Greece showing the greatest awareness, with nearly 3 in 4 people being aware of anti-Violence against Women and Girls (VAWG) campaigns. As discussed in the individual country reports in the consortium, each country has taken a different approach in highlighting support services.

Domestic Violence and Abuse and COVID-19

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 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 COVID-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 COVID-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 Covid-19 contract 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 at Figure 2.

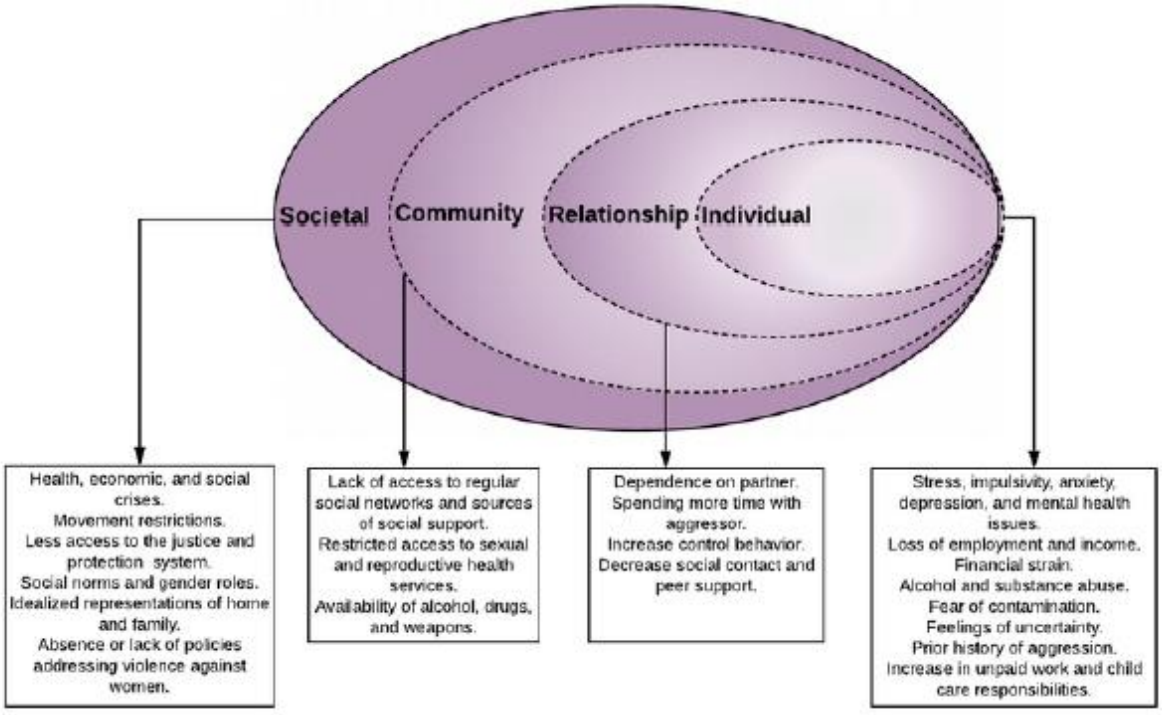

Figure 2 An overview of the impact of lockdowns on DVA survivors

(Sánchez, Vale, Rodrigues, & Surita, 2020)

As of week 2021-5 (11th Feb 2021), 495 672 COVID related deaths have been reported in the EU/EEA, which illustrates the current level of impact that the pandemic has had at time of report publication.

Table 6 COVID outbreak across the partnership[2]

Partner Country	**COVID-19 Related deaths (correct as of 11th Feb 2021)**	**Total population**	**Deaths as % of population**
UK	117,166	67,886,011	0.17%
Italy	91 273	60,461,826	0.15%
Romania	18 961	19,237,691	0.098%
Greece	5 972	10,423,054	0.057%
Cyprus	212	1,207,359	0.017%

All of the partner countries in the consortium have noted an increase in DVA cases during the COVID-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 COVID-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 phone line saw an increase in calls by 27%, with its website seeing a 125% increase in visits in the same period compared to the previous week (Home Affairs Committee, 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 (National Stalking Support Charity) reporting a, "50–70% increase in initial requests for support via email from both victims and wider services in the months from April 2020 compared to the previous 3 months" (Bracewell, Hargreaves, & Stanley, 2020, p. 3).

In Italy, according to ISTAT surveys, during the first lockdown (from March 1 to April 16) the number of calls to helpline numbers increased by 73% compared to the same period in 2019. 2,013 victims asked for help (+59%). 45% of the victims who called the helpline '1522' reported fearing for their

[2] *SOURCE: https://www.ecdc.europa.eu/en/cases-2019-ncov-eueea*
data.gov.uk

safety or life. Additionally, 72.8% do not report the crime to the police (less than the previous year) because it happened within their family. In 93% of case, the violence takes place at home. In 64% of cases callers reported witnessing violence: 56% of the requests for help come from victims with children and 34% from victims with young children. 64% of victims with children (722 people) reports that minors have witnessed the violence and/or that minors were the victims of the violence. According to the ISTAT surveys, the regions with the most calls were Tuscany, Piedmont, Emilia Romagna, and Sardinia. These regions constitute the area where the project was carried out. The number of calls from men (both voluntary and forced by anti-violence centres) were twice as high compared to the same period of 2019.

In Romania the increase in DVA has been declared a public health issue[3]. Regarding the cases of domestic violence, they were 4.85, 4.25 and 3.77 times (on average 4.3) more numerous than in a non-pandemic period. It was noted that the pandemic caused depression and anxiety as well as worsening of pre-existing mental illness. Because of isolation, stress, decreasing income and several hours spent in the company of the same persons, aggression and violence increased. Notable during this period was the initiative of the National Agency for Equal Opportunities between Women and Men and of other social actors and NGOs active in the field of DVA, who have been trying to make this issue more visible, to raise awareness of the phenomenon to the community and to induce change.

In Greece the General Secretariat for Family Policy and Gender Equality (G.S.F.P.G.E.) acknowledges that home quarantine and movement restrictions aimed at minimizing the spread of the Covid-19 resulted in DVA being more frequent, more serious, and more dangerous for women and their children. Many women found themselves in dangerous situations, with the pandemic being a perfect storm for controlling them and increasing isolation with violent husbands/partners, behind closed doors, separating them from the people and resources that can best help them[4]. A significant increase in complaints of DVA was recorded during the days of national lockdowns and forced confinement at home due to the Covid-19 pandemic, according to data presented to the special parliamentary committee on Equality, Youth and Human Rights, by the Secretary General of Family Policy and Gender Equality, Maria Syrengela.

[3] https://www.juridice.ro/697689/violenta-domestica-este-in-sine-o-pandemie.html.

[4] General Secretariat for Family Policy and Gender Equality: Bimonthly Report Newsletter: Policies and Actions of the G.S.F.P.G.E for the Prevention and Response to Violence Against Women and Domestic Violence, During the Movement Restriction Due to the Pandemic of the Covid-19 in Greece. Analysis of Gender-Based Violence Data from the Network of Structures and the SOS Hotline 15900 (March 2020 -April 2020)

In Cyprus there has been a reported increase in DVA reports by 40%. The reason for this increase was the fact that people were either working from home and/or not working at all and thus victims spent more time with perpetrators. The Association for the Prevention and Handling of Violence in the Family (APHVF), as the only association working with domestic violence issues, kept all of its services running and additionally, in order to adapt and respond to the increased needs, the Association expanded its services and human resources. This included the collaboration with external professionals, in order to increase the number of front-line professionals available in each shift and service. Moreover, APHVF arranged for renting of additional accommodation for women victims of violence and their children fleeing from violent partners. Furthermore, the Association introduced new services such as a live chat and SMS services, as well as counselling sessions through teleconference, so as to provide remote support to the victims of DVA. Also, APHVF developed protocols for handling this COVID-19 crisis in the associations' services and updated all its manuals.

Regulatory and Legislative Frameworks Across the OSSPC Consortium

The United Nations (UN) has been active in the field of violence against women since 1967 with the adoption of the Declaration on the Elimination of Discrimination against Women by the General Assembly, which later developed into CEDAW, the Convention on the Elimination of All Forms of Discrimination against Women, WHICH entered into force as an international treaty on 3 September 1981. Specific to the EU, the Council of Europe has adopted several instruments to combat violence against women such as Recommendation REC(2002)5 and a Convention addressing human trafficking. The Istanbul Convention has been the first treaty providing minimum standards on criminalising violence against women. At EU level several actions have been taken. Directives against trafficking in human beings, on victims' rights, and the European Protection Order are applicable to victims of violence against women. The Parliament, Council and Commission have adopted resolutions, conclusions and strategies on the topic. However, both the Council and the Parliament have urged the Commission to take more steps to combat violence against women (European Parliament, 2011). A detailed outline of each of the partner countries legislation around DVA is included in the respective country reports. The main pan-EU strategy that has driven the country responses to DVA is the Istanbul Convention.

The Istanbul Convention (Council of Europe Convention on preventing and combating violence against women and domestic violence, 2011), was the first legally binding instrument providing a comprehensive prevention, protection, prosecution and support framework to combating gender-based violence against women. Specifically, it frames all VAWG as a violation of rights and gendered discrimination. The Convention outlines a range of acts to criminalise 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 including stalking, forced marriage, female genital mutilation, forced abortion, forced sterilisation, and honour crimes. The Convention states public policies should play a role in the prevention, protection and support for victims of domestic violence, including witnessed violence suffered by minors, as well as supporting rehabilitation of perpetrators. Of specific interest for this project, the Istanbul convention highlights how the rehabilitation of perpetrators is a key tool in any initiative or action against gender-based violence. Rehabilitation must be preceded by a careful risk assessment in order to identify and facilitate appropriate perpetrator treatment and recovery, and avoid relapse (based on provisions from the 1993 UN Declaration on the Elimination of Violence Against Women, the 2005 Recommendation 5 from the Council of Europe, the 2011 European Parliament Resolution on priorities and set a new framework for combating violence against women, point 24 of the Istanbul Convention, article 16, points 1, 2, 3).

The Istanbul Convention has been signed by all of the partners in the OSSPC project however the UK remains the only country in the partnership who has not ratified it (Table 8). Although the UK Government has introduced a new Domestic Violence Bill which it states will ensure that the UK meets the majority of the requirements of the Istanbul Convention, without the ratification the requirements are not legally binding.

Table 7 Partner counties position in relation to the Istanbul Convention

	Signed	**Ratified**	**Entry into force**
Cyprus	16/06/2015	10/11/2017	01/03/2018
Greece	11/05/2011	18/06/2018	01/10/2018
Italy	27/09/2012	10/09/2013	01/08/2014
Romania	27/06/2014	23/05/2016	01/09/2016

United Kingdom	08/06/2012	-	-

(Council of Europe, 2020)

Perpetrator programmes are important elements of an integrated and comprehensive approach to preventing and combating violence and abuse against women. There is much variation amongst perpetrator programmes across Europe and this is due to differences in legislative and economic circumstances, but also to different social, political and cultural patterns. However, there is little systematised knowledge about the differences between and within European countries in general. Therefore, one of the objectives of this project is to obtain well-founded background knowledge about the character of this phenomenon and its current state in Cyprus, UK, Italy, Greece and Romania.

In Romania, there are no coordinated measures yet regarding work with perpetrators. In January 2017, Government declined funding of 'National Programmes of Interest' designed to tackle violence against women, which included also funding for centres to work with perpetrators, citing lack of funding. There is also an inadequate level of training for all agencies and institutions involved in the fight to eliminate gender-based violence, including security, educators, health and judiciary (European Network for the Work with Perpetrators of Domestic Violence, National Report 2017 Romania).

In the National Report of Cyprus, the need to promote research that focuses on perpetrators of DVA, to train psychotherapists working with perpetrators of DVA and raise awareness on the issue of treating perpetrators is highlighted as at the moment there is only one organization providing prevention programmes (European Network for the Work with Perpetrators of Domestic Violence, National Report 2016 Cyprus).

Additionally, in Greece, there is no requirement for staff at the state's helpline, counselling centers and shelters to be specialized, and the workplace training they receive is mainly theoretical whereas there are no programmes for perpetrators (European Network for the Work with Perpetrators of Domestic Violence, National Report 2016 Greece)

In Italy, the law 119/14 acknowledges, for the first time, the importance of work with perpetrators. This legislature indicates that the National Plan should include the development of perpetrator programmes and the elaboration of relevant guidelines for such work (European Network for the Work with Perpetrators of Domestic Violence, National Report 2016 Italy).

In the UK, although there are various perpetrators programmes offered, these are not developed and delivered in rural areas. In the UK report, the gap in understanding what works in DVA prevention and the need for future research and evidence is underlined too. Detailed overviews of the perpetrator provision in each partner country can be found in the respective country reports.

OSSPC Primary Research

Methodology

Ethics Procedure

Prior to any fieldwork being carried out the fieldwork methods and associated documents including guidance notes went through rigorous Ethics approval procedures in each of the partner countries. This included participant information sheets, consent forms and data collection templates for each data collection method (Appendices 1-3).

The following data collection methods were conducted:

- Focus Group Vignettes (Appendix 1)
- Focus groups with professionals working in the field of DVA: (Appendix 2)
- Online survey (in each Country) with survivors of DVA: (Appendix 3)
- Perpetrator Interview schedule (Appendix 4)

Sampling and data collection

Focus Groups

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 (Bryman, 2004; Tombs, 2000).

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. The backgrounds of the participants included social work, police, local authority, midwifery, statutory, psychologists, lawyers and voluntary agencies. All participants had experience in supporting either survivors or perpetrators of DVA.

The focus groups ranged 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 (Appendix 1). Vignettes describe hypothetical scenarios designed to solicit participants' professional views and opinions and encourage discussion and debate. Each country was able to adapt the vignettes to align to cultural and social norms. They were distributed to focus group participants in advance of the session, to enable greater reflection, and 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 held on virtual meeting platforms and facilitated by one or two research team members. They were recorded and transcribed, with detailed notes also taken in case of malfunctioning software. English translations were provided by Greece, Italy, Romanian and Cyprus as part of the data analysis process. Data was analysed using CATMA data analysis software.

Victims

The aim of the survey was to understand victims/survivors' experiences of DVA with a focus on the support offered to their perpetrators. Therefore, the survey instrument asked for their perspectives on support for perpetrators of DVA. Consideration was given to the length of the questionnaire, as people are more likely to complete questionnaires of a shorter length (Markstedt & Vernersdotter, 2013; Rolstad, Adler, & Rydén, 2011), therefore the majority of questions were quantitative (simple check boxes), however some free-text options were included to give participants the opportunity to share their subjective experiences. The survey was created and delivered either via the online JISC platform or in a paper copy and included a participant information sheet. Before considering the findings, it is important to consider how the sampling strategy impacted on the results. In the UK, the victims' survey was shared via our partner agency (The Hampton Trust) but also distributed by social media, in particular Twitter and Facebook (FB), as a result of the C-19 pandemic. The impact that this had on the findings is that it may have disproportionately accessed respondents who had not received services when they experienced DVA.

Perpetrator Interviews

Interviewing is a useful method for gaining an understanding of an individual's current or past experiences (Darlington & Scott, 2002). Perpetrator interviews were facilitated through negotiation with local partners: The Hampton Trust in the UK, and through the partner organisations in Cyprus, Greece, Italy and Romania. A wide range of methods for undertaking the interview was offered to the participants. This included traditional methods as face-to-face and telephone interviews, as telephones should not be considered a lesser option (Holt, 2010; Sturges & Hanrahan, 2004) and the pandemic necessitated this in some cases. In all cases these were men who had accessed a significant group work programme. The aim of the interviews was to gain an understanding of the perpetrators' experiences of the current support services and also what further services they felt would be helpful (Appendix 4 – Interview schedule). Interviews were carried out by one member of the research team; participant information forms were supplied, and the interviews were approximately 45-60 minutes in length.

A summary of all participants is at Table 9.

Table 8 OSSPC Project Data Collection Summary

Country	Number of Questionnaires	Number of Interviews	Number of Focus groups	Number of Focus group participants
Cyprus	19	3	2	10
Greece	20	3	3	49
Italy	8	5	5	45
Romania	24	5	3	33
UK	24	2	7	36
Totals	**95**	**18**	**20**	**173**

Sample Limitations

There were significant limitations in the data collection period in this study due to the global Covid-19 pandemic which began just before the inception of the consortium and remained throughout the time period of this work package. The victims survey was promoted and distributed by social media, in particular twitter, as a result of the pandemic. All partner countries went through national lockdowns during this period and so all fieldwork was moved to online via virtual meeting platforms, such as Zoom. This meant that there was no ability to do face to face networking or

relationship building in advance of the data collection and may have inhibited engagement, particularly with perpetrator interviews. In some countries, such as Greece, there is not an organised perpetrators programme, and only actions of penal mediation are carried out under the General Prosecutor's Order. A further barrier for data collection in the consortium was the difference in organisations in the partnership- some were front-line DVA support organisations who had access to their own service users, whereas others were research and/or policy making organisations who had to access participants via third parties.

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. 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). The UK data was coded first. 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 (coding framework at Appendix 5). Analysis was conducted in line with the key aims of the project and categorising these into key thematic areas. These themes were then sent to the partner countries and used as a coding framework for their data.

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. Questions were

not mandatory, 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.

Fieldwork Findings

Please see the individual country reports for a more detailed breakdown of key findings from the data collection process.

Focus Group Findings

Table 9 summarises the numbers of participants for the focus groups across the five countries. This section now summarises the focus group findings by country and then synthesises the information across the five countries.

Greece

Forty-nine participants took part in three focus groups in Greece. They highlighted structural, cultural, legal and patriarchal barriers to successful interventions with perpetrators and victims. They advocated for better training for front line workers, as well as in educational settings, in order to identify and respond to suspected DVA. They encouraged greater awareness raising with the general public in order to challenge traditionally accepted behaviour. One significant barrier was a lack of familial or social support for victims which results in their remaining in a relationship with their perpetrators. They highlighted a particular difficulty in identifying victims of DVA in cases where victims and perpetrators were migrants, as the current legal system would mean victims were more likely to be arrested than be supported, if they were without residence papers. They also emphasised how perpetrators must be motivated for change, in order for an intervention to be successful, however, noted that there continues to be very limited data available on perpetrator intervention programmes in Greece.

Italy

There were a total of 42 professionals who participated in five focus groups in Italy. Participants highlighted the need for more specialised and broader interventions to perpetrators of abuse, as well as better cooperation by all the corresponding service providers. There are gaps in provisions for perpetrator programmes, and none available for female perpetrators, and significant barriers in the labelling and stigma associated with the term 'perpetrator'. Successful interventions were those in which perpetrators acknowledge the harm they have done, and perceive the intervention programme as an opportunity for change. Participants advocate for improved training and awareness raising to promote the services available and to encourage perpetrators to be motivated to engage with the intervention programmes.

Romania

A total of 33 professionals participated in focus groups in Romania from a variety of criminal justice and social welfare backgrounds. They emphasized the need for greater and more specialized interventions for perpetrators of DVA, as well as greater cooperation and collaboration between agencies. Interventions need to be tailored to the individual involved and take a holistic and multi-disciplinary approach to both victim and perpetrator. They highlight the extensive gaps in provision of services for DVA perpetrators alongside extensive social, cultural and motivational barriers to engaging in programmes. Some communities, such as Roma and those living in rural areas, are at particularly high risk of repeat victimization because of culturally and socially accepted norms surrounding DVA, gender stereotypes and a lack of familial and support services. Perpetrators are generally described as male, often with a history of drug or alcohol abuse or poor mental health, adverse childhood experiences, and victims as female, with children and a financial or emotional dependence on their perpetrators. They advocate for additional awareness-raising programmes but highlight some excellent good practice from the limited services that do exist.

Cyprus

Ten participants took part in focus groups and highlighted specific cultural, religious, and patriarchal barriers to successful interventions with perpetrators and victims. However, the APHVF perpetrator programme is a new programme which has not yet been evaluated and therefore there

is limited data as to whether it is a success. Nevertheless, participants advocate for a collaborative, inter-agency approach to perpetrator interventions and for greater awareness raising programmes with the general public, education and healthcare settings in order to promote socially acceptable behaviour and encourage greater reporting. There was some disagreement between those participants who favoured greater legislative powers and those who believed legislation could inhibit perpetrator's willingness to attend. They highlighted a particular difficulty in identifying victims of DVA in cases where victims and perpetrators were Muslim migrants, due to traditional, patriarchal gender stereotypes. They also emphasised how perpetrators must be motivated for change, in order for an intervention to be successful, however, that motivation is sometimes constrained because of the stigma associated with being labelled a DVA perpetrator. Perpetrators were described as being predominantly male, with a history of drug and alcohol misuse and mental ill-health. Aligned to this, victims were described as exclusively women and children and participants noted a particular challenge in getting women to come forward where they feared their children could be removed from them by social services because of the current legislative framework.

United Kingdom of GB & NI (UK)

A total of 36 professionals participated in focus groups in the UK. Despite many successful intervention programmes currently in operation, DVA intervention provisions are piecemeal and vary greatly from one geographic region to another. There is no unified approach to programmes nationally which is exacerbated by a lack of resources and inadequate training and support for practitioners. That said, participants advocated for tailored, holistic intervention and education programmes to address DVA, which is delivered through a collaborative, inter-agency framework that supports perpetrators, victims and their families. Key to positive intervention outcomes was the motivation of the perpetrators themselves, as many programmes are voluntary. Education and healthcare settings were identified as potential areas for promoting healthy relationships and positive role-modelling. The participants identified a number of barriers to successful interventions, including those with addiction issues having to complete related intervention programmes before DVA programmes, lack of engagement or motivation from perpetrators themselves, the stigma associated with the label 'perpetrator', as well as structural barriers in areas such as resources, accommodation, translations, and awareness-raising programmes.

Perpetrators were described as predominantly male, with a history of mental ill-health, adverse early life experiences, and drug or alcohol addiction issues. Distinctions were made between those living in urban areas and those in more rural settings, with the former having greater access to the support services and intervention programmes, whilst the latter at greater risk of repeated behaviour because of their more isolated environment.

Common themes and concerns across the five nations

Across the five nations, 160 participants contributed to focus group discussions about a range of topics related to DVA. A comparison of their findings indicates that strong themes permeate the practices of frontline and key workers in addressing DVA. All of the countries involved emphasised a lack of service provision and, where services exist, limited training and expertise for those dealing with DVA. There is simply not enough funding being channelled into this area. There is an acknowledgement that victim programmes receive a greater proportion of funding, but as the Italy report underlines, work with perpetrators is key to preventing and combating violence. Some nations, such as Cyprus, have very sparse and limited services with only one programme in the country, whereas for others, such as the UK, the availability of piecemeal resources depends on the geographical region, described as a 'postcode lottery'. Rural areas are particularly under-resourced in all countries, which is especially concerning when there are additional barriers for victims in those areas, with limited social networks and support, and an increased risk of repeat victimisation. It is strongly recommended that, in order to reduce recidivist DVA, significant additional resources must be put into perpetrator programmes in all of the countries involved.

Additionally, where perpetrator programmes exist, inter-agency collaboration and coordination is crucial to providing holistic, tailored interventions that address perpetrator behaviour and motivations, but likewise support victim-survivors and any children or family members. Without a cohesive, evidence-based response, the family unit can fall through gaps in service provision, resulting in an increased risk that the perpetrator will return to family homes. This would also address the fear that prohibits many victims from reporting their experiences.

Perpetrators across the countries are described as predominantly male, usually fathers and husbands, with a history of drug and/or alcohol misuse or abuse, mental ill-health or instability and irregular employment. They may have a history of childhood trauma or abuse, low level criminality and low educational attainment. A significant barrier to accessing DVA programmes is the need to

address addictions, such as drug misuse, before a perpetrator can begin a programme. This is anathema to any attempts to intervene as early as possible and can result in delays to intervention programmes and a risk of further DVA. The patriarchal social structures many exist within means that a trigger, such as loss of job or home, can result in a sense of injustice that entrenches repeated violent behaviour.

Perpetrators are often described as having traditional, 'cultural' or patriarchal views; for some countries this has been identified in migrant and minority communities (for example, Cyprus), whereas others recognise this as a pattern for the majority of perpetrators, regardless of ethnicity (Italy). Therefore, many professional workers suggest educational intervention programmes in schools and colleges to promote positive relationship building and self-esteem at any early age.

Delivery of intervention programmes differs across the nations, with some countries having specific legislation mandating perpetrators onto programmes whereas others are voluntary. Focus group participants were equally split as to whether there should be greater criminal justice interventions or the promotion of self-motivation as a key precursor to any programme. For those perpetrators who are mandated to attend programmes, focus group participants highlight a denial of responsibility, minimising their actions and justifying their behaviour. Therefore, it is imperative that for intervention programmes to be successful, perpetrators must acknowledge their responsibility for their own behaviour.

Aligned to this point, the UK, Cyprus and Italy highlight the extent to which stigma and taboo continues to be associated with DVA. This links to existing gendered norms and expectations of masculinity. Being labelled a perpetrator can be a barrier for some men to accessing support. For example, in Italy perpetrator programmes are described as 'counselling' services in order to engage with at-risk men who would otherwise resist engaging because of the label of 'perpetrator'.

Victims are predominantly described as women, often minors, usually mothers, who are often dependent on their partners for financial and psychological support. They are described as being at particularly high-risk when pregnant or having recently given birth. Victims are fearful of losing custody of their children, and some fear social services and police and are therefore reluctant to report.

All of the country reports underline the importance of awareness-raising, and engagement with doctors, religious leaders, media, police and social work staff in recognising, reporting and responding to DVA as early as possible is emphasised.

To conclude, as demonstrated in the individual reports, in order for perpetrator programmes to be successful, they must be widespread, well-resourced and integrated within other community and support service systems. They must offer a tailored, holistic approach that supports the family unit. They rely on perpetrators being motivated and committed to changing their behaviour and accepting responsibility for what they have done. Without resources into these services, intervention packages will continue to be piecemeal, irregular, less likely to succeed.

Many of the organisations in the countries evaluated in this report are to be commended for the pioneering and proactive work they do in addressing perpetrator violence, despite a paucity of resources. It must be noted however that they are working and referring to, on the whole, a specific type of perpetrator. They describe those on the margins of society, those who have unreliable employment, drug and alcohol problems, and limited educational outcomes. This typology makes up only part of our social structure. It is therefore concerning that there is very little engagement with perpetrators from more stable social backgrounds, including those working in professional or established employment, and those on higher incomes. It raises questions as to whether there is a wider group of perpetrators who are successfully avoiding identification because of their social and cultural capital. There is also only sparse discussion on female perpetrators, and little provision mentioned for LGBTQI individuals who may resultantly be at greater risk because of a lack of targeted resources. Stigma exists in the realm of DVA, not just with known perpetrators, but also in regard to those unknown perpetrators who continue to act with impunity.

Perpetrator Interview Findings

Table 9 shows the spread of interviews across the five nations. In total 18 perpetrators of DVA were interviewed.

Greece

Three perpetrators were interviewed in Greece. Reflecting on potential causes and triggers for their behaviour – they described being beaten by their parents when young or acknowledged the role of stress and anger as pre-cursors. They highlighted the disparity in the way those accused compared to those accusing, were dealt with in the criminal justice and wider support systems. One gave an

example of the police humiliating him upon arrest, and another thought the trial process was unfair. They also highlighted greater difficulties accessing services for perpetrators compared to victims. The barriers for perpetrators included lack of awareness and publication of what support was available, long waiting lists for programmes, having to use private services or drive long distances to receive help. However once help was provided, they found it friendly, non-judgemental and supportive. They learnt techniques to control their anger - stopping before they 'erupted'; and re-examined their behaviour - realising the consequences for others. They reported outcomes such as no longer shouting as much, noted their children appeared calmer, they no longer raised their hand and were less likely to become jealous. As such, whilst difficult to initially obtain support, once received, it appeared to be extremely beneficial.

Italy

Five perpetrators took part in interviews in Italy. Although they stated services were not well advertised - when used, they found them supportive and non-judgemental. Most did not immediately associate their behaviour with violence and highlighted the difficulties in gaining awareness that their actions were inappropriate. This may have been due to the fact that most had suffered violence and abuse during childhood, and therefore such actions were potentially somewhat normalised to them. One noted by blaming others (or minimising their behaviour), they avoided the pain of having to take responsibility for their actions themselves. However, some participants felt shame. and eventually recognised the impact of their behaviour on others by talking about, or watching a film reflecting the issues. They advocated the use of smaller groups and potentially bespoke services for those who did not have Italian as their first language. Therefore, the importance of recognising the inappropriateness and potential underlying causes of their behaviour was key in these narratives.

Romania

There were five perpetrators interviewed in Romania. Difficulties within the criminal justice system were highlighted. Examples included one participant feeling he had been provoked by the victim, another felt the sanctions imposed - not being able to see his son for six months - were unfair, on

both him and his child. Access to support was described as limited in that it was not well advertised, necessitated participants paying privately or using support networks, for example the church. Some stated the support was provided too late or was offered whilst the perpetrator would have been at work. Difficult upbringings and adverse childhood experiences were mentioned with one participant stating his parents treated him like a servant, he was forced to miss school and they regularly beat him. Despite feelings of guilt and remorse, for example as being seen as a 'bad man', programmes of assistance were seen as supportive. They raised awareness of inappropriate behaviour and participants gained qualifications or learnt techniques to help them control their anger or nerves. In summary understanding and support from the criminal justice system and wider agencies was lacking, though once accessed programmes were viewed as understanding and supportive.

Cyprus

Three perpetrators took part in the interviews conducted in Cyprus. One highlighted how the police did not show respect towards him. Programmes for perpetrators were not well known with some clients having to go private. Perpetrators commented they felt apprehensive, and change was not easy, but for example they became aware they were becoming someone they did not want to be, or saw their son engaging in similar behaviour, so realised he needed help. Previous victimisation – being subjected to psychical, psychological and verbal violence was described. This perpetrator stated how growing up he felt incompetent, therefore wanted to reassert his own importance in society – reflective of his individual need for power and control. Another acknowledged stress as a trigger. Programmes assisted in giving them someone to talk to, getting them to realise the consequences of their actions, by teaching anger management techniques, eliciting empathy and allowing them to express their emotions. This was said to decrease both the frequency and intensity of the violence used and had the effect of their children becoming calmer and expressing themselves without fear. As such recognition of the effect of their behaviour was noted as important, and understanding the potential triggers and underlying causes, in conjunction with learning techniques to assist them, led to behaviour change.

United Kingdom of GB & NI (UK)

Two perpetrators agreed to take part in the UK. There were several examples provided of how they did not find required support. First some of the court decisions appeared unrealistic – for example not ever being able to return to their home. Second an example of a missed opportunity was provided, when disclosure to a GP resulted in a lecture rather than referral to appropriate services. Finally access to perpetrator services differed geographically and long waiting lists were recognised as another barrier to receiving appropriate help. Perpetrators indicated the initial difficulty of seeing themselves as an abuser– and identification as, and label of being a 'perpetrator' was not liked. Suggestion was made that some other title may be more appropriate. An element of minimisation was also seen, with comments such as they hadn't actually hit anyone. In relation to causation and potential triggers, behaviour was seen to reflect earlier relationships, and stress and alcohol were described as exacerbating maladaptive behaviour. When support was given it was liked and seen as non-judgemental and beneficial in getting them to recognise their behaviour as inappropriate and teaching them techniques to improve their current and future relationships. However, the difficulties in sustaining 'good' behaviour were recognised. Therefore broader societal issues surrounding training of healthcare professionals, appropriateness of sanctions and labels of perpetrator, as well as general concerns regarding access to programmes, were raised in these narratives.

Overall findings from perpetrator interviews

Eighteen interviews with perpetrators (all male) were conducted. Five were interviewed in both Italy and Romania; three were interviewed from both Greece and Cyprus, and two were interviewed in the UK. Access to others was attempted, though this proved unsuccessful for a variety of reasons including criminal justice denials of access, or perpetrators not wishing to participate.

Participants were asked about their knowledge and experiences of gaining support from programmes or other professionals, what they found useful, and how potentially assistance could be improved. Some interesting insights were gleaned, several patterns and core themes were noted across perpetrators in different nations, and findings were akin to what has been described in previous research.

All countries highlighted physical barriers to accessing services for perpetrators. Whilst there was a mixture of services being mandated by the court, or gleaned voluntarily, many articulated how there was a general lack of awareness regarding what perpetrators programmes were available, and generally their existence was not well known. Difficulties in access included:

- geographic disparity - some places having more services than others; some having to travel long distances to obtain them
- timing - long waiting lists; running in the daytime when attendees should be at work, and
- funding – with several trying different services or paying for private assistance.

Some motivational barriers were also apparent. Some discussed they were apprehensive, or at first, they did not like going, but virtually all participants noted that once programmes were accessed, they were enjoyed, they felt supported and the environments were non-judgemental.

There were also social psychological barriers for engagement. For example, the negative connotations associated with the social label of 'perpetrator' was discussed, which amplified pre-existing feelings of guilt, remorse, embarrassment and shame felt by the individual.

Moreover, it was apparent that some did not associate their behaviour with violence or minimised its effect on others. For example, referring to incidents as 'nothing important' or highlighting the abuse was never physical. Some were aware that this may be a means of transference – blaming others in amplifying or exaggerating the effect so as they did not have to feel the pain and shame of taking responsibility for their own actions.

There were also other means of externalising blame noted in the perpetrator interviews. Some were distal factors. For example, many mentioned their adverse childhood experiences including experiencing physical and psychological abuse. This may have resulted in them internalising such behaviour as 'normal' or 'acceptable' or may reflect themselves becoming abusive in order to reassert their own power and control. Externalisation of blame was also witnessed in mentions of more proximal 'triggering' situations. Many highlighted stress, anger, alcohol and being provoked (i.e. victim blaming) as pre-cursors to their inappropriate behaviour.

The benefits of programmes were strongly advocated and included enhanced self-reflection and awareness. Recognition that their behaviour was inappropriate and the impact it can have on others

(e.g. fear) as well as themselves (e.g. losing access to their children) was key. Most also mentioned that whilst difficult in maintaining behaviour change, they found many benefits in learning new techniques – for example to counteract anger or express their emotions in more constructive ways. They gave examples of how this had benefitted their current relationships and recognised the positive effect in their future life.

A need for greater awareness and enhanced support from professionals was also advocated. Missed opportunities included recognising the need for assistance in healthcare settings (such as GP surgeries) were apparent. Similarly, punitive court disposals (such as stopping perpetrators returning home or seeing their children) may be counterproductive. Such measures may bring additional pressures (such as homelessness, stress, isolation or loneliness) which could lead to relapse or additional problems. It seems apparent that short term fixes are delivered rather than the more strategic, long term support and assistance which is required.

Victim Survey Findings

Findings: Victim/Survivors' Survey

Introduction

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 accessed by 95 participants across the 5 countries and completed by 93 participants. (Figure 3) and ethnicity is shown in Table 10.

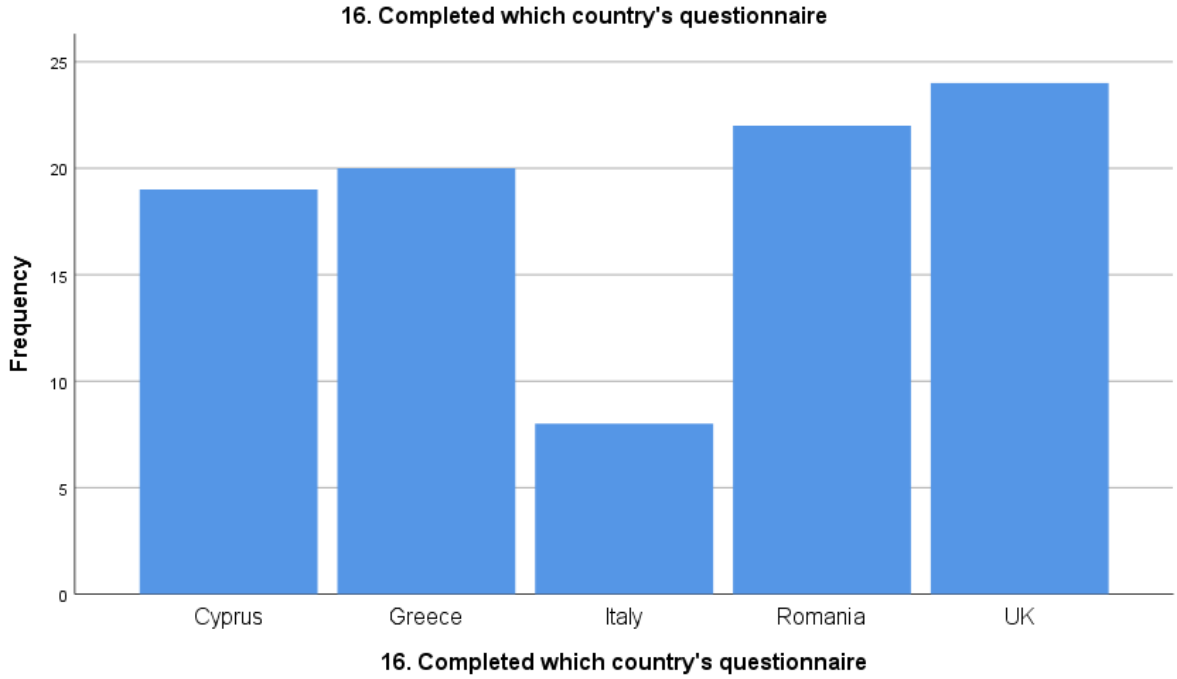

Figure 3 Total number of participants by Country

Table 9 Ethnicity of Participants

Ethnicity	Number	Percentage
Albanian	4	4.3
British	16	17.2
Bulgarian	1	1.1
Cypriot	10	10.8
Fulani	1	1.1
Greek	22	23.7
Hungarian	1	1.1
India	1	1.1
Irish	1	1.1
Italian	7	7.5
Romanian	20	21.5
Unknown	9	9.7
Total	93	100.0

Table 11 shows the from which source participants accessed the questionnaire. The majority form social media (n=41) or local services (n= 27).

Table 10 Source for accessing the questionnaire

		Frequency	Percent %
Valid	Twitter	6	6.5
	A friend	3	3.2
	A poster in the local DVA services	2	2.2
	A professional from the local services	27	29.0
	Other	11	11.8
	Facebook	35	37.6
	Total (number of participants answered)	84	90.3
Missing		9	9.7
Total (number)		93	100.0

Demographics

Of the 93 participants who filled in the questionnaire, 2 were male (both from the UK) and 88 were female, and 3 did not give their gender. In 81 cases the 'abusers' for the female survivors were male, one person stated 'other' when asked the gender of the abuser and 7 stated 'female', however this may not be a partner, as several participants noted they had been in more than one abusive relationship, and sometimes the abused was a family member. Both male survivors experienced abuse from female perpetrators. The range of ages for participants was from 18 – 69 (Mean age 40.5, Median 39 and Mode 38), with 47 participants being 30 years or younger see Figure 4. Fifty of the participants stated that they had children.

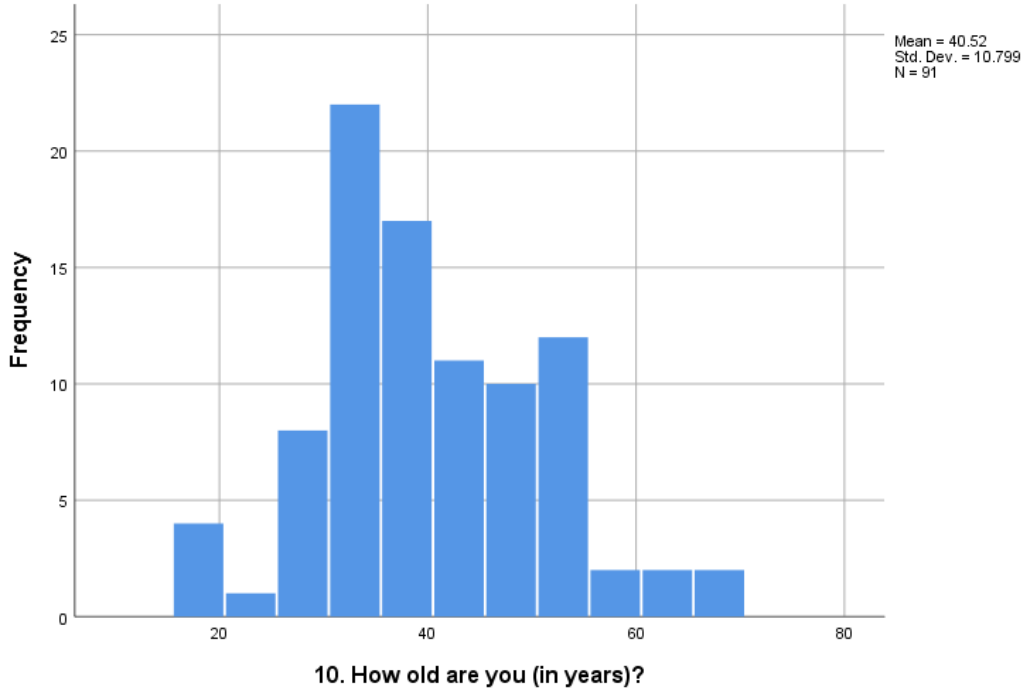

Figure 4 Age in Years

Themes from the Victims/Survivors' Questionnaires

A number of themes and associated sub-themes were identified:

- Barriers to Accessing Support
    - Ineffective Health Responses
    - Victim Blaming and Patriarchal Value Judgements
    - Criminal Justice System Interventions
- Effective Support
- Attitudes to Perpetrator Interventions

Barriers to Accessing Support

When it came to accessing support one of the first barriers needed to be overcome was the victim acknowledging they need support and that there is support available to them. There were some differences between each country with some participants showing greater awareness of support

options than others, however the relatively low numbers for each country make for an incomplete picture and comparison. Of the 87 participants who answered the question on seeking help, 44 people stated it took them 5 years or more before they thought about accessing help. There could be a number of reasons for this but one UK participant explained that for them is was linked to shame:

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

39.8% of participants stated they knew where to access help (Table 13). 49.5% of participants stated that they did not feel there was a good awareness of DVA in their community. Of those seeking help 50 participants stated that they had contacted the police at least once.

Table 11 Seeking Support

Question	**Agree or Strongly Agree %**	**Disagree or Strongly Disagree %**	**Neither agree nor disagree %**
2.1. There is a good general awareness of DVA as a social problem in my community.	30.1	49.5	20.4
2.2. I knew where to go to get help.	39.8	15.1	43
2.3. I was able to access DVA support when I needed it.	54.8	24.7	19.4
2.4. The help was offered at the right time for me.	49.5	24.7	24.7

As can be seen in the chart (Figure 5), the majority of the victims that took part in the survey had spent several years or more within the abusive relationship, with 29 stating a decade or more.

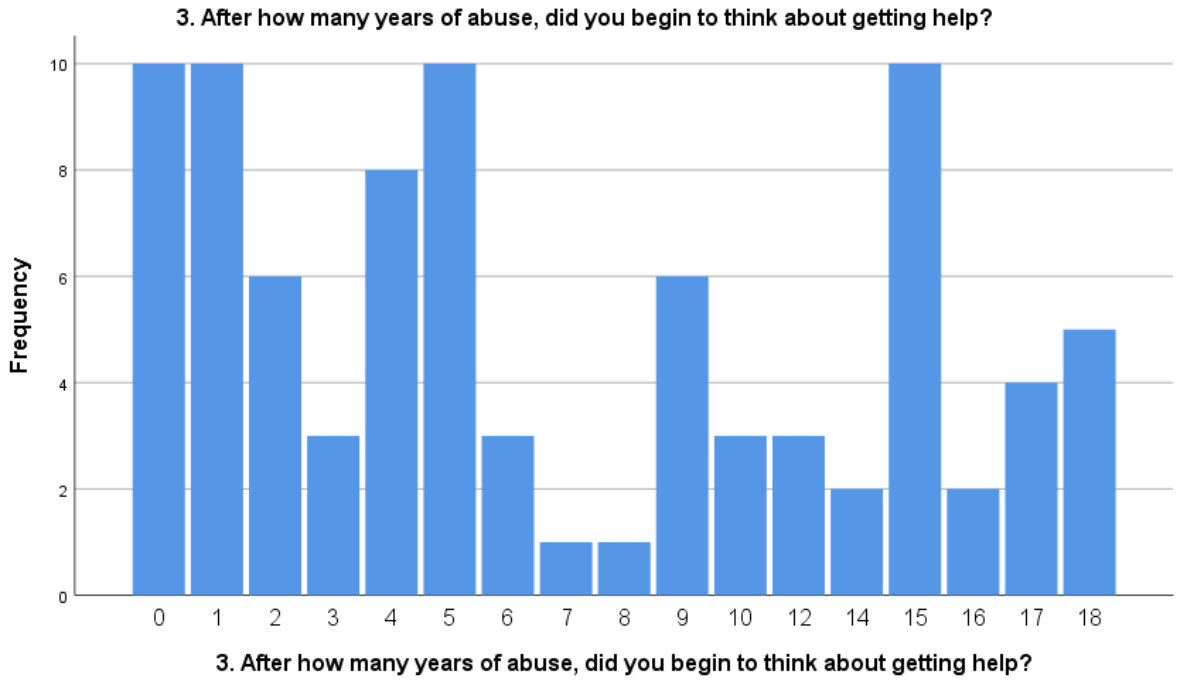

Figure 5 Getting Help (After X number of years of abuse)

When considering the barriers that kept them from accessing support a variety of reasons were identified. 24.7% of participants said they did not know where to get help and they did not feel it was offered at the right time. 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, not being believed, services only available during working hours, and lack of social housing. One participant from Romania and one from the UK also noted that social services took their children away. One participant described 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." (UK)

Another received an ineffective response from service:

'The social services, who knew and said they could not do anything' (Italy)

These negatives comments reinforce the importance of a positive and helpful response to the victim's initial disclosure.

Ineffective Health Responses

An issue that was found in the UK data but not from the other four countries was ineffective responses from health services, with issues raised such as general medical practitioners (GPs), who failed to recognise the abuse being reported to them, or noting incidents as marital issues. This, however, could link to the next theme that of victim blaming and patriarchal value judgements, as this aligns to social norms and cultures.

Victim Blaming and Patriarchal Value Judgements

A number of participants stated they had felt blamed by the professionals, for example:

'In one case, the police officer blamed my for the domestic violence.' (Greek participant)

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' (UK Participant)

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, protect their children 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' (UK participant)

A further theme that arose was linked to the impact and values underpinning a patriarchal structure and system. In the UK 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. Related to their recovery one person noted that society's values linked to her reason for staying:

'I realised I accepted and persisted in a toxic relationship because of the eyes of the world' (Romanian participant)

These findings presented from the data 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, & Pratt, 2009; Brem et al., 2019; Cerulli, Poleshuck, Raimondi, Veale, & Chin, 2012; Idriss, 2020; Laskey, Bates, & Taylor, 2019; Ragavan et al., 2020). As such, they contribute to the existing knowledge database in this field of research and policy.

Criminal Justice System Interventions

Participants were asked about their experiences of the criminal justice system and these are shared at Table 14.

Table 12 Involvement with the Criminal Justice System

Question	**Agree or Strongly Agree (n=)**	**Disagree or Strongly Disagree (n=)**	**Neither agree nor disagree (n=)**
2.5. When I experienced DVA criminal justice agencies were involved (Police, courts, legal support).	53.8	35.5	8.6
2.6. The criminal justice responses were effective	19.4	38.7	40.9
2.7. The criminal justice responses were helpful	21.5	38.7	38.7
2.8. The criminal justice response was vital to my safety.	19.4	36.6	41.9
2.9. My abusive partner was held accountable through criminal justice responses	18.3	55.9	24.7

Over half noted that the criminal justice system had been involved, although were less certain about its effectiveness, with less than 22% feeling that the system had been effective, helpful or vital to

their safety. Only 18.3% felt that the abusive partner had been held accountable by the services they sought support and redress from. As already shown number of participants reported that the support from the police was unhelpful or lacked knowledge and the system was slow:

'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.' (UK participant)

'The negativity of the police officers and the way they behaved to me; I think that this behaviour re-traumatised me. The long time it took for legal procedures to go through. The fact that he (the abuser) is not in prison.' (Greek Participant)

A number of survivors reported that they felt they were being blamed rather than the actions for the perpetrator as the following quote illustrates:

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

Moreover, a number related the response of the police back to the theme of patriarchal value judgements:

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

'The judge was a man and clearly took offender's side of the story.' (Greek participant)

The findings also 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.

However, one participant from Greece and two participants from Romania did feel the authorities had been helpful, as this quote shows:

'I felt safer knowing that an authority was monitoring our situation.' (Romanian Participant)

Effective Support

An important outcome from this data was that half of the participants (51.6%) said that if the abuse had ended, they would have stayed in the relationship (Table 2-6) and 48.4% agreed with the statement if my abusive partner was not violent, then most of the time my relationship was fine. This highlights the complexity of the issues and experiences of victim-survivors and perpetrators.

Question	**Agree or Strongly Agree %**	**Disagree or Strongly Disagree %**	**Neither agree nor disagree %**
If my abusive partner was not violent, then most of the time my relationship was fine.	48.4	36.6	14
If the abuse had stopped, I would have stayed in the relationship.	51.6	26.9	20.4
My abusive partner was offered support by the services to change their behaviour.	21.5	60.2	17.4
For an abuser to accept help, they need to realise there is a problem with their behaviour.	90.3	3.2	5.4
If there had been help for my abusive partner, things might have been different.	50.5	21.5	26.9
I would have preferred to have accessed support for myself, my abusive partner, and (if applicable) children.	80.6	6.5	11.8
My abusive partner could have been helped if the right help had been available.	54.8	24.7	19.4

Table 13 Types of Support Needed

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, access to training and qualifications, being listened to, specialist support services, shelters, legal advice, employers, the realisation they were not to blame, cognitive behavioural therapy, being believed, DVA workshops, and having a personal alarm for example:

'I felt that there is definitely a problem; that somebody else understands me (my counsellor) and sees it as abuse; that it wasn't things of my imagination' (Greek participant)

'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.' (UK participant)

"I took part to a campaign against abusers and I saw that I am not alone and helpless. I managed to take the side of the abused women including me in front of the persons who were against the campaign

and supported the abusers. This was an act of courage for me because I had kept quiet about what happened until then" (Romanian participant)

Attitudes to Perpetrator Interventions

The majority of participants strongly agreed that for an abuser to accept help, they needed to realise there is a problem with their behaviour (90.3%). Over half the participants (54.8%) felt that their abusive partner could have been helped if the right support had been available and 50.5% felt that if such support had been offered it would have made a difference to their circumstances and the existence of abuse.

The participants were asked for their suggestions on how the perpetrators of abuse were responded to. The majority of answers related to a need for increased punishment which include such examples as more severe penalties for breaching court orders, increased monitoring by the authorities, 'beating them', removing parental rights and imprisonment e.g.

'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.' (UK participant)

Some suggested that they needed help and should be offered it but it must come with restrictions:

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

They also wanted the manipulative behaviour of perpetrators recognised, victims to be taken seriously and believed and addressing underlying societal issues that allows for toxic masculinity and such abuse to continue:

'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.' (UK participant)

'I would enforce the penal mediation because that is the only way abusers might truly change' (Greek participant)

A predominant theme from the Greek participants was the focus on wanting the perpetrators to change behaviours, and become 'better husbands', for example, not wanting to engage in affairs with other women, to take responsibility for the children, not to use drugs and alcohol and make him be positive about his family.

However, another seemingly alternative viewpoint that came through was many believed the perpetrators could not change, for example:

I don't believe that the perpetrators can change. My husband certainly doesn't.' (Greek participant)

Participants suggested changes also needed to take account of the children and trauma caused, as well as more awareness raising on violence, especially to older people. There were also some less punitive suggestions regarding support that should be offered such as anger management, behaviour change and specific cognitive behavioural therapies:

'for modification of the thoughts the attitudes and their behaviour" (Romanian participant).

'abusers offered counselling and advice to manage their anger.' (UK participant)

'I would like my husband to seek and receive help. I liked that my counsellor empowered me in order to convince him to get help and prepared me for his negativity regarding getting help' (Greek participant)

However, others felt there was a need to address the possible cause of the abuse, for example:

"I'd look for solutions to change violent behaviour from childhood through educational programs" (Romanian participant)

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 and the need for structural change.

Limitations

There are several limitations to this data analysis. Firstly, the number of participants is small and not equitable across the five countries. Access to services and the service themselves differ across the five countries, as does the legislation and criminal justice responses to perpetrators of abuse. The data was translated into English and therefore they may be some nuances lost in the translation. The research was conducted between June and December 2020. There were a number of limitations for the data collection, as it each research team used different methods, depending on the organisations access to potential participants, and also due to the number of participants in each category differing across each country.

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 evidence suggests that many victims of abuse did not get the services they needed, and services were not meeting their needs in real time. However, for those that accessed services there were some key themes related to effective support, which included being listened to and believed, alongside the more practical support.

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. Key messages from the victims' perspective urged for the perpetrator to 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.

A surprising statistic was that half the participants did not think of seeking help for five years or more, and therefore this does raise the question why do those suffering abuse seek help earlier? It could be that they do not think they are victims, and are themselves taking the blame, it could be

that they do not feel they would be believed or perhaps feel they deserve it. These themes have been at the heart of much of the literature on why victims stay in relationship. There is definitely a need to raise awareness that abuse in relationships is not acceptable and that people should not feel they should have to live their lives in this way, as well as a need to challenge the underlying societal norms that hold up such beliefs such as hegemonic masculinity and the sanctity of marriage. 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 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.

The Gaps and Needs in Relation to Perpetrator Work Across the Consortium

Individual (ontogenetic) level		
Readily available practical support	Early intervention	
Interpersonal (micro) level		
Reduction in stigma for help-seeking	To receive a positive response at initial disclosure	Effective police/Criminal justice responses
Institutional (meso) level		
Professional/community Training on DVA	Professional Training Coordinated Community Response to DVA	Increased community awareness/training Funding for services in all regions (rural/urban)
Societal (macro) level		
Increased awareness of DVA at societal level	Rejection of Patriarchal & sexist assumptions	

1. The Importance of a Coordinated Community Response Approach

One aspect of DVA support and provision which was highlighted as important by all of the partner countries was the need for a Coordinated Community Response (CCR) to DVA. This is indeed highlighted in the Istanbul Convention as imperative to an effective response to DVA, and is named as one of the 'four pillars of the convention' (2020). However, in the country reports it was clear that the CCR response is not widely functioning in many places, which is linked back to the previous point on funding as well. Without widespread funding and provision of services across all areas it is impossible to ensure there is a consistent level of provision. Each country had specific recommendations based on local, regional and national priority, legislation, practice and policy, but all were consistent in recommending a CCR approach.

Findings from the UK (see UK country report) highlight that in some places there is evidence of a well-functioning CCR approach which is integrated within the wider community. In the CCR model, perpetrators fit within the broad concept of 'being held to account'. However in the UK context Standing Together Against Domestic Violence (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 Domestic Homicide Reviews (DHRs) the perpetrator can be invisible, with the predominant focus remaining solely on the victim herself. 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 (STADV, 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. DVPPs 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, p. 3). They focused on the ways in which perpetrator programmes increase 'space for action' among other measures (Kelly & Westmarland, 2016).

Research from Italy highlighted the need for coordinated professional networks that serve both to train the wider community on gender-based violence, including in awareness around indicators, responses, and referral pathways, but also to link up DVA professionals with political decision makers. Political decisions should be made with the help of collaboration protocols that represent the needs of the different regions to combat domestic and gender-based violence.

Findings from the research in Greece emphasised the need for coordinated, interdisciplinary and cross-sectoral (horizontal and vertical) action of public and non-governmental bodies, cooperation of the involved services and utilization of the complementarity of the structures (multi-agency approach), as well as expansion of services in the field of social care. In parallel, a coordinated, interdisciplinary and cross-sectoral action of public and non-governmental bodies with intensive awareness strategies that will encourage the reporting of incidents of gender-based violence can be critical in combating gender-based violence. They recommended that organisations specializing in the management of cases of gender and domestic violence (G.S.F.P.G.E, EL.AS, EL.STAT, Courts, Hospitals) to adopt a common methodology for collecting statistics and to work together to establish a recording mechanism. The Gender Equality Observatory with updated indicators can play an important role in measuring the phenomenon.

Research from Cyprus found similar gaps in the CCR approach. They found that while protocols and other manuals promote the cooperation between all competent authorities and services, as well as suggest ways and mechanisms for the coordination of services, there still seems to be some minor gaps in providing coordinated actions and procedures in which victims are involved. The evaluation of existing policies, the constant renewal of the guidelines and the development of protocols of cooperation among all the relevant services will contribute to better coordination of services and the improvement of the services provided to victims and perpetrators. Moreover, without prejudice to the judicial discretion, a coordinated and systematic implementation of protection measures will contribute to the efficient protection of victims and their families throughout the criminal proceedings. In sum, the main gaps and challenges which were identified are the lack of adequate training of the professionals, the lack of professionals (especially of translators), the work and case overload in all competent authorities, the reduced geographical coverage of support services, the lack of research and statistics, and the absence of restorative practices.

Research from Romania emphasised that, in order to improve services for perpetrators, an important factor is increasing the involvement of state institutions in providing services (church, social services, police). Specifically they recommended the need to implement the provisions of

Law no. 217/2003 for preventing and combating domestic violence, in its consolidated and completed form, and to respect the recommendations of the Istanbul Convention on approaching the issue of domestic violence from a dual perspective, both from the victim and from the perpetrator by: increasing the number of centres for victims of DVA and of sheltered apartments, setting up centres for working with perpetrators in each city, creating new positions in the organizational structures of public institutions, hiring staff and training specialists in the field of working with perpetrators, developing training programmes in the field of domestic violence and of working with perpetrators, developing clear procedures in working with perpetrators and integrated interventions of the specialists involved, working in multidisciplinary teams. They also highlighted the need to increase the responsibility of the main actors (teachers/educators, doctors, priests, the police, social-work staff) in recognizing/identifying and reporting, as early as possible, situations of DVA, strengthening collaboration protocols between various public and private institutions (police, court, psychiatry, social services, nurseries/ kindergartens/schools, doctor's offices, day care centres for children, etc.) and the operationalization of existing services (mobile emergency response teams and/or monitoring the compliance with protection orders with the support of electronic bracelets). They emphasised that if the phenomenon of DVA is to be effectively reduced and adequate protection of vulnerable victims is to be achieved, a paradigm shift and intensive training in a human rights philosophy of all relevant professions is needed.

Overview of the Coordinated Community Response Model

The Coordinated Community Response (CCR) to DVA was an approach that was born out of the Duluth model and is a core feature of the Istanbul Convention in terms of recommended approaches to deal with DVA. 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 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, Jacobs, Montique, Croom, & Lawrence, 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 DVA 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 (Figure 6).

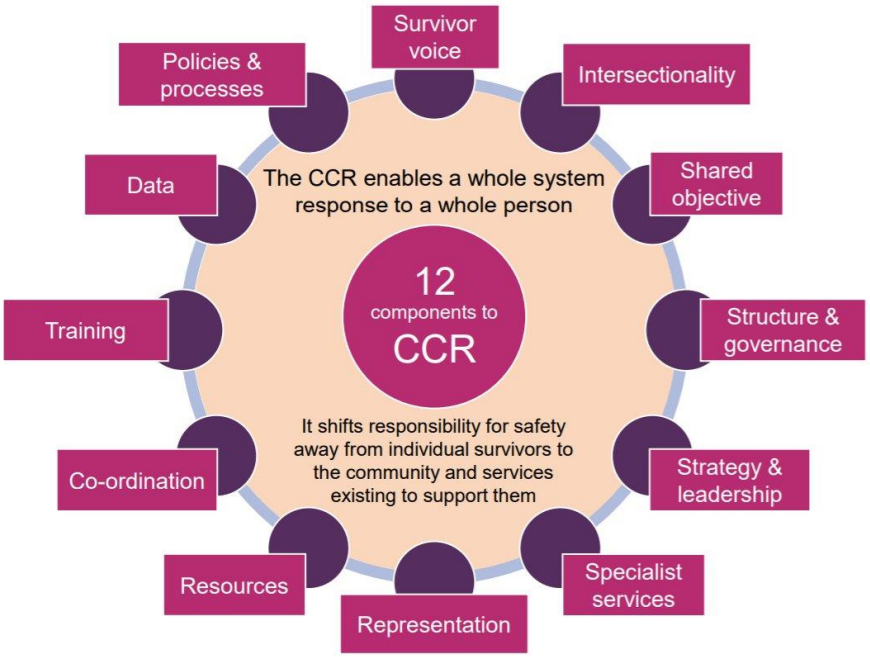

Figure 6 (Standing Together Against Domestic Violence, 2020, p. 12)

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. 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 (STADV, 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.

2. Resourcing Pressures

Funding issues arose many times in the fieldwork in all streams. Many participants expressed frustration at the lack of consistency in provision across their regions, with rural and urban disparities noted. In the majority of cases there is less service provision in rural areas. In general, there was a sense that there are 'postcode lotteries' or location based differences in service provision which meant that perpetrators access to support services are heavily impacted by local commissioning arrangements and local decision makers priorities. Indeed, in Cyprus there is only one perpetrator service for the whole country. It is strongly recommended that, in order to reduce recidivist DVA, significant additional resources must be put into perpetrator programmes in all of the countries involved.

3. The Importance of Health Services in recognition and intervention with DVA Perpetrators

A theme that arose in the research was the classification of perpetrators are tending to be predominantly male, usually fathers and husbands, with a history of drug and/or alcohol misuse or abuse, mental ill-health or instability and irregular employment. In the perpetrator interviews participants often disclosed a history of childhood trauma, including experiences of violence themselves, which points us to a need to focus on early intervention. Due to the complex intersecting issues which often related to a need for health care, including mental health and substance use issues, pointed to a need for health care services to be integrated into the

coordinated community response. However, saying that, as the 'typical perpetrator' was deemed to be complex in the fieldwork, it raises the question of whether services are missing the more mainstream men, who are less likely to access support services.

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 of seeing and hearing 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 that was 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.

4. Community Training: The need to train professionals in managing perpetrator disclosure and risk

To ensure a functioning Coordinated Community Response it is essential to have trained professionals in the wider community in addition to those who are DVA specialist workers. Ideally all professionals who may come into contact with victims and/or perpetrators of DVA would be trained to deal with disclosure, manage and make a referral to specialist support, and preliminary risk management advice. It was highlighted among all the partner countries that this was not consistent across all communities, in particular in terms of training around how to manage perpetrator disclosures.

Research from Romania noted that there was a need to recognize that there are currently no training programmes in the field of work with perpetrators. The number of accredited specialists is very small, and that in order to provide quality services we need training courses on the specifics of working with perpetrators for all specialists involved in the field of DVA. As mentioned in the previous section, they highlighted the importance of wider community services to be trained and able to link up the voluntary and statutory services.

Research from Cyprus noted that even though training opportunities for professionals who come in contact with victims are available, it is uncertain how often and to what extent they are available for all professionals. Moreover, there is a lack of evaluation of those trainings and there is no system of quality assurance. Regular trainings of judges and prosecutors on victims' rights and needs, as well as on communication and questioning methods are highly recommended to be introduced. Awareness raising seminars on the notions of 'victims' and certified trainings on methods, practices and techniques for the support and protection of victims is also recommended for practitioners in public services and NGOs who come in contact with victims. The frequency of training is an essential element in the constant update of the knowledge and capacity building of professionals. Finally, as an interviewee suggested[5], the creation of a registry of qualified professionals will safeguard and contribute to offering high quality services to victims of crime.

Research from Italy highlighted how essential it is to work in a network with professionals from different services that are trained on. The services are clearly in need of that. There is still a lot of work to be done in terms of knowledge on how to detect the indicators of violence, the experience of operators facing situations of abuse, and the effective referral of men to specific centres.

In Romania there was an emphasis that training needs to include a focus on key members of the community including teachers/educators, doctors, priests, the police, social-work staff. They also found that early intervention programmes in schools to educate young people themselves about healthy relationships. This was similarly found in the research in Greece, where the importance of well-trained school teachers and support staff were emphasised. Various needs were identified such as skills and training of front-line professionals to be able to assess and evaluate each case correctly to be able to refer them to the correct service.

In research from the UK it was also highlighted that training around perpetrator work within the community is still lacking. A particular area of importance that was foregrounded both in the literature and in all of the fieldwork streams was the importance of health services in an effective

[5] Vociare interview no. 5.

perpetrator response. More often than not, participants disclosed that victims and perpetrators often present to health services first and often do not receive a good response.

5. Publicity: Increased public awareness of perpetrator programmes

It was highlighted in the research that there was a need for publicity campaigns to challenge wider societal norms and stereotypes. There were two strands to this. The first was that there was a need to target young people in schools as part of an earlier intervention to support healthy relationships. The second was that enduring patriarchal attitudes are an ongoing barrier to help-seeking for both victims and perpetrators. As outlined in the Istanbul Convention patriarchal structures are key in understanding the wider gender inequality which relates to DVA perpetration. Patriarchal norms and values were discussed across the fieldwork, with it being particular recorded as an issue within UK, Greece, and Cyprus. We found that there is an enduring 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 martial 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. In the victims surveys it arose that many women had received advice from professionals which related to traditional gendered heterosexual roles. It was clear that survivors' intersectional identities impacted on their experiences of help-seeking. In Greece it was noted that there were specific difficulties in identifying victims of DVA in cases where victims and perpetrators were migrants, as the current legal system would mean victims were more likely to be arrested than be supported, if they were without residence papers. In Cyprus the research highlighted a particular difficulty in identifying victims of DVA in cases where victims and perpetrators were Muslim migrants, due to traditional, patriarchal gender stereotypes. In UK research one survivor in particular 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. Thus, it is clear that wider societal assumptions about women's role in marriage, and in the community, impacts on help seeking for victims and perpetrators to recognise abusive behaviours.

6. Stigma: Contentious points on the language of 'Perpetrator'

An interesting subtheme that occurred in the research in some of the partners- in particular the UK and Italy, was an expressed discomfort by some fieldwork participants on the negative stereotypes and labelling associated with the term 'perpetrator'. A reoccurring theme in the focus groups and perpetrator interview fieldwork streams was a level of discomfort around the term 'perpetrator'. Some participants found it a barrier which in some ways put people off accessing services as they found it to be a label which amplified pre-existing feelings of guilt, remorse, embarrassment and shame felt by the individual. Research from the UK, Cyprus and Italy highlight the extent to which stigma and taboo continues to be associated with DVA. Being labelled a perpetrator can be a barrier for some men to accessing support.

In research from Italy they found that discomfort with the language was the greatest barrier that prevents men from accessing the programmes promoted by the centres is the "perpetrator" (maltrattante) label in its name (Centro Ascolto Uomini Maltrattanti). When the services and legal counsellors suggest the centres to a man, they often omit that part of the name and present it as a "counselling centre for men". According to them, the "perpetrator" label creates distance and stigmatization, although it could encourage them to take more responsibility and be clearer about the reason why they are referred to the service. They found that the general message of the perpetrator being a "monster" does not help the men to take responsibility, but rather fosters a sort of helplessness that makes it impossible to promote a different social message.

In the UK research, 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 instead 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. This presents an ideological conundrum about whether the language around perpetration should be adjusted to encourage potential service users to come forward or access services, or whether by doing this it fails to fully hold perpetrators to account for their behaviour.

Conclusion

As can be seen from the gaps and needs identified in relation to perpetrator work across the partner countries, there are key thematic areas which impact on the access and provision of perpetrator work. These can all be broadly related to the need for a coordinated community response model across all regions, which would include cohesive localized referral pathways, adequate funding which is proportionate to population and region, and strong publicity both to help victims and perpetrators to recognize the abuse, but also to do so in a way which reduces stigma for help seeking, but still holds perpetrators to account. These provisions are key in the Istanbul Convention, which had been ratified in four out of the five partner countries, however perpetrator provision is still lagging behind. Community training is essential to reinforce this approach, as a reoccurring theme was that victims and perpetrators initially tried to access support through health settings (including substance misuse services) however did not often receive appropriate onward referrals to specialist support services. The need to offer services which reduce the stigma around receiving help was an ongoing theme in the fieldwork, with participants (both professionals and service users) across the partner countries noting their discomfort with existing language of 'perpetrator'. How to manage this, whilst still holding perpetrators to account, is a vital question going forward. Ultimately, this research found an enormous amount of good practice across the partner countries and evidence that effective service provision for perpetrators can inspire behavior change, harm reduction, and positive futures.

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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					
The criminal justice response was vital to my safety.					

	Strongly Agree	**Agree**	**Don't agree/ Disagree**	**Disagree**	**Strongly Disagree**
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?	

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?	
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 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

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Appendix 4: Perpetrator Interview Schedule

PERPETRATOR Interview Questions

Semi-structured interview- the questions are to be used as a guide

Please thank the participant for taking part and completing the demographic questionnaire. Explain the process of the interview and safeguarding (see interview guidance).

Please start the interview by asking a couple of warm-up/rapport building questions, such as how they are. And then use the following questions as a guide.

1) Do you feel that domestic violence and abuse (DVA) support services (for victims and perpetrators) are well publicised in your community?

2) Have you engaged with DVA perpetrator support services on a voluntary or mandatory basis? (i.e. Have you been forced/compelled to attend through a court mandate)

3) Have you had criminal justice agencies (Police, courts) involved due to DVA you have been accused of committing?

4) Tell me about your experiences of accessing support for DVA perpetration?

5) How did you feel when you recognised or were told that elements of your behaviour were abusive?
    a. How did you come to recognise this? Or Could you tell me a little more about your behaviours?
    b. Did you have any professional support to work this through with you?

6) What do you think has been the most useful intervention you have received (formal or informal) to support you in reducing or stopping DVA?

7) What did you feel was the most positive aspects of accessing support (to you, to others)?

1) _____Have you had any other experience of DVA, as a victim yourself, or experience in childhood?

2) If you could change one aspect of DVA support, to improve it, what would you change? And why?

Appendix 5: 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
    - Why don't people engage?
- TC1C- Positives: Good Practice/What works
    - 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: Miscellaneous areas which are important to note

Partnership report by the consortium;

Bournemouth University

Association for the Prevention and Handling of Violence in the Family (APHVF)

C.A.M Centro di Ascolto Uomini Maltratanti Onlus

Directia de Asistenta Sociala si Medicala (DASM)

Syndesmos Melon Gynaikeion Somatheion Irakleiou kai Nomoy Irakleioy and Simeio Evropaikis Gnosis AMKE

European Knowledge Spot

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