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Standards for Domestic Abuse Perpetrator Interventions

Overarching principles and practice guidelines for commissioning and delivering interventions for perpetrators of domestic abuse

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Executive summary

This piece of work was commissioned by the Home Office to develop evidence-based standards for interventions with perpetrators of domestic abuse. The technical annex in Appendix 1 provides more detail about the approach to this work.

The first task was to clarify which perpetrator interventions were in scope. As the standards were commissioned by the Home Office, they follow the definition enshrined in the Domestic Abuse Act 2021[1]. This means that they include not only intimate partner violence and abuse, but also other violence and abuse where the victim and perpetrator are aged 16 or over and are personally connected. Hence, adolescent/adult child to parent violence or abuse (sometimes called inter-generational abuse) is included but child (under age 16) to parent abuse is not: practice is emerging in this area currently. Whilst some forms of 'honour' based violence and abuse are also included, there is currently very little research or practice-based evidence on perpetrator interventions in this arena, including work with multiple perpetrators.

The second task, which was undertaken with key stakeholders was to develop a typology of interventions in a field which until relatively recently was limited to behaviour change group work with perpetrators of intimate partner violence and abuse (known as domestic violence perpetrator programmes (DVPPs) or domestic abuse perpetrator programmes (DAPPs)). Systems change work was excluded, such as Safe and Together, Multi-Agency Risk Assessment Conference (MARAC) and Multi-Agency Tasking and Coordination (MATAC): these may result in interventions that are covered here, but they are not in themselves direct perpetrator interventions. Interventions that are not specific to domestic abuse perpetrators, for example being arrested by the police, were also excluded. Currently, the scope does not include interventions delivered by HM Prison and Probation Service (HMPPS).

The typology of interventions that the standards cover is listed below.

Help-seeking **-** This covers interventions established for people to talk about their behaviour at an early point. They are usually brief interventions that operate as a pathway into other responses. Example: Respect Phoneline.

Early responses **-** This covers work that is a step before long term behaviour change – it may involve group or one to one work to provide information about domestic abuse, and/or to motivate perpetrators to consider a behaviour change programme. These are usually

[1] Section 1 of the DA Act provides that both the person who is carrying out the behaviour and the person to whom the behaviour is directed towards must be aged over 16. 'Child' is defined in s.3(4) of the Act as being a person under the age of 18 years, but this relates to when the child is a victim of domestic abuse as it is described in s.3 - the child sees or hears, or experiences the effects of, the abuse between the perpetrator (A) and the victim (B) and is related to A or B.

shorter-term interventions. Example: Change that Lasts Early Awareness Raising (CLEAR), Cautioning and Relationship Abuse (CARA).

Behaviour change work **-** For those where abuse has become an ongoing pattern, longer term interventions (these standards propose at least 22 weeks) offer the possibility of rethinking and changing how they relate to others. Often combined with risk and needs assessment, individual one to one work where needed, case management and multi-agency processes. Examples: Respect accredited Domestic Abuse Perpetrator Programme's (DAPPs), Make a Change.

Intensive multi-agency case management - Has emerged to work with 'high harm, high risk' cases identified by police on the basis of repeat call outs and/or multiple victims but could also cover other harm and risk levels. The key characteristic here is direct work backed up by a systems response - the coordination of agency responses, it can also include individual one to one work. Examples: Drive, Prevent and Change (PAC), See Change.

The third task was to draft the standards themselves. The approach we took is outlined in more detail in the Technical Annex. It was known from the outset that the evidence base on interventions was weak in many areas. First, a rapid evidence assessment was conducted to capture academic literature. We also reviewed other sets of standards from around the world. This was supplemented by practice-based evidence through a series of 16 roundtables attended by 297 practitioners and policy makers. A small number of victim-survivors (8) and perpetrators who had accessed interventions (7) were also consulted. It was also important to recognise that there are three existing sets of accreditation standards in the UK that these needed to complement rather than be in tension with: they are not a replacement for accreditation, but rather a higher-level set of principles that can be applied when making decisions about commissioning. Given the evidence base is still developing they should be revisited as the knowledge base expands.

Based on the literature review and practice-based evidence, seven standards have been developed.

1. The priority outcome for perpetrator interventions should be enhanced safety and freedom (space for action) for all victim-survivors, including children.

2. Interventions should be located within a wider co-ordinated community response in which all agencies share the responsibility of holding abusive behaviour in view, enabling change in perpetrators and enhancing the safety and freedom (space for action) of victim-survivors and their children.

3. Interventions should hold perpetrators to account, whilst treating them with respect, and offering opportunities to choose to change.

4. The right intervention should be offered to the right people at the right time.

5. Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap.

6. Interventions should be delivered by staff who are skilled and supported in responding to domestic abuse.

7. Monitoring and evaluation of interventions should take place to improve practice and expand the knowledge base.

Each of the seven standards with linked practice guidelines are discussed in more depth in turn in this document.

The Domestic Abuse Perpetrator Intervention Standards

From the approach outlined in the executive summary and detailed further in Appendix 1, the following seven standards have been developed (see **Box 1**).

Box 1. The seven standards for domestic abuse perpetrator interventions

1. The priority outcome for perpetrator interventions should be enhanced safety and freedom (space for action) for all victim-survivors, including children.

2. Interventions should be located within a wider co-ordinated community response in which all agencies share the responsibility of holding abusive behaviour in view, enabling change in perpetrators and enhancing the safety and freedom (space for action) of victim-survivors and children.

3. Interventions should hold perpetrators to account, whilst treating them with respect, and offering opportunities to choose to change.

4. The right intervention should be offered to the right people at the right time.

5. Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap.

6. Interventions should be delivered by staff who are skilled and supported in responding to domestic abuse.

7. Monitoring and evaluation of interventions should take place to improve practice and expand the knowledge base.

The evidence that underlies each is presented in turn alongside the policy and practice guidelines which should inform decisions on commissioning. Both the standards and corresponding practice guidelines are collated into one grid in **Appendix 4**.

Standard 1: The priority outcome for perpetrator interventions should be enhanced safety and freedom (space for action) for all victim-survivors, including children.

This standard represents the overarching lens through which the other standards should be understood.

Table 1. Standard 1.

The priority outcome for perpetrator interventions should be enhanced safety and freedom (space for action) for all victim-survivors, including children.	1.1 Safety and freedom for all victim-survivors (including children) should be clearly prioritised in the intervention's rationale, structure, procedures and intended outcomes. Victim-survivors have a right to know if a specific threat is made to their (including their children's) safety. 1.2 Interventions should not take place without integrated support for victim-survivors, for which there should be parity of provision. This support should be victim-survivor led in terms of the frequency and mode of support. Where possible partnerships with 'by and for' organisations are best practice. The same member of staff should never work with both the victim and perpetrator. 1.3 Clear information describing the intervention and the expected outcomes should be provided to both perpetrators and victim-survivors in a range of formats (a specific webpage, printed sheets) and in languages reflecting the populations they will serve. It is imperative not to overclaim the potential benefits and to outline any additional risks. 1.4 There should be clear and regular lines of communication between perpetrator intervention teams and victim-survivor support teams to share information so that changes in risk can be rapidly shared, appropriate actions taken, ensuring that victim-survivors (including current and ex-partners) receive timely information. 1.5 This standard represents the overarching lens through which the other standards need to be understood.

Integrated support for partners and ex-partners of domestic abuse perpetrators and prioritising their safety as a core pillar of perpetrator intervention work is a well-established global norm (see, for example, Stewart et al., 2013, Morrison et al, 2019a). Having this as

the primary standard is in line with other sets of standards internationally, which lead with standards with similar wording.

The importance of this as the primary standard was underlined in the academic literature, also reflected by practitioners in the roundtables (the roundtables are listed by topic as part of the technical annex in Appendix 1):

> *The aim of the project is to protect women and children.* (Roundtable 1)

> *We owe it to the victims for them to have support – they should have an equal opportunity for a service.'* (Roundtable 1)

That this is the first, and overarching, standard reflects the importance it is afforded in academic, policy and practice evidence.

Support for victim-survivors is a core component in this standard. However, research shows that this needs to be more than a generalised offer of support. It is the integration with the perpetrator intervention that matters, it cannot be completely detached as this precludes the dynamic management of risk. This in turn requires that integrated support workers for victim survivors need to have an in-depth understanding of the intervention, the work done with perpetrators and a sense of being part of a team. This was emphasised in the roundtable with integrated support workers:

> *It is crucial that those working with victims have a firm understanding of how the programme works and what it covers. In many cases workers supporting survivors are given a leaflet as to what it covers, and this is not good enough. They need comprehensive training so that they really understand the programme, how it works in practice*. (Roundtable 16)

Hence, support goes beyond just making victims 'aware of' or making a referral to a local integrated support organisation (Phillips, 2015). Safety for victims (including children) requires active steps to be taken and information about progress or risk should be given directly to the victim or partner support worker (Mullender and Burton, 2001).

Support for victim-survivors should include the provision of information. Some of the participants in the victim-survivor roundtable emphasised that this needs to be available even when other forms of support are not wanted.

> *She needs a full information pack on what the course will cover in detail, what support there is for her, and what can be expected*. (Victim-survivor)

> *Some women find it really useful to know what partner is doing on programme - learning new skills can be discomforting if you do not understand e.g. what is a time out.* (Roundtable 4)

It was also emphasised that this material needs to be available in a range of formats for different groups of victims.

> *LGBT, deaf, BME … give people the information in a format that works for them*. (Victim-survivor).

There is recognition in the literature that it can be difficult to support victims to understand the limitations of what the work with perpetrators may achieve (Morrison et al., 2019a). This is why the standards include a requirement not to overstate the potential benefits, alongside other safety measures such as having separate workers supporting the victim-survivor to the one delivering the perpetrator intervention (as emphasised in the roundtables).

Finally, although less information is readily available about how best to work with forms of family violence beyond intimate partner violence, and where there may be more than one victim and/or perpetrator, it is still recommended based on emerging research that they be based on the experiences and voices of victim-survivors in line with how intimate partner violence interventions have developed (Gangoli et al., 2022).

Standard 2: Interventions should be located within a wider co-ordinated community response in which all agencies share the responsibility of holding abusive behaviour in view, enabling change in perpetrators and enhancing the safety and freedom (space for action) of victim-survivors and children.

Table 2. Standard 2

Interventions should be located within a wider co-ordinated community response in which all agencies share the responsibility of holding abusive behaviour in view, enabling change in perpetrators and enhancing the safety and freedom (space for action) of victim-survivors and children.	2.1 To deliver interventions safely and effectively, organisations providing specialist domestic abuse perpetrator work should have an established track record of responding to domestic abuse. 2.2 Integrated victim support staff should share information where there is a safeguarding concern. Otherwise, the integrated victim support service is a confidential service and information should not be routinely shared. 2.3 Interventions should be embedded in local communities and/or have built strong local partnerships, including with 'by and for' services where available. 2.4 Referral to a perpetrator intervention should not be used as a reason to close cases, there are specific responsibilities around holding and monitoring risk that remain with statutory agencies. 2.5 Where an intervention is being delivered by a statutory organisation or on behalf of a statutory organisation, consideration should be given to the legal requirements for compliance and the responsibilities and obligations of the statutory organisation. 2.6 Interventions should demonstrate adherence to up to date best practice by seeking accreditation through an appropriate route such as the Correctional Services Advice and Accreditation Panel or Respect Standards. This is in line with the National Statement of Expectations (Home Office, 2022).

The origin of many of the current interventions with perpetrators was the Duluth model, in which work with men was nested within a Co-ordinated Community Response (CCR): this began from the principle that it was the responsibility of all agencies to hold perpetrators to

account in order to enhance the safety and freedom of women and children (Pence and Paymar, 1993). This has continued to be of importance across the world – for example the Work with Perpetrators European Network (WWP EN) guidelines for standards (covering members in 33 European countries) state that perpetrator programmes must be a part of a holistic intervention system and not be run in isolation (WWP EN, 2018).

It is the sharing of responsibility, not just information, that creates a context in which accountability becomes meaningful – that the same message and expectations are reinforced across the system and statutory agencies hold their roles and powers within this (Humphreys et al., 2000, Mullender and Burton 2001, Pattabhiraman, Kyalwazi & Shore, 2021, Rosenbaum & Geffner, 2001). Several roundtables with practitioners made the point that too often acceptance into an intervention was regarded as sufficient reason to close a case, especially within children's social care: this is not the intention of a CCR.

> *He is attending because mandated by children's social care, but not engaging. Problem is that all children's social care want to know is if they have attended and then they close the case – they should want to know more than this*. (Roundtable 2)

> *I was sat in MARAC recently and a man had breached restraining order 13 times, nothing done, but seen to be OK as she 'engaging with support'. This isn't safety, we are now better at assessing need and dangerousness, but what about safety? Serious concerns should lead to different actions.* (Roundtable 3)

Knowledge and understanding about domestic abuse, including forms of family abuse, is an essential requirement for effective and thoughtful practice. It was already noted in Chapter 2 that there is recognition internationally that minoritised groups have been poorly served to date, and that the evidence base is far weaker here. The roundtables focused on specific communities concurred that specialist knowledge from within each community was essential in ensuring that that the content and approach was appropriate. The potential of co-facilitation with community members was also a common theme. This reflects the 'by and for' principle: specialist services that are led, designed, and delivered by and for the communities they aim to serve.

The importance of case management and coordination with other local agencies is necessary to meet the needs of both victim-survivors and perpetrators (Cantos and O'Leary, 2014), which may include individual counselling, substance misuse issues, financial, immigration, legal or educational support (Babcock et al., 2016). A lead professional may already be coordinating an individual or whole-family plan, within which organisations may play a crucial part. Being embedded in a local community, and/or having built enduring connections is an important foundation for being able to access the right resources for individuals and to extend the reach of existing services.

> *Competitive funding means sometimes pop-up organisations get contracts. Organisations should be established and have sustained locally – this is preferable to the regular restarts* (Roundtable 7).

Accreditation ensures that organisations are meeting or working towards minimum standards throughout their work. Roundtable participants highlighted that 'working towards' is not enough – that funders and commissioners should also be interested at what stage those who are 'working towards' are at. Research shows that commissioners are very aware of the dangers of commissioning poor quality interventions, and that the meeting of a standard that has a linked assessment process such as that provided by Respect was one way of increasing their commissioning confidence (Westmarland and Zilkova, 2022).

Standard 3: Interventions should hold perpetrators to account, whilst treating them with respect, and offering opportunities to choose to change.

Table 3. Standard 3

Interventions should hold perpetrators to account, whilst treating them with respect, and offering opportunities to choose to change.	3.1 Interventions should treat perpetrators with respect modelling the opposite of all that is abusive, while holding them accountable for the harm they have caused to others and offer opportunities to choose not to use violence or abuse. 3.2 Interventions should be evidence based and focus on the forms of power, control and exploitation that research and practice have shown to be part of domestic abuse. Interventions could also include violence interruption strategies and emotional regulation techniques as elements within a wider programme of work. 3.3 Behaviour change interventions (as defined earlier) should take into consideration the length of time needed to meet the behaviour change objectives. 22 weekly sessions for groupwork programmes or 16 weekly sessions for one-to-one work could be used as the minimum expectation for intimate partner violence and abuse [2], but longer programmes are needed for some. 3.4 Behaviour change interventions should use a groupwork model where possible, sometimes in combination with one-to-one work. This does not preclude one-to-one work being used where this is the most appropriate model of intervention for the individual perpetrator. 3.5 Behaviour change interventions for intimate partner violence should be delivered in person where possible. Facilitated remote access work (but not digital/e-learning unless solely supplementary) can be used where this is the most appropriate model and the potential impacts on victim-survivors have been fully considered. 3.6 Behaviour change interventions which are delivered as groupwork, should have two facilitators, and less experienced staff should be partnered with more experienced staff. Best practice is that groups be co-facilitated by a male and female

[2] As defined earlier in this report on page 4-5, shorter interventions are possible but would come under the category of early response rather than behaviour change.

	staff member, except for groups for same-sex intimate partner violence which may not require a facilitator of the opposite sex.

Our findings show that accountability is an important thread in literature and practice, but that it must be explored relationally with facilitators modelling respect towards each other and service users (in line with the first of the Principles of Effective Intervention that highlights the importance of approaching behaviour change from a position of respect). Some aspect of accountability or responsibility is incorporated into most perpetrator interventions whatever their theoretical approach (Grealy et al, 2013). While some level of minimisation and blaming others is often seen at the beginning of interventions, the objective of many interventions is to shift this and to support the client to take ownership of their use of power and control (Hamberger, 2001). As the participants in the roundtables put it:

> *It's about understanding someone's trauma history – not excusing behaviour but understanding [them]*. (Roundtable 3)
>
> *Unaddressed traumas are not an explanation of excuse, but they are a challenge for intervention.* (Roundtable 14)

The roundtables made clear that accountability means different things to different people. It is used here to mean a commitment and process to recognise and change harmful behaviours: it is accountability to victim-survivors and to children, to wider communities and to oneself. Recognising the harms one has caused is a necessary first step to behaviour change. It is not a punitive or blaming response, but rather seeks a willingness to listen and communicate honestly.

For interventions where behaviour change is the goal, groupwork is the preferred format in many standards (Austin and Dankwort, 2003), with most programme participants also endorsing this as a positive model of intervention (Morrison et al., 2019b). In the US and Canada, 97% of behaviour change programmes occur in a group format (Cannon et al., 2016). This is said to have several clinical/behaviour change advantages, including helping perpetrators overcome not only denial (Lehmann and Simmons, 2009) but also feelings of shame, which may increase motivation to stay in the programme (Maiuro, Hagar, Lin and Olson, 2001). The importance of being engaged and encouraged by peers, and the space to process new ideas and information has been documented in groups (Kelly and Westmarland, 2015), and there are benefits in terms of diversity within groups (Holtrop et al., 2017). There are many examples in the literature of motivational approaches being used as a precursor to behaviour change, either as part of assessment or shorter interventions to ready someone for behaviour change. Coming under the umbrella of what Lehmann and Simmons (2009) label 'strengths-based approaches' (including motivational interviewing, cognitive behavioural interventions, and the Good Lives Model) sit many

approaches that are often situated as in opposition to ‘traditional’ or ‘feminist’ models of practice. However, in practice the UK has tended to take an eclectic approach to intervention design, drawing from a broad toolbox of approaches to best work with the perpetrators they are trying to engage.

There is not much research that explores the impact of content on perpetrators, which elements or topics prompt an interest in change. The Project Mirabal interviews with perpetrators in the UK did explore that, and found that sessions which expanded notions of violence and abuse, addressed sexual violence and the impacts on children were what male perpetrators of intimate partner violence found the most challenging and revealing (Kelly and Westmarland, 2015).

Although some interventions such as ‘anger management’ have long been criticised as not appropriate as a standalone intervention due to their lack of consideration of power and control and simplistic content (Gondolf and Russell, 1986), others have argued that there is a rationale for including some techniques as a violence interruption strategy within a wider behaviour change programme. Wistow et al (2017) argue that tools offered in behaviour change programmes such as the ‘Time Out Technique’ can be useful in reducing physical violence as long as it is not misused (as a further or new form of power and control over the victim). Overall, as Maiuro et al. (2001) highlighted, research shows that perpetrators are diverse and since research is yet to differentiate which elements make a difference for which participants, standards should take an inclusive rather than exclusive approach.

While no specific research has been conducted into the effects of different facilitator teams in terms of gender (Babcock et al., 2016), it was clear from the roundtables that they saw this as preferable if not essential.

> *If anything, the balance should be tipped towards the female, because they will not accept any type of, not only challenge, but even compromise from a female*. (Roundtable 1)

The topic of ‘how long’ or, in US treatment terminology, the ‘dose’ that perpetrators should receive is one that is debated. However, it is widely acknowledged that behaviour change takes time. It is not just the number of hours of ‘treatment’ that is important, it is also the space to think in-between sessions, and to conduct any homework as necessary. Most of the practitioners spoke about expecting homework/consolidation/practice/’give it a go’ tasks between group sessions. This is why a number of weeks have been recommended rather than specified a number of hours intervention. It has not been specified which of these should be one to one, which should be groupwork, nor which should be online or in person – hence emphasising that change takes time, but that models of intervention and delivery will vary.

That behaviour change takes time is a key theme throughout the literature. This is not to suggest that there is not an important place for other interventions – simply that there is a value in differentiating long term behaviour change programmes from other types of perpetrator interventions which is what these standards have tried to do in the earlier stages of this document. For example, based on the Prochaska and DiClemente's (1984) transtheoretical Stages of Change framework, Begun et al. (2001) highlight the time needed to travel through these steps:

> *Considerable time is required to make a significant change in entrenched, habitual behaviors. The cumulative behavioral and attitudinal change demands associated with the cessation of intimate partner violence are monumental. The individual must change attitudes and behaviors that have been developed over a lifetime and which are often reinforced by societal norms.* (pg. 120).

This is backed up by Project Mirabal in the UK which concluded:

> *Many men, at the end of the programme, note that it takes consideration, time and reflection to understand, unpick and change embedded patterns of behaviour and habits. Many women noted that at the outset their partners thought they could attend, 'tick a few boxes' and carry on as usual. It is the length and depth of DVPPs (domestic violence perpetrator programmes) which makes it possible to go beyond simple behaviour disruption to deeper changes which make a difference.* (Kelly and Westmarland, 2015, pg. 46)

There are also ongoing debates about effectiveness of remote access interventions – whereby perpetrators access online, 'live' interventions from their home or other location (such as a probation office or community centre). While some outside the UK were starting to consider such approaches pre-Covid-19 (particularly some rural areas of Australia and North America), this was an approach that had not been tested in the UK until Covid-19 forced them to significantly alter their practice. Research specifically in the perpetrator intervention field is limited, but what exists shows some benefits and some risks (Bellini and Westmarland, 2021, 2022; Rutter, Hall and Westmarland, 2022). Given the risks and the limited research, this document takes a cautious position that may change over the next few years, that behaviour change interventions should only be delivered using a remote access format entirely if face to face work is not available and all risks are fully considered.

Standard 4: The right intervention should be offered to the right people at the right time

Table 4. Standard 4

The right intervention should be offered to the right people at the right time.	4.1 Organisations should have a written model of work that sets out the objectives, nature, content and intended outcomes of each intervention offered and which groups of domestic abuse perpetrators it is appropriate for and how support for victim-survivors will be integrated. 4.2 Assessments should be proportionate to the intervention being delivered and should enable identification of specific needs related to risk and/or the perpetrator's capacity to participate in an intervention. Where additional or complex needs are identified a plan (and where necessary a referral pathway) for addressing these should be identified. 4.3 Interventions should be appropriate to the assessment and be responsive to adaptation where necessary. Where adaptation is needed for a specific perpetrator population (such as where perpetrators have problems with mental health, drug and/or alcohol misuse) co-facilitation with a relevant skilled practitioner should be considered. 4.4 Assessment processes should enable identification of primary perpetrator and not deliver perpetrator focused interventions to victim-survivors who use resistance. Where a perpetrator may be a victim (for example, mothers in cases of 'honour'-based violence and abuse, adolescents who use violence who have also experienced child sexual abuse) there should be a clear pathway of referral to support them, whilst they engage with an adapted and appropriate perpetrator focused intervention. 4.5 Participation in an intervention should not seen as a route to maintain or reassert control over an ex-partner through repeated or extended court proceedings. Motivation should be carefully assessed throughout the intervention Perpetrators who are currently (or have recently been) party to private law children proceedings should be assessed for their suitability by programme staff independently of any prior assessment or recommendation by a referring agency or solicitor.

	4.6 Joint work is rarely suitable in cases of intimate partner violence, it should only be undertaken if proactively requested by the victim-survivor, once perpetrator behaviour change work has been undertaken, and a further suitability assessment has been conducted separately with the perpetrator and the victim-survivor. Similar caveats apply to informal or formal mediation, reconciliation or religious arbitration work for all forms of domestic abuse.

There is a body of research which emphasises the importance of assessment to move away from a 'one size fits all' model and enable a more client centred approach (Maiuro and Eberle, 2008). As Babcock puts it:

> *There are ample reasons why perpetrators should not simply be enrolled in a cursory intake. At a minimum, a proper assessment should determine whether a client is suitable or not suitable for a particular program and whether he or she poses a continuing danger to the victim*. (Babcock et al, 2016, pg. 379)

Some programmes, particularly those linked to the criminal justice system, have moved towards aligning their programmes with the Principles of Effective Intervention (PEI). The PEI are backed up by a large body of international research that demonstrate general behaviour change programmes for offenders have greater reductions in recidivism when they follow these principles (Bonta and Andrews, 2017). It is generally acknowledged that the first three of these principles – Risk, Need and Responsivity (known collectively as the RNR principles) are the most important.

There is still some debate in the field about whether non-criminal justice focused perpetrator interventions should be moving closer towards the PEI. Some US interventions have begun the process of aligning their programmes with these principles (Radatz et al., 2021). On the one hand, the amount of additional resource needed to fully align programmes should not be under-estimated. On the other hand, many interventions are already following many of the principles to some extent.

The move towards a more tailored approach to interventions does have some evidence of achieving better outcomes (Travers et al., 2021). This includes tailoring interventions to offending patterns and/or readiness to change (see e.g., Arias, Arce and Vilariño, 2013; Babcock et al., 2016), however this is more resource intensive than the current workforce and resources are able to achieve. More research is needed on the costs and benefits of moving closer towards more tailored approaches in England and Wales and the specific components of the RNR model that would have the largest impact on domestic abuse perpetration (Travers et al. 2021). Outside of long-term behaviour change interventions, there is evidence of more targeted, individualised one to one interventions such as Drive showing positive outcomes (Hester et al., 2019).

A comprehensive assessment allows for a perpetrator's needs (criminogenic and non-criminogenic if that language and distinction is useful for a given intervention) to be identified. This will sometimes require additional work internally, or sometimes require external referral pathways (still working within the remit of Standard 2):

> *We have a range of learning needs in our groups, and extra support can be offered in and outside the group if needed when completing tasks*. (Roundtable 2)

There are some areas of ongoing debate within the perpetrator intervention field – how best to provide interventions to women perpetrators, respond to women who use force, and the role of so called 'couples counselling' and mediation type services.

There was a specific roundtable (number 8) for practitioners to talk about women perpetrators and women who use force. There was a high degree of agreement between the participants in the roundtable. It was clear that there was a gap in availability of high-quality interventions for women perpetrators. This was the case both for women who use violence against female partners and for those using violence against male partners. There was also said to be a gap in understanding the needs of women victim-survivors of domestic abuse who use force. This was the case for intimate partner violence cases, and in cases of family violence and abuse, for example where mothers-in-law or mothers were both experiencing violence and abuse from male family members but also perpetrating violence and abuse against younger female members of the family (Gangoli et al., 2022).

> *Women's access to offender programmes is much more limited than men's access*. (Roundtable 8)

> *There are gaps in relation to women using force against men and women using force against other women*. (Roundtable 8)

> *We have a problem of repeat perpetrators where nothing happens and a female when she first uses violent resistance is intervened with. I worry that [name of programme] is identifying more women – that they are up tariffed, whereas men are down tariffed*. (Roundtable 8)

> *[We should not be] using a men's programme model and calling it a gender-neutral programme that anyone can go on*. (Roundtable 8)

A further intervention that is debated internationally is how safe and effective jointly working with victims and perpetrators of domestic abuse is. Many attending the roundtables felt that this was not an appropriate method of intervention in relation to domestic abuse, and this was also the view of the women victim-survivors who were consulted (noting though that this group was made up of ex-partners who may be less invested in the possibility of this type of

intervention). However, some highlighted that this type of intervention was happening and therefore should be included within the standards:

> *Couple interventions and anger management are potential no go areas, couple work is only possible if risks have been managed and are being held by agencies – how to determine 'low' risk and what would effectiveness be of these interventions? We need an alignment of approach and how the victim-survivor can be on an equal footing. Worry that the message is that issue is between the two rather than with the perpetrator*. (Roundtable 15)

> *It must be separate and never together otherwise he can control and you would feel you had to do it if you wanted to keep children*. (Victim-survivor)

It is also important to remember that these standards are for all forms of domestic abuse, and that there are some forms of family violence, particularly adolescent to parent violence or abuse, where joint working is more commonplace.

Standard 5: Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap

Table 5. Standard 5

Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap.	5.1 Interventions should recognise that those from minoritised groups may have experienced barriers and disadvantages and that change is more likely where these are acknowledged and addressed. 5.2 The foundation of seeking power and control applies across all communities, however, how it is expressed and justified is likely to vary. Work should explore variations in gender and generational norms and how they affect mechanisms of power and control. 5.3 Work should explore the individual, familial and wider beliefs that permit, justify or minimise abuse (in some situations, victim-survivors and perpetrators may frame these beliefs in narratives of culture, faith, religion and/or community values) alongside those which do not support it. Whilst this can become a source of insight in work with victim-survivors and perpetrators, it is important that practitioners do not reinforce stereotypes of entire communities. 5.4 Different approaches need to be developed for heterosexual women and/or LGB and/or T perpetrators and adult child to parent violence and abuse. Existing approaches may need to be adapted for people from minoritised groups on the basis of ethnicity/race and neurodivergent perpetrators for whom learning, social and communication differences/difficulties need to be addressed. 5.5 Community language specific direct work (one to one and group) could be made available and can be more effective as it enables both prompt access and a joint exploration of meaning.

Across all the roundtables there was recognition that interventions have struggled to include all perpetrators: that those who are minoritised through race/ethnicity, sex and gender, sexuality and/or disability have had less access and that their needs are not always understood or adapted to. In the few cases where it has been considered, this has usually been in relation to intimate partner violence, with family violence even further left behind (Gangoli et al. 2022).

The academic literature also questions the 'one size fits all' (Cannon and Buttell, 2016; Maiuro & Eberle, 2008) approach, suggesting 'little or no special effort is being made to understand or accommodate the needs of minority populations' (Williams & Becker, 1994, p. 287). This has often been framed through culture and 'cultural competence' (Sue, Arredondo, & McDavis, 1992; Weaver, 1998; Weaver & Wodarski, 1995) – reflecting an assumption that it is only those who are minoritised for whom culture is a relevant issue. The issue is framed here as one of ideas and beliefs, present in all social groups, that create conducive contexts (Almeida & Dolan-Delvecchio, 1999; Almeida, Woods, Messineo, & Font,1998) for violence and abuse. Such contexts often also include alternative ideas and beliefs that support non-violence: practitioners should integrate curiosity about both in their work with perpetrators and victim-survivors.

Behaviour change work with men who are minoritised by race and ethnicity has been found to be more effective in groups with shared heritages (Aymer 2011; Parra-Cardona et al. 2013; Waller, 2016; Williams, 1992) and some argue that facilitators should come from the same backgrounds (Pattabhiraman, Kyalwazi, & Shore, 2021). At the same time, in the workshops some practitioners noted that diversity in group work could be a source of insight and learning. This should be seen as a both/and rather than an either/or.

> *Addressing cultural influences within the content of the programme can be a learning experience for the men within the group*. (Roundtable 2)

The knowledge and practice base here needs building in a UK context since most of the research is from the US.

Access to interventions can be physically limited if venues are not equipped for wheelchair users. Other access limitations may be due to language – both first language (including British Sign Language) and language use in relation to neurodiversity. Practice has included translators, but this is usually limited to one in group work and is often inadequate as translators seldom have expertise in domestic abuse. Practice based knowledge suggests that language specific groups are preferable, as they enhance communication, participation and understanding.

> *It is more effective in community languages, it is too easy otherwise to get distracted by cultural issues – but that needs investment in the workforce.* (Roundtable 7)

Both roundtables and academic sources (Gray et al., 2020) concur that generic behaviour change content is not appropriate for LGB and/or T perpetrators, since it takes heterosexual partnerships as the default. In same sex relationships there can be additional challenges in identifying the primary perpetrator and of exploring the different ways power and control operates in these relationships (Gray et al., 2020). For example, it may be wrongly assumed that the physically larger partner is the primary aggressor. Specific forms of abuse within LGB and/or T relationships such as identity abuse (such as threatening to 'out' a

partner) may be overlooked and remains under-researched (Donovan and Barnes, 2019). There were also concerns about generic behaviour change content being used without adaptation for women:

> *A men's programme cannot be made gender neutral, and I have reservations about anything gender neutral. We need to be more exploratory with women [...] Still need to look at intent behind behaviour – but if intent is to stop his control that is very different to wanting to control him.* (Roundtable 8)

The data on work with neurodivergent perpetrators is sparce, but one ongoing study suggests that undiagnosed ADHD/Autism may be interpreted as belligerence and lack of engagement by practitioners (Renehan & Fitz-Gibbon, 2022). Reasonable adjustments to learning styles can mitigate this, as can co-facilitation with neurodivergence trained and highly skilled practitioners. Capacity assessment procedures should be undertaken where capacity is in question for victim-survivors or perpetrators.

Perpetrators from minoritised groups may have experienced barriers and disadvantages which will interact with their choice to use violence and abuse. Space for this to be recognised, and possibly even worked with, is not the same as enabling these experiences to be used as a legitimation of violence and abuse. Practice based evidence from the workshops suggested that such recognition can create more space for change and was more likely where practitioners were from the same minoritised groups. However, there is also a recognition that mainstream services do need to be more responsive as most perpetrators from minoritised groups will not have this option.

Standard 6: Interventions should be delivered by staff who are skilled and supported in responding to domestic abuse

Table 6. Standard 6

Interventions should be delivered by staff who are skilled and supported in responding to domestic abuse.	6.1 Staff should receive induction training to enhance their knowledge on domestic abuse, how protected characteristics can intersect, local safeguarding and multi-agency processes and the intervention they are working within. This also applies to integrated support workers. Continued professional development should update on new knowledge and practice, including the impact on victim-survivors, including children. 6.2 Interventions should be delivered and managed by a team which seeks to reflect the communities they serve. 6.3 Staff delivering interventions should have access to regular internal line management supervision and funded, high quality, external clinical supervision. Staff who are supporting but not delivering interventions could be offered the same support. 6.4 Workloads should not exceed the number that can be carried out safely, and delivered equitably, for specific interventions. This applies to both integrated victim support and perpetrator work. 6.5 People perpetrating domestic abuse should not be delivering perpetrator interventions. Any previous use of domestic abuse should be disclosed. An enhanced Disclosure and Barring Service (DBS) check should be completed (though with evidence of substantive personal change work previous offending is not necessarily a bar to delivering perpetrator interventions).

Research has highlighted the importance in having and a knowledgeable, confident, and supported team of staff (Stover and Lent, 2014; Morrison et al., 2019a). This also came across very strongly in the practitioner roundtables:

> *Standards do not make the work safe - it is those delivering them*. (Roundtable 8)

> *Trained staff – and enough of them*. (Roundtable 2)

> *The work needs strong and deep DA knowledge, safeguarding, foundational training, links to victim-survivor work. This influences what people do in the room and outside the room. It is not just the groupwork but all the follow up*. (Roundtable 2).

Both the literature and many roundtables stressed the importance of training which addresses the up-to-date evidence base on domestic abuse in general, perpetration and victimisation. There also has to be a motivation to undertake this work in a way that offers respect to each person whilst holding perpetrators responsible for the harms they have caused (Morrison et al, 2019a).

Evaluations from the US suggested that DAPPs can be less effective with some minoritised men, pointing to a need for greater staff diversity and knowledge. Williams and Becker (1994) note that 'little or no special effort is being made to understand or accommodate the needs of minority populations' (pg. 287). Others have pointed to the different experiences of culture, community, and family that perpetrators may have (Pence and Paymar, 1993; Zellerer, 2003) and experiences of being harmed through racism, ablism, heterosexism. A number of commentators argue that the ability to be responsive is likely to increase effectiveness (Buttell & Pike, 2003; Cavanaugh & Gelles, 2005; Holtzworth-Munroe & Stuart, 1994). The roundtables revealed that practice is developing in England and Wales, but language specific provision in group work, alongside LGB and/or T and neurodiverse groups remain the exception. Group work in some areas of England and Wales, particularly London, is increasingly diverse, and many practitioners pointed to the insight that such diversity can prompt. This is a "both/and" issue – some perpetrators are happy to attend a diverse group. For others, and the roundtables suggested this was particularly the case for black African/Caribbean/British men, community specific provision was considered vital.

For practice to be responsive training this must cover multiple disadvantages and how they affect access; and the ways domestic abuse is understood and experienced (Babcock, Green, & Robie, 2004; Stover, Meadows, & Kaufman, 2009, Stover & Lent, 2014). There are also specific competences required in relation to assessment, group and one to one work (Stover & Lent, 2014, Whitfield, Anda, Dube and Felitti, 2013) including being trauma informed (Kirby et al., 2012; Murphy & Ting, 2010; Taft, Watkins, Stafford, Street, & Monson, 2011) and understanding the overlaps with complex needs including mental health (Spencer et al. 2017; Trevillion et al. 2012; see Oram et al. 2014; Shorey et al. 2012; Stuart et al. 2006 for how this applies to women who use force) and substance misuse (Butters, 2021, Stover & Lent, 2014, Wilson et al. 2014). Humphreys et al. (2000) summarise this as it is training which embeds policy in practice.

The literature on effective practice in perpetrator work, reflecting a wider move, increasingly focuses on reflective learning for staff (Davys & Beddoe, 2020). Here staff supervision "aims to get workers to think critically about their perceptions and actions" (Gibbs, 2001, p. 7) where "the supervisor's role becomes one of ensuring the space and context for learning" (Davys and Beddoe, 2020, p. 101).

> *Time to prepare and debrief, supervision and training support, counselling and clinical supervision, open dialogue with managers*. (Roundtable 2)

This supervision space should be one to explore complexities and challenges (Stover & Lent, 2014, Day, Chung, O'Leary & Carson, 2009) as well as preventing 'drift' away from the model of work (Hollin, 1995). This includes the ways gender norms may play out in staff teams and there is a suggestion that female co-facilitators should have a "women only space" to discuss and debrief with each other (Evans & Robertson, 2021, p. 5; Vlais et al., 2017, p. 102), alongside the availability of external clinical supervision for all team members (Evans & Robertson, 2021).

However, there was also a recognition that we are not where we need to be in terms of a well-trained, experienced workforce for England and Wales and a hope that these standards would take this into consideration.

> *We have an under-developed provider market and an under-developed workforce. We need to be mindful that providers might not be able to recruit people with all the training already in place and maybe some learning on the job might be necessary.* (Roundtable 2)

> *Standards should not set services up to fail – give due regard to the limited existed workforce*. (Roundtable 2)

Standard 7: Monitoring and evaluation of interventions should take place to improve practice and expand the knowledge base.

Table 7. Standard 7

Monitoring and evaluation of interventions should take place to improve practice and expand the knowledge base.	7.1 Clear and consistent records should be in place to enable safe and effective delivery of the intervention and identification and prompt responses to increases to risk/safeguarding concerns. 7.2 Data should be collected on interventions, in line with their model of work and aligned to their referral and funding requirements, including on outcomes relevant to their intervention and who is (and importantly who is not) currently accessing their intervention. 7.3 The experiences of a) victim-survivors (including children) associated with perpetrator service users and b) perpetrator service users should be gathered and used as a source of learning. There should be a transparent process and timeline for gathering and reflecting on this information within teams (proportionate to the size of the organisation). 7.4 Existing interventions could be externally evaluated. Interventions should always be independently evaluated when new approaches are being piloted.

Case management systems are required to monitor each case and measure overall effectiveness, including for minority groups (Gray et al., 2020, p. 22; Morrison et al., 2019a, p. 2684). Having a clear model of work, with intended outcomes should then be reflected in how change is evidenced from both perpetrators and victim-survivors. In a review of standards in Australia 'victim/survivor freedom and safety was a key outcome addressed in all MBCP [Men's Behaviour Change Programme] evaluations' (Nicholas et al., 2020, p. 95) In the UK, this has been found to be important for victim-survivors, for practitioners delivering perpetrator interventions and for funders and commissioners (Westmarland et al. 2010). The importance of victim-survivor freedom also came through from multiple directions in this current project, hence its emphasis in the first of the standards. It therefore follows that there should be systems in place to explore the extent to which this change has taken place as a result of the intervention.

Consult with survivors in the design of services. (Roundtable 2)

We need more consensus on how we measure change. (Roundtable 5)

There is a strong thread in some of the literature about monitoring of practice as a route to ensuring minimum standards are met through attention to quality and accountability (Morrison et al., 2019a; Westmarland and Zilkova, 2022). Accreditation provides a route for ensuring that standards are being met, and that quality is maintained over time.

> *When standards are low and compliance is relatively easy, irresponsible programs may actually gain stature from the approval process.* (Tolman, 2001, pg. 225).

At the same time, organisations should be using their own monitoring data as a source for reflection and learning: who is and is not taking up the intervention; engagement and completion rates; which topics are sources of insight and challenge; the interface between perpetrator work and victim-survivor support.

While monitoring data should be collected for all interventions, some may also benefit from external, independent evaluation. Independent evaluation offers the possibility of taking a fresh view of interventions and models, having external perspectives on how far the model of work is being implemented, if it is being done equitably, and where there are gaps and areas for improvement. However, it is recognised that not all interventions will be ready for or have the capacity to engage in an external evaluation. Given the number of gaps and areas for improvements, there does need to be space for innovative approaches. Independent evaluation should always be in place for new innovative approaches, with a dual emphasis on whether this can be said not just to be effective but also safe practice. Having an evaluation plan and providing results of evaluation has been highlighted as important within the Principles for Effective Intervention (Bonta and Andrews, 2017). Key to this is developing a broad understanding of what counts as 'success', such as the six measures of success developed as part of Project Mirabal or the EU funded Project IMPACT which produced the Impact Outcome toolkit.

Summary

This has been a substantial project delivered in a very short timeframe. The seven standards and corresponding policy and practice guidelines have been developed in consultation with practitioners, policy makers, academics, victim-survivors and perpetrators. It is intended that they will underpin the development of safe and effective domestic abuse perpetrator interventions across England and Wales.

The work did reveal some serious gaps in the evidence base, especially in terms of how current responses can be extended to cover all forms of domestic abuse and to diversity within perpetrators. In addition, scaling up provision faces the challenge of recruitment, this is a specialist area that needs capacity building through both a workforce development plan and agreed training standards. Meeting this challenge would also offer an opportunity to expand the pool of staff who belong to currently underserved communities.

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Appendix 1 Technical Annex

Part A. Background and context

This annex details the approach taken for a short timescale project, commissioned by the Home Office, to develop a set of standards for domestic abuse perpetrator interventions in England and Wales. The requirements were that: the standards were evidence based; they cover a broad range of interventions (beyond behaviour change programmes); and that they include forms of family abuse as well as intimate partner violence and abuse as covered by the definition in the Domestic Abuse Act 2021 (Domestic Abuse Act 2021 (legislation.gov.uk)). That said the focus has been primarily on intimate partner violence abuse and adult child to parent violence and abuse as these are the areas where there are few (if any) interventions currently. There is some early exploration through practice-based knowledge of forms of family abuse where there are multiple perpetrators, for example, 'honour' based violence and abuse.

The standards should be understood in the context of, or in conjunction with, other relevant government guidance including the Domestic Abuse Statutory Guidance, Controlling or Coercive Behaviour Statutory Guidance (when published), the Tackling Domestic Abuse Plan, the Supporting Male Victims Position Statement and the Violence Against Women and Girls National Statement of Expectations.

There are a number of dimensions to consider when developing standards which address what is currently considered as 'best', 'safe' and 'effective' practice. Internationally, the (English language) knowledge base is heavily skewed towards research and practice from the US (and to a much lesser extent Australia, Canada, the UK and New Zealand), and towards behaviour change groupwork interventions for intimate partner violence and abuse - with most study samples made up of white, heterosexual, male perpetrators.

On the one hand, the 'what works' field is full of contentions. In terms of behaviour change programmes, the most accurate statement one could make would probably be that they do create change, but that that change is limited for some and there is significant room for improvement. However, an increasing number of UK based studies have shown that perpetrator interventions can and do have positive impacts (Dobash et al., 1997; Kelly and Westmarland, 2015; Bloomfield and Dixon, 2015; Hester et al., 2019). We need to move away from the global 'do they work' question to a more sophisticated understanding of how and why different interventions work with which groups of perpetrators in order to move the field forward. Many of the 'do they work' style studies have significant limitations that are not easily overcome in working with these populations (for example high levels of research

sample attrition and low rates of participation by victim-survivors[3]). In the UK, the research evidence base has also been affected by the relatively small number of interventions and perpetrators accessing them which has limited sample sizes.

There is increasingly strong evidence in the field of offender behaviour change more broadly, through models and frameworks such as the Principles of Effective Intervention (Bonta and Andrews, 2016), the Good Life Model (Ward, 2002), and other strengths-based approaches (Lehmann and Simmons, 2009). How these are used in practice has tended to be guided by the needs and profiles of different groups of perpetrators (e.g., nature of criminal justice involvement, motivation to change).

An additional limitation for the evidence base in which the standards are based is that the international literature tends to be limited to intimate partner violence and abuse and there is widespread recognition of limitation even within this, for example in relation to same sex relationships, female perpetrators, people with disabilities, and minority groups. The wider reach into forms of family abuse that the standards required has not yet been addressed in any depth in academic research. It is for this reason that a key part of the approach was to organise a series of roundtables to draw on practice-based knowledge to start to address some of the gaps.

It is because of this limited evidence base, which is even more sparse when we consider England and Wales, that it is argued it would be premature to place too stringent a set of standards upon perpetrator interventions. There must be room for innovation and development, so these are seen as a starting point to be built on and adapted as the evidence and practice bases expand.

There are some key elements that have framed the thinking in developing these standards, from both practice and academic evidence. Firstly, these standards should not conflict or be in tension with those already being widely used in England and Wales (see **Box 2** below). Secondly, that they should take lessons from the academic research on standards from other jurisdictions. Thirdly that they should move beyond intimate partner violence and abuse and include interventions other than behaviour change group work. Lastly, that it should be considered what might enable the wider reach into groups that are currently not well served by current provision.

The standards do not cover management of the organisations. That said, it is not always straightforward to separate these, the quality of interventions and their sustainability depend on the organisations that deliver them ensuring that practitioners have the skills and knowledge required and that they are supported to the work to the standards. There was

[3] Whilst acknowledging that the Domestic Abuse Act uses victims and survivors, we choose to use the concept of victim-survivor to recognise that these are not separate groups of people and that both are simultaneous aspects of lived experience during and in the aftermath of violence and abuse. This concept enables recognition of strengths and actions during and after abuse, which the term victim cannot accommodate.

widespread consensus across statutory and non-statutory sectors that interventions could not be separated from the organisations and the infrastructure that underpins them.

A review of existing research on standards for domestic abuse perpetrator interventions

In this section summaries of the standards are presented alongside the evidence base on them that the literature review revealed. **Box 2** summarises the three sets of standards currently in use in England and Wales:

- Correctional Services Advice and Accreditation Panel (CSAAP) comprising of academics and expert practitioners who provide independent advice on accreditation to Her Majesty's Prison and Probation Service (HMPPS) across a range of offender types;
- Respect Principles and Standards which are specific to domestic abuse;
- Welsh Government Perpetrator Service Standards which are intended to apply to a range of forms of Violence against women and Girls (VAWG) including sexual violence.

It is not surprising, therefore, that it not straightforward to easily map across the three.

Box 2. Three standards of most relevance to this project

CSAAP (Correctional services Advice and Accreditation Panel) (UK)	Respect Principles and Standards (4th ed) (UK)	Welsh Gov Perpetrator Service Standards (VAWDASV)
1.Evidence-based and/or have a credible rationale 2.Address factors relevant to reoffending and desistance 3. Targeted at appropriate participants 4. Develop new skills (as opposed to only raising awareness) 5.Motivate, engage, and retain participants 6.Delivered as intended by staff with appropriate skills and quality assured, via: (6a) a quality assurance plan, and (6b) by providing quality assurance findings 7.Evaluated, via: (7a) an evaluation plan, and (7b) by providing results of evaluation every 5 years	Principles 1. Safety first: Do no harm 2. Sex and gender informed approaches 3. Sustainable change 4. Inclusive services, responsive to diverse needs 5. Highly skilled and supported workforce 6. Ongoing monitoring and evaluation 7. Commitment to coordinated multi-agency working Sections A. Management of the organisation B. Structured intervention programme delivery C. Intensive case management intervention delivery D. Integrated support service E. Equality, diversity and inlcusion	1. Referrals 2. Eligibility criteria 3. Consent 4. Assessment 5. Links to partner work 6. Intervention 7. Re-Assessment 8. De-selection 9. Drop out 10. Progress assessment 11. Service evaluation 12. Staff selection 13. Staff training and continuous professional development (CPD) 14. Clinical supervision 15. Professional support 16. Health and Safety 17. Equality and diversity 18. Complaints 19. Environment and Culture 20. Record keeping 21. Information sharing 22. Links to children's services 23. New services and innovation

Two further approaches to standards that have attempted to do something different within the field were identified. The first approach comes from the Centre for Innovative Justice in Australia who have developed '12 foundations' - core principles rather than prescriptive standards (Vlais, Campbell and Green, 2019). **Box 3** shows two of these foundations to give a flavour of this approach.

Box 3. Centre for Innovative Justice - Foundations of practice

1. The needs and experiences of family members affected by a perpetrator's use of violence need to be central to all the ways that a perpetrator intervention system responds to that violence. A system's responses need to be undertaken on behalf of and

in solidarity with family members, guided by their goals and struggles both to resist the violence and to express their dignity.

2. Government and non-government agencies have a collective responsibility to bring perpetrators into view in a way that acknowledges adult and child victim-survivors' dignity and contributes to their safety and wellbeing. Each agency can map its roles and responsibilities for doing so as part of an ongoing, collaborative mapping exercise, so that these are transparent and serve to synergize positive outcomes across agencies.

A second approach that has emerged outside of the general 'standards' approach is Vermont, in New England, US. The Vermont Council on Domestic Violence recently moved from a very long (over 100) list of standards to condense their approach to a values-based system, **Box 4** lists the six values.

Box 4. Vermont's Values for Community and System Accountability

1. Survivor voices and experiences
2. Personal, community, and system accountability and support
3. Equity
4. Flexibility
5. Dignity and respect
6. Transformation and hope

It is worth noting that extensive research has been done on the development of standards in the US, including tracking the development of them over time. The Standards have benefited from conversations with some of those researchers in the US and Australia during this project.

Many of the early papers on perpetrator intervention standards focused on 'making the case' for why they were needed, best practice suggestions for developing them (involving both community workers and academics) and outlining current debates. All were based on groupwork perpetrator 'programmes' based in US and most sought to make the case that whilst there were benefits to having state standards, care should be taken not to make these too rigid because the knowledge base on what works to reduce perpetrator's use of abuse was still in its infancy. There was concern that the introduction of standards might limit innovation and development. Simultaneously there was a call for standards to be evidenced rather than only having a philosophical base, whilst recognising that much of the evidence remained to be built.

Two early content analyses of US Standards were conducted by Austin and Dankwort (1999) and Bennett and Vincent (2001). Both studies found that regardless of the particular set of standards, there were some elements that were common across the US. They also found some disagreements, for example Bennett and Vincent (2001) point to states barring

the use of particular interventions such as ‘conjoint therapy’ (what is sometimes known as ‘couple’s counselling’ in the UK) as more varied (and arguably more controversial) than some of the other elements.

In 2008 Maiuro and Eberle provided an updated content analysis of US standards, which is summarised in **Box 5**.

Box 5. Maiuro and Eberle (2008) content analysis of US standards

1. The minimum length of treatment specified 2. Specification of treatment orientation, methods, and content 3. Preferred or allowable modalities of treatment 4. Whether research findings were mentioned or endorsed as a basis for development of treatment standards 5. Methods for developing and revising standards 6. Minimum education required for providers

More recently, Richards et al. (2021) sought to update the Mauiro et al. (2008) analysis, finding that many (72% of the standards in their sample) had included the requirement to use risk assessments at intake. They also investigated to what extent US standards had integrated the PEIs – specifically risk, need, responsivity, treatment and validity. They found that while standards had continued to evolved, that PEIs had not been fully integrated into US state standards.

Finally, Flasch et al. (2021) also ran an updated content analysis on US standards. They found that minimum length of ‘treatment’ (here meaning ‘batterer intervention programme’) varied substantially, with an average number of required weeks being 27.6 and the corresponding average number of hours of ‘treatment’ being 44.2. There remained a high preference for group treatment, required by 95.5% of standards, although supplementary individual work was allowed. A broad range of prohibited primary theoretical approaches was found, with ‘victim coercion, blame, victim responsibility, or victim participation’, ‘circular causality or family systems approaches to violence’ and ‘focus on anger management’ all being prohibited in at least 50% of US state standards. A wide range of training requirements were found. Flasch et al. suggest that further research could look at the impact that state standards have on outcomes.

Overall, the literature shows a consensus that research on the effectiveness of perpetrator interventions remains vastly underdeveloped globally in terms of what is most useful and for whom.

Part B. Research methods

Alongside the academic evidence assessment, it was important practice-based knowledge informed the development of the standards. Ethical approval was granted by Durham University Department of Sociology Research Ethics Committee covering all strands of the study. The methods are described below.

Review of existing literature

A wide-ranging literature search was carried out using Google Scholar. A total of 52 different search combinations were used – the terms used and results for each are outlined in the table in **Appendix 2**. The searches were conducted in July 2022 and no 'from' date was specified given the continued importance of some early work in this field. Care was taken to include different terminology (batterer intervention programmes, behaviour change programmes, domestic abuse perpetrator programmes), both US and UK spellings of key terms (programme/program and behaviour/behavior) and the Google scholar search was limited to papers written in the English language. Each paper was reviewed for relevance and duplication. This search was supplemented by a call for unpublished and/or practitioner literature, and this did include some research written in other languages which were translated.

Practitioner roundtables

16 online roundtables were held, with 297 practitioners or policy makers attending. Most were from England and Wales, with a small proportion from Scotland. A wide range of services were represented, including those from both statutory and voluntary sector organsations. The majority of those attending were involved in the direct delivery of interventions with perpetrators. The roundtables were facilitated by members of the team, were recorded, and notes were taken. A set of five core questions were used and in each instance facilitators probed for the evidence supporting contributions. For those delivering interventions, they were asked:

- What are the core standards you work with and anything that you think is missing?
- What is required for interventions to be effective?
- What is required for interventions to be safe for survivors and their children?
- Are there any no go areas that should be prohibited?
- How can minoritised groups be best served by this type of intervention?

Roundtables addressing specific communities or topics were also held, which were cross cutting in terms of the interventions discussed. Here, the core questions were:

- What type of interventions exist for perpetrators in this group?;
- Are the generic interventions used or appropriate?

- What would make interventions safe for survivors (including children) in relation to working with this client group?
- Are there no go areas that should be prohibited?
- What would make interventions more effective with this client group
- What should funders be looking for in claims that this group will be well served?

The topics of the roundtables were as follows:

1. Behaviour change (front line practitioners and practice managers)
2. Behaviour change (open to all practitioners, managers and policy makers)
3. Behaviour change (managers and policy makers)
4. Behaviour change (statutory)
5. One to one work
6. Early intervention
7. Intensive case management
8. Female perpetrators and women using force
9. Neurodiversity
10. LGB &/or T
11. Minoritised communities (Black African/African heritage)
12. Minoritised communities (Asian/Asian heritage)
13. Adolescent (age 16+) and adult child to parent violence and abuse
14. Mental health
15. Substance misuse
16. Victim–survivor support workers

The roundtables were rich in content and provided rare spaces in which the statutory and voluntary sectors engaged in a joint exploration of topics. A number of areas of misperception were both raised and addressed by those participating, and some moves towards areas of consensus were made. The roundtables confirmed the limited knowledge base, including from practice, of a number of areas and the challenges to extending the reach of current provision to all who could benefit from it.

Review of existing perpetrator intervention standards

24 sets of existing standards were collated covering Wales, the UK, Australia, many US states, Canada, and some European countries. These are listed in **Appendix 3**. They were used to inform the standards and specific wording of the standards proposed in this report.

Consultation with victim-survivors

Eight victim-survivors of domestic abuse were consulted, facilitated via Welsh Women's Aid's Survivors Network. The consultation lasted two hours and was held on zoom at the preference of those participating. To increase anonymity with such a small group no individual demographic characteristics was collected, but as a whole the group was largely White British, included speakers of other languages including Welsh and British Sign Language, and were mostly aged between 30-50 years old. Some had had direct experience of at least one perpetrator intervention, all had been victims of intimate partner

violence and abuse and were separated from the abusive partner at the time of the consultation, and many were still experiencing post-separation abuse.

Consultation with perpetrators

Following suggestions made in several roundtables, the writers amended the original ethics application and were given approval to work with the Hampton Trust who consulted with seven service users of perpetrator interventions on behalf of the research team. Following informed consent procedures, service user participants were asked to look at the seven standards and provide feedback on 1) whether they thought the standards were understandable and written in a straightforward manner 2) if there was anything they thought should be taken out (and why) and 3) if there was anything they thought should be added (and why).

Consultant feedback

The consultants chosen for this project – listed on page 2 - were highly experienced practitioners and/or those with expertise about specific communities. They sent feedback that was taken into consideration when finalising the wording of the standards. The document was also sent it for international peer review and received comments from highly experienced practitioners and sector leaders in the US and Australia.

Limitations

Limitations were largely linked to the short timescale that the work was required to be completed within. The literature review was restricted to papers published in English, the writers were only able to speak to a small number of victim-survivors, the time for analysis of both the literature and the roundtables was restricted, and the standards were not able to be taken back to those who had been involved in the roundtables for feedback.

Appendix 2 Google Scholar Search Results

As part of the Rapid Evidence Assessment (REA) a wide-ranging literature search was carried out using Google Scholar. The search terms used and results for each are outlined in the table below. The searches were conducted in July 2022 and no 'from' date was specified.

Terms included the English UK and English American spellings of:

1. 'programme' and 'programme' and

2. 'behaviour' and 'behaviour.

	Search Term on Google Scholar	Results
1	"domestic abuse perpetrator" AND "service standards"	1
2	"domestic abuse offender" AND "re-education"	1
3	"domestic violence perpetrator program" AND "standards"	46
4	"domestic abuse programme' AND "quality assurance"	25
5	"Domestic violence perpetrator programme" AND "standards"	58
6	"Domestic violence perpetrator programme" AND "Accreditation"	34
7	"domestic violence perpetrator program" and "quality assurance"	4
8	"Domestic violence perpetrator programme" and "quality assurance"	8
9	"domestic abuse perpetrator program" AND "quality assurance"	0
10	"domestic abuse perpetrator programme" AND "quality assurance"	8
11	"batterer intervention programme" AND "standards"	41
12	"batterer intervention program" AND "standards"	933
13	"batterer intervention program" AND "guidance"	659
14	"batterer intervention program" AND "accreditation"	100
15	"men's behaviour change programs" AND "accreditation"	10

16	"men's behaviour change programmes" AND "accreditation"	1
17	"men's behaviour change programs" AND "quality assurance”	6
18	"men's behaviour change programmes" AND "quality assurance"	0
19	"men's behavior change programmes" AND "quality assurance"	0
20	"men's behaviour change programmes" AND "standards"	4
21	"men's behavior change programmes" AND "standards"	0
22	"men's behaviour change program" AND "accreditation"	4
23	"men's behavior change program" AND "accreditation"	0
24	"men's behaviour change programme" AND "standards"	1
25	"men's behaviour change program" AND "quality assurance”	4
26	“domestic violence perpetrator intervention” AND “standards”	26
27	“domestic abuse intervention” AND “quality assurance”	60
28	"batterer intervention" AND "standards"	2,860
29	“batterer interventions” AND” standards”	202
30	“batterer intervention" AND "guidance"	2,040
31	"batterer intervention" AND "accreditation"	268
32	"men's behaviour change intervention" AND "accreditation"	0
33	"men's behaviour change intervention" AND "quality assurance”	0
34	"men's behaviour change intervention" AND "standards"	1
35	“family violence interventions” AND “standards”	241
36	“family violence intervention” AND “standards”	606

37	“domestic violence perpetrator treatment” AND “standards”	299
38	“domestic abuse treatment” AND “quality assurance”	6
39	“batterer treatment” AND “standards”	1,370
40	“batterer treatment" AND "guidance"	906
41	“batterer treatment" AND "accreditation	355
42	"men's behaviour change treatment" AND "accreditation"	0
43	"men's behaviour change treatment" AND "quality assurance”	0
44	"men's behaviour change treatment" AND "standards"	0
45	"family violence treatment” AND “standards”	96
46	"relationship abuse" AND "standards" (standards meeting)	1,500
47	"abuser" AND "standards"	53,100
48	"batterer services" AND “accreditation"	4
49	"batterer services" AND "service standards"	1
50	"domestic abuse" AND "re-education"	791
51	"intrafamilial violence" AND "re-education"	22
52	"interfamilial violence" AND "re-education"	4

Appendix 3 List of Standards Collated

1. Alabama Coalition Against Domestic Violence (ACADV)

2. Applied Research Forum - National Online Resource Center on Violence Against Women (USA) A Review of Standards for Batterer intervention Programs (1997)

3. All Wales Minimum Standards. Routine Enquiry into Domestic Abuse, Pregnancy and Early Years (2021)

4. Australian Institute of Health and Welfare. Monitoring perpetrator interventions in Australia. Cat. no. FDV 7. Canberra: AIHW. (2021)

5 Batterer Intervention Coalition Michigan - website

6. Child and Family Service, Hawai'i State Judiciary – Hawai'i Batterer Intervention Standards (2010)

7. Colorado DVOMB Standards (2021)

8. Commonwealth of Australia (Department of Social Services) - National Outcome Standards for Perpetrator Interventions - Council of Australian Governments (2015)

9. Department of Attorney General and Justice (2012). Minimum Standards for Men's Domestic Violence Behaviour Change Programs, Sydney New South Wales: New South Wales Government

10. H.M Prison and Probation Service - Accreditation and Process Guidance, Correctional Services Accreditation and Advice Panel (2021)

11. National Institute for Crime Prevention and Reintegration of Offenders (NICRO) – South Africa

12. North Macedonia - standard and procedures for the work of a counselling for domestic violence perpetrators (2018)

13. Oklahoma, Attorney General – Title 75 (2008)

14. Oregon Department of Justice Division 87 Batterer Intervention Program Rules (2005)

15. Queensland Government - Practice principles, standards and guidance (2021)

16. Relive - National guidelines of treatment programs for men authors of violence against women in affective relationships

17. Respect Standard - Respect (2022)

18. Standard of the Bundesarbeitsgemeinschaft Täterarbeit Häusliche Gewalt e.V. Working with perpetrators in cases of domestic violence (2021)

19. Standardi programa rada sa počiniocima nasilja u partnerskim odnosima (2019)

20. Standardi za provođenje zaštitne mjere obveznog psihosocijalnog tretmana (2019)

21. Subcommittee of the Criminal Justice Policy Advisory Commission - CT Domestic Violence Offender Program Standards (2019)

22. Vermont Statewide Standards for Domestic Violence Accountability Programming (2015)

23. Victoria State Government, Family Safety Victoria - Men's Behaviour Change Minimum Standards (2017)

24. Welsh Government - Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards (2018)

Appendix 4 Summary Table of Standards and Practice Guidelines

1. The priority outcome for perpetrator interventions should be enhanced safety and freedom (space for action) for all victim-survivors, including children.	1.1 Safety and freedom for all victim-survivors (including children) should be clearly prioritised in the intervention's rationale, structure, procedures and intended outcomes. Victim-survivors have a right to know if a specific threat is made to their (including their children's) safety. 1.2 Interventions should not take place without integrated support for victim-survivors, for which there should be parity of provision. This support should be victim-survivor led in terms of the frequency and mode of support. Where possible partnerships with 'by and for' organisations are best practice. The same member of staff should never work with both the victim and perpetrator. 1.3 Clear information describing the intervention and the expected outcomes should be provided to both perpetrators and victim-survivors in a range of formats (a specific webpage, printed sheets) and in languages reflecting the populations they will serve. It is imperative not to overclaim the potential benefits and to outline any additional risks. 1.4 There should be clear and regular lines of communication between perpetrator intervention teams and victim-survivor support teams to share information so that changes in risk can be rapidly shared, appropriate actions taken, ensuring that victim-survivors (including current and ex-partners) receive timely information. 1.5 This standard represents the overarching lens through which the other standards need to be understood.
2. Interventions should be located within a wider co-ordinated community response in which all agencies share the responsibility of holding abusive behaviour in view, enabling change in	2.1 To deliver interventions safely and effectively, organisations providing specialist domestic abuse perpetrator work should have an established track record of responding to domestic abuse. 2.2 Integrated victim support staff should share information where there is a safeguarding concern. Otherwise, the integrated victim support service is a confidential service and information should not be routinely shared.

perpetrators and enhancing the safety and freedom (space for action) of victim-survivors and children.	2.3 Interventions should be embedded in local communities and/or have built strong local partnerships, including with 'by and for' services where available. 2.4 Referral to a perpetrator intervention should not be used as a reason to close cases, there are specific responsibilities around holding and monitoring risk that remain with statutory agencies. 2.5 Where an intervention is being delivered by a statutory organisation or on behalf of a statutory organisation, consideration should be given to the legal requirements for compliance and the responsibilities and obligations of the statutory organisation. 2.6 Interventions should demonstrate adherence to up to date best practice by seeking accreditation through an appropriate route such as the Correctional Services Advice and Accreditation Panel or Respect Standards. This is in line with the National Statement of Expectations (Home Office, 2022).
3. Interventions should hold perpetrators to account, whilst treating them with respect, and offering opportunities to choose to change.	3.1 Interventions should treat perpetrators with respect modelling the opposite of all that is abusive, while holding them accountable for the harm they have caused to others and offer opportunities to choose not to use violence or abuse. 3.2 Interventions should be evidence based and focus on the forms of power, control and exploitation that research and practice have shown to be part of domestic abuse. Interventions could also include violence interruption strategies and emotional regulation techniques as elements within a wider programme of work. 3.3 Behaviour change interventions (as defined earlier) should take into consideration the length of time needed to meet the behaviour change objectives. 22 weekly sessions for groupwork programmes or 16 weekly sessions for one-to-one work could be used as the minimum expectation for intimate partner violence and abuse [4], but longer programmes are needed for some.

[4] As defined earlier in this report on page 4-5, shorter interventions are possible but would come under the category of early response rather than behaviour change.

	3.4 Behaviour change interventions should use a groupwork model where possible, sometimes in combination with one-to-one work. This does not preclude one-to-one work being used where this is the most appropriate model of intervention for the individual perpetrator. 3.5 Behaviour change interventions for intimate partner violence should be delivered in person where possible. Facilitated remote access work (but not digital/e-learning unless solely supplementary) can be used where this is the most appropriate model and the potential impacts on victim-survivors have been fully considered. 3.6 Behaviour change interventions which are delivered as groupwork, should have two facilitators, and less experienced staff should be partnered with more experienced staff. Best practice is that groups be co-facilitated by a male and female staff member, except for groups for same-sex intimate partner violence which may not require a facilitator of the opposite sex.
4. The right intervention should be offered to the right people at the right time.	4.1 Organisations should have a written model of work that sets out the objectives, nature, content and intended outcomes of each intervention offered and which groups of domestic abuse perpetrators it is appropriate for and how support for victim-survivors will be integrated. 4.2 Assessments should be proportionate to the intervention being delivered and should enable identification of specific needs related to risk and/or the perpetrator's capacity to participate in an intervention. Where additional or complex needs are identified a plan (and where necessary a referral pathway) for addressing these should be identified. 4.3 Interventions should be appropriate to the assessment and be responsive to adaptation where necessary. Where adaptation is needed for a specific perpetrator population (such as where perpetrators have problems with mental health, drug and/or alcohol misuse) co-facilitation with a relevant skilled practitioner should be considered. 4.4 Assessment processes should enable identification of primary perpetrator and not deliver perpetrator focused interventions to victim-survivors who use resistance. Where a

	perpetrator may be a victim (for example, mothers in cases of 'honour'-based violence and abuse, adolescents who use violence who have also experienced child sexual abuse) there should be a clear pathway of referral to support them, whilst they engage with an adapted and appropriate perpetrator focused intervention. 4.5 Participation in an intervention should not seen as a route to maintain or reassert control over an ex-partner through repeated or extended court proceedings. Motivation should be carefully assessed throughout the intervention Perpetrators who are currently (or have recently been) party to private law children proceedings should be assessed for their suitability by programme staff independently of any prior assessment or recommendation by a referring agency or solicitor. 4.6 Joint work is rarely suitable in cases of intimate partner violence, it should only be undertaken if proactively requested by the victim-survivor, once perpetrator behaviour change work has been undertaken, and a further suitability assessment has been conducted separately with the perpetrator and the victim-survivor. Similar caveats apply to informal or formal mediation, reconciliation or religious arbitration work for all forms of domestic abuse.
5. Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap.	5.1 Interventions should recognise that those from minoritised groups may have experienced barriers and disadvantages and that change is more likely where these are acknowledged and addressed. 5.2 The foundation of seeking power and control applies across all communities, however, how it is expressed and justified is likely to vary. Work should explore variations in gender and generational norms and how they affect mechanisms of power and control. 5.3 Work should explore the individual, familial and wider beliefs that permit, justify or minimise abuse (in some situations, victim-survivors and perpetrators may frame these beliefs in narratives of culture, faith, religion and/or community values) alongside those which do not support it. Whilst this can become a source of insight in work with victim-survivors and perpetrators, it is important that practitioners do not reinforce stereotypes of entire communities.

	5.4 Different approaches need to be developed for heterosexual women and/or LGB and/or T perpetrators and adult child to parent violence and abuse. Existing approaches may need to be adapted for people from minoritised groups on the basis of ethnicity/race and neurodivergent perpetrators for whom learning, social and communication differences/difficulties need to be addressed. 5.5 Community language specific direct work (one to one and group) could be made available and can be more effective as it enables both prompt access and a joint exploration of meaning.
6. Interventions should be delivered equitably with respect to protected characteristics that intersect and overlap.	6.1 Staff should receive induction training to enhance their knowledge on domestic abuse, how protected characteristics can intersect, local safeguarding and multi-agency processes and the intervention they are working within. This also applies to integrated support workers. Continued professional development should update on new knowledge and practice, including the impact on victim-survivors, including children. 6.2 Interventions should be delivered and managed by a team which seeks to reflect the communities they serve. 6.3 Staff delivering interventions should have access to regular internal line management supervision and funded, high quality, external clinical supervision. Staff who are supporting but not delivering interventions could be offered the same support. 6.4 Workloads should not exceed the number that can be carried out safely, and delivered equitably, for specific interventions. This applies to both integrated victim support and perpetrator work. 6.5 People perpetrating domestic abuse should not be delivering perpetrator interventions. Any previous use of domestic abuse should be disclosed. An enhanced Disclosure and Barring Service (DBS) check should be completed (though with evidence of substantive personal change work previous offending is not necessarily a bar to delivering perpetrator interventions).
7. Monitoring and evaluation of interventions should	7.1 Clear and consistent records should be in place to enable safe and effective delivery of the intervention and identification

take place to improve practice and expand the knowledge base.	and prompt responses to increases to risk/safeguarding concerns. 7.2 Data should be collected on interventions, in line with their model of work and aligned to their referral and funding requirements, including on outcomes relevant to their intervention and who is (and importantly who is not) currently accessing their intervention. 7.3 The experiences of a) victim-survivors (including children) associated with perpetrator service users and b) perpetrator service users should be gathered and used as a source of learning. There should be a transparent process and timeline for gathering and reflecting on this information within teams (proportionate to the size of the organisation). 7.4 Existing interventions could be externally evaluated. Interventions should always be independently evaluated when new approaches are being piloted.