A Review of Domestic Violence Perpetrator Programs in the UK

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Abstract

The aim of the current study was to conduct a review of current intimate partner violence (IPV) perpetrator provision within the UK. The objective of the review was to explore the characteristics of intervention programs currently within the UK. Using a questionnaire based design we explored characteristics of current programs including program structure, program logistics, facilitator characteristics and facilitator insights around the programs. A number of organisations completed the questionnaire (N = 21) and a review of existing literature was performed to explore the general characteristics of programs being delivered within the UK. Within the sample we found the feminist approach was still influential but that facilitators also reported a need to ensure programs are more inclusive in their service provision to represent the diversity of perpetrators found. An unexpected finding from this study was the resistance of many organisations to engage with the research through an apparent suspicion of the agenda and motivation of the research team.

Keywords: intimate partner violence, domestic violence, treatment, Duluth, UK

The Duluth Model was established in the United States in 1981 as an intervention derived from the Duluth Domestic Abuse Intervention Project (Pence & Paymar, 1993). The Duluth model curriculum was developed by activists within the battered women's movement and five battered women (Pence & Paymar, 1993) who believed domestic violence was caused by men's patriarchal ideology. The Duluth derived program therefore focused on re-educating partner violent men. Re-education (rather than treatment) was deemed appropriate as men's violence to their intimate partners was understood as not "stemming from individual pathology, but rather from a socially reinforced sense of entitlement." (Paymar & Barnes, ND). Using the "Power and Control Wheel" was central as partner violence was understood as being motivated men's need for power and control over women. Women's aggression was understood as self defensive.

The authors of the model omitted to acknowledge the problems that are associated with generalising from such a small and unrepresentative sample (Dutton & Corvo, 2006). Ellen Pence did however write prior to her death "By determining that the need or desire for power was the motivating force behind battering, we created a conceptual framework that, in fact, did not fit the lived experience of many of the men and women we were working with. … Speaking for myself, I found that many of the men I interviewed did not seem to articulate a desire for power over their partner. Although I relentlessly took every opportunity to point out to men in the groups that they were so motivated and merely in denial, the fact that few men ever articulated such a desire went unnoticed by me and many of my coworkers. Eventually, we realized that we were finding what we had already predetermined to find" (1999; pp.29-30).

Despite Pence's shift in position the Duluth model and programs derived from it are prevalent throughout the Western world.

This may well be moot if programs based on Duluth or Duluth/Cognitive Behavior Therapy hybrids were effective. Research has been consistent that such approaches are not effective however (Babcock, Green & Robie, 2004; see also Babcock & La Taillade, 2000; Daly & Pelowski, 2000; Feder & Wilson, 2005). This is probably due to the model ignoring treatment need factors such as emotional dysregulation (Birkley & Eckhardt, 2015) and relationship dynamics such as bidirectional IPV (Langhinrichsen-Rohling, Misra, Selwyn & Rohling, 2012).

By ignoring the range of influences (e.g., social, developmental, and biological) that contribute to the perpetration of IPV, interventions and treatments are unlikely to be successful. Studies that have examined the success rates of the Duluth Model intervention program have unsurprisingly found it to be unsuccessful. Babcock et al. (2004) performed a meta-analysis of 22 studies that evaluated such treatment program for domestically violent men, and found minimal effects, concluding that the current interventions are inadequate in reducing recidivism much beyond the effect of arrest and other criminal justice sanctions. Dutton (2006) reviewed both its lack of efficacy and the wealth of evidence contradicting its feminist foundations, concluding that its continued use is impeding effective treatment and judicial responses.

Many researchers (e.g., Ehrensaft, 2008) argue that a movement beyond gendered theories of treatment is imperative, and to negotiate a move towards a developmental approach; taking in all the important associated risk factors and developmental correlates. New treatment programs must be built on strong, empirically-tested foundations based on the wealth of information that exists about

the risk factors involved including the general violence and substance abuse literatures. Many researchers have suggested improvements for intervention strategies. For example, Graham-Kevan (2009) argued that in the absence of effective IPV programs, general (Non-IPV) violence programs could be examined in the context of IPV perpetrators. Ideally however, IPV programs should be designed to target criminogenic risk factors in a therapeutic, rather than educational manner (Dixon, Archer & Graham-Kevan, 2012). Other researchers argue that risk assessment should encompass both perpetrator and victim characteristics (e.g., Kropp, 2009) in order to more fully understand an individual's or couple's risk and intervention need factors. What is imperative is that assessments and interventions are informed by rigorous scientific analysis rather than social ideology, political correctness or inertia.

Effectiveness of Perpetrator Programs

The evidence for the effectiveness of current provision is mixed, and often depends on the ideological beliefs of the authors. Feminist researchers tend to speak more favourably of the current perpetrator programs and claim greater effects than the evidence can support. For example, Gondolf and Jones (2001) used a multi-site evaluation to create a natural quasi-experiment. They concluded their evaluation demonstrated that those who completed the programs in their study were 44%-64% less likely to re-assault their partner than those men who did not complete the program. Completion or drop-out from a lengthy program however is not random. For example, using a prospective design, Gruznski and Carrillo (1988) compared completers, intake completers, and partial program completers and found that factors such as a history of abuse victimization, witnessing domestic violence in the family of

origin, educational attainment and employment status all distinguished drop-outs from completers. Hamberger and Hastings (1989) also compared drop-outs and completers and found drop-outs were younger, had lower employment levels, and higher pretreatment levels of police contact for drug and alcohol related offenses, higher levels of borderline and schizoid tendencies, than completers. This suggests that failing to control for pre-existing characteristics of participants in IPV programs can result in unreliably favourable results. Therefore, issues with attrition and poor reliability of the instruments used where not acknowledged in Gondolf's evaluation. Dutton and Corvo (2007), in their reply to Gondolf's critique of their 2006 paper, state that "...the burden of disproving efficacy replaces the burden of demonstrating efficacy...counter to the basic principles of evidence-based practice" (p. 664).

Despite the mixed evidence presented for the programs that are informed by feminist ideology, it is still the dominant curriculum used within the US. The Duluth model remains a political model that rejects any emotional and psychological issues a male perpetrator may have as these are seen as excusing his violence; here public policy is being dictated by politically motivated activists rather than by those who would be considered experts such as academics and psychologists (Dutton & Corvo, 2006).

Perpetrator Programs in Europe

The majority of research examining perpetrator programs and their effectiveness have been based in North America (e.g. Babcock et al., 2004; Eckhardt et al., 2013). There has been little published until recently about the way perpetrator programs are delivered and evaluated within Europe. Graham-Kevan (2007) discusses the lack of cohesive policy within the European Union at the time the paper was published and

comments that, like with the US, the curriculum of perpetrator programs could be shaped by politics and not by evidence and science.

Hamilton, Koehler and Lösel (2012) reviewed perpetrator programs that existed in practice in Europe. Their results revealed data from 19 of 23 countries – four countries did not deliver programs. The most common model/approach was CBT (70%) followed by pro-feminist (54%) and psychodynamic (31%). Forty-one percent used a combination of pro-feminist and CBT. On average the programs had been running for eight years with the UK having the longest one at 25 years. In contrast to the findings of Babcock et al. (2004), Hamilton et al. found that CBT was implemented more commonly alongside the pro-feminist models rather than instead of.

Akoensi et al. (2013) further systematically reviewed existing provision within Europe finding only 12 evaluations that fulfilled their criteria. The authors were critical of evaluation design including issues with a lack of comparison group, selection bias, attrition and the heterogeneity of the men within the programs. They concluded that they could not draw any firm conclusions about the effectiveness of the delivery of programs within Europe.

Perpetrator Programs in the UK

The perpetrator programs present currently within the UK appear to be influenced by the same model that informs treatment programs within the US. Eadie and Knight (2002) discuss the development of perpetrator programs within the UK crediting the Women's Aid federation with raising awareness and acknowledging them as experts within the area. They discuss frustrations in the 1980s that whilst the victim movement was supporting women, "male perpetrators were not being confronted with

their behaviour" (p. 167-8). Graham-Kevan (2007) comments that whilst the efforts of this movement deserving of praise for female victims, it does not mean they are qualified to dictate interventions with perpetrators.

The organisation that accredits programs within the UK is called Respect. Respect is a Government funded charity that petitions to inform policy; their purpose of accreditation includes to provide a recognised framework and to set the standards for work with perpetrators. Dixon, Archer and Graham-Kevan (2012) reviewed the validity of Respect's position statement including the analysis of several assumptions that form the foundation of the model. These feminist informed assumptions include, but are not limited to, the notion that the majority of violence is committed by men, that women's violence is usually defensive and that gender is the most important factor in terms of perpetration and victimisation. Dixon et al.'s analysis highlights that the feminist perspective is still hugely influential in the UK system, despite the wealth of research that has contradicted it. Furthermore, they call for more methodologically rigorous evaluations and evidence that can inform practice. Debbonnaire and Todd (2012) from Respect, wrote a commentary stating that their work is informed by quality research and practice. In fact, their paper included few references to the literature with those that were present being feminist in nature. Interestingly, this is a criticism by Archer, Dixon and Graham-Kevan (2012) in their rejoinder.

It is clear that within the UK, as within the US and Canada, that there is still a strong feminist influence in practice. There have been many studies conducted in North American examining the effectiveness of these perpetrator programs (e.g. Babcock et al. 2004) but there have been very few studies detailing evaluations of perpetrator programs in the UK. Those that are have been accompanied by similar

issues as those from North America including small sample sizes, lack of long-term follow up, a lack of a control group for comparison, and issues with selection criteria/bias (see Dutton & Corvo, 2006 for a review of these issues within the US).

The first known evaluation of a UK perpetrator programs came from Dobash, Dobash, Cavanagh and Lewis (1999) who describe the introduction of perpetrator services and interventions originating as late as 1989. Their evaluation centered around two programs within Scotland (CHANGE and Lothian Domestic Violence Probation Project) which focused on the offender, his violent behavior the need for him to change. The authors believed they were addressing some of the issues with previous evaluations (described above) by using three time periods, including partner reports, a larger sample size and including a comparison group – this was a group of men who experienced other Criminal Justice System (CJS) sanctions. At time one interview there were no differences between the baseline measures for these two groups; however at time two follow up questionnaires and court records revealed an apparent reduction in violence towards partners for the program group when compared to the other CJS group. There were however no effect sizes reported to really understand how great a desistance was found; furthermore there were issues with attrition.

Bowen, Gilchrist and Beech (2005) similarly evaluated a court-mandated pro-feminist rehabilitation program based on the Duluth model. The authors explored the effectiveness of the intervention across an 11 month follow up but concluded it had not significantly reduced reoffending amongst the program completers. In contrast, their results appear to support the overlap between IPV and other types of aggressive behavior that feminist researchers so often deny.

Morran (2013) utilised a qualitative methodology and interviewed 11 men who were voluntarily attended one of two UK IPV programs. Morran described an absence within the literature of studies that examined some of the dynamics and context of perpetrators' lives that could positively, or negatively, impact on their desistance. Many feminist researchers (e.g. Dobash & Dobash, 1998) have suggested that the only reliable source of program effectiveness is partner reports because men's own observations could be seen as ongoing abusive tactics. However, Morran highlights that consideration of men's own accounts of their IPV would help create tailored and personalised interventions; this is in contrast to the Duluth model. Morran's analysis revealed the multi-faceted nature of men's desistance from violence against their partners with many issues being similar to other offenders. The author recommends a reassessment of the current interventions to consider other aspects of men's lived experience such as disrupted attachment which could create their desire to control (Dutton & Sonkin, 2003).

The few other UK specific papers have either concentrated more on the victim's perceptions of the perpetrator services (Madoc-Jones & Roscoe, 2010) or perceptions of the service providers (Featherstone & Fraser, 2012). Stanley, Graham-Kevan and Borthwick (2012) acknowledged within the literature there was little recognition of men's role as father's in both the US and UK perpetrator programs. They reported very preliminary results of an evaluation of a voluntary program that offered a range of therapeutic approaches in individual sessions. Part of the program involved teaching men to recognise the effect their abuse had on the children. Those who were involved with child services demonstrated more engagement compared to those who were not. Most women further noticed a change in their partner's behavior

and police data showed a decrease in offences compared to the two years prior to the program starting.

Theoretical frameworks are crucial in helping guide practitioners and professionals in their practice (Dixon & Graham-Kevan, 2011). Indeed, current practice in the UK is still strongly influenced by feminist work (Dixon et al., 2012) rendering all other research and theories into violent behavior effectively irrelevant; this can often stop practitioners considering alternative methods of intervention (Corvo & Johnson, 2003). The Duluth model seems to have experienced an "immunity" from having to answer to any external empirical evaluation; the political concerns are given more weight than the science (Corvo, Dutton & Chen, 2008; p.112). Furthermore, critics caution that programs cannot necessarily be lifted out of one political and cultural context and placed effectively within another (Akoensi, et al., 2012)

Aim of the Current Study

The literature review above addressed the question of what current research exists evaluating perpetrator programs within the UK. The aim of the current study was to conduct a review of current IPV perpetrator provision within these areas. The objective of the review was to address the following key research question: what are the characteristics of IPV perpetrator intervention programs within the UK? This will include reviewing the population they serve (e.g. male or female; age range), source referral (e.g. court-mandated, voluntary/self-referred) and the program characteristics (e.g. length of program, number of sessions, modality, curriculum informing the program).

Method

Design and sampling strategy

The aim within this study was to try and collect as many responses to the survey (described below) as possible from a variety of providers of domestic violence perpetrator intervention across the UK. Ethical approval was gained through the University of Cumbria and additionally through the UK's National Offender Management service to be able to have access to front line staff. Emails were also sent to all the Police and Crime Commissioners within the UK to gain the information they held around organizations delivering programs. Further Internet services were conducted to contact charities and organizations that were linked with these services. Letters or emails were sent to approximately 134 prisons, 33 probation services and 51 additional organizations. This is a total of 218 services with responses from 21 organizations leaves an approximate 10% response rate.

Measures

As this review formed one part of a larger multi-national research project, the questionnaire based measure used here was similar to that use within other countries. The questionnaire entitled the National Survey for Domestic Violence Intervention Programs was developed at Tulane University in conjunction with the Association of Domestic Violence Intervention Programs (ADVIP). It is structured with sections that allow information to be gathered on multiple levels including: program structure and content (e.g. "what modalities do you use to deliver treatment to domestic violence perpetrators?" and "what does your intake/assessment procedure consist of?"), program logistics (e.g. "Approximately how many perpetrators does your program serve?" and "Please provide percentages for the demographics of client

population"), facilitator characteristics (e.g. "what are the educational requirements for facilitators of domestic violence perpetrator treatment at your agency?" and "Please identify the number of intervention facilitators by gender"), facilitator insights (e.g. Who do you think most often initiates physical violence against their intimate partners?" and "In general, male perpetrators are motivated to abuse their partners for what reason?"), views on state/provincial standards and program improvement (e.g. Do you think your state's standards adequately provide effective interventions for perpetrators?"). The majority of questions were closed and required participants to respond on either a Likert scale (e.g. 1 = strong agree – 5 = strongly disagree), provide percentages or rate importance (e.g. 1 = not at all important to 3 = very important). Other qualitative questions allowed participants the opportunity to give more detailed responses around areas such as delivery (e.g. How would you deal with a client in your group who seems to be co-operating with the program but who remains quiet and rarely talks?), specific services (e.g. "Do you provide any LGBTQ specific services? Please describe) and overall program quality (e.g. Describe any ways this intervention program could be improved).

The survey further asked details around the demographics of the respondent including questions around age, gender, educational achievements and ethnicity. Through seeking ethical approval (described above) we were asked to remove these questions and so do not report the responses for these questions here (please see appendix for full questionnaire).

Results

The first finding to note here was around a general unwillingness of many organisations to participate in the study. Many organisations failed to complete the

questionnaire, with others contacting the research team but then later refusing based around reason such as differing ideological positions. One organisation apologised by saying, "Now I know the source of the research I do not wish to respond". There was a suspicion around motives, funding, agenda and how the data would be used. Generally speaking, these suspicions and doubts came from organisations that are known to be feminist orientated. Despite the anonymous nature of the questionnaire it was not possible to encourage many of these organisations to take part.

The data from the anonymous questionnaire was analysed with a view to providing a summary of responses within the different sections of the paper. These will be discussed by section below:

Program Structure and Content

Amongst respondents, all treatment programs said they used a group setting to deliver treatment and interventions to perpetrators. A further 61.9% indicated they additionally used individual delivery, 9.5% also used family interventions and 4.8% indicated they used couple therapy. No respondent indicated they used couples therapy in groups.

Domestic violence perpetrator programs provided a large range of services and information for their clients including a wide variety of skills and tactics. All organisations indicated they provided perpetrators with skills around identifying and managing emotions, communication skills, general self-awareness, general coping skills and life skills (100%). The majority of providers also taught anger management and impulse control skills (95.2%), conflict resolution skills (95.2%), the impact of abuse on victims (90.5%), the effects of violence on children (90.5%) and about identifying power and control tactics (81%). Furthermore a significant proportion

also provided services to teach meditation and relaxation exercises (76.2%), consciousness about gender roles (76.2%), taught about socialization factors (76.2%), changing pro-violent/irrational thoughts (71.4%), understanding childhood experiences (71.4%) and assertiveness training (66.7%). Far fewer agencies explored the impact of healing from past trauma (14.3%), identifying mutual conflict cycles (4.8%) or work around grief (9.5%).

All agencies provided this information at check-in time and discussion. The majority used both role play (95.2%) and also handouts and exercises (90.2%). DVDs and audio were used by a number of organisations (81%) with goal setting (76.2%) and progress logs/use of journals (61.9%) being used frequently too. Lectures were used relatively infrequently (23.8%) but a further 9.6% indicated the use of autobiographical exercises including discussions.

Next, the survey explored what participants and facilitators considered the primary treatment/intervention approaches of their programs. The majority of providers included Cognitive behavioral therapy (CBT; 85.7%) and motivational interviewing (81%) as part of their interventions. Significant proportions also included work around social learning (66.7%), and strength-based approaches (57.1%). Over half the providers used some form of work around power and control (52.4%) although only a much smaller number identified their work as feminist (19%). Also used frequently were solution focused work (52.4%), self-help and peer support (47.6%), client centered work (33.3%) and psychoeducational interventions (28.6%). Those used less frequently were narrative therapy (19%), trauma focused (9.5%), family systems therapy (4.8%), a psychodynamic approach (4.8%) and emotion regulation (4.8%).

In terms of how providers ranked the importance of the different approaches these were largely in line with what is indicated above. For example the one ranked most important was CBT (52.4%), it was further ranked commonly at number two (19%) and three (19%). Motivational interviewing the next most common approach ranked at number one (23.8%). Power and control was ranked as one to five for over half the providers (52.4%).

There was a wide range of program lengths. Some providers indicated the number of sessions was dependent on need; one provider indicated a program could run between 12 and 52 sessions depending on the need of the client. The average number of sessions across the providers was 29.15 overall but some providers provided a breakdown of group and individual sessions. For example some providers used 15 groups sessions and four individual sessions. Others indicated it varied by intensity; one provider indicated it would be 65 sessions for a high intensity program but only 32 for moderate intensity. The range across the whole sample was between 12 and 70 sessions. The average duration of session also varied from 30-60 minutes (4.8%), 60-90 minutes (19%), 90-120 minutes (23.8%), 120-150 minutes (33.3%) and some 150 minutes plus (19%).

The majority of providers had sessions running once a week (42.9%) with the second most common being twice a week (19%). Again, there was a wide range of session frequency here. Some providers indicated their sessions were three times a week (4.8%), 3-4 times a week (14.3%) but one provider indicated their sessions ran daily. There was an average of 8 people in each session. In terms of the setting of the sessions, a significant number took place in prison (33.3%) and the same proportion also took place in a community setting (33.3%) with an additional number taking place in probation settings (14.3%) and private facilities (10%) and other (10%).

The majority of organisations had a 60 minute plus intake/assessment procedure (85.7%) with the remaining being between 31 and 59 minutes (14.3%). All providers included an oral interview as part of their assessment and the majority also included some sort of standardized questionnaire (76.2%). These questionnaire based measures included psychometrics, personality assessment, measures of abusive behavior and many included risk assessment measures (e.g. DASH, SARA).

Programs provided additional services to their clients. These varied in number and some are likely a function of the setting in which the programs existed. Most common additional services were some form of career services (42.9%), counselling for those with substance abuse problems (38.1%), educational resources (38.1%), job training (38.1%) and housing (33.3%). Others were offered crisis management (31.1%), employment assistance (28.6%), financial help (28.6%), food (23.8%) and included mentoring as part of their provision (23.8%). Seen less often were parenting classes (14.3%), clothing (14.3%), help with transportation (9.5%), assistance in terms of police/safety (9.5%) and community advocacy (9.5%). Under the heading of other (57.1%) providers had indicated they offered signposting and referral to additional services (19%). A small proportion (9.6%) indicated they did not actually provide these additional services but these were part of the wider prison service.

In terms of contact with the victims, the providers indicated once again a wide range of contact. The majority indicated the facilitators never contacted the victim (approximately 72%). Others indicated they either directly or indirectly contacted the victims before, during and after treatment. Many indicated this was through the use of a women's safety worker and ranging from a few times to as often as the victim requested. Of the agencies who participated in the study a number offered services to victims. A number offered peer support groups (26.6%), legal assistance, (19%),

transitional housing (14.3%), shelter beds (14.3%), social services assistance (e.g. child care, food stamps; 14.3%) and mental health treatment (4.8%). A number of agencies also indicated they offered "other" services and these included crisis support, counselling, resettlement services, trauma recovery groups, signposting to specialist groups, and the use of women's safety workers as a layer of support.

Program Logistics

Programs served a wide range in terms of the number of perpetrators. The data gives here varied by measure which made it difficult to average. For example some indicated it was 40 per year whereas other indicated number per course and others gave a running total of historical numbers. The range of numbers no doubt reflects the variety of organisation size captured within the current data set. The majority of organisations provided their training in English only. One organisation indicated it also provided for those of European nationalities and a further one organisation indicated some of the materials could e presented in up to 14 different languages.

The majority of organisations (81%) served only male perpetrators in their provision. The remaining organisations included either a small number of women (10-15% for one provider) with three others indicating it was around 50:50. One of the latter did include victim figures so it may have confused this figure. This was reflected in the majority indicating their sole provision was men (81%). Similarly for sexuality 52% of the sample indicated their provision was solely provided for heterosexuals with a 33.3% indicating over 90% of those included on their programs were heterosexual. One organisation indicated they did not have access to that information. Similarly the proportion of providers indicating they offered provision to other sexualities was small: lesbian (0-1%), gay (0-20%), bisexual (0-8%).All

providers indicated they had not served transgender people within their sample – either highlighting it was 0% or a few indicating they did not have access to this information.

Regarding ethnicity, program providers indicated that as low as 40% of their sample was white but as high as 94.5%. Ranges could be seen for mixed background (0-30%), black (0-18%), Asian (0-35%). Regarding locality of provision there were many providers who were not able to provide us with the percentage of urban vs. rural populations. Rural populations ranged between 0% and 60% where as for Urban it was 0% to 90% plus. Again with age, many were unable (or perhaps unwilling) to provide information around age group but what was suggested indicated that there was a variety across the age groups: under 18 (0-19.5%), 18-24 (0-75%), 25-39 (0-80%), 40-54 (0-41%), 55-64 (0-20%) and 65 plus (0-9%) indicating a possible decrease of violent behavior with age as indicated by previous research (e.g. Walker & Richardson, 1998; O'Leary, 2006).

With the exception of those commenting on a prison sample, providers were not able to comment on the employment status of their clients. Those that were able to indicated the majority were full time, part time or unemployed rather than of a student or retired status. Average estimates of income for their clients ranges from £12,000 to £20,000 with some commenting on the deprived nature of their local areas.

As with other characteristics there was a range of responses around the referral pathway for program clients. Professional referrals ranged from 0% to 100%, court mandated was 0% to 99% and social service agency/family court was 0% to 95%. Voluntary referral was 100% for one provider but then ranged from 0% to 40% and family/friend referral was the lowest with the majority saying 0% and one provider stating 10%.

Many of the providers indicated they had partnerships or relationships with other relevant agencies. The most common two here were social services (81%) and substance abuse programs (81%). Many were connected to law enforcement agencies (76.2%) and the courts (61.9%) along with advocacy groups (42.9%). Less common relationships were with shelters (28.6%) and behavioral health organisations (19%). Frequency of contact and quality of contact with these relationships varied. For example 57.9% of the sample rarely or never engaged with the Courts but of those who did 38.1% rated the quality of the relationship as good to excellent. Social services was the most common additional agency that providers were in touch with 42.8% of the providers being often or always in touch. Of these, 57.2% indicated the quality of the relationship was good or very good. In contrast the majority of providers rarely or never engaged with advocacy groups (66.7%) or behavioral health (66.7%).

Respondents estimated what percentage of the program funding came from a variety of sources. The majority of funding seemed to come from government funding at the national and local level. The perpetrator provided funding for only two organisations, a contribution of 20% and 50% respectively.

Facilitator Characteristics and Insights

Respondents further completed information around the facilitators' requirements, characteristics and perceptions of program effectiveness. For 14.3% of respondents there were no educational requirements for facilitators to deliver programs. For 71.4% of programs there was a requirement to have at least a high school qualification and for a further 14.3% a Bachelors degree was required. No agency stated the need for postgraduate, doctoral or medical level qualifications. However,

five of the agencies indicated additional requirements of training such as safeguarding qualifications, counsellor accreditation or Respect group facilitator training. When asked what the typical educational attainment was for facilitators 47.6% responded that high school level qualifications was typical, 71.4% indicated degrees level qualifications were typical and 23.8% indicated MSc/MA level qualification could typically be found amongst the facilitators. As above, typically there were "other" qualifications present around counselling experience and NVQ qualifications. Typical facilitators were stated as having anywhere between one and 20 years experience working in the field with the majority falling between one and 10 years.

In terms of other types of training, respondents indicated anywhere between 0 (9.5% said they receive 0 hours of training) and 80 hours per year were spent on domestic violence specific training. Between 0 and 15 hours a year on non-domestic violence related mental health training and between 0 and 44 hours of "other" types of training ever year. Respondents indicated spending anywhere between 0 and 250 hours a year around case reviews and peer support.

The number of female facilitators within the current sample varied between one and 14 with one provider stating 100.For male providers the figures were smaller between one and six although one agency did state again there were around 100 facilitators that were male. This respondent is likely to be reporting on a larger agency.

Facilitators were asked what they perceived the most important factors that cause domestic violence perpetration. The findings here are illustrated in the table below:

[insert table 1 about here]

When asked who most often initiates physical violence within the relationships 66.7% indicated the male most often initiates whereas 28.6% indicated males and females about equally initiate physical violence. Regarding non-physical forms of violence 38.1% thought males most often initiated, 4.8% thought females most often initiates and 47.6% indicated this was something males and females did about equally. The majority of participants (61.9%) indicated the impact on victims was greater for females than males and 38.1% indicated they felt it impacted on males and females equally. In considering what motivates perpetrators to be abusive, 42.9% felt in general men wanted to dominate and control their partner and 42.9% further felt it was a way to express anger or other emotions. A smaller proportion (4.8%) felt it was in retaliation for something the partner did. In general, when considering a female's abusive behavior only 19% believed it was motivated by the desire to dominate and control, 52.4% saw the expressive nature of the aggression and 9.5% felt it was in retaliation.

Data Collection

The majority of the providers did collect data on their programs (95.2%) however one provider did not. This data was largely descriptive (61.9%) with less than half the providers (28.6%) collecting outcome data around recidivism rates. The majority of the sample (42.9%) collected this data monthly, quarterly (14.3%) or yearly (4.8%). This data was collected mostly by the agency (61.9%) and not as frequently by external evaluators or researchers (23.8%). Satisfaction with the data collection ranged from completely (9.5%), very (28.6%) moderately (42.9%) to slightly (14.3%) and not at all (4.8%).

Over 90% of those completing the questionnaire indicated a 60-97% completion rate when asked to estimate the number of clients who completed the program after having taken the initial assessment. A further 9.6% estimated much lower at 28-30% of those who started completed. In terms of recidivism over half the sample (57.1%) did not know whether their program completers went on to reoffend or be arrested for IPV related incidents within one year of finishing the program. The remaining providers estimated between 0 and 20% go on to reoffend.

The majority of the programs were used according to a written curriculum (85.7%). Where this was not the case a small number (4.8%) used it according to the philosophy and expectations of the agency. Less than half the sample (23.8%) indicated the treatment interventions were the same for all clients with the remaining number (76.2%) indicating they adapted their interventions to fit the needs of the clients. A further proportion (38.1%) indicated they had developed their interventions specifically for various client needs and contexts. Those that had indicated this were asked to specify what populations these were for, these included: different needs within the group, the use of a framework as a result of sessions with a psychiatrist, adapted for language, adapted for learning styles, adapted for those with learning difficulties, mental health problems and substance misuse, different populations, different levels of violence, for female perpetrators, for cultural diversity.

When asked to describe any training or strategies that facilitators receive or use to make treatment interventions culturally sensitive to the given population there were a range of responses. Some indicated that there was equality and diversity training available (on induction and annually updated), others indicated that supervision was used to explore cultural issues, liaising with relative agencies,

adapting materials (e.g. ethnically diverse power and control wheel) where as others were not aware or did not receive any. One participant cited "we do not allow culture to be used as a reason for abuse, however we acknowledge it has an influence in the same way drugs, alcohol, childhood etc does". Challenges that facilitators experience in making interventions relevant to populations with respect to ethnicity, gender, class, sexuality, disability, religion, age or citizenship status were also varied. Several participants raised concerns around religious beliefs supporting abuse towards women and girls whereas others pointed to a lack of insight into specific minority groups made it more challenging to meet their needs. Language is sometimes seen as a barrier to access and disability requiring specific adaptations was seen as challenging due to resources to support this not always being available (one participant gave an example of the hearing loop). Some indicated there were no challenges where as one participant suggested "these are far too many and complex to list here!".

When asked whether they provided any LGBTQ specific services the majority said no. Only 14.3% did provide any specific interventions. Some of those who specified no added it was because they provided a service exclusively for male violence against women. When asked what specific services participants would like to see implemented some felt a program written to reflect dynamics within same-sex relationships was needed whereas others felt more was needed around awareness raising. One participant reported they wished to see LGBTQ services integrated with the main groups, something that had been requested by service users. Another commented on the development of a program covering all interpersonal abuse which would cover this type of abuse as part of it. One participant suggested there was not necessarily a need for a separate service. Participants felt more understanding around factors affecting the individual was required to understand the differing needs of

LGBTQ populations. Other participants commented services would look quite different as abuse in same-sex relationships may have a different dynamic (e.g. context of "outing", homophobia, gender). One participant commented that "they want to be treated the same throughout the program in our experience" whereas another suggested they would need to be treated in a separate group.

Views on Program Improvement and State/Provincial Standards

Overall all participants were moderately, very or extremely satisfied with the effectiveness of their program. When asked about the standards for perpetrator programs in the UK some had a very strong understanding (38.1%), a moderate understanding (47.6%), some were not sure about whether there were any standards (9.5%) and one participant stated the UK did not have any (4.8%). Within this, 38.1% indicated they agreed or strongly agreed that the UK standards adequately provided effective intervention for perpetrators, 23.8% were unsure and 28.5% disagreed or strongly disagreed. When asked the same question specifically for female perpetrators 57.1% disagreed or strongly disagreed with only 9.5% agreeing. Similarly, for same-sex perpetrators 61.9% disagreed with only 9.5% agreeing. However, for specifically male perpetrators 57.2% did agree that the UK standards adequately provided effective intervention. Table 2 details how effective participants felt the country's standards were at addressing each possible cause of IPV.

When asked what they thought was most effective about the UK standards many did not know. Others alluded to the Respect standards stating they are visible, the standards are easy to get hold of and are clear. Some participants felt positive towards the revision and integrating of new research and practice. Some participants were less

positive with comments including "Virtually nothing. They should be scrapped" and comments around the restrictiveness which impacted on innovation in practice. When asked about the least effective side, many did not comment whereas others pointed to the issues around a one size fits all approach. A selection of comments can be found in Table 3.

Participants indicated in the majority they adhered to the standards always or often (66.7%), this was followed by sometimes (19.0%) and rarely/never (9.6%). They supplemented the standards often/always (42.8%), sometimes (28.6%), rarely (9.5%) and never (14.3%). Participants wanted to make several changes to the standards though. A common recommendation was around expanding provision to cover female perpetrators and those in same-sex relationships. There were also comments including a single set of standards (for statutory and non-statutory provision) which is evidence based, raise awareness and knowledge of IPV in other agencies (e.g. courts, social care). Other comments centered on the practicalities of the standards, funding, facilitating and key performance targets. Some more critical comments called for the abandonment of the current standards: "Respect should be scrapped and a fresh start made – as advocated by the Centre for Social Justice, Dr Louise Brown and others"; and around more transparent publication of effectiveness.

Results from review of available literature

With a low response rate to our questionnaire, we felt it important to consider other available literature on programs and chose to focus specifically on the two main accreditation routes found within the UK. Within the UK there are a series of accredited programs that have been designed to reduce re-offending. These can be

accredited through a governmental panel and through Respect, a feminist charity. To discuss each in turn:

The Correctional Services Advice and Accreditation Panel (CSAAP)

Accreditation within the criminal justice system describes the process of validating and approving interventions in a similar way to within the fields of education and professional training (Ministry of Justice, 2014). CSAAP was established in 1999 and initially accredited interventions delivered with the prison system but also now provides advice for NOMS and the Ministry of Justice. Accreditation criteria include having a clear model of change, targeting a range of dynamic risk factors, effective methods and being skill oriented and programs are accredited for five years after which they are reviewed to ensure they still meet the criteria. Within the area of domestic violence, there are four programs accredited through this process: Building Better Relationships, Community Domestic Violence Programme, Healthy Relationships Programme and the Integrated Domestic Abuse Programme.

Healthy Relationships Program (HRP)

HRP is a cognitive behavioral program that is targeted at male heterosexual IPV offenders that are of medium or high risk to harm. It is 24-68 sessions program (dependent on risk) which aims to decrease problem thinking related to abusive behavior, emotional mismanagement, other problems around self-regulation (e.g. around impulsivity), deficits in social and communication skills and antisocial peer associations that may endorse the abuse of women.

Community Domestic Violence Program (CDVP)

This is a community delivered program that aims to reduce risk of IPV towards women in relationship by facilitating men to change their attitudes and behavior to increase safety and reduce risk of all family related violence. CDVP is a cognitive behavioral program, which consists of 25 group work sessions across 9-13 weeks

Integrated Domestic Abuse Program (IDAP)

A community based IPV program designed for men who have been violent in their intimate relationships with the aim to ending all violence against their female partners. Participants learn here about abusive behavior and new skills to help them develop non-abusive relationships. IDAP is a cognitive-behavioral program which consists of 27 group work sessions across approximately 27 weeks.

HRP, CDVP and IDAP have similar theoretical frameworks with the primary aim of reducing violence against women and children. Bullock, Sarre, Tarling and Wilkinson (2010) describe that CDVP and HRP identify issues around self-control and work with CB models to address these. IDAP has a more feminist focus and focuses on the role of "culturally reinforced attitudes of power/control over women" (p. 1).

Building Better Relationships Program (BBR)

BBR represents what was the next stage in NOMS development of IPV perpetrator programs (Ministry of Justice, ND). In 2009, NOMS reviewed IPV programs being offered as part of a wider review of interventions they delivered. They concluded with a commitment to "provide a flexible, responsive, contemporary, and evidence-based program for perpetrators have resulted in our developing BBR" (Ministry of

Justice, ND; p. 3). BBR is suitable form heterosexual men who use violence against their female partner and those who have been assessed as medium to high risk. It consists of 24 weekly group sessions across four modules: foundation module, My Thinking, My Emotions and My Relationships. It aims to reduce risk and promote safety through helping men to achieve a better understanding of their IPV, enhance motivation to engage, encourage men to identify and build on their strengths and skills, develop practical and sustainable strategies for change and promote the quality of life of everyone affected by their aggression.

There are few reviews available of these programs. Bloomfield and Dixon (2015) performed an outcome evaluation on IDAP and CDVP covering 6,695 offenders between 2002 and 2007. They found small but significant reductions in IPV reoffending including at a two year follow up. They conclude that whilst their findings were promising, many of the men did go into reoffend and that more up to date evidence around IPV and generally violent offending needs to be adopted into such programs.

Bullock et al. (2010) explored the implementation of IPV programs within the probation and prison service using IDAP, CDVP and HRP. Their finding revealed there was some uneven practice in terms of program delivery with some adhering strictly to the principle and other deviating. Furthermore, data collection around these programs also varied with prisons tending to keep better records than probation services where there were very few programs in the community that collected pre, post and follow up data (n = 40 out of a total of 2,986).

Respect accreditation

Within the UK there is a further level of accreditation that some seek to achieve, that of the feminist organisation Respect. Respect (2012) indicates the accreditation standard applies "to all organisations providing domestic violence prevention programs (DVPPs) working with men who use intimate partner violence (IPV), and also providing integrated safety services (ISS) for partners and ex-partners of these perpetrators" (p.1). They describe the development of accreditation so people can be assured of a "high quality safety-focused service from organisations accredited by Respect". Working with both perpetrators and victims is Respect's minimum unit that is required for consideration for accreditation. Their accreditation is currently only applicable to violent men and their female partners/ex-partners. Respect state that working with perpetrators can only be done so safely if there is s an ISS that also contacts partners and ex-partners to provide them with a support service.

The aims of a Respect accredited service (from Respect 2012) include to increase the safety of victims, assess and manage risk, be part of a community response to IPV, provide services which recognise a diverse community which includes being accessible , promote respectful relationships, work accountably, support social change and offer a complete response. There are two stages of accreditation including Safe Minimum Practice, which involves being assessed and meeting the majority of the criteria and full accreditation where an organisation meets all 94 of the requirements in the Standard. The Accreditation materials then go on to detail these criteria under a series of headings around management of the organisation, service structures and process, diversity, risk management, children and partnership working.

The model by which organisations should align their work is feminist in nature and focuses on a man's use of violence as an instrumental mechanism to exert

violence and control over his female partner. Programs should reflect this by ensuring the perpetrator is held completely accountable and responsible for his violence which is a behavior he has chosen to engage in. The principles here clearly state that "a willingness to choose to use violent and abusive behavior towards a partner is influenced by learnt expectations and a gender-based sense of entitlement" (p.28) and the "denial and minimisation of abusive behavior or any justifications for using abusive behavior including the use of drugs or alcohol" (p 29). By aligning a treatment program with these principles ignores the wealth of research that indicates the high correlations between perpetration and victimisation of IPV (e.g. Bates, Graham-Kevan & Archer, 2014), bidirectionality in IPV (e.g. Charles, Whitaker, Swahn & DiClemente, 2011) as well as the increase risk this poses (e.g. Marcus, 2012). Men are held accountable for their IPV and there is a denial of even being able to explore the context of aggression being used – for example if it is under the influence of drugs/alcohol, if it is as a pattern of mutual aggression, if it is as a function of something other than these feminist assumptions. In discussing risk management the assumption is that violence is always uni-directional. At no point within the whole Standard is it suggested that women should be asked about their own behavior, despite this being something which would have a significant influence on risk.

Respect lobbies the Government and is influential in terms of policy development (Dixon et al., 2012), and yet its narrow focus on gender as the most important factor in IPV ignores research that demonstrates the overlap of IPV and other types of aggression (e.g. Bates et al., 2014), as well as a wealth of research detailing other risk factors associated with IPV for men and women (e.g. Moffit,

Caspi, Rutter and Silva, 2001; Thornton, Graham-Kevan & Archer, 2010; Thornton, Graham-Kevan & Archer, 2012; Felson & Lane, 2010).

Dixon et al., (2012) wrote a critique of the Respect position statement and the eight assumptions derived from this, interestingly this statement (or any mission/position statement) cannot be found online and Respect have failed to provide the authors with one despite multiple attempts at contact.

There are few evaluations present of these programs but one significant here for Respect accredited programs was Project Mirabel, conducted by researchers at Durham University. Kelly and Westmarland (2015) sought to develop a new methodological approach to evaluating DVPPs to offer what they term a "third generation" (p. 4) perpetrator program methodology. They describe first generation methodology as concentrating on behavioral responses with success defined as a reduction in violence measured by convictions or self-reports. Second generation used a more experimental design using interventions and a control condition or a multi-site evaluation (e.g. Gondolf, 2002). Kelly and Westmarland addressed this by including case studies of DVPPs, longitudinal survey data with women, longitudinal interviews with men and women, plus data on DVPP impact on children and program integrity. They further used a matched control group of women receiving support as victims but where there was no DVPP support for their male partner. Comparing their treatment group with the control group they authors state that they *"largely found there to be no significant differences in reductions in violence and abuse"* (page 8). The authors also failed to conduct any statistical analysis of pre and post intervention changes. The authors conclude that across the data that the Respect accredited programs under examination ($N = 12$) were successful in improvements of respectful communication, improvement in women's expanded space for action,

quantitative reductions in physical and sexual violence, improved shared parenting, limited improvements in awareness of self and others and largely a reduction in children's fear. These 'improvements' however were drawn from comparing all starters with those that completed. For example when comparing reductions in physical and sexual violence, the pre-program sample size was 99 but the post sample size was only 52, such a comparison is useless in ascertaining whether female victims experienced reductions in physical and sexual violence because the pre-program group contained almost twice as many participants as the post-program group. It is highly likely that those who dropped-out were significantly different to those who remained. Indeed, this may be the reason why pre- and post-program statistical analysis was not conducted: as programs such as SPSS would automatically only include participant data where both time points were represented. The authors made no attempt to explain this in the report of in personal communications with one of the authors (Graham-Kevan, 2015). Instead selected interview quotes were used to support their comparisons of men's experiences and women's experiences of change.

There were also significant issues including a lack of clarity around follow up times and sample sizes, failure to ask about women's own aggressive behavior, lack of effect sizes being reported, and a lack of exploration around attrition of participants. Therefore, no conclusions can currently be made in regards to the efficacy of these Respect accredited programs.

Discussion and Conclusions

The aim of the present study was to review and explore the existing provision of IPV perpetrator programs within the UK. The present study generated a wealth of

information around what the current perpetrator provision is within the participating organisations.

In terms of program approach and delivery, all programs within the current sample delivered programs in a group setting, this was still the most often used approach although some did also use individual sessions and one program include a couples therapy session. CBT was the primary focus of the programs with over half also having a focus on power and control. Only 19% of the sample identified their program as being primarily feminist. Some believe that group work is what enables men to change by engaging in a process where they see themselves as others through being challenged (Kelly & Westmarland, 2015). The use of CBT related techniques within these programs shows a move beyond purely education based programs and interventions using this approach have been found to be effective (Dixon et al., 2012) The majority of programs identified they only worked with male perpetrators and those who identified as heterosexual. A small number identified work with female but it is thought these figures may be conflated by also including victim services within this (as indicated by at least one program). This was not a surprising finding as it is well known that there is a paucity of perpetrator services currently available for female perpetrators and those from LGBTQ populations. There has been a wealth of literature that details women's propensity for aggression and control (e.g. Archer, 2000; Bates et al., 2014; Bates & Graham-Kevan, 2016) as well as literature highlighting the prevalence of aggression in same-sex relationships (e.g. Renzetti, 1992; Lie, Schilit, Bush, Montague & Reyes, 1991; Bologna, Waterman & Dawson, 1987). Yet there is a lack of service provision for these victims and perpetrators. Current feminist and Duluth inspired models will especially not be appropriate within these populations and many participants in the current study stated these would need

to be dealt with separately as populations. Only 14.3% of programs had LGBTQ specific provision. All comments around this in the current study related to sexuality with no program even commenting on provision for transmen or transwomen. There was a variety in opinion in how to address this with some suggesting they integrate provision for everyone in to the same group whereas others suggested they would need a separate service.

Facilitators indicated the most important causes of IPV to be difficulty in managing emotions, poor communication/conflict resolution skills and attitudes that were supportive of violence. Interestingly patriarchy was one of the least frequently cited reasons for IPV along with poor education and oppression/discrimination. From the wide range of possible causes given to participants to consider the majority of participants had indicated that most of them were somewhat important in influencing IPV and abusive behavior. It is possible that this demonstrates a change in thinking about the causes of IPV across the sector but it is also possible that due to a lack of engagement with several feminist organisations that we have not captured the full range of insights.

Participants largely agreed that IPV was either initiated by men (this was the most endorsed opinion) or was perpetrated equally be men and women. Men's motivations to perpetrate IPV were seen as being mostly driven by the desire to dominate and control but some participants did indicate that they can also be motivated by expressing anger and emotions with fewer still suggesting it could be motivated by retaliation. Women's IPV in contrast was seen largely as expressive and less so in terms of the desire to dominate and control. These perceptions broadly fit with some of the more feminist perspectives on IPV in that men's aggression is seen as a tactic used to dominate and control his female partner (e.g. Dobash & Dobash,

1979) however facilitators did acknowledge the possibility of bi-directional violence which demonstrates an awareness of the context in which IPV is taking place.

Nearly all programs collected data but the majority of this was descriptive with very few (28.6%) collecting any outcome data around recidivism. This finding indicates most programs cannot be engaging in methodologically rigorous evaluation to ensure their program outcomes are successful. Indeed, this fits with previous research (e.g. Bullock et al., 2010) that has indicated the variation in data collection with prisons conducting more rigorous assessments than some community and probation based services.

Most adhered to the curriculum of the program but 76.2% indicated they adapted the programs to fit the needs of the perpetrator this included in terms of learning disabilities, language skills and learning styles rather than as tailored to the type of aggression found or the consideration of mutuality in aggression. This is a positive finding as it indicates the "one size fits all" approach of the traditional feminist model is becoming less popular with programs and facilitators recognising the need to explore the context of aggression and the function it serves for the perpetrator rather than making assumptions. In their evaluation of program integrity, Bullock et al. (2010) found that there was wide variation in the degree to which providers deviated from the manual in response to the group dynamics.

Most were satisfied with the effectiveness of their program. There was however, some disagreement around the UK standards. Some participants endorsed them commenting on the importance of Respect accreditation however others indicated the standards should be much more inclusive of a variety of perpetrator characteristics (e.g. around gender and sexuality). There was also a call to have more published studies around the effectiveness of the programs. This fits with a lot of

research currently within the field that is calling for more evidence based practice around the use of DVPPs (e.g. Dixon et al., 2012; Graham-Kevan, 2007; Dutton & Corvo, 2007).

The findings across the current sample and the review of current accreditation processes indicates the Duluth model and feminist approach to DVPP is still strongly influential within the UK.

Limitations and challenges

An obvious limitation for this review is the response rate of providers and organisations. Within only 21 organisations choosing to take it is likely there is a significant bias present within the results here. We hoped that the nature of the study would encourage all organisations to anonymously take part and report on their DVPPs and we are disappointed that some felt ideological differences were a reason not to engage in evidence based practice.

Furthermore, whilst we used a mix of quantitative and qualitative based questions to gather a mix of data, it is possible we did not capture the full scope of questions that should be asked here. The questionnaire originated from the US, we adapted it to suit the UK in the use of terminology and context but it is possible we missed some aspects specific to the UK.

Implications

The high frequency of IPV can be seen as reflective of the high levels of interdependence found within romantic relationships (Finkel, 2007). This interdependence renders conflict as inevitable and given that typical conflict will begin with verbally aggressive behavior it is not surprising that elevated levels of non-

violent conflict predict higher levels of violent behavior in relationships. Finkel (2007) further contests that this interdependence is also responsible for increasing the motivation to influence the partner's behavior because it is that behavior that predicts the individual's own outcomes (Felson, 2002). Felson (e.g., 2002, 2010) was one of the first proponents of studying IPV in the context of other types of aggression. He argued that rather than studying IPV solely from a patriarchal perspective, it should be examined in terms of the characteristics of the perpetrator (at a micro level), instead of society (at a macro level).

Finkel, DeWall, Slotter, Oaten and Foshee (2009) suggested it is not rare for someone to experience violent impulses during serious relationship conflict. Their results demonstrated that some people experienced the impulses without acting on them. Finkel et al. feel that is it "essential...to understand the psychological mechanisms by which individuals override these impulses in favour of nonviolent conflict behavior" (p. 495). So, contrary to the belief of some (e.g., Dobash & Dobash, 1979), violent impulses towards partners are not something solely experienced by patriarchal men. Implications from Finkel's work and the current study are that interventions should be focusing on individuals and their characteristics rather than seeing IPV as a macro, societal problem that requires social change. Rather than educating men about power and control using a "one size fits all" approach, practice should be tailored to different circumstances. Finkel et al. (2009) suggested an approach based on self-regulatory training and demonstrated the effectiveness of a similar self-regulation bolstering in one of their studies.

The feminist approach is still so hugely influential in practice despite the wealth of literature not only criticising it but also providing a variety of alternative models and methods to try. The lack of research informed practice here is quite

unique and does not seem to be as great a factor in less politicised field (e.g. other types of aggression).

Conclusions

The Duluth model is cited as still being very influential in UK based work with IPV perpetrators. Phillips, Kelly and Westmarland, (2013) detail in their study that DVPPs have developed in the UK through "ongoing reflections on a rich diversity of practice, underpinned by a gendered analysis f domestic violence" (p.3). Feminist models of DVPPs work on assumptions about perpetrators but without functional assessments of behavior for men and women it is not possible to fully understand and therefore effectively intervene (Dixon et al., 2012). Until there is a better link between research and practice, and research and policy then this field will continue to be influenced by an ideological and inappropriate model. Rather we should move beyond gendered analysis and feminist models and explore existing programs used for generally violent offenders and seek to adapt these to working with those who are domestically violent (Graham-Kevan, 2007).

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Table 1:

Facilitators' perceptions around causes of domestic violence.

	Not at all important	Somewhat important	Very important
Poor self esteem	9.5%	42.9%	47.6%
Power and control	4.8%	42.9%	47.6%
Poor anger management	9.5%	42.9%	42.9%
Difficulty managing emotions	4.8%	23.8%	71.4%
Patriarchy	23.8%	52.4%	23.8%
Dependency on others	23.8%	47.6%	28.6%
Traditional gender roles	9.5%	57.1%	33.3%
Past trauma	19.0%	47.6%	33.3%
Family violence/abuse	4.8%	52.4%	42.9%
Mental health issues	14.3%	57.1%	28.6%
Poor self-awareness	9.5%	42.9%	47.6%
Aggressive personality	19.0%	66.7%	14.3%
Other personality issues	19.0%	61.9%	19.0%
Poor communication/conflict resolution skills	4.8%	19.0%	76.2%
Poor general coping skills	9.5%	33.3%	57.1%
Negative peer influences	14.3%	66.7%	19.0%
Substance abuse	4.8%	57.1%	38.1%
Attitudes supportive of violence	9.5%	33.3%	57.1%

Having abusive partner	23.8%	57.1%	19.0%
Work/environmental stress	19.0%	76.2%	4.8%
Faced oppression or discrimination	33.3%	61.9%	0%
Poor education	42.9%	47.6%	9.5%
Unemployment/low income stress	19.0%	57.1%	23.8%
Parenting stress	9.5%	71.4%	19.0%

Table 2:

To what extent do current perpetrator intervention standards address each of these possible causes?

	Not at all	Slightly	Moderate	Very	Complete
Poor self esteem	14.3%	14.3%	47.6%	23.8%	-
Power and control	4.8%	4.8%	23.8%	47.6%	19%
Poor anger management	4.8%	9.5%	23.8%	52.4%	9.5%
Difficult managing emotions	9.5%	9.5%	14.3%	57.1%	9.5%
Patriarchy	9.5%	28.6%	23.8%	33.3%	4.8%
Dependency on others	23.8%	28.6%	28.6%	19.0%	-
Traditional gender roles	9.5%	9.5%	28.6%	47.6%	4.8%
Past trauma	33.3%	33.3%	23.8%	9.5%	-
Family violence/abuse	14.3%	28.6%	38.1%	19.0%	-
Mental health issues	23.8%	42.9%	23.8%	9.5%	-
Poor self-awareness	9.5%	19.0%	42.9%	28.6%	-
Aggressive personality	9.5%	28.6%	42.9%	19.0%	-
Other personality issues	19.0%	33.3%	33.3%	14.3%	-
Poor communication/conflict resolution skills	9.5%	4.8%	14.3%	61.9%	9.5%
Poor general coping skills	4.8%	19.0%	23.8%	47.6%	4.8%
Negative peer influences	4.8%	19.0%	42.9%	28.6%	4.8%
Substance abuse	9.5%	23.8%	42.9%	19.0%	4.8%
Attitudes supportive of violence	4.8%	4.8%	19.0%	38.1%	33.3%

Having abusive partner	19.0%	42.9%	19.0%	14.3%	4.8%
Work/environmental stress	23.8%	42.9%	19.0%	14.3%	-
Faced oppression or discrimination	38.1%	47.6%	9.5%	4.8%	-
Poor education	28.6%	42.9%	14.3%	14.3%	-
Unemployment/low income stress	23.8%	52.4%	19.0%	4.8%	-
Parenting stress	14.3%	38.1%	33.3%	14.3%	-

Table 3:

Qualitative comments around the most and least useful aspects of the UK standards.

Most effective	Least effective
Having a visible organisation that promotes standards	I have many doubts about standards. They are restrictive and tend to reduce innovation
Standards are clear and relatively easy to get hold on	Insufficient resources/
The quality and assurance measures that we work to, ensure effective outcomes	Not compulsory
We provide a variety of treatment pathways and appear to be constantly reviewing and integrating new research and practise.	Some issues with consistency of programme re-writes
Virtually nothing! They should be scrapped	The current Respect standard is overly complicated, difficult to achieve and includes some items that are of low relevance to the standards
We find the standards set by Respect very effective	The current standards include some items that are not evidence based…and others that are not legally possible to guarantee…These mean they are less likely to be adopted by all programs and commissioners.
	The feminist paradigm. Male perpetrators and female victims only.
	Overlong programs which produce endless drop outs and total non-focus on the individual
	The limitations on who can attend the program. The lack of consideration of trauma on the individual's thoughts and behaviour.
	Too focussed on a particular approach to delivery and ethos, aetiology of Domestic Abuse

Appendix 1: Questionnaire

Tulane University/Association of Domestic Violence Intervention Programs
National Survey for Domestic Violence Intervention Programs

Please fill out all the questions to the best of your ability. This survey is confidential. By using this survey, we seek to better understand the types of services provided, so as to help in the effort to reduce domestic violence in our communities and keep victims safe. By returning this survey, you consent to this study. Thank you for your participation. For any questions or comments please contact Dr Elizabeth Bates (Elizabeth.Bates@cumbria.ac.uk)

Programme Structure and Content

1a. What modalities do you use to deliver treatment to domestic violence perpetrators? Please tick all that apply.

a. Group
b. Individual
c. Couples
d. Couples groups
e. Family

1b. What types of services and information does your programme provide to domestic violence perpetrators? *Please tick all that apply.*

Anger/impulse control skills___	Identifying/managing emotions___	Meditation/relaxation exercises___	Identifying power/control tactics___
Communication skills___	Conflict resolution skills___	Assertiveness training___	Identifying three-phase battering cycle___
Identifying mutual conflict cycles___	Changing pro-violent/irrational thoughts___	Consciousness raising about gender roles___	Socialization factors___
Impact of abuse on victims___	Effects of violence on children___	Grief work___	Understanding of childhood experiences___
Healing from past trauma___	General self-awareness___	General coping skills___	Life skills___

1c. How are these services and information provided? *Tick all that apply*.

a. Check-in time and discussion___
b. Lectures
c. Handouts and exercises___
d. Role play___
e. DVDs and/or audio
f. Goal-setting
g. Progress logs/journal writing___
h. Other_____

1d. What do you consider the primary treatment/intervention approach(s) that your programme uses for perpetrators? *Please tick all that apply and rank order them in the order of their importance to your programme (1=most important, 2=2nd important, 3=3rd important and so on).*

Narrative therapy___	Family systems____	Cognitive behavioural therapy___	Feminist___
Power/control (Duluth)___	Client-centred___	Psychodynamic___	Solution focused___
Psychoeducational___	Motivational interviewing___	Trauma-focused___	Strengths-based___
12-step___	Self-help/peer support___	Social learning__	Do not know___
Other			

2a. How many sessions is the perpetrator treatment programme? _____

2b. What is the average duration of each session?
- a. 30-60 minutes___
- b. 60-90 minutes___
- c. 90-120 minutes___
- d. 120-150 minutes___
- e. 15o+ minutes___

2c. How often do sessions meet?
- a. Twice a week___
- b. Once a week___
- c. Twice a month___
- d. Once a month___
- e. Other_____

2d. On average, how many clients are in a session? _____

2e. What is the setting of sessions?
- a. Inpatient___
- b. Outpatient___
- c. Prison___
- d. Other___

3a. How long is your intake/assessment procedure on average?
- a. Less than 15 minutes
- b. 16-30 minutes
- c. 31-59 minutes
- d. 60 minutes or more

3b. What does your intake/assessment procedure consist of? *Tick all that apply*
- a. Oral interview
- b. Administration of standardized questionnaires (please describe):

_____
_____
_____

3. What additional services do you provide to domestic violence perpetrators? *Tick all that apply*.

Crisis management___	Parenting classes___	Substance abuse counselling___	Mentoring___
Career services___	Transportation___	Housing___	Financial___
Food___	Clothing___	Police/Safety___	Educational resources___
Job training___	Employment___	Community advocacy___	

4a. What services does your agency offer for victims? *Tick all that apply*.
- a. Shelter beds
- b. Peer support groups
- c. Mental health treatment
- d. Legal assistance (e.g., with restraining orders)
- e. Transitional housing
- f. Social service assistance (e.g., in getting food stamps, child care, etc.)
- g. Other_____

4b. Please indicate the approximate number of occasions perpetrator programme facilitators have contact with victims during the following treatment periods (for example, 1 time etc.)
- a. Never___
- b. Before treatment___
- c. During treatment___
- d. After treatment___

Programme Logistics

5a. Approximately, how many perpetrators does your programme serve? _____

5b. Please list the languages in which you provide services. _____

6. Please provide *percentages* for the demographics of client population.

Gender:	a. Female___ b. Male___ c. Other___

Sexuality: a. Heterosexual___ b. Lesbian___ c. Gay___ d. Bisexual___ e. Trans M to F___ f. Trans F to M___ g. Other_____
Ethnicity 1. White _____ 2. Mixed background _____ 3. Asian, Asian English, or Asian British _____ 4. Black, Black English or Black British _____ 5. Other ethnicity (Please specify) ……
Locale: Rural___ Urban___
Age: a. Under 18___ b. 18-24___ c. 25-39___ d. 40-54___ e. 55-64___ f. 65+___
Employment: a. Unemployed___ b. Part-time ___ c. Full-time ___ d. Retired___ e. Students___ f. Prisoners___
Please estimate average annual income of client population £_____per year

7. Approximately what percentage of clients are referred to services through the following methods?
   a. Professional referral___
   b. Family/friend referral___
   c. Voluntary___
   d. Court-mandated___
   e. Social service agency or Family Court_____
   f. Other_____

8. Which other services do you have relationships with? *Please tick all that apply.*

Service	**Quality of relationship**	**Frequency of contact**
Courts___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always
Social Services___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always
Advocacy groups___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always
Behavioural Health___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always

Substance abuse programmes___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always
Shelters___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always
Criminal Justice System___	a. Poor b. Fair c. Good d. Very Good e. Excellent	a. Never b. Rarely c. Sometimes d. Often e. Always

9. Approximately what percentage of programme funding comes from the following sources?
   a. Perpetrator___
   b. Government: National___Local___
   c. Private donations___
   d. Foundations___
   e. Other_____

Facilitator Characteristics

10a. What are the educational requirements for facilitators of domestic violence perpetrator treatment at your agency? *Please tick all that apply.*
   a. No educational requirements _____
   b. Less than high school___
   c. High school qualifications___
   d. Bachelor degree___
   e. MA/MSc___
   f. PhD/DSW/PsyD___
   g. MD___
   h. Other_____

10b. What is the typical level of educational attainment for facilitators? *Please tick all that apply.*
   a. Less than high school___
   b. High school qualifications___
   c. Bachelor degree___
   d. MA/MSc___
   e. PhD/DSW/PsyD___
   f. MD___
   g. Other_____

10c. What other specialized trainings does the typical facilitator have? *Please indicate number of hours per year. If none, write "0"*
   a. Domestic violence specific. Hours per year___
   b. Mental health – not DV related. Hours per year___
   c. Case reviews and peer support. Hours per year___
   d. Other_____

10d. How many years of experience does the typical facilitator(s) in your programme have? _____

11. Please identify the number of intervention facilitators by gender.
   a. Female___
   b. Male___
   c. Other___
   d. Not applicable___

Facilitator Insights

12. When thinking about causes of domestic violence, what do you think are important factors? *Rate each according to their importance:*
1 = Not all important
2 = Somewhat important
3 = Very important

Poor self-esteem___	Need to exercise power and control___	Poor anger management skills___	Difficulty managing emotions___
Patriarchy___	Dependency on others___	Traditional gender roles___	Past trauma___
Violence/Abuse in family of Origin ___	Mental health issues (e.g., depression)___	Poor self-awareness___	Having an aggressive personality___
Other personality issues___	Poor communication/	Poor general coping	Exposure to negative peer

	conflict resolution skills___	skills___	influences ___
Substance abuse___	Attitudes supportive of violence___	Having an abusive partner___	Work/environmental stress___
Having faced oppression/ discrimination___	Poor education___	Unemployment/low income stress___	Parenting stress___
Other _____			

13a. Who do you think most often initiates physical violence against their intimate partners?

a. Males___
b. Females___
c. Males and females about equally___
d. Don't know___

13b. Who do you think most often initiates non-physical forms of violence against their intimate partners?

a. Males___
b. Females___
c. Males and females about equally___
d. Don't know___

13c. The impact of domestic violence is greatest on who?

a. Male victims___
b. Female victims___
c. Male and female victims about equally___
d. Don't know___

13d. Children who witness domestic violence are more likely to become perpetrators themselves later in life when they witnessed what type of violence?

a. Father on mother___
b. Mother on father___
c. Either father on mother, or mother on father___
d. Don't know___

13e. In general, male perpetrators are motivated to abuse their partners for what reason?

a. To dominate and control___
b. As a way to express anger or other emotions or communicate___
c. In self-defense___
d. To retaliate for something their partner did___
e. Don't know___

13f. In general, female perpetrators are motivated to abuse their partners for what reason?

a. To dominate and control___
b. As a way to express anger or other emotions or communicate___
c. In self-defence___
d. To retaliate for something their partner did___
e. Don't know___

14a. How would you deal with a client in your group who seems to be co-operating with the programme but who remains quiet and rarely talks?

_____
_____
_____

14b. How do you deal with a client who is dominating the group by always wanting to talk, giving others his/her opinions without being asked?

_____
_____
_____

14c. How would you deal with a client who questions your programme's approach or material, or your position as group facilitator?

_____
_____
_____

14d. How would you deal a group where the members show support for a member who appears to not be taking responsibility for his/her behaviour?

_____
_____
_____

14e. If a client tells you that the accusations against him/her were either false or exaggerated (e.g., says that his/her partner started the fight, and that he/she was only acting in self-defence), what percentage of the time do you think the client is being truthful as opposed to minimizing/blaming the victim? Why?

_____
_____
_____

Views on Standards and Programme Improvement

15a. Is data collected on your domestic violence perpetrator programme?

a. Yes___
b. No___

15b. If yes, what kind of data does this programme collect?

a. Descriptive data (e.g., information from assessment such as age, ethnic background, crime history, whether voluntary or court-referred)
b. Client satisfaction survey
c. Outcome data on recidivism rates (who re-offends during or after the programme)

15c. How often is this data collected?

a. Monthly___
b. Quarterly___
c. Semi-annually___
d. Yearly___
e. Other_____

15d. Who collects the data and evaluates the programme?

a. The agency
b. Researchers outside of the agency
c. Other_____

15e. How satisfied are you with your programme's data gathering?

a. Not at all___
b. Slightly___
c. Moderately___
d. Very___
e. Completely__

16a. Please estimate the percentage of clients who complete the programme after having completed the intake/assessment: ___%

16b. Please estimate the percentage of clients who go are arrested for domestic violence within one year after programme completion: ___% _____

17. Are treatment interventions (*tick all that apply)*

a. Used according to the written curriculum?__
b. If no written curriculum, used according to agency's philosophy of treatment and expectations?___
c. The same for all clients?___
d. Adapted to fit the various needs of clients?____
e. Developed specifically for various client needs and contexts?____
f. Don't know____

28. If Interventions and/or programmes are adapted or developed to fit the needs of clients, please specify for what population(s) and the specific ways they have been adapted or developed for these population(s)

_____
_____
_____

19. Describe any training or strategies that facilitators receive/use to make treatment interventions culturally sensitive to the given population

_____
_____
_____

20. Describe any challenges facilitators have experienced in making interventions relevant to treatment populations with respect to ethnicity and/or race, gender, class, sexual orientation and identity, disability, religion, age, or citizenship status—

_____
_____
_____

22. Describe any training or educational needs facilitators may have related to cultural sensitivity and providing relevant cultural services to populations

_____
_____
_____

23a. Do you provide any LGBTQ specific services? Please describe.

_____
_____
_____

23b. What LGBTQ specific services would you like to see implemented?

_____
_____
_____

23c. What specific needs do you think LGBTQ clients need apart from the standard intervention?

_____
_____
_____

24. How satisfied are you overall with the effectiveness of the programme?

a. Not at all satisfied
b. Slightly satisfied
c. Moderately satisfied
d. Very satisfied
e. Extremely satisfied

25a. How aware are you of state/province standards for perpetrator treatment programmes?

a. My country does not have any written standards__
b. Not sure whether or not my country has standards or do not know what they consist of
c. Have a poor understanding of these standards___
d. Have a moderate understanding of these standards___
e. Have a very strong understanding of these standards

If your ticked either "a" or "b" above and you live in a country that does not have written standards or you are not familiar with them, then please answer all the questions in 29-30 below according to the standards or expectations of *the agency you work for*.

25b. Do you think your country's standards adequately provide effective intervention for perpetrators?

a. Strongly disagree
b. Disagree
c. Neither agree or disagree
d. Agree
e. Strongly agree

25c. Do you think your country's standards adequately provide effective intervention for female perpetrators?

a. Strongly disagree
b. Disagree
c. Neither agree or disagree
d. Agree
e. Strongly agree

25d. Do you think your country's standards adequately provide effective intervention for same-sex perpetrators?

a. Strongly disagree
b. Disagree
c. Neither agree or disagree
d. Agree
e. Strongly agree

25e. Do you think your country's standards adequately provide effective intervention for male perpetrators?

a. Strongly disagree
b. Disagree
c. Neither agree or disagree
d. Agree
e. Strongly agree

25f. Previously you were asked to rate what you believe are the most important causes of domestic violence. Here is the list again. To what extent do current perpetrator intervention standards address each of these possible causes?

Poor self-esteem a. Not at all__ b. Slightly__ c. Moderately__ d. Very e. Completely__	Need to exercise power and control a. Not at all__ b. Slightly__ c. Moderately__ d. Very e. Completely__	Poor anger management skills a. Not at all__ b. Slightly__ c. Moderately__ d. Very e. Completely__	Difficulty managing emotions a. Not at all__ b. Slightly__ c. Moderately__ d. Very e. Completely__
Patriarchy a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Dependency on others a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Traditional gender roles a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Past trauma a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__
Violence/Abuse in family of Origin a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Mental health issues (e.g., depression)___ a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Poor self-awareness___ a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely_	Having an aggressive personality___ a. Not at all__ b. Slightly__ c. Moderately__ d. Very e. Completely__
Other personality issues a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Poor communication/ conflict resolution skills a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Poor general coping skills a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Exposure to negative peer influences ___ a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__
Substance abuse a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Attitudes supportive of violence a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Having an abusive partner a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Work/environmental stress a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__
Having faced oppression/discrimination a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Poor education a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Unemployment/low income stress a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__	Parenting stress a. Not at all__ b. Slightly__ c. Moderately__ d. Very__ e. Completely__

25g. What do you think is most effective about your country's current standards? (*If you do not know, write "do not know"*.)

_____
_____
_____

25h. What do you think is least effective about your country's current standards?

_____
_____
_____

25i. What changes do you think should be made to your country's standards?

_____
_____
_____

26a. How often do you faithfully follow your country's standards?

a. Never
b. Rarely
c. Sometimes
d. Often
e. Always

26b. How often do you supplement your country's standards?

a. Never
b. Rarely
c. Sometimes
d. Often
e. Always

26c. Please describe how you supplement your country's standards.

_____
_____
_____

26. Describe any ways this intervention programme could be improved.

_____
_____
_____