# A Review of Domestic Abuse and Sexual Violence Perpetrator Services in Cardiff and The Vale of Glamorgan

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# 1 Executive Summary

This report is a review of Domestic Violence and Abuse (DVA) Perpetrator Services in Cardiff and The Vale of Glamorgan, with a less in-depth mapping of Sexual Violence (SV) Perpetrator Services. The report consists of a rapid review of European literature on the effectiveness of interventions with DVA perpetrators; semi-structured interviews (n=44) with key staff in DVA perpetrator services in Cardiff and The Vale of Glamorgan (Cardiff and The Vale of Glamorgan), key staff in DVA victim services in Cardiff and The Vale of Glamorgan, staff in other services who have worked together with the DVA perpetrator services in Cardiff and The Vale of Glamorgan, and representatives from other services and organisations nationally, including SV perpetrator services; and an assessment of the motivational interviewing (MI) skills of staff working directly with DVA perpetrators in Cardiff and The Vale of Glamorgan. These data sources are combined to produce a review of services in the area in a wider European context.

DVA perpetrator services in Cardiff and The Vale of Glamorgan are mapped and compared with what is known about effective service delivery elsewhere based on a review of European research literature. An overview is given of services in the context of what is known about effective service delivery for preventative, early intervention, medium-risk, and high harm interventions. The review includes sections focussing on each of these different types of service. This categorising of services is not perfect and does not describe all the ways in which these services differ, but it does provide a practical way to compare similar services. The overview of DVA perpetrator services is placed in the wider context of services, including police, probation, social services, and criminal justice interventions that work with DVA perpetrators. Services that work with sexual violence offenders are also mapped. How these services collaborate and possibilities for improving collaboration are also explored. This includes a brief review of multi-agency referral panels for high-harm DVA perpetrators.

There have recently been preventative, early intervention, medium-risk, and high harm programmes in the area. There are no longer any programmes in The Vale of Glamorgan, outside of criminal justice services. There is also no medium-risk service in Cardiff. The strengths and opportunities for development of the current services are placed against a backdrop of what is known about evidence-based practice. The

preventative and early intervention services we look at (IRIS+ and CLEAR) are relatively new but show good promise. The high-harm service (Drive) has recently had a fuller review. It is an innovative service with a strong impact. CLEAR and Drive were benchmarked against Welsh Government Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards, which provide additional benchmarking to the 'comprehensive and robust means of ensuring safe and effective delivery' that the Respect Standards provide (*Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards*, 2018, p.11). We paid particular attention to a key staff skill, emphasised in the VAWDASV Perpetrator Service Standards: the use of motivational interviewing (MI) methods. We found that staff had received inadequate training. More training could further improve their service user engagement strengths and impact.

DVA Perpetrator Services are collaborating, also with wider services, though there is room for improvement in this collaboration. The lack of medium-risk services is a gap, and also impacts on collaboration. The possibilities for the development of two multi-agency hubs are explored: a hub for high-risk offenders (not just domestic violence offenders), and a DVA hub for services working with victims and perpetrators. Drive, the high-harm programme could be involved with both hubs.

In exploring the effectiveness of DVA perpetrator interventions, motivational interviewing (MI) is identified as a key skill for front-line staff. The level of proficiency of staff in the region is assessed and recommendations for further training are made.

# 2 Introduction

The aim was to map services working with DVA perpetrators in Cardiff and The Vale of Glamorgan, and their impact. In doing this we have used the data we collected on local programmes to benchmark them against the delivery of perpetrator programmes elsewhere, and against the VAWDASV Perpetrator Standards Checklist[1]. We also set out to identify good practice in programme delivery not currently available in the region. Both the benchmarking and exploration of other programme delivery types have been supported by a rapid, but fairly comprehensive review of literature on the effectiveness of European perpetrator programmes.

A key part of this data has been interviews with service providers and key stakeholders such as South Wales Police, South Wales Police and Crime Commissioner and Social Services. During interviews we also explored the different approaches to a 'perpetrator panel' as a referral route and support structure for high-harm domestic violence (DVA) perpetrators.

A key skill for staff working in these services, across risk/harm levels, is motivational interviewing (MI), its use is also part of VAWDASV Perpetrator Service Standards. We used the VASE-R (Video Assessment of Simulated Encounters – Revised; Rosengren et al., 2005), assessment instrument to measure the implementation of MI across the DVA perpetrator services in the local area.

We intend this report to help to inform regional commissioners of the most effective programmes that fall into preventative, early intervention, medium-risk, and high-harm services suitable for the region.

Quotes from interviewees are identified by *italics*. These sources have not been specifically identified to ensure anonymity.

[1] The Welsh Government developed Perpetrator Service Standards in collaboration with colleagues from statutory, non-statutory, non-government organisations and third sector service providers, researchers, policy makers, commissioners, and funders. A checklist was included as part of these standards to facilitate benchmarking (*Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards*, 2018).

# 3 Methodology

This review used a combination of a literature review, interviews, and an assessment of the motivational interviewing skills of staff who work directly with DVA perpetrators.

## 3.1 Literature review

A rapid review of literature was conducted, similar to the review conducted by Miles et al. (2018). We captured some slightly newer articles but, unlike Miles et al., we restricted our search to European literature as we felt that "caution should be exercised when generalizing the results of the North American reviews that… (dominate this field) …. to a European context, given the highly politically charged and culturally embedded nature of domestic violence" (Akoensi et al., 2013, p. 1207). Our initial search was a key word search: (domestic violence OR domestic abuse OR Batterer OR famil* violence OR spousal abuse OR int*partner violence OR IPV) AND (Program* OR treat* OR intervention OR therapy OR counsel* OR rehab OR domestic violence perpetrator program OR psycho*) AND (Effect* OR outcome* OR Eval* OR experiment OR RCT OR quasi experiment* OR trial OR empirical OR Recidiv* OR Re-offen* OR re-arrest OR Recon*) of the Scopus, OVID & Medline databases, since 2017. We combined this with literature from a similar search conducted by Lilley et al. (2018).

The literature was divided into sections depending on whether the focus was on:

1) Preventative interventions
2) Early interventions
3) Interventions targeting medium-risk perpetrators
4) Interventions targeting high-harm perpetrators

5) Interventions within the criminal justice system

Further searches were conducted targeting each of these sections, for example by searching for literature about a particular service. Internet searches were also used to conduct these searches in order to try and capture some grey literature. After removing irrelevant articles, and duplications of the same study we had 135 pieces of literature all focussed on the question "what works with domestic abuse perpetrators to prevent or reduce the risk of ongoing abuse?"

Other literature searches were conducted, for example around sexual violence services by searching for literature specific to the services currently operating.

Many of our initial searches included non-European literature, we draw on this where there is a paucity of European literature. We have highlighted in the text when we have used non-European literature.

We used an existing dataset of literature focusing primarily on motivational interviewing and DVA for the section on motivational interviewing. No new systemic searches were conducted.

There may be many relevant unpublished papers that have not been included but could have been valuable.

## 3.2 Interviews

The original interview plans developed during this review: the list we had been given of local services proved to be inaccurate. It included a service that had recently been de-commissioned and did not include a key preventative service. The map of local services formed in parallel with a changing list of potential interviewees. We had also been asked to explore the experience of the Cwm Taf Domestic Abuse Perpetrator

Panel (DAPP), only to find this had never been established. Instead, we conducted a rapid survey of relevant similar panels nationally. This led us to conduct interviews with professionals involved in panels in Croydon, Worcester, Sandwell & Northumbria. There was variation in all these areas in how the panel was organised, but there was a local Drive, or similar service in all these areas. We had also planned to conduct interviews with service users of local perpetrator and victim services. Some were planned and one had been conducted when 'lockdown' due to the Covid-19 pandemic led us to abandon that idea. The one interview that was conducted with a service user of perpetrator services was not used. Also, some interviews with professionals, like the mental health representative on the Cardiff MARAC, became impossible amidst the pressures of the Covid-19 pandemic. However, 44 interviews were conducted in total, with eight staff members from local DVA perpetrator services, four staff members from local DVA victim services, twelve other professionals from local services, and twenty individuals with a regional perspective, or a perspective on DAPPs and similar structures.

Topic guides were based on:

1. Information needed for assessing the VAWDASV Perpetrator Service Standards
2. Other relevant information about local services
3. Experiences and views around collaboration
4. Experiences and views of DAPPs and similar structures (MARACs, MATACs etc,)

## 3.3 Assessment of motivational interviewing skills

This review aimed to focus on Motivational Interviewing (MI). as a core skill for staff working with DVA perpetrators. In order to do this the Video Assessment of Simulated Encounters – Revised (VASE-R; Rosengren et al., 2005) was administered, along with a brief demographic questionnaire, that included question about training and work experience. The VASE-R is a video-based method for assessing respondent skill in MI. The VASE-R consists of video presentation of three vignettes in which actors portray substance abusers. Respondents are prompted to identify or generate written responses consistent with MI principles. The VASE-R includes 18 items (6 per vignette) that

produce a total score and five subscale scores (i.e., Reflective Listening, Responding to Resistance, Summarizing, Eliciting Change Talk, & Developing Discrepancy). We have only included the total score in this review. We had to adapt the materials of the VASE-R slightly so that it could be administered online via video conferencing. The written answers were returned electronically and were scored using detailed guidelines available in a scoring manual. The anonymised responses were scored independently by an expert MI practitioner and trainer. The VASE-R has strong concurrent validity and inter-rater reliability (see section 4.9).

# 4 Services in Cardiff and The Vale of Glamorgan

## 4.1 Preventative services

Primary and secondary preventative programmes (tertiary prevention is covered in section 4.2) often focus on victims (see the Glossary in section 8.2, in the appendices for definitions of these terms). A local example is the 'Ask Me' programme, a preventative programme that is delivered by Welsh Women's Aid in partnership with local communities. The scheme allows everyday people to become Community Ambassadors. Two days of training aims to equip them with an understanding of domestic abuse and how to respond to survivors.

The aim is to enable local communities to play an active role in ending violence against women and girls (VAWG), including domestic abuse. 'Ask Me' is part of Change that Lasts (CtL). CtL was developed by Women's Aid (England) and Welsh Women's Aid, with a focus on finding the earliest possible opportunities to intervene, and the aim of addressing gaps in current VAWG service provision. ('About Change That Lasts', 2020; *Change That Lasts: Transforming Responses to Domestic Violence and Abuse*, 2015; *Women's Aid Change That Lasts Summary*, 2015). There are currently thirteen 'Ask Me' schemes in England (*Ask Me - Women's Aid*, 2020). The 'Ask Me' scheme in Wales is open to those who live, work, study or volunteer in Cardiff, and some other areas of Mid-, West- and North- Wales. There are two other strands to the CtL programme in Cardiff: CLEAR (Change that Lasts Early Awareness Raising), an early intervention for domestic violence perpetrators (see section 4.2), and 'Trusted Professional', a preventative programme focused on front-line professionals (see section 4.1.2)

Some preventative programmes have focused, at least partly, on perpetrators; either through targeting lay groups, or professionals:

### 4.1.1 Primary preventative programmes that aim to raise awareness amongst lay target groups or the general population

A recent initiative by Cardiff Metropolitan University, in partnership with other European Universities, worked with 600 to 700 school pupils (boys and girls)

enrolled in schools in Cardiff, Spain, Italy, Romania, Portugal and Poland (Vives-Cases et al., 2019), aiming to work with 12- to 15-year-olds. In Cardiff they worked with 12–13-year-olds, *'as GCSEs take up lots of time'*, in Poland they could only work with 17-year-olds *"due to the social climate – teachers can be arrested for trying to educate pupils on sexuality"*.

The programme consisted of seminars with teachers, workshops with pupils creating short films about GBV (Gender Based Violence), and exhibitions of the films with participants, their families, authorities, and other stakeholders. The films focused on highlighting the skills needed to resolve dating violence and on changing gender role myths (Pérez-Marco et al., 2020) "Peer learning, creativity and positivity are key", with a "focus on (getting) young people to create videos of good outcomes, which are then used as a teaching aid for peers". Compared with a control group, sexist attitudes and aggression decreased significantly, although more for girls than for boys (Lights4Violence, 2020a, 020b, 2020c). The study approached dating in the physical space, but participants highlighted that their relationships "might take place mostly in the virtual space. They brought in discussions about bullying and cyber-bullying, many kids made films about this". The researchers also discovered that "age 12 may already be too late to intervene early, as many have been exposed to or witnessed IPV (intimate partner violence). Boys were reporting this higher than girls". The evaluation of this programme is still ongoing.

More widely, there have been a range of programmes that aim to have a preventative impact on (potential) perpetrators. One way of raising awareness is through the use of media, for example poster campaigns. However, recent U.K. research (Shortland & Palasinski, 2019) highlighted that campaigns that focus on strong stereotypes of male perpetrators have actually been found to *increase* domestic violence. Programmes may be more effective if they focus on moderate levels of abuse and are less emotive, though there is no clear evidence for what the most effective approaches are for awareness raising through media.

In a recent meta review of 22 studies evaluating UK based multi-agency early interventions for domestic violence (Cleaver et al., 2019), seven of the studies included primary or secondary preventative interventions. Of these studies, four included some focus on potential perpetrators. One of these (Hester & Westmarland,

2005) focussed on professionals (see below) and three studies (Fox et al., 2014; Fox et al., 2016; Hale et al., 2012) looked at school based DVA prevention programmes. They found that both boys and girls who had received the intervention became less accepting of domestic violence and more likely to seek help compared with a control group. However, they also found that there 'is a risk, with explicitly feminist approaches, of alienating boys' (Fox et al., 2014, p.29) who were engaged in these programmes, and reducing their effectiveness. Involving boys and girls in the design of pro-feminist programmes is offered as a potential solution. Both girls and boys who participated in these programmes had objected to feeling that viewpoints were being imposed upon them. Programmes are more effective if the starting point is the experience of the target group. Possibilities for exploring this further are indicated by a 'mounting momentum for engaging men and boys as part of efforts to prevent men's violence against women in the UK' (Burrell, 2018, p. 15).

Stanley et al. (2015) drew conclusions from evaluations of 25 years of schools-based preventative interventions in the U.K, combined with interviews with international experts in the field of prevention. A trend was found for programmes to be increasingly identifying perpetrators as a primary target for change. It was also 'generally agreed across all forms of consultation that messages for boys should be positively framed and should avoid a blaming approach that could provoke resistance' (p.127). The review identified elements that contribute to the success of programmes, for example including local elements in programme design and content and ensuring that both individuals delivering and receiving the intervention contribute to its development.

A more recent example is the Change Up programme, which used a social norming approach (SNA) to address domestic violence and abuse with young people aged 13–14 at two schools in the U.K. (Rogers et al., 2019). SNA is an evidenced-based methodology that focuses on strengths and building on individual's own norms, rather than pathologizing behaviour, as part of a motivational interviewing strategy (Berkowitz, 2005). Using baseline and repeat surveys, the Change Up project was found to have 'enabled some key changes in norms and attitudes about coercive control' (p.517).

International research yields similar findings. An international review of 25 years of preventative work with young people found them 'wanting identity-affirming, strengths-based programming (that also addresses, but is not limited to, GBV prevention)' (Crooks et al., 2019. p.46).

Bystander Interventions train participants to challenge domestic abuse / dating violence and sexual violence perpetrators, support victims and diffuse potentially harmful situations. In doing this they aim to raise awareness and change attitudes. Miles & De Clare (2018) give an overview of international bystander intervention research, coming to the conclusion that support for their effectiveness is mixed but finding that they may be valuable as part of 'a whole system approach to tackling domestic abuse' (p.32).

A recent U.K. example is the Intervention Initiative, which is a facilitated bystander intervention educational program to prevent violence, abuse, and coercion. It has been commissioned by Public Health England for use by all English universities. Fenton & Mott (2018) found significant differences in some pre- and post-intervention measures of some attitudes linked to GBV in a study of first year students at Exeter University. It was also piloted at four Universities in Wales: Aberystwyth University, Cardiff University, Swansea University, and the University of South Wales (through a degree programme delivered in Coleg Gwent). They found that "Students who attended the programme… increased their knowledge of domestic abuse and sexual violence and have also changed their attitudes in line with the knowledge they have received". (Welsh Women's Aid, 2018, p34). Wider implementation was recommended.

A US bystander intervention model, The Mentors in Violence Prevention (MVP) uses a peer-learning model. There has been a qualitative evaluation of its implementation at three schools in the Scottish Highlands (Williams & Neville, 2017). Fuller evaluation is needed; however, the peer-learning model was found to strengthen engagement, facilitate the involvement of wider networks, and positively influence attitudes to GBV.

There is some evidence that bystander and some other preventative interventions within educational institutions can have positive impact and could be considered as

part of a local strategy for reducing domestic violence, if designed carefully to empower both boys/men and girls/women and build on their strengths.

#### 4.1.2 Preventative programmes that increase awareness and appropriate responses by professionals and agencies that may work with domestic violence perpetrators.

Programmes that increase awareness and appropriate responses by professionals to domestic violence, and evaluations of the effectiveness of these programmes, have primarily focused on improving the responses to victims. This is true of Hester & Westmarland's study (2005), which evaluated the impact of 34 programmes funded through the Home Office Violence Against Women Initiative (VAWI) These evidence-based programmes aimed to ascertain which approaches and practices were effective in supporting victims and tackling violence against women. The focus on perpetrators was minimal but there was, for example, an initiative that delivered training to magistrates in order to reduce attrition within the criminal justice sector. The experience of perpetrators was not a focus.

A particularly strongly developing field in the U.K has been around interventions that aim to improve the responses of health care professionals. These interventions have provided training to these professionals, and sometimes extra embedded specialised support within the healthcare setting, to help identify victims earlier and signpost or refer appropriately to further support. The Identification and Referral to Improve Safety (IRIS) model has been shown to increase referrals significantly in primary care (Sohal et al., 2020) and to be adaptable and feasibly deployed to other health care settings, for example sexual health clinics (Sohal et al., 2018) and dentistry (University of Bristol, 2017). The IRIS model has now been rolled out by a social enterprise set up specifically for this task (*IRISi—Our projects*, 2020) and has now provided training at an estimated 850 general practices in 36 localities in the UK. It is also testing and adapting the model for implementation in emergency departments in six European countries, women's, and maternal health services in five European countries, and to inform work on violence against women and girls in low- and middle-income countries.

In Cardiff, the programme had initially met some resistance from GPs; *"GPs don't want to get involved, because they're worried, they are going to open this whole can of worms…* (and there's) *more training and then?* (they're) *going to be stuck in this conversation that they haven't got time for when they've just got 7 or 8 minutes"*. It really made a difference that there was a clinician, a GP, involved in delivering the training. Not long into the training and *'they are talking about their chronic pain patients…having one of their own really helps…at the beginning they don't really want to do the training but by the end they're all talking about patients who might have been involved with this and…they are all engaging in conversation - to hear it come from a GP about the health benefits that really gets them listening…* (the victims aren't) *coming with domestic abuse but they're coming with chronic pain or stress or sleep problems…'*

> *There was this patient they were seeing all the time and after she came to IRIS, they stopped seeing her. They really noticed… "she's not coming all the time anymore". Actually, she was getting the support she needed.*

The Enhanced Identification and Referral to Improve Safety programme (IRIS+; Williamson et al., 2015) is an expansion of this programme that does also have a focus on (male and female) perpetrators as well as male and female victims. '(As IRIS) *we could always take male victims, but we haven't had many… and to be honest there's not a lot we can offer them'*. Training for GPs is provided, and specialised workers are available at GP surgeries for initial conversations, assessment, and referral to specialised services for possible perpetrators identified by GPs. It is being trialled in Bristol and Cardiff. An evaluation by The University of Bristol is ongoing (*IRIS*+, 2020).

IRIS+ is very much at an early stage in terms of supporting perpetrators to access appropriate support. Strong links have been established with other local programmes, like CLEAR (see 3.2); "*the personal connection* (with CLEAR team members) *helps."* And there were signs that GPs, at the four surgeries in Cardiff where IRIS+ is located, were becoming more aware of perpetrators; *"one case, in particular, she was a standard IRIS client, but the GP thought to refer her husband. It was fantastic this wouldn't have happened before…"*

Also, in Cardiff, 'Trusted Professional' ('Trusted Professional', 2020; *Women's Aid Change That Lasts Summary*, 2015) is another part of the CtL programme (see section 4.1.2), a one- day training that is delivered to front-line practitioners that work in non-statutory organisations. The training focusses on recognising behaviours associated with domestic violence, responding appropriately, and signposting to specialist services. We were informed that 'Trusted Professional' includes a focus on recognising perpetrator behaviour, responding to perpetrators, and signposting to services that support them (including CLEAR, described in section 4.2), and that internal evaluations indicated a significant increase in practitioners' ability to recognise, respond and refer to perpetrators. The training aims to complement training that supports public sector bodies to implement the Ask & Act principles in responding to domestic violence (*Ask & Act*, 2020; *The 10 Principles of "Ask and Act"*, 2017). This initiative is fairly new. It will be evaluated as part of an ongoing wider evaluation of CtL schemes by London Metropolitan University.

With IRIS+ and 'Trusted Professional', there are strong initiatives in Cardiff aimed at improving early identification and signposting of perpetrators. Both projects are being evaluated independently by University teams.

## 4.2 Early intervention services

There is an early intervention perpetrator intervention in Cardiff (though not in The Vale of Glamorgan): CLEAR (Change that Lasts Early Awareness Raising) is part of the Change that Lasts (CtL) programme and developed in line with the wider CtL principles as a parallel response to perpetrators.

CtL programmes are run by regional Women's Aid organisations. These regional CtL programmes include 'Specialist Services' in some areas of England and Wales. CLEAR is the specialist service in Cardiff and is delivered by Respect. It is designed to address and raise awareness of VAWG. We focus here on the short, structured awareness-raising intervention. This is usually delivered as seven one-to-one sessions, but there is some flexibility in how it is delivered (it could also be partly delivered to a group). It provides individual needs assessment and case management,

and an awareness-raising course, followed by referral and introduction to further services. The approach is strengths-based.

Victim support with CLEAR is integrated, in line with The Respect Standard (*The Respect Standard, Third Edition*, 2017) and VAWDASV Perpetrator Service Standards (*Perpetrator Service Standards*, 2018). CLEAR referrals immediately trigger a referral to RISE (Recovery Information Safety Empowerment), who provide support to partners. The lead provider in RISE is Cardiff Women's Aid (CWA; *Cardiff Women's Aid*, 2020), with RISE being a partnership between CWA, BAWSO (Black Association of Women Step Out; *BAWSO: Information, Advice and Support for Black & Minority Ethnic Women in Wales*, 2020), a voluntary organisation, supporting BAME (Black, Asian and Minority Ethnic) women in Wales experiencing abuse, and Llamau (*Llamau*, 2020), Wales' leading charity for young people and women facing homelessness ('*RISE - Recovery, Information, Safety, Empowerment - Cardiff Council'*, 2020). While a man is on the CLEAR programme, there are fortnightly case management meetings with victim services to exchange information for safety planning, assess the impact of the programme and ensure the partner is informed. Men must give contact details of their (ex-)partner in order to join a service. An external stakeholder understood how this was needed for safeguarding but expressed concerns that this may sometimes be an extra barrier to engagement. *"It's already a big step that you're accepting help but that can be a big barrier to them*". CLEAR staff told us "*We only have one case where a man refused to provide his ex-partner's details and then we didn't offer him the service... to my knowledge the sharing of information has not had any negative impact on the relationships we have built up with those men we are working with. The guiding principle for sharing is: 'is this going to improve the safety of his partner or ex-partner?'."*

The CLEAR programme was developed to fill a gap in provision. At the time it was developed, there were already high-harm (see section 4.4) and medium-risk (see section 4.3) services in Cardiff. However, shortly after CLEAR began, all services for medium-risk perpetrators in Cardiff and the Vale were decommissioned. CLEAR aims to engage perpetrators of domestic abuse at the earliest possible opportunity. Interviewees reported that there were a few participants in CLEAR that, due to behaviours being more entrenched, would have ideally been referred onwards to a medium-risk programme.

> *So CLEAR is really focused on men whose behaviour isn't entrenched or is less complex, where there's perhaps been an isolated incident of violence, so it is really at that early stage. Sometimes they do turn out to be more complex or have more entrenched problems. That's where referral through…. would have been really useful, but that has just not been possible, because (the medium-risk service) was in that process of closing down when CLEAR was established.*

CLEAR had even supported a Drive (high-harm programme, see section 4.4) client:

> *so, one particular client had turned out to be higher risk and actually had already been referred to Drive but he couldn't be taken on by Drive yet because of ongoing court proceedings, so CLEAR held him……. We worked with starting building up the relationship and then said to him "you know, we're not really the right program for you, you could be getting support elsewhere" and then that was passed through to Drive… He had actually referred himself… so he was clearly, despite the complexities of the situation and the high risk, he was seeking support. We were very open and upfront with him about the whole situation, we managed to engage him enough, so he wasn't so daunted, he was OK, he recognised 'this isn't right, but I am now going to get the support that I need…'*

By March 2020, CLEAR had received 27 referrals and had fourteen engagements. We were told that *"a key indicator of readiness to engage seems to be men acknowledging that their partner is afraid of them."* Self-referrals and referrals from Children's Social Services have provided most of the participants for CLEAR so far.

The current programme is a pilot, available only for men (and their partners) in Cardiff. At the time of writing, CLEAR is awaiting the results of an independent evaluation by London Metropolitan University. It is being packaged as a ready-to-commission intervention that can complement existing services, and its suitability as a potential court diversion programme is being evaluated. There is precedent for

early intervention perpetrator services having mixed referral routes, that include police referrals, and effectively reducing risk to victims (Donovan et al., 2010).

In England and Wales, costly and time-consuming court processes can be avoided by taking no further action or issuing an out of court disposal (OOCD). This also applies to domestic violence offences, especially if the offence is relatively minor ('low-harm') and is a first offence. Simple or conditional cautions may be issued. A simple caution is a formal warning from a police officer following an admission of guilt; a conditional caution (introduced by the Criminal Justice Act 2003 and later amended by the Police and Justice Act 2006) is a caution with conditions attached. Failure to comply with the conditions will usually result in prosecution for the original offence. A conditional caution may include a rehabilitative condition, which aims to help offenders change their attitude in order to stop them from committing further offences. Where rehabilitative conditional cautions are available, police should issue fewer simple cautions. The rehabilitative intervention may include attending awareness classes, for example on the effects of drugs. Similar awareness raising courses have been developed for domestic violence. They do not operate in Cardiff, but CLEAR had been in touch with local police '*who are developing court diversion programme ideas".* CLEAR could be adapted to this work. We compared the CLEAR approach with two existing court diversion courses that are run in other parts of the country: the Hampton Trust's Caution and Relationship Abuse (CARA) programme and RISE Mutual's 'PIPA' (Preventing Intimate Partner Abuse) programme (see Table 1).

CARA has established itself as an effective intervention. A Cambridge University Randomised Control Trial (RCT) found a 27% reduction in the severity of offending for men who followed this programme (Chilton, 2012; Lee, 2014.; Strang et al., 2016). Given the relatively low cost of the programme, this makes a programme like CARA a potentially attractive investment for Police & Crime Commissioners. Starting in Hampshire, CARA programmes are now spreading across the Southwest and the Midlands. The PIPA programme operates in Northamptonshire (and London). Northamptonshire police are currently tracking participants over a period of two years to measure PIPA's effectiveness (*Office of the Northamptonshire Police, Fire and Crime Commissioner Update*, 2019). These models all do differ slightly, with CARA (and CLEAR) emerging from third sector initiatives. RISE Mutual is now an

independent social enterprise, but it began as a project within London Probation Services. Their PIPA approach is rooted in probation service models. They are also able to offer a medium-risk intervention for female perpetrators, *'with a trauma-informed approach'*. Partner support for victims '*varies dependent on force area as to who is doing the contact*'; this can either be someone from the organisation running the programme or the police safeguarding team. Risk information is shared.

We know all these programmes are likely to have some effectiveness. However, it is less clear which aspects of them are most effective. Donovan et al. (2010) evaluated two slightly different early intervention programmes. 'Both programmes provided evidence that the early intervention model was effective. For the majority of victims/survivors, engagement with the projects made it less likely that they would experience repeat referrals to the project (Gateshead), or report repeat incidents to the police (Cumbria)' (p.101). An interesting finding was that for some staff on these programmes 'work to motivate perpetrators to engage.... was perceived to be outside their remit' (Donovan et al., 2010, p. 104). A key recommendation of the evaluation was that 'if voluntary perpetrator programmes are to continue, training should be developed to build confidence in practitioners to motivate and undertake preparatory work with perpetrators' (Donovan et al., 2010, p. 106; see section 4.9 for a broader discussion of motivational enhancement).

In a review of 22 published evaluations of multi-agency early interventions in the U.K. (Cleaver et al., 2019), only three of the interventions were tertiary (with the others being primary or secondary preventative interventions). These were Lee (2014), which focused on the experience of men attending the CARA programme (see above), Donovan et al. (2010; see previous paragraph) and Clarke & Wydall (2013), which focusses on 'Making Safe', a programme to rehouse perpetrators, provide them with a key worker, and support victims to stay safely in the family home. They conclude there are 'potential benefits for victims when perpetrators leave the family home '*as part of a structured intervention*' (Clarke & Wydall, p. 404). They also recommend an integrated family approach to working with domestic violence: 'For *far too long there has been a tendency for victim services and perpetrator interventions to operate separately, thus failing to acknowledge the interconnectedness between victims, perpetrators and their families'* (p.403).

A very different approach to early intervention is an online computerised support programme that was offered as a partnership between Flintshire County Council, Reslate, Seetec and Phoenix Domestic Abuse service in Blaenau Gwent in South Wales. This was a very small pilot that was concluding as we wrote this report. "Early indications suggest that digital interventions may be a viable and effective solution for service users, especially in areas of rurality" (*Flintshire County Council Domestic Abuse Hub; Initial Pilot Results*, 2020, p. 7; see also *Red Snapper Group - Tackling Domestic Abuse in North Wales through the Intervention Hub*, 2020.). These findings would be in line with Swedish research that concluded that their internet-based CBT (Cognitive Behavioural Therapy) programme 'focusing on enhancing conflict-resolution skills and emotion-regulation ability has the potential to reduce IPV among self-recruited individuals with mild forms of abusive behaviour in intimate relationships', and that, more widely, "emotion-regulation training is potentially a key therapeutic component that ought to be incorporated in interventions targeting IPV" (Hesser et al., 2017, p. 1163). Similar findings were found in an earlier Swedish study (Sygel et al., 2014).

The potential for this work was highlighted during the writing of this review, as the U.K. found itself in the middle of the Covid-19 pandemic 'lockdown'.

Given that "variation in seriousness and repetition may not be the consequence of a stable type, but instead be the stage of escalation the violence has reached" (Walby & Towers, 2018, p.10) and that relatively low-cost early interventions can have a significant impact in lowering recidivism, there are strong arguments to develop and maintain these interventions *"It's trying to prevent those first offenders becoming those high-risk ones"*

## Evaluation against VAWDASV Perpetrator Service Standards

As part of this review, the CLEAR programme was evaluated against the published VAWDASV standards. Using the commissioning, accountability and audit questions used for services that have not yet undergone specialist accreditation, it was found that the pilot fulfilled the requirements of the standards. As a fully funded project that aims to fill gaps in existing provision and produce a commissionable package, it

was able to reach under-served cohorts while establishing an evidence base thanks to the external evaluation. Outcomes were monitored for service users, and the service was found to operate in a trauma-informed manner. The full review can be found in the appendices.

**Table 1. Comparison of (potential) Domestic Violence Court Diversion Programmes.**

| **Name:** | CARA | PIPA | CLEAR |
|---|---|---|---|
| **Description:** | Developed and run by The Hampton Trust | RISE Mutual has developed OOCDs with Victim Support | Part of Change that Lasts in Cardiff (see above) |
| **Referral route:** | Court Diversion for first-time DVA offenders | Court Diversion for first-time DVA offenders | Self-referral and Children's Social Services |
| **Frequency and length of sessions:** | 2 Saturdays +/- 5 hours (including breaks), 4 weeks apart. | 5 weekly sessions, 3 hours long. Follow-up support is available. | Flexible length. Often around seven sessions |
| **Format:** | Entirely group work following a structured manual, includes individual and group exercises. | Entirely group work, which includes individual (final session) and small group exercises. Version also for female offenders. | Currently one-to-one, but could be group work, very flexible format |
| **Focus:** | Awareness raising, minimal focus on behaviour change but opportunities to reflect on the offence, signposting to further help | Domestic Abuse awareness raising but with some focus on behaviour change and adaptability to individual needs, possibility of follow-on support | Awareness raising and preliminary support in identifying and changing abusive behaviour. Strengths-based approach |
| **Key models that inform content:** | Duluth Power and Control (Feminist Theory), Victim Impact Awareness, CBT informed exercises, Good Lives Model | Motivational Enhancement, CBT, Conflict Resolution, Solution-focused Brief Therapy and Feminist Theory. | Solution-focused, based on goals that are jointly set by attendees and facilitators. Feminist Theory |
| **Facilitator Training and skills:** | 4 days of training followed by shadowing and assessment of facilitation skills | Usually one BBR accredited facilitator (see section 4.5) and one post-graduate trainee | Facilitators with experience in victim and perpetrator work, short trainings in brief therapeutic interventions. |
| **Evaluation:** | Evidenced reduction in offending through an RCT conducted by Cambridge University | No independent evaluation has been conducted yet, but pre- and post-attendance questionnaires are collated and internally evaluated. Police tracking is taking place for two years. | The whole CtL programme, including CLEAR, is currently being evaluated by London Metropolitan University. |

## 4.3 Medium-risk services

By medium-risk services we understand services that target perpetrators who require a more intensive intervention than early interventions but do not need the intensive levels of support and/or disruption that high-harm services provide. The most common behaviour change programmes for these DVA perpetrators in the UK commonly follow a model that combines multi-agency risk management and support, behaviour change interventions that are often delivered in a group, and victim support. This type of programme is what is commonly referred to as a Domestic Violence Perpetrator Programme (DVPP). These programmes are historically rooted in the 'Duluth model' that developed in Duluth, Minnesota in the 1980s (*History and Recognition*, 2017). Originally this model was grounded in an understanding of men abusing their female partners as intentional behaviour, driven by a need for power and control. "Patriarchal terrorism" is a way of describing the abuse that takes place and was seen to "typify… participants in the Duluth-type programs" (Gondolf, 2007, p.4). Programmes tend now to take a broader gender-informed perspective and more complex understanding of the psychological processes (Phillips, 2015).

This section describes these programmes and their local implementation. It also gives an overview of what we know about their effectiveness, focussing on some key factors. The groups described below are targeted at men who are seeking help for their abusive behaviour to their partners. While this reflects the vast majority of perpetrators who seek support, we recognise that these groups exclude male perpetrators who are in relationships with other men, or female perpetrators in relationships with men or women. These limitations are explored in section 4.8.

While the Duluth approach remains influential with DVPPs in Europe, these programmes are now likely to be informed by CBT and/or psychodynamic methods, often combined with gender-informed understandings of IPV (Hamilton et al., 2012). This understanding has its roots in feminist theories, which have developed and increasingly takes a broader perspective than seeing "patriarchy as *the* cause of IPV" (George & Stith, 2014 p.2). Approaches to behaviour change with their roots in criminal justice rehabilitation, like the Good Lives Model (*The Good Lives Model of*

*Offender Rehabilitation - Information*, 2020), and in substance misuse services, like motivational interviewing (MI; Miller & Rollnick, 2002), are also influential.

In a recent survey of DVPPs in the U.K. the approaches used included CBT (85.7% of programmes), motivational interviewing (81%), social learning (66.7%), strength-based work (57.1%), power and control (52.4%), solution focused work (52.4%), self-help and peer support (47.6%), client-centred work (33.3%), psycho-educational interventions (28.6%), narrative therapy (19%), trauma-focused work (9.5%), family systems therapy (4.8%), psychodynamic therapy (4.8%), and emotion regulation (4.8%) (Bates et al., 2017). Unfortunately, this survey received responses from fewer than 10% of the DVPPs they approached. The survey did not explore the extent to which these programmes were gender-informed, or what that looks like in practice - they did report that 19% of the programmes "identified their program as being primarily feminist" (p.24). Respect (*Respect | Home*, 2020), the accrediting organisation for DVPPs in the U.K., requires that organisations that they accredit to run DVPPs "work in a way that is gender informed, recognising the gender asymmetry that exists in the degree, frequency and impact of domestic violence and abuse. They understand that men's violence against women and girls is an effect of the structural inequality between men and women and that its consequences are amplified by this. A gender analysis includes violence and abuse perpetrated by women against men and abuse in same-sex relationships, and these also require a gender informed response" (*The Respect Standard, Third Edition*, 2017).

Because of the response rate to Bates et al.'s (2017) survey it is impossible to assess the relative importance of the different approaches they asked about across the whole sector. But the survey does reflect a previously established widespread heterogeneity of approaches (Feder & Wilson, 2006). Modern approaches are likely to combine sociocultural understandings of IPV, including a focus on gender and power, with psychological understandings of IPV (Askeland & Råkil, 2018).

What we found talking to our interviewees, of whom seven had experiences of DVA perpetrator groups with men, is that there was a strong recognition of the role of gender in the work they had done. The socialisation of men, their ideas about what it means to be a man, the challenges men face, and their attitudes towards women were all seen as important, alongside a recognition of the impact of trauma, their own mental health issues, their poor communication skills etc. It was recognised that

deeply engaging with these other issues is also needed and *"without that relational depth, you're not going to get anywhere"*.

To add to the complex picture of the varied approaches taken by DVPPs, are the differences that can exist between the approaches DVPPs claim to use, and what is actually delivered in the programme. MI, which is highlighted in the Welsh Government's Perpetrator Service Standards (*Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards*, 2018) as part of the skill set of staff in perpetrator services, has a strong evidence-base (see section 4.9) and is a core aspect of behaviour change work within the U.K. criminal justice system (see section 4.5). All the programmes that work with DVA perpetrators in Cardiff and The Vale of Glamorgan, claim to be informed by MI. In section 4.9, we explore the extent to which staff working with DVA perpetrators in Cardiff and The Vale of Glamorgan have received training in MI and have the skills needed to implement the methodology.

We were not able to directly review a DVPP programme in Cardiff and The Vale of Glamorgan. Based in Barry, Atal y Fro had delivered these programmes. However, these services had been de-commissioned in November 2019. The reasons for this de-commissioning are not publicly available which limits any learning there could have been.

After several months without a CEO, we found Atal y Fro to be energised by the arrival of a new CEO and focused on their victim services, which have always been their core work. Staff who had worked directly with perpetrators had left, but it was clear that a passion for perpetrator work had existed at Atal y Fro. A DVPP had run for several years, and the organisation had been committed to "*providing a complete 'wrap around' package for the whole family*" (*Atal y Fro - Domestic Violence and Abuse Services*, 2020).

With CLEAR providing an early intervention programme, and Drive working with the highest risk perpetrators, a lack of services for the broad range of risk levels between these services was keenly felt.

> *That really is a big gap in that medium risk area…They were too high risk for CLEAR and not necessarily in the scope for Drive; all I*

> *could offer was to encourage them to liaise with their probation officer and he was actually saying to me that he wanted support.*

Despite the wide acknowledgement of this gap, there were very mixed feelings about DVPPs, from *"We need a DVPP!"* to "*Drive is valued - can a DVPP programme earn the same valuing?"* to *"when there was an Atal y Fro programme, one probation officer was working closely with them and generally that had been okay…"* to "there's a *the need for DVPPs to be high quality; delivery has not been consistently so"* to "*facilitators aren't always skilled enough*" to *"(in the groups) things are being made worse*".

Just talking about the needs around social services we heard that the need for support for perpetrators, who didn't meet the high-harm threshold of Drive, was so great that "*the Drive team in Cardiff have been bombarded with child social services referrals - they have even offered to spot-purchase Drive case management… Also, there are indications of some social workers distorting risk to get perpetrators onto MARAC, so they can get them onto Drive*". (MARAC = Multi Agency Risk Assessment Conference), But despite this, there was sometimes still no enthusiasm for a DVPP:

*"I've worked in other local authorities, and they don't have any perpetrator programmes – or they will, but it will be a group, rather than individually tailored. I've found that a couple of people in the groups have spurred each other on. Some people will take something from it, but I've not found the group settings as effective."*

In contrast to this perspective, where it seems that attendees are not being supported to question some of their attitudes, the feeling was also expressed that groups could be too focussed on the deficits of attendees:

> *The deficit-led approach can work but it's certainly not the best way of doing this sort of work. There needs to be some challenge and there needs to be some difficult conversations. And these men, by having taken that step to try change, they're feeling under threat. You need to really build a relationship with somebody before you challenge them.*

At their worst groups assumed that the domestic violence was explained entirely by men's intentional actions to gain power and control over their partners and a didactic process of explaining this to them would change their behaviour. However, as an interviewee said: *"people don't change, by and large with this process… it creates defensiveness"*. Another interviewee said: "*we tell them that a relationship based on power and control doesn't work… but then we do the same with them."*

Interviewees, like the interviewees quoted above, who did have experience of running groups, generally acknowledged the complexity of this group work. The positive aspects of men's group work were also appreciated: a space where because "men learn to be men in front of other men", now they "can unlearn some of the more unproductive lessons about manhood and relearn and reinforce some of the more positive lessons" (Brooks, 1998. p.104).

Important aspects of group work talked about included:

- A shared space for learning from each other's experience and where they can see each other develop and change
- A place where men can learn about healthy supportive relationships *with other men*
- A place where men can find ways of recognising and sharing their emotions appropriately
- With a male and female facilitator working together, there are opportunities for supportive and positive role modelling and for the modelling of healthy collaboration between men and women
- Men challenging each other about their behaviour and attitudes can be more powerful than a professional doing so
- The facilitators model respectful assertiveness, how to disagree without conflict
- Groups provide different learning modalities, with group exercises, role play etc., and create opportunities for men to engage who find it difficult to talk

Some of these aspects are alluded to in the VAWDASV Perpetrator Service Standards, e.g. the need for supervision to support the management of group dynamics (*Violence Against Women, Domestic Abuse and Sexual Violence*

*(VAWDASV) Perpetrator Service Standards*, 2018, *Standard 14.i.e*, p.21); the need for groups to have two facilitators; and that "consideration should be given to whether facilitators should be different genders (e.g. if the intervention is targeting gender is targeting gender stereotypes), in order to demonstrate positive role-modelling" (*Standard 6.i,* p17); and the need for integrated support services (throughout the document).

While the complexity of this group work was widely appreciated, it was also recognised that it was not always delivered to high standards:

*people have just set up things and gone off course because there is nothing there….*

*(group programmes) can feel pretty ramshackle at times. Poor performance doesn't get picked up and addressed. There are no clear minimum standards*

*Often there is not enough skill around the emotional process*

*I found the previous programmes a bit punitive, a bit confrontational, and you were just arguing most of the time. And the men vote with their feet, and it wasn't moving people on, and it was too focused on past negatives rather than the strengths. We developed a strength focussed approach, we got information from many sources including probation.*

One interviewee who had worked abroad had been surprised to see some of the poor standards in the U.K. *"Where I worked (outside the U.K.), the facilitators were experienced psychologists"*.

Being a psychologist, is of course, no guarantee of good facilitations skills. Neither are generally low levels of educational qualifications an indication of being a poor facilitator; Bates et al.'s (2017) found 47.6% of programmes said facilitator's "typical educational attainment was… high school level qualifications" (78% of the staff working with DVA perpetrators in Cardiff that we interviewed had a Bachelor or Master's degree). While low educational attainment, in itself, is not an indicator of poor facilitation skills, it does possibly reflect the lack of valuing of the role, that

there are no minimum standards for individual facilitators, and that there is no accreditation system for individual facilitation staff outside the criminal justice system (see 4.5).

In this review we focus on one key facilitation skill, namely the use of MI, and look at its value and implementation in more detail in section 4.9. MI provides a way of building on strengths in order to bring about change. As an experienced DVPP group facilitator said when we interviewed them for this study:

> *Motivational interviewing is a key part of the work we do to try to inspire change... We try to use positive language that avoids the men getting over-defensive but getting them to identify themselves how their own lives can improve. And setting goals themselves for things that they would like to change. We try to thread themes... We try to weave things through and then.... we'll keep coming back to it, and keep going back it, and progressing on that...*

Another experienced facilitator said *"motivational interviewing would be helpful... It would be a start"*

Lilley-Walker et al.'s ('Daphne III'; 2018) evaluation of European domestic violence perpetrator programmes included 33 studies (ADVA and Sue Penna Associates, 2009; Barz & Helfferich, 2006; Bullinger & Väth, 2005; Debonnaire & Walton, 2004; Echauri et al., 2013; Echauri Tijeras, 2010; Echeburúa et al., 2009, 2010; Gabriel & von Wolffersdorff, 2006; Garcia et al., 2008; Garfield, 2005; Gloor & Meier, 2003; Holma et al., 2006; Jackson, 2013; Kavemann & Hagemann-White, 2004; Kraanen et al., 2013; Kratky et al., 2011; Kraus, 2013; Leite et al., 2008; Liel, 2013; Lorenz et al., 2013; McConnell, 2014; McCracken & Deave, 2012; Milner & Singleton, 2008; Power & Clarke, n.d.; Price, 2008; Smith, 2011; Socialstyrelsen, 2010; Stanley, 2011; Stevenson et al., 2011; Subirana-Malaret & Andres-Pueyo, 2013; Taylor, 2005; Törmä & Tuokkola, 2009; Williamson & Hester, 2009) looking at programmes that included non- criminal justice system community interventions. Many of these studies are hampered by high dropout rates, poor research design and just five had an experimental or quasi-experimental design. None of these five studies are from the U.K., but all show significant improvements amongst those men that do not drop

out. Three studies were from Spain, all with a primarily CBT-based intervention, and were included in another meta-review of Spanish DVPPs (Ferrer-Perez & Bosch-Fiol, 2018). This review looked at thirteen different programmes, seven of which reported measures of success. These programmes were a mixture of voluntary and court mandated programmes, with a range of intervention types, including CBT and the Duluth model. A wide range of dropout rates (5.7%-57%), and a wide range of measured 'successes' (23.8%-93.5% of completers had positive changes) were found (p.889). They did not discover any effect from the type of intervention, but voluntary participation seemed to improve outcomes.

One of the Daphne III studies (Garfield, 2005) compared three DVPP programmes in the U.K., linking the success of the groups to the quality of the facilitation (which ranged from poor to good). Recommendations included that facilitator "have adequate training on skills for facilitation and the development of the alliance" (Conclusions, p.22). They found that confrontational approaches undermined effectiveness, by undermining the therapeutic alliance, and that groups need to be directly checked for the quality of the alliances and general facilitation. They recommended using both third-party observers and group participants for this checking.

Cunha & Gonçalves, (2015) was not included in the Daphne III meta-analysis but seems to meet the criteria. The study has a quasi-experimental design around an MI and CBT based intervention. Men who attended the intervention showed significant reductions in the perpetration of physical and psychological violence against their partner, compared with the control group. The researchers saw the success of their programme as being strongly linked to their MI approach. Men in both arms of the study were recruited because they had been sentenced previously for a DVA offence. The men themselves chose whether they wished to be part of the intervention, which was a research design weakness.

- There are several research programmes currently focussing on the effectiveness of DVPPs, and similar, programmes in the U.K. Two examples are: REPROVIDE Workstream 2 (University of Bristol, 2020). REPROVIDE is a large scale RCT, delivered over five sites involving three Respect accredited organisations, using a treatment programme developed in line with Respect

standards (*The Respect Standard, Third Edition*, 2017). It draws on a wide range of approaches, including CBT, "with sessions on topics such as: recognising abuse; denial and minimisation; identifying urges to perpetrate abuse and cooling-down strategies; effects of domestic violence and abuse on partners and children; masculinity; loving relationships and accountability" (University of Bristol, 2020).

- Up-2-U (Ford, 2019) is a smaller scale RCT of a criminologically informed intervention. Built around the RNR (Risk, Needs and Responsivity) model, it recognises "that people use DVA for different underlying reasons. These may range from learned behaviour, including but not restricted to attitudes that promote male dominance and control, to lack of skills in emotional management and conflict resolution" (Pearson & Ford, 2018, p.4). In the first stage of the programme "motivational interviewing (MI) techniques are used to promote positive engagement with the programme, to build on motivation to change, and to build rapport, in recognition that clients present with varying levels of readiness to change" (p.8).

It is to be hoped that these research programmes and other current research will add significantly to our knowledge of what works with DVPPs.

## 4.4 High-harm services

The Drive (*Drive Project*, 2020) is an intensive intervention that works with high-harm and serial DVA perpetrators. The pilot sites opened in 2016, as part of an RCT looking at effective interventions with high-harm perpetrators. Of the three original Drive pilot projects, only the Drive Cwm Taf service still exists. New Drive programmes however, opened in Croydon, Worcester, Birmingham, Sandwell, and Cardiff in 2018. Safer Merthyr Tydfil (*Safer Merthyr Tydfil*, 2020) runs the Cwm Taf and Cardiff services. These are both set to expand their geographic areas, and a third service will be opened to the East (Swansea and Bridgend) soon. Concurrently the police are re-organising the four Basic Command Unit (BCU) areas into three areas that align with local health board areas. These three areas will each have their own Drive programme. Together these three Drive Programs will cover the whole of the South Wales Police force area and approximately 40% of the population of Wales. This enormous expansion reflects the success of the Drive programme in South Wales, and its widespread appreciation.

The RCT that led to the development of the Drive service model was the largest evaluation of a perpetrator intervention ever carried out in the UK. The evaluation was also "a sophisticated 'third-generation' evaluation, with randomisation, control groups, longitudinal comparison of perpetrator behaviour, consideration of victims-survivors and children's safety and 'space for action', and an analysis of impacts on and effects of the wider system of agencies" (Hester et al., 2019, p.8). The Drive programme distinguishes itself also by the strength of its impact, with significant reduction in the number of service users perpetrating physical abuse, sexual abuse, harassment, stalking, and in jealous and controlling behaviours (Hester et al., 2019).

The model is fundamentally different from all previous third sector interventions. We were told both that it is a game-changing intervention and "*not really a perpetrator programme."* In terms of approach, Drive has more similarities with probation service case management. It combines 'disrupt activities' – non-contact multi-agency interventions with, where appropriate, intensive case management, behaviour-change interventions and support. A criticism we heard was that Drive are doing the work that probation officers should be. The added input was indeed welcomed by probation officers; "*as a probation officer I don't have capacity. For*

*them to take a bit of the load off it has been great…"* And *"having Drive involved can take the pressure of having to see someone when they've done that. They update me regularly."* Drive's input was however appreciated beyond the increased capacity. There was also recognition that they bring something very different: "(at probation), *we have an enforcement role, and this puts barriers up…They come from a different background… Their skills dealing with people is key. They look at what support is needed"*. A social worker gave us a similar perspective: *"I do think that not being from statutory services does help – we are always on the back foot because people always fear what we are able to do."*

The 'disrupt' activities also go far beyond anything that probation could do: *"support was an underlying element of disrupt, for example getting someone rehoused so they don't go back to the victim."* We conducted interviews with Drive case managers and representatives of voluntary and statutory sector organisations that had worked with Drive, Drive clients and the victims of Drive clients. This included representatives from police, probation services, social work and four IDVAs (Independent Domestic Violence Advisors) from two different victim services: RISE Cardiff (*RISE - RISE Cardiff*, 2020), the main victim service in Cardiff, and the Dyn project (*Dyn Wales | Dyn Project*, 2020), which works with male victims.

There had been some caution about Drive at the start, as a third sector organisation: *"We will always be cautious with third sector organisations"*. *"It was a third sector provider – there was the assumption that they wouldn't do a good job"*. That caution changed however:

> *Some of the social workers were quite reluctant; they didn't know what the project was about. But now it's really good, they want the case managers to be involved, the father or mother of a child, depending on who the perpetrator is*

> *We met them in a team meeting – they've selected staff that are so knowledgeable; it never would have crossed my mind that they would have had that kind of skill level. If you're going to be running a programme like Drive, you need to have that skill level. I think that came across in how they presented, and how they've been as well with the cases. Also, when I've asked them for advice and*

> *guidance, it's always been there. There's never been someone trying to blag their way through any advice or questions – what they're feeding into has a lot more of a significant impact. If we're thinking of children being at risk, they need to have that skill level.*

Being a voluntary sector organisation was in fact seen, eventually, to have advantages (see also above) and they have gained a reputation for their specialised expertise:

> *I found working with Drive really useful – they are very good at becoming involved quickly, and (provide) intensive support for both perpetrator and victim... It's really good to get their view of either side of the domestic abuse – they are able to help me weigh up risks and identify risks that I might not have thought of, because of their specialist knowledge...Because they're in a specialist role, they can add that expertise to our work (as social workers).*

Having strong support for perpetrators makes it possible for social services to work in a different way:

> *Historically in social services we've said, "leave him or we'll take your children" and then we just push it underground... the women would come and say "I wish I'd never phoned the police" because of the threat to their children. Obviously, we have to protect the child, absolutely, but the communication with the victims - survivors - and the men is crucial in order to overcome that. We need to work together with them as a family, otherwise we just create other problems.*

The work of Drive seems to have encouraged services to see working with the whole family, including perpetrators, as important:

> *A lot of people think that Drive are just on the side of perpetrators, but it's actually primarily there to protect victims so that needs challenging. And that model is really beneficial... (as an IDVA), I'd love for Drive to be everywhere*

> *I think the Drive project is a really positive thing, it allows for engagement with both partners, especially where most organizations will shut them down after non-engagement. Domestic abuse is such a complicated thing with numerous requirements. With Drive everything doesn't have to be done within a certain time; people are given the chance to engage, which I feel that a lot of organisations don't give them that chance to engage which ends up with repeat behaviours, repeat domestic abuse, new victims. Not everybody can be changed, but it's always positive when you see a change and 100%, we see that happening*

> *I think the perpetrator element is particularly useful – what we (social workers) find is that if the perpetrators aren't getting that support, the pattern continues in every relationship. We can work as much with the victims as we want, but it's the perpetrators perpetrating the behaviour that we need to get to the crux of.*

> *I have seen a shift in certain perpetrators' perspectives, and willingness to... maybe an element of owning the behaviours. I wouldn't say they're fully there – but there's definitely a shift in starting to own those behaviours, rather than victim blaming.*

As in that example, their approach is also seen as having created interventions that would not have been possible:

> *There's been cases where the guy wouldn't engage but was concerning. This one case: I could only put him down in custody. Until Drive got involved, we didn't realize how severe his mental health problems were. They updated me regularly... looking at opportunities. I was even able to use MAPPA to get a mental health assessment at (prison), where he went eventually. He has now been sectioned. It was a serious further offense waiting to happen. He became more upfront about what was going on. (The case manager) was able to go in and give him the help needed. I was part of the problem, part of the establishment. He was in and out of prison - short sentences - but not engaging with me. Without their*

*support I believe he would have killed his mother. His mother is now thankful that he is getting the support he needed. That extra amount of support is so invaluable"*

We were given many examples, like this, of effective multi-agency working where Drive were able to use their specialist skills and overview of a situation to support other parts of the system around an individual to work together. The importance of this multi-agency working is explored in section 5.

The IDVA support around Drive runs concurrently with Drive support and means that, rather than the typical three months of support that IDVAs are able to offer, the Drive IDVA can work longer, and can persist for longer in trying to get a victim to engage:

*I really like the Drive model because it allows clients (victims) to engage when they're ready to, allowing them to know that you're there so they can come back.*

They have been seen also as helping creating space for learning:

*The work between Drive and WISDOM has flagged the limitations in terms of existing perpetrator interventions.*

This space for learning and the strengths and weaknesses of working and learning together are looked at more in section 6.

Drive staff themselves were enthusiastic about the work. They highlighted however one area where there could be improvement: the training they received. They recognised that no-one knew what the work would be like when they started. "*We had to learn on the job." "The training was based on IDVA training and DVPP work." "Lots of it was great; I learnt a lot... but there was nothing about how to engage with those complex clients." "The training has got better."* The need to further improve training to target the skills that Drive case managers need is also highlighted in section 5.8.

There are other interventions that contain 'disrupt activities'; the MATAC (Multi-Agency Tasking and Coordination) model in Northumbria is a police-led intervention

(Davies & Biddle, 2018). Initially, unlike with Drive, there was no specialised behaviour change work attached, but men who engaged were being referred to a local DVPP (see section 5.3) and other existing services, including mental health, housing, and substance abuse. The chaotic and complex nature of this client group meant that no clients actually got past the assessment stage with the DVPP service, and three one-to-one support workers were taken on to provide behaviour change support and the support needed to engage with other services (MATAC Manager Northumbria Police, personal communication, 4th May 2020). Initiatives for shared learning have been established between Drive and MATAC. There remain differences and there is a potential for using their different experiences to develop both services. The referral process, for example, is different for MATAC than it is for Drive. The differences are explored in section 6.6

MATACs have also been established in fourteen areas in Scotland (*Police Scotland*, 2015; *Whole Lives: Improving the Response to Domestic Abuse in Scotland*, 2017) and in North Yorkshire (*MATAC (Multi-Agency Tasking And Coordination): Tackling the Most Harmful and Serial Domestic Abuse Perpetrators*, 2018). A similar programme, ADAPT (Agencies Domestic Abuse Perpetrator Tasking), has just been launched in North Wales (*ADAPT Pilot Launched - News and Appeals - North Wales Police*, 2019).

These new high-harm interventions are all based around intensive case-management, with disrupt activities being part of the focus. Where these programmes do not exist, DVPPs (in the U.S. often called Batterer Intervention Programs) are the go-to intervention, also for high-harm perpetrators. (Juodis et al., 2014). This is despite issues around clarity about their effectiveness (see section 5.3), and the challenges of engaging men with more complex needs (like most of the Drive cohort – see Hester et al., 2019). Drive has been a break-through in terms of effective service delivery for high-harm perpetrators.

### Evaluation against VAWDASV Perpetrator Service Standards

The Drive programme in Cardiff and The Vale of Glamorgan was evaluated according to the Welsh Government's published VAWDASV standards. As the programme is at

an advanced stage in the Respect accreditation process, the full checklist was used to assess the ways in which it meets the standards and the remaining areas for further work. Broadly speaking, the programme strongly fulfils the requirements of the standards and shows a careful regard for professionalism and effectiveness. Areas for improvement include a need for refresher training in MI; maintaining links with partner services, despite high staff turnover within these services; greater follow-through in establishing contact with ex-partners; and ensuring all staff are aware of access to employer-provided personal emotional support. The full review can be found in the Appendices.

## 4.5 DVA perpetrator services in the criminal justice system

Her Majesty's Prison and Probation Service (HMPPS) is configured differently in Wales than England, with prison and probation services combined within one directorate (*The Proposed Future Model for Probation: A Draft Operating Blueprint*, 2019). Bringing back the privatised management of lower risk offenders into statutory probation services also started earlier in Wales and was completed in December 2019. Behaviour change activities were not brought back into HMPPS but continue to be provided by external 'Innovation Partners' (*5 Things You Need to Know about Probation Reform*, 2020). Though this too is set to change ('Private Firms to Lose Role in Probation Services', 2020).

Building Better Relationships (BBR) is the only accredited programme for domestic violence offenders in Wales. It is targeted at men assessed as moderate risk in custody and for men assessed as either moderate or high risk in the community. It runs throughout Wales as a group programme that consists of four six-session modules. One or two pre-group sessions precede the group work, and there is an individual session at the end of each module. Accredited Programmes receive their accreditation from the Correctional Services Accreditation and Advice Panel (CSAAP).

BBR was introduced in 2012, replacing the Integrated Domestic Abuse Programme (IDAP). The new programme design was based on a literature review of empirical and theoretical research on risk factors, protective factors, desistance, and strength-based approaches to intervening in domestic violence (Bowen, 2011).

BBR retains elements of the feminist / gender-informed approach, which focusses on patriarchal power and control and was at the heart of IDAP. However, it is theoretically more holistic than IDAP was, drawing, for example, from CBT, the Nested Ecological Model (Bronfenbrenner, 1989), the General Aggression Model (GAM; DeWall et al., 2011), and desistance theory (Crawford, 2017). It is grounded by Risk, Needs and Responsivity (RNR) principles and multi-agency collaboration. DVA is understood in the context of environmental, social, and personal stress factors in an offender's current situation and life history. BBR claims to have more flexibility and possibilities for tailoring to individual needs than IDAP (*Impact Case*

*Study: Combating Interpersonal Violence*, 2014). While the evidence-based process for developing BBR is to be welcomed, its reception has not met entirely without criticism; an interviewee said: (IDAPs) "*simplicity and repetitiveness had been useful and has been lost"* and replaced with *"complex psychological models that some men struggle with",* and there is less *"open room for discussion because there is so much to fit in."* An impact evaluation of BBR is planned for 2020 (*The Proposed Future Model for Probation: A Draft Operating Blueprint*, 2019).

MI is a key element of accredited programmes, and more widely part of the national standards for the management of offenders for England and Wales (Ministry of Justice, 2015). All group facilitators, also for other accredited programmes, are expected to have appropriate experience of working with offenders using MI, before embarking on training. The first step is successful completion of 'Core Skills' training. It is a requirement for entry onto BBR training for new facilitators. This training consists of preparatory self-study and four days of intensive training. While this training covers the practicalities of session planning, reporting etc., it is largely focused on MI skills, which need to be sufficiently demonstrated in practice sessions to pass the course. These skills are also expected to be demonstrated during practice sessions during the BBR training itself. When BBR provision was still 'in house' in probation services, there was even higher quality control around MI skills, and more generally around programme compliance and the levels of skills and experience required. BBR training was only available to facilitators with experience of running less complex groups, who had also completed a Domestic Violence Awareness Training in addition to the Core Skills training. They would start the work by co-facilitating with an experienced facilitator. All sessions were recorded on video. Sections from one in five videos would be selected by a treatment manager to view together with the facilitator: scoring and giving feedback on their facilitation. This level of training and support was felt to be necessary: *"DVA programmes were considered the most difficult programmes to run… more difficult than sex offenders… You can have powerful and intimidating characters; facilitators can be swallowed up if not well trained, monitored and supported – like throwing them to the lions."* Hence, "a strong framework for monitoring and supporting (facilitators)… is important" (Bullock et al., 2010).

BBR aims to work collaboratively with other agencies to manage risk and reduce re-offending, while promoting the safety of current and future partners and children (*Building Better Relationships Theory Manual. Version 1.0*, 2015). The modular structure allows it to be run on a rolling basis. It aims to increase a perpetrator's understanding of why he abuses his partner, improve relationship skills, and reduce risk factors (*Building Better Relationships Facilitators Manual. Version 1.0*, 2015). Spousal Assault Risk Assessment (SARA -V3 – see section 6.5; Kropp & Hart, 2015) scores are used to inform decisions around eligibility.

BBR groups are run within Cardiff and The Vale of Glamorgan. While external partners were generally positive about these groups, we heard of long waiting lists: "*you've got to sometimes wait nine months for someone to get on a group."* This is consistent with findings in the *Wales NPS Inspection Report (*2019): "The waiting time before an individual could start an accredited programme was much too long in some instances" (p.7). The disruptive changes to probation services in recent years have undoubtedly played a role in this. Provision of behaviour change interventions was privatised in June 2014, along with the case management of lower risk offenders, with the creation of regional Community Rehabilitation Companies (CRCs). The contract transferred to the current provider in February 2019 when the first provider, *Working Links*, went into administration. The new provider is *Wales Probation Services*, part of Kent, Surrey, and Sussex Community Rehabilitation Company (KSS CRC). Seetec, the ninth largest employee-owned company in the U.K., operates KSS CRC (*KSS CRC*, 2020). A new tendering process is currently underway (*View Notice - Sell2Wales*, 2020).

In addition to BBR, and other accredited programmes, since 2015 Rehabilitation Activity Requirements (RARs) can also be included by a court as part of a community or suspended sentence order (*The Implementation and Delivery of Rehabilitation Activity Requirements*, 2017). Court orders, which RARs replaced, used to specify both the nature and amount of an activity to be undertaken. Now, (some of the) activities may only be determined following a post-sentencing assessment. RARs can also be focused on the behaviour change of DVA perpetrators. For example:

- Respectful Relationships is a ten-session structured intervention for 'low- and medium-risk' domestic violence perpetrators. The intervention is suitable for

heterosexual and homosexual IPV perpetrators, and for familial violence perpetrators.

- Compulsive Obsessive Behaviour Intervention (COBI) is a programme that is currently being developed by Wales Probation Services specifically to with people who have been prosecuted for stalking. Facilitators need to be experienced, have successfully completed Core Skills training, and/or be clinically qualified, like a forensic psychologist or clinical therapist.
- Tailored individual activities. These activities have, on occasion, been delivered by Drive (see 4.4) case managers. *"Drive offers to work on the basis of RAR days with offenders – not many other services which will… Probation offender managers are very keen for services that can provide structured RARs"*

While it is required that accredited programmes be evidence-based, this is not necessarily as true for RARs, though they tend to be built around similar principles (*RAR Guidance*, 2019).

Within Cardiff and The Vale of Glamorgan there is no provision of behaviour change interventions for DVA perpetrators in custody. There are no domestic abuse behaviour change programmes in HMP Cardiff, where "40% of the population had been identified as perpetrators or potential perpetrators of domestic violence" (*Report on an Unannounced Inspection of HMP Cardiff by HM Chief Inspector of Prisons,* 15-26 July 2019. p.8.). One interviewee thought that these figures may be higher, as they had experienced that *"more than 80% of prisoners have domestic violence issues in HMP Parc."* Given that HMP Cardiff predominantly provides for prisoners serving short-term sentences, remand prisoners and prisoners awaiting sentence, and *"you'd have to be serving an 18-month sentence or more to get on a BBR programme",* an intervention other than BBR would be needed to meet this need. *"Interventions have been delivered in Cardiff prison in the past mostly to individuals"*. BBR is provided in nearby HMP Parc in Bridgend, HMP Swansea and HMP Usk-Prescoed.

Lilley-Walker et al.'s ('Daphne III'; 2018) evaluation of European domestic violence perpetrator programmes included 35 studies that contained evaluations of programmes within the criminal justice system (Arrigoni et al., 2013; Bächli-Biétry,

2006; Barz & Helfferich, 2006; Bilby & Hatcher, 2004; Boira et al., 2010, 2013; Bowen et al., 2005; Bullinger & Väth, 2005; Bullock et al., 2010; Calvo et al., 2011; Debonnaire & Walton, 2004; de los Galanes & Tabernero, 2013; Diranzo et al., 2012; Dobash et al., 1999; Echauri Tijeras, 2010; Echeburúa et al., 2006; Echeburúa & Fernández-Montalvo, 2009; Garcia et al., 2008; Gloor & Meier, 2003; Hofinger & Neumann, 2008; Kavemann & Hagemann-White, 2004; Kratky et al., 2011; Kraus, 2013; Leicester-Liverpool Evaluation Group, 2005; Liel, 2013; Lila et al., 2013; Novo et al., 2012; Perez Ramirez & Garcia, 2010; Pérez Ramírez et al., 2013; Quintas et al., 2012; Rodriguez, 2012; Rodríguez-Espartal & Lopez-Zafra, 2013; Socialstyrelsen, 2010; Tejerina & Martínez, 2011; Törmä & Tuokkola, 2009). The evaluations found positive impacts for most of these studies, although often small. There is also great variation in the results, methodological problems with many studies, and a lack of clarity around the interventions used, or around which elements of the intervention may be effective. A range of behaviour change models was employed in these programmes; CBT was mentioned in 29 studies, the Duluth model in ten studies (nine of which also mentioned CBT as a model), Emotional Therapy was mentioned in one study, Psychodynamic therapy in one study, Restorative Justice approaches in one study, and Bronfenbrenner's Ecological Model in one study. One study had no information about the models used in the programme. CBT approaches seem to dominate, but there can be a large variation in what the use of these models means in practice. Schucan-Bird et al. (2016) identified a changing emphasis in the theories underpinning interventions, especially a shift in "causal explanations for domestic violence being rooted in patriarchal theories vs. individual psychopathology" (p.73). It is often not clear where the programmes in these studies find themselves in regard to this shifting understanding. A recent international systematic review of court mandated DVA perpetrator programmes by the College of Policing (Vigurs et al., 2015) found no significant impact for these programmes. However, an evaluation of IDAP, the precursor of BBR, and the Community Domestic Violence Programme (CDVP), another no longer operational probation programme, found that both IDAP and CDVP had small but significant effects in reducing domestic violence and any re-offending in a two-year follow up period, with IDAP having a slightly greater impact (Bloomfield & Dixon, 2015). Good data collection tools had been built in to IDAP in order to strengthen the evidence-base (Bilby & Hatcher, 2004).

Haggård et al. (2017) compared the recidivism of 340 convicted male IPV offenders who began IDAP in the Swedish Prison and Probation Services, comparing them with 452 convicted male IPV offender controls. Analyses 'adjusted for individual baseline risk and follow-up time suggested marginally and non-significantly lower reconviction rates in IDAP participants versus controls' (p. 1027).

In looking at which domestic violence offenders may be less likely to benefit from existing interventions, Green & Browne (2020) highlighted problems with affect regulation and antisocial personality traits. Fernandez-Montalvo et al. (2019) found support for the combined treatment of addictions and IPV perpetration in a small-scale RCT. BBR is due to be evaluated (see above). Hopefully, this evaluation will avoid many of the methodological problems present in these other studies, and preferably help create guidelines for the appropriateness of BBR with different sub-groups of offenders and/or indications of how it could be adapted to meet their needs.

Probation Services and their Innovation Partners have faced huge challenges in recent years, some of which are outlined above. We did however encounter indications of important strengths. We were told that staff are *"enthused by the employee-owned trust." "There is good staff retention now, relatively good in Wales compared with other parts of the U.K." "In most areas, waiting times are within expectations."* And that the service is *"generally working well above what we would expect given the current situation."*

A potential opportunity to improve the provision to offenders in custody was identified; "*there is now a commitment for Welsh prisoners to be in Welsh prisons and this gives a potential opportunity to re-look at delivery of programs in prisons. There is no programme currently in Cardiff prison because of the type of prison it is, but there is an opportunity now to look again at what is possible."*

Enthusiasm was also expressed for the *"desire around VAWDASV to share practice and experience… Generally, there's a desire in Wales for greater collaborative work and VAWDASV drives this."* There is a wish to work *"closely with universities",* for *"more collaboration… with the voluntary sector"*, though the *"current contracts have uncertainty around tendering (which) makes this difficult to work on at the*

*moment." "We all have a part to play in making our communities safer."*
Collaboration between services is explored in section 5.

## 4.6 Family

There are no interventions in Cardiff and The Vale of Glamorgan, that see themselves as family system interventions. Miles & De Clare (2018) in their report for the Welsh Government 'Rapid Evidence Assessment: What works with domestic abuse perpetrators?', drew attention to Dutton's (2012) reflections recognising that historically the domestic violence sector has "a clear distinction between perpetrator and victim (usually seen as male and female respectively) …(leading)… to a narrow focus in treatment responses." This approach does not allow services to work with reciprocal violence, or in general deal with the complexity of dysfunctional relationships, instead taking refuge in "a stereotypical dichotomous approach" (Miles & De Clare, 2018, p.10). And yet, all the perpetrator services we looked at worked in partnership with services working with the victim. Together they were working with the couple or whole family. Staff working in services generally felt that this dichotomy of interventions was "good enough" most of the time. But we were also given numerous examples of when it failed: "*There is some mutual couple violence. It's difficult to ascertain who the victim is or even if there is any victim or they're both victims. I haven't done much perpetrator work so… that's when things become a little bit difficult because I haven't been trained for this. It's a shame that I don't know enough about it so I can't provide them with everything they need"*. In same-sex relationships this can be especially difficult: *"there was a slight confusion on who was the victim and the perpetrator recently, so* (the IDVA) *ended up getting the* (male) *perpetrator."*

Traditionally services working with victims have focused on short-term interventions for safety planning, practical support, and some immediate emotional support (Hobson, 2014), and have given little attention to the psychological needs of victims. The PATH (Psychological Advocacy Towards Healing) intervention for domestic violence victims (Evans et al., 2018) is an attempt to address this. An RCT with the PATH model showed a greater improvement in the mental health of women in the intervention group at a 12-month follow up (Ferrari et al., 2018). There is a PATH IDVA in Cardiff, who fed into this review. There are long waiting lists to see her - *"the waiting list is five or six months"* and the model is *"typically more effective for women who are post-domestic abuse."*

The psychological needs and mental health problems of victims, whether they predate the relationship, are caused by, or exacerbated by it, have a huge impact on victims' capacities, including their capacity for healthy relationships. Being a victim of DVA is possibly the biggest predictor of future victimisation (Walby and Allen, 2004). Repeat victimisation is driven partly by psychological mechanisms, including complex mental health needs stemming from childhood (Ørke et al., 2018). And victim perpetrated IPV is an important risk factor for physical and psychological IPV revictimization (Kuijpers et al., 2012, p.33). This situation, and the difficulties services face in responding appropriately, is illustrated by a situation that was relayed to us of a victim attacking and wounding her ex-partner and smashing the windows of his car on discovering he had a new partner. However, her victim support worker dismissed her needing any psychological or behavioural support, as *"she had been triggered"*. This attitude is not universal; another IDVA talked about victims becoming perpetrators *"because it's their way of coping with what they've been through, and they end up preying on the perpetrator. There's an argument about whether they're a perpetrator if they're just reacting - but there's still injury"* they recognised that *"there are sometimes quite high psychological needs, which is a lot of my clients to be fair"*

We heard of victims repeatedly ending up at MARAC – with new perpetrators. By not providing the same level of behaviour change support to some of these victims as we are now doing with some perpetrators, we are possibly failing to help them, and their children, stay safe.

Miles & De Clare (2018) highlighted three pieces of research evidencing whole family approaches:

1. Buller et al. (2016) found that by reducing stressors on the whole family, it is possible to reduce IPV perpetration
2. An RCT of a preventative intervention with couples at risk of IPV, found that this couples intervention resulted in them displaying less IPV than a matched control group (Feinberg et al. 2016), and
3. In another RCT, mothers who had experienced domestic abuse delivered a dating abuse prevention programme to their teenage daughters who had been exposed to the

abuse. They found this intervention reduced both the daughters' victimisation and perpetration of abuse (Foshee et al. 2016).

Closer to home than these pieces of international research, 'For Baby's Sake' is an innovative whole-family intervention that works with parents from pregnancy to two years postpartum to break cycles of domestic abuse and improve outcomes for children. The programme has been evaluated by researchers from Kings College London (Domoney et al., 2019). They conclude that "it is possible to implement a whole-family domestic abuse intervention within community settings, and to work intensively with mothers and fathers with the aim of improving outcomes for children living with domestic abuse" (p.549). This evaluation is ongoing. 'Steps to Safety' is another evidence-based intervention that focuses on increasing parents' capacity for mentalisation / reflective functioning; increasing parents' capacity for emotional regulation and interpersonal functioning; and providing an introduction to early parenting, in order to prevent domestic violence. A feasibility study has been conducted by Oxford University researchers (McMillan & Barlow, 2019).

In a recent review of the evidence-base for couple therapy, family therapy and systemic interventions, Carr (2019) concludes that "couple therapy is appropriate for treating relatively mild-to-moderate situational intimate partner violence and preventing it from escalating into severe violence" (p.504). There is a rich literature on systemic approaches, which seems to have had remarkably little influence on DVA services.

The answer may, however, not lie in completely re-inventing services, but, at least partly, in stronger collaboration between perpetrator and victim services, a greater sharing of expertise, and a shared willingness to find non-dichotomous approaches to working with complex dysfunctional relationships. We need to "focus our efforts not only on ending violence against women but on ending all forms of violence in relationships" (Stith et al., 2012).

The development of this approach may be a process, which is already underway. We heard repeatedly that victim services had to varying degrees expressed caution and distrust towards perpetrator services when they started. While we heard that there were still remnants of this, the IDVAs we spoke to, who had worked more intensely together with perpetrator services, expressed enthusiasm for this collaboration, and

that it had changed the way they work. "*I was really impressed with the work they did engaging with the husband of my client. I was really impressed with the work they were doing with him they supported him, but the focus was on making it safe for anybody he was in a relationship with."* There is still a long way to go through when things aren't clear cut:

> *In situations where there is ambiguity about who is the victim and who is the perpetrator, Drive will usually stay away from cases… Interventions involve disruption of perpetrators, which might victimise the victim… (and there's) often no support for the perpetrator in their victimization, victim services won't touch them. There was a 'victim' who was on remand for assault. She had an IDVA and support, but there was no support for the male perpetrator (who had been assaulted). Gender is the main factor in this. What about a worker who knows how to work with both victims and perpetrators?*

> *Separation of perpetrator and victim training seems to not be relevant… (the) complexity of relationships doesn't fit the victim/perpetrator binary. Specialised workers should always receive training in both.*

## 4.7 Ensuring services include minority groups

There is nothing in the structures of the IRIS+, the local preventative programme (see section 4.1.2), CLEAR, the local early intervention programme (see section 4.2), or Cardiff Drive, the local high-harm programme (see section 4.4), that inherently exclude minority groups. The DVPPs, which we discuss in section 4.3, are group programmes which, because of their group format and their focus, on the experience of men who have become abusive to their female partners, do exclude some DVA perpetrators. Those excluded include:

- Female DVA perpetrators
- DVA perpetrators whose proficiency in English precludes them from a group
- DVA perpetrators with shift-work patterns, unable to commit to a weekly group
- LGBTQ+ (lesbian, gay, bisexual, transgender, and related communities) DVA perpetrators
- DVA Perpetrators who because of a disability or (mental) health problem are unable to attend a group

Drive has, for example, supported DVA perpetrators with all these characteristics. For DVPPs, one solution, where there are not sufficient numbers to justify specialised groups, is to provide a parallel one-to-one programme. We interviewed a practitioner involved in such a programme elsewhere in the U.K.

They noticed that as soon as social workers were made aware of the one-to-one work being offered to DVA perpetrators who could not attend the DVPP group, a whole new stream of referrals came in. There was no need to advertise further because capacity was quickly reached. This referral route may explain why no gay men were referred to this service. In the first few months, new referrals were mostly women. Some of these women were in same-sex relationships. They also worked with a transgender man in a relationship with a cis woman, and a man who began transitioning to a woman during their support. They found that there were more similarities than differences, in terms of the support that they gave in these one-to-one sessions, to the work done in a DVPP group, although generally there were more mental health and emotional dysregulation issues. A sensitivity and awareness to

service user's own experience of their gender was key – *"sometimes just as simple as asking how someone would like to be referred to, for example."*

We know that lesbian and bisexual women experience DVA at a similar rate to women in general (around 1 in four). One in three of those women has experienced DVA from a man, but two in three lesbian and bi-sexual women who have experienced DVA, have experienced it from a female partner (Hunt & Fish, 2008). Female perpetrators made up 6.5% of the Drive DVA perpetrator cohort at the three Drive pilot sites during the research phase of the U.K. Drive programme (Hester et al., 2019). The proportion of DVA perpetrators who are female is likely to be higher at lower levels of risk ('Domestic Abuse Is a Gendered Crime', 2020), so it would seem important for DVPPs programme to be able to meet this need.

The service above was not meeting the needs of male DVA perpetrators who are violent to their male partners. Services to meet these needs are not widely available. Drive in Cardiff has worked with male DVA perpetrators (see section 4.4). Nationally the Respect men's DVA helpline (*Home | Domestic Abuse Affects Men Too | Men's Advice Line UK*, 2020) has worked with GALOP (*Galop – The* LGBT+ Anti-Violence Charity, 2020) to develop responses to male victims in same-sex relationships. A response to male perpetrators has not been developed. This potentially large group is not being reached: while 17% of men in general say they have experienced DVA, 49% of gay and bisexual men have experienced at least 1 incident of DVA since the age of 16 (Guasp, 2015).

## 4.8 Sexual violence services

While this review focusses primarily on services that work with DVA perpetrators, we are aware of the many ways domestic violence and sexual violence are linked. Sexual violence and coercion can be an intrinsic aspect of the domestic violence experienced by many women. Living in fear of an abusive partner can limit the possibilities for withholding consent.

Some DVA perpetrators may also be far more likely to be sexually violent than others. Using data from four psychometric tests / survey instruments, Hall et al. (2012) divided a group of 340 domestic violence offenders into eight sub-types. There was a strong correlation between one of these sub-types (men characterised as dominating and isolating, with high levels of psychological abuse) and forced sex (.795 correlation).

A review of over 500 articles found that children subjected to sexual violence are far more likely to have been exposed to DVA (Herrenkohl et al., 2008). Services working with DVA perpetrators will be working with men who have been sexually violent to their partners, and with men whose children will have experienced abuse, or be at high risk, from them, or someone else.

Despite the strong links between domestic and sexual violence, we found no active links between DVA perpetrator and SV perpetrator services in Wales. There was however a universal recognition of the overlaps and a wish to establish connections in order to explore ways to collaborate and learn from each other. As a professional within sex offender services said, "*I'm sure domestic violence services could be flagging sexual abuse more.*"

> *Some of them (Drive clients) have been sexual offenders and have been arrested, but it's never gone to court because the victims won't testify.*

> *I don't know much at all about any behaviour change stuff for sex offenders locally. I've heard some mention of Circles but I'm not sure how I know about it... I think I've seen a presentation by StopSO.*

*There's definitely space for sexual violence and domestic violence services to work more closely together.*

This brief mapping is aimed to support the building of those links.

### 4.8.1 HMPPS sexual violence services

Unlike domestic violence behaviour change programmes within the criminal justice system (see section 4.5), sex offender programmes were not privatised in 2014, but remained within the NPS. Sex offending services within the NPS are however also going through a transition. Fairly recent research (see Mews et al., 2017 for an overview) found that these programmes often make little or no difference. There were even small increases in the sexual and child image reoffending rates for offenders following some of these programmes in prison. Weaknesses highlighted included that these programmes could be inflexible to individual needs, and that there may be a risk that by focussing on offending behaviour in a group context, as the programmes did, that behaviour could be normalised by the group. The previous Sex Offender Treatment Programme (SOTP) was replaced by a new strengths-based approach. However, a recent report found "many NPS staff, of all levels, were struggling with the perceived dichotomy between the new strengths-based approach and an approach based on an understanding of public protection and the 'best predictor of future behaviour being past behaviour'" (*Management and Supervision of Men Convicted of Sexual Offences*, 2019, p21). There are now two new programmes:

- Horizon is a programme for men over 18 who have been assessed as medium-risk and have been convicted of a sexual offence. There is a focus on criminogenic needs - things that an offender needs but are lacking. An offender's failure to meet their needs without committing crime is addressed by working on their problem-solving, self-regulation and relationship skills.
- Kaizen is a programme for adult males who are assessed as high or very high risk. It is for people who have been convicted of violent or sexual offences. Kaizen is based upon Risk, (criminogenic) Need and Responsivity. With

Kaizen there is a greater recognition of the biological, psychological, and social factors linked to offending behaviour. The approach remains strengths based.

HMP Cardiff predominantly provides for prisoners serving short-term sentences, remand prisoners and prisoners awaiting sentence. There are therefore no sex offender programmes in HMP Cardiff. These programmes are run in HMP Parc (Bridgend) and HMP Usk-Prescoed. They are also run in the community in Cardiff, where there is also an i-Horizon programme for internet-only offenders. A 'New Me Skills' programme, an adaptation of Kaizen, is in development for sex offenders with a lower IQ. Except for a process evaluation of Horizon (Ministry of Justice, 2019), no evaluations have yet taken place of any of these programmes.

### 4.8.2 Circles of Support and Accountability

Established in Canada in 1994, Circles of Support and Accountability (CoSA) is an intervention that is based strongly on restorative justice, and the Good Lives Model. Rather than focussing on deficits, CoSA works with sex offenders, focussing on their strengths and supporting them to become better functioning members of society. Four to six trained volunteers form a circle of practical and emotional support and aim to reduce the social isolation of a convicted sex offender. The dynamic factors these volunteers focus on, including social isolation, have been identified as risk factors for sexual offending recidivism (Marshall, 2010). Around the volunteers is a further circle of professional support. Circles UK is funded by the Ministry of Justice. Local providers deliver CoSA in different areas of England and Wales. In Wales, the National Probation Service is the provider of Circles Cymru, with approximately 20 circles of support. Recent funding cuts have reduced the number of circles in the UK (*Circles UK Annual Review 2018-19*, 2019). This is despite there being quite strong evidence for the effectiveness of CoSAs.

An evaluation of the early work in Canada found 70% less recidivism with offenders engaged with CoSA than those who did not engage (Wilson et al., 2007). A recent U.S. research study had a stronger design, as an RCT. CoSAs significantly reduced sexual recidivism, lowering the risk of re-arrest for a new sex offence by 88%. During the RCT, for every dollar spent "the program... yielded an estimated benefit of $3.73"

(Duwe, 2018, p479). Unfortunately, U.K. (and other European) research has tended to be very small scale and qualitative and/or explorative. Examples include:

- a pilot programme of an adapted CoSA, where support is commenced in prison and then "through the gate", showed promise as an intervention (Kitson-Boyce et al., 2018)
- a qualitative study of fourteen high-risk offenders showed that there had been no reconvictions for a sexual offence during the four years they were followed, and that CoSA had played a key role in identifying increases in risk with some, leading to appropriate interventions (Bates et al., 2007)

Despite the weak U.K research, international research indicates that the work can be effective in reducing offending. The model has continued to develop and be adapted to work with female perpetrators, online perpetrators, young people, and perpetrators with learning difficulties (McCartan et al., 2018).

With Circles Cymru being embedded in probation services, joint working with probation is strong, as it is with the police.

### 4.8.3 Sex Offender Services (StopSO)

StopSO (*StopSO UK: Tackling Sexual Abuse*, 2020) trains and accredits therapists to provide support to sex offenders. They receive requests for support from sex offenders and from people who fear they may offend. They have trained over 170 therapists and receive over 800 requests for help a year. They have a triage process for assessing risk and matching with an appropriate therapist. Support can often start within days of a request. There is a large demand for their service, despite clients having to pay for therapy themselves. We were told that about 20% who approach them are unable to pay *'These men are asking for help, and they can't always be offered help'*. Though they claim that their approach is based on evidence, there has, as yet, been no formal evaluation of their service.

With links to StopSO, there is a group programme for Sex Offenders in South East Wales. Some of the men on the group have convictions; others have not yet committed an offence.

#### 4.8.4 Lucy Faithfull Foundation

The Lucy Faithfull Foundation (*About | How We Tackle Child Sexual Abuse*, 2020) works to reduce child sexual abuse. They run several services:

- The Stop It Now! helpline is an anonymous and confidential service available to anyone with concerns about child sexual abuse, including those worried about their own sexual thoughts or behaviour towards children and anyone with concerns about their online behaviour, but also anyone else with concerns about sexual abuse - including survivors and professionals
- The Inform Plus programme is a ten-week course for groups of 6-10 individuals, who have been arrested, cautioned, or convicted for internet offences involving indecent images of children.
- The Inform Programme is a course for partners, relatives, and friends of anyone who has been accessing indecent images of children online. Each group typically has up to six members, who meet for five sessions
- The Inform Young People's Programme is an educative programme for young people in trouble with the police, their school or college for inappropriate use of technology and the internet (for example, sexting, possession and/or distribution of indecent images of children, engaging in risk taking behaviours online, such as accessing adult pornography). They can also work with families / caregivers
- The Stop it Now! Website (*Stop It Now*, 2020) is for people who are concerned about their online viewing of sexual images of children, their families and friends, and professionals who work with these groups

There are currently no Lucy Faithfull groups in Wales. However, Stop It Now! Wales is staffed by one full-time member based in South Wales and one part-time member based in North Wales. Between them, they offer:

- Information around preventative measures that adults can take to protect children from sexual abuse
- Child sexual abuse awareness seminars to parents and carers

- Child protection and safeguarding training to multi-agency professionals across Wales. The project is hosted by the NSPCC (National Society for the Prevention of Cruelty to Children) in Cardiff.

## 4.9 The key role of motivational interviewing

Motivational Interviewing (MI; Miller & Rollnick, 2002) is a counselling approach that combines client-centeredness with a directive, focused and goal-orientated style that aims to encourage change. Key concepts include the stages of change (that motivation to change varies and tends to go through stages which all need a different approach) and exploring ambivalence. Motivational Enhancement (ME) was developed from MI; it was originally a specific four-session adaptation of MI, used in alcohol recovery ('Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity)', 1993). ME tends now to refer to any brief adaptation of MI, especially when used at the beginning of treatment.

Motivational Interviewing is both a central methodology for HMPPS interventions (see section 4.5) with a strong history and evidence-base (McMurran, 2009), and part of the VAWDASV Perpetrator Service Standards (*Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards*, 2018). There is general evidence for MI as an effective way of engaging with participants in many different types of behaviour change interventions. A review of 72 MI RCTs found that it "outperforms traditional advice giving in the treatment of a broad range of behavioural problems and diseases" (Rubak et al., 2005, p.305)

There is also evidence of its value specifically with behaviour change interventions with domestic violence perpetrators:

- A quasi-experimental trial of a 6 week ME intervention focussed on IPV perpetrators who were judged to be highly resistant to intervention. From a sample of 486 perpetrators, 141 (29%) were selected as being highly resistant. They were assigned to a standard (16-week) intervention or a 6-week ME group, followed by 10 weeks of standard intervention. Completion of this group was significantly higher (84.2%) than both resistant clients (46.5%) and non-resistant clients (61.1%) in a standard intervention (Scott et al., 2011).
- A single individual Brief ME session prior to men starting a DVA group programme was associated with increases in session attendance and treatment compliance for the next 6-months (Crane & Eckhardt, 2013).

- Schumacher et al. (2011) also developed and piloted a 90-minute ME intervention to address IPV in alcohol treatment-seeking men. At 3- and 6-month follow-up, there were improvements in self-reported alcohol outcomes, anger, and verbal and physical aggression.
- In a Spanish RCT, Lila et al. (2018) used individualized motivational plans (IMPs) with 50% of men attending DVA perpetrator groups (n=160, 80 in both groups). These plans were based on MI, stages of change, and strength-based theory principles. Men who were supported using these plans "finished the intervention in a more advanced stage of change…, reported less physical violence…, and had a higher reduction in recidivism risk" (p. 309). Another similar Spanish study (Romero-Martínez et al., 2019) found that men supported with an IMP (n=53) were more accurate in decoding emotional facial signals and presented better cognitive empathy (perspective taking) than a control group (n=40). These factors are theoretically linked, as protective factors, to reductions in IPV.
- Vigurs et al., (2015) conducted a systemic review of the use of MI with IPV perpetrators. They found successful treatment effects, but felt that there were, as yet, too few studies to draw firm conclusions but that MI is "a potentially promising area of intervention, deserving of further study" (p. 34).

We assessed the MI skills of nine local staff who directly work with DVA perpetrators, including five Drive case managers, using the VASE-R (Rosengren et al., 2005, 2008, 2009). The VASE-R has been developed as a measure of the practical use of MI skills. It consists of video vignettes of clients. After each vignette one or two questions are asked about how the practitioner would respond to this client in the situation described, for example "*Write a summary that you might say to Ulysses and which touches on the things that you think are most important*" (Rosengren et al., 2005, p.12). Practitioners are given between 45 and 120 seconds to give a written response. These responses were provided as typed-up anonymised responses to an experienced motivational interviewing trainer who scored responses using a structured scoring manual (Rosengren et al., 2009).

VASE-R has been shown to have high scoring reliability, excellent internal consistency, and strong concurrent validity, with scores correlating highly and significantly with, for example, the Motivational Interviewing Treatment Integrity

scale (Moyers et al., 2005). A score of 0-36 for a measure of overall proficiency in using MI skills is created for each participant. Scoring norms and benchmarks are suggested, based on datasets from novices, recent trainees, and members of the Motivational Interviewing Network of Trainers (Rosengren et al., 2009).

The scores we found (n=9) ranged from 10-24 (Mean=15.8, Standard Deviation = 4.8) for the measure of overall proficiency. The VASE-R sets beginners' proficiency at a score of 26 and above and advanced proficiency at a score of 31 and above. These calculated cut-off scores are based on scores of trainees at the end of an intensive practice-based training (n = 111), and scores of experienced MI trainers (n = 66). None of the sample reached the cut-off score for new trainees. Based on these scores, the staff in perpetrator services in and The Vale are not yet adequately informed by MI in accordance with VAWDASV standards.

The VASE-R scores contrast with the feedback we repeatedly received about the ability of Drive and CLEAR case managers to engage with clients and to bring about real change. This feedback was, with Drive, supported by examples and clear empirical evidence of the impact in an RCT evaluation report (Hester et al, 2019).

There is strong evidence (see above) that MI skills positively impact on outcomes. None of the staff involved had received any MI training in the current year, and all had received less than twenty days of MI training in their career, one person had not received any training in MI at all. Training, for some at least, had not included any skills practice or feedback on skills development.

> *I had MI training many years ago, (but) there was no specific training in relating skills (despite) reflective skills and ability to take feedback and be self-critical being vital.*

The success of all perpetrator programmes, and possibly especially DVPPs (see section 4.3), may be partly reliant on staff being properly trained and supported to use MI. We heard, for example, that Drive case managers are working in ways that align with MI principles, by starting with any goals that a client might set:

> *What's really good is that they don't just have to focus on the abusive behaviour. For example, someone we (social care) are*

*working with now blames it all on the alcohol. So, they'll say 'right, let's do substance misuse' and support them to get them involved with a substance misuse organisation. They're very broad, they'll go wherever that person feels they need support. (They) will go through those motions until eventually that person says 'actually, it's my behaviour'. They're bound to have all of that denial, all of that blame, so they've got to work through those layers before they get to 'I'm the one to blame – it's my behaviour.' (Drive have) got the time and the resources to be able to do that.*

However, it also seems likely there is room for improvement.

# 5 The collaboration between services

Multi-agency work is at the heart of domestic violence perpetrator work. It is one of the principles that drives the Respect accreditation standards: "Domestic violence and abuse cannot be addressed by one agency alone and work with perpetrators should never take place in isolation. Organisations are committed to working with partners to improve responses as part of their local multiagency arrangements" (*The Respect Standard, Third Edition*, 2017, p.6). The importance of multi-agency work is also highlighted in the VAWDASV Perpetrator Service Standards (*Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Perpetrator Service Standards*, 2018), which highlight five key areas of multi-agency work:

i. Establishing an understanding of 'what works' with VAWDASV perpetrators
ii. Informing the commissioning of effective and sustainable VAWDASV perpetrator services
iii. Developing prevention and early intervention approaches to VAWDASV perpetration
iv. Improving VAWDASV perpetrator service links, communication and sharing of effective practice
v. Developing a skilled and resilient VAWDASV perpetrator service workforce

This report aims to contribute to the understanding of what works (key area i), highlighting how services can develop, including prevention and early intervention services (key area iii). We have included an exploration of the training needed to support a skilled and resilient workforce (key area v). In looking both at what works, and the skills needed to implement that work, we hope also to contribute to informing commissioning (key area ii). Multi-agency work has been highlighted in the links that the local IRIS (see section 4.1.2), CLEAR (see section 4.2) and Drive (see section 4.4) services have established. It is these service-delivery links, communication, and opportunities for the sharing of effective practice (key area iv) that we explore in more detail below.

Mirroring the structure of the full report we will explore collaboration with:

1. Preventative services and the wider system of services
2. Early intervention services and the wider system of services

3. Medium-risk services and the wider system of services
4. High-harm services and the wider system of services
5. Between DVA perpetrator services

We finally explore the

6. Referral processes for higher harm perpetrators, looking at the different models that exist for this, and could be developed in Cardiff and The Vale of Glamorgan

The importance of multi-agency work for domestic violence services is emphasised in the NICE 'Domestic violence and abuse: multi-agency working' Public Health Guideline. Seventeen recommendations are made for commissioners, providers and professionals in health and social care, specialist domestic violence and abuse services, criminal justice settings and detention centres. Recommendation 14 focusses on the commissioning and evaluation of tailored interventions for people who perpetrate domestic violence and abuse (NICE, 2014), and recommendations 2-4 also have relevance for DVA perpetrator services.

## 5.1 The collaboration between preventative services and the wider system of services

IRIS+ and the CtL 'Trusted Professional' services (see section 4.1) both aim to increase awareness and referrals from professionals as a preventative measure. Both are being evaluated currently, by The University of Bristol and London Metropolitan University respectively. A measure of their impact will be the extent to which they have raised awareness and really got the professionals they work with 'on board'. IRIS+ is already showing promising signs of establishing the relationships needed to do this. The involvement of a GP in the delivery of training was highlighted as an aspect of the programme that really worked (see section 4.1). The strong multi-disciplinary input was key, as the GP understood that if the intervention was to appeal to GPs, they would need to see the direct links to their core work, a reduction in ineffective but demanding uses of their time, and positive impacts on health outcomes. More generally the intervention is likely to be raising awareness of the social determinants of health, and the role that GPs can have in addressing these. As such, this intervention is very clearly a public health measure. IRIS+ was established as a university research programme led by researchers in the domestic violence and health research group, based in the Centre for Academic Primary Care (CAPC), Population Health Sciences, Bristol Medical School and the Centre for Gender Violence Research in the School for Policy Studies, University of Bristol. These strong university links are also part of the multi-agency framework needed for the successful implementation of programmes, like IRIS+, that are broadening involvement in preventative work. The involvement of IRIS+ with individual clients is brief. A positive outcome is clients' engagement with other services. The focus of this engagement has been the CLEAR service. We explore this relationship in more detail below. The early contact with clients does potentially give an opportunity to gather a holistic picture of their situation. It is too early in the development of the programme to assess how much this happens. But this broad picture can be useful for thinking about interventions in far broader terms than direct behaviour-change work. The complex aetiology of domestic violence perpetration means that a whole range of interventions can make a difference. Some of the services that have been referred to earlier in this report make use of nested ecological models (for example, Diranzo et al., 2012) to categorise these different influences, or risk factors for IPV.

These models are sometimes referred to as Bronfenbrenner's (1989) and sometimes as Dutton's (1995) nested ecological model in reference to the original human development model or to Dutton's adaptation of it to domestic violence perpetrators. They look at factors at different levels:

- Individual (also known as ontogenetic) level, for example biological factors like an individual's health
- Microsystem level, the immediate dyadic relationships
- Mesosystem level, the family system
- Exosystem level, for example the immediate neighbourhood
- Macrosystem level, the cultural context

In a metanalysis of data from 85 studies, Stith et al., (2004) looked at evidence for predictive factors for physical abuse for male and female perpetrators and victims. There are huge gaps in the predictive model they created, for example very little is known about these factors for male victims. They did find some stronger factors for male perpetrators, especially at microsystem level (e.g., marital dissatisfaction, $r=.30$) and ontogenetic level (various other forms of abuse, but also illicit drug use ($r = .31$), having attitudes condoning violence ($r = .30$), traditional sex-role ideology ($r = .29$), and alcohol abuse ($r = .24$) etc.). Some of these factors, like traditional sex-role ideology might, be the direct focus of perpetrator interventions, but other factors, like drug and alcohol use might be as important to address to reduce risk. Or as Buller et al (2016) found in an Ecuadorian study, providing food transfers to impoverished families also reduced IPV as it reduced couples' conflict and stress, improved household well-being and increased female partners' decision making, self-confidence and freedom of movement. There is more than one way to reduce risk; working together with services that focus on these other risk factors exponentially increases any impact DVA perpetrator services might have.

There are currently no other preventative programmes in Cardiff and The Vale of Glamorgan, but any new programmes will also be reliant for their effectiveness on a being strongly linked to other services and wider systems. They will also need to be aware of the broad spectrum of factors that influence DVA perpetration if they are to be effective public health interventions.

## 5.2 The collaboration between early intervention services and the wider system of services

CLEAR is *the* early intervention in Cardiff. (There is no early intervention in The Vale of Glamorgan). IRIS+ is a potential route in, but currently key referral routes are self-referrals and social services. There may be opportunity for a court diversion route (police referrals). With these different referral routes, and the building of relationships with referring agencies that this affords, there is an opportunity to create a joined-up service, strongly linked to police, social work, and health services, as well as victim services, with an approach that flexibly meets the needs of these different referrers and has clear value for these partners. Some of these relationships are strong: "*Initially we were based in the same building as IRIS+ advocates, which made a big difference to getting started with those relationships. Our first referrals came from IRIS, in July last year*".

More widely, speaking with services throughout the area, the importance of these personal relationships was repeatedly mentioned: knowing each other helped build the trust needed to work together. Building these relationships with other teams was more difficult. The high turnover in staff in both victim and social services was an issue that came up repeatedly, not only with CLEAR, but with all the services we talked to, including staff from victim and social services. This presents challenges for the work, for example when there is shared case management of a couple with victim services:

> *There's a lack of understanding of our work, and sometimes an ambivalence. Frequent change-over there makes it difficult to establish a good working relationship. We want to be challenged and questioned about our work with these men, by people working with the women.*

Also, in social services:

> *So much work to do with social services! So many teams in Cardiff have high turnover of staff and managers, that we're back at square one frequently. Lots of time taken up with actively re-building relationships with teams; organisational knowledge is*

> *frequently lost. (Our work is) not part of the conversation yet in some teams; persistence of communication is the key.*
>
> *It's a real uphill battle. You've got to change the culture and there's a lot of learning to be had. Going out to the teams takes up a lot of our time. With some teams it's like they've never met you before and you think "I was just here six months ago". It is that kind of persistence…*

The wider issues around, and potential for, social services involvement with domestic violence perpetrator services are explored in further detail below, as are the factors other than personal relationships that may improve collaboration: co-location, mutual respect and understanding, and providing a clear added value to partners in meeting *their* aims (see sections 4.4 and 4.5).

Part of the work of CLEAR is supporting the men they work with to engage appropriately with other services. Staff were clear about the need for this holistic view of the situation, the importance of a wide range of support, as well as the need not to disempower their clients. Often, they would spend time explaining, giving information etc. and then send a client away with a phone number, but also when… *"he came back the next week, and said he couldn't make the phone call (due to mental health issues), can you help me?",* they'd support him to make the call. Even though the direct involvement from CLEAR staff with other services is usually not necessary, there is a great need for them to be well informed about the availability of other support, and for those other services to be aware of CLEAR, and their potential impact on families. As assessed risk levels increase, as we go through perpetrator services, the need for more direct contact with other services becomes stronger, but also given the very real possibility of some low-risk clients just being at an earlier stage of escalation, and of risk-assessments not always capturing the actual level of harm, effective multi-agency support at this level, may be reducing harm significantly.

## 5.3 The collaboration between medium-risk services and the wider system of services

As there are currently no medium-risk services in Cardiff and The Vale of Glamorgan, it is not possible to assess the strength of links with other services. We know that there are potential referral routes, from other perpetrator services locally, and these are explored below. Staff in social services and probation also talked to us about the need for medium-risk services (see section 5.3)

During this study we also spoke to Equilibrium, a medium-risk DVA perpetrator programme in Swansea. Although part of a multi-agency hub (see section 5.5), they are funded by social services, staffed by social workers, and all their referrals come from social services, which excludes men without children. However, most DVPP services have several referral routes. A DVPP programme in the Northeast of England reported that "almost half of the referrals into the DVPP come from children's services including Children's Social Care, Family Intervention Programmes, the courts and CAFCASS (men who have made an application to court for contact with their children). Referrals also come from police, probation or the local Multi-Agency Risk Assessment Conferences (around 20% of referrals) and from self-referrals - people living in the community who recognise that they need help themselves (these make up around 30% of referrals)" (Barnardo's, 2014). Besides the need for strong collaboration with social services, police and probation, other links are likely to be needed, for example with mental health, housing, and substance misuse services.

These services receive a broad range of men who have been abusive to a female partner, with quite varied levels of risk. (Providing support to medium-risk perpetrators who don't meet this profile is explored in section 4.8). In Cardiff and The Vale of Glamorgan, we would expect to see a service like this, accepting clients that are slightly too high-risk for CLEAR, or men who need a longer intervention after completing CLEAR support. The group would also accept MARAC clients who are not complex or high enough risk to warrant a Drive intervention, or who have been supported by Drive, and where now ongoing less intensive support is now needed. Besides the complexities this brings for group facilitation, it also means that an adaptable approach is needed around supporting these men to engage with other

services. This may sometimes mean just signposting. In other situations, the intensive collaboration with partner agencies, that Drive is able to do, may also be needed. For those men where social services is involved with their family, the level of intensive collaboration needed may often be very similar to the joint working that Drive strives to achieve.

The success of a medium-risk programme relies heavily on buy-in from other services, especially social services. Social services would preferably be involved in the development and roll-out of this service, to ensure collaboration is more likely to happen and that the service is meeting their needs.

## 5.4 The collaboration between high-harm services and the wider system of services

*When DRIVE has worked with a perpetrator that has alleged abusive behaviour from one of my victims, they have been able to call me up and fact check this. When I have needed information on how to safely contact a victim living with a perpetrator, DRIVE has been able to provide this. We have coordinated planning, discussed risk, and ensured safeguarding protocol is followed in contacting perpetrators.*

The collaboration between Drive and other services has also been explored in section 4.4. The strong collaboration with victim services was highlighted. Having a specialised IDVA has the advantage that they are well-informed and work closely with the Drive team. The way of working, involving longer-term work, is also different to other IDVA support. They clearly saw themselves as part of the team. Having just one specialised IDVA also has disadvantages. The service is vulnerable to staff absences or attrition. Also, it does not support the wider building of links and sharing of learning between the Drive and RISE teams.

The collaboration with police and probation is also strong in Cardiff. The physical siting of Drive in a Cardiff police station, where they share office space with the MOSOVO (Management of Sexual Offenders and Violent Offenders) team, has been very helpful:

*Being co-located creates expeditious disruption. And for the police, Drive being located there, we've had the feedback that we're decreasing their demand on the ground. And it means that we can take clients who are far more chaotic.*

*So, the police have said to me, "don't take him, he's a master manipulator, you'll never get anywhere with him" … (now) he's doing so well… so a police officer asked me the other day, "is he dead, because we haven't heard anything from him for so long?"*

The advantages, for others, of this co-location have also been touched on earlier (section 4.4).

Drive seems to have successfully reached out to the criminal justice system, providing an approach that fulfils a need that the criminal justice system recognises but cannot fulfil itself. With some groups of offenders there have been increasing efforts to bring together crime reduction and public health perspectives. In section 4.8.1. the challenges for probation officers in combining these two perspectives, when working with sex offenders, was already touched on. Another area where these two perspectives converge is in working with offenders with a severe personality disorder. (Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder). The Offender Personality Disorder Pathway (OPDP) in Wales is, for example, co-commissioned and managed by Public Health Wales and the HMPPS in Wales in partnership. Linked to this has been an increased focus on Adverse Childhood Experience (ACE) (An Inspection of the National Probation Service in Wales, 2019, p.23). We saw evidence of how embedded this is becoming; police who we spoke to also highlighted the importance of ACEs – this had clearly become part of the vocabulary and thinking amongst some police officers. However, because of their statutory role in crime reduction, and the culture of the organisations, there are limits as to how far they can go in embracing a health perspective. Drive seems to have successfully linked into this, while gaining the trust and respect of these services, and a recognition of what Drive provides, that the criminal justice system cannot.

Drive has not been able to form that same level of collaboration with health services. This is most acutely felt around the mental health needs of clients. We heard many examples of the frustrations for drive case managers because this collaboration hasn't been established.

> *It took a year to arrange mental health assessment for one client; they wouldn't even tell us if the GP had submitted a referral, we couldn't chase up progress. The client is 19 and had to give CAMHS consent and the doctor in adult services didn't have any of that information.*

*He's made several serious and violent suicide attempts and been hospitalised for them. But mental health services say that he doesn't have mental health issues.*

Generally, case managers were left with the frustration of feeling that "*most Drive clients have quite severe mental health issues... and there is not enough support for them." "How can we get mental health services more involved?"* was a recurring question. The poor sharing of information between Drive and mental health services was also raised as an example of the frustrations of this relationship:

*Mental health services are very reluctant to share information with other services, particularly police. Reasons cited are often confidentiality – 'GDPR'... It seems like safeguarding legislation doesn't have the same weight.*

Unfortunately, we were unable to talk to anyone from mental health services. There is, however, possibly a culture clash, where patient-doctor confidentiality creates a fundamentally different culture to the culture of the crime reduction field. Safeguarding issues can over-ride the strong tendency not to share information with outside agencies (GMC, 2020), but it is likely that this is exercised with far more caution, and with awareness of the potential for undermining the trust needed between patients and health services, a trust that can be particularly vulnerable with mental health patients (Brown et al., 2009). And yet, Drive has the potential to really support mental health services:

*I met one client's psychiatrist and I told him that he'd stabbed somebody and all the other things that he'd done, his very erratic behaviour. The psychiatrist had no idea what was happening, he was seeing him: "how are things?" "Fine." "Okay." "Fine." 15 minutes. Keeping him on the anti-psychotic medication with absolutely no idea and no information about what was going on. So that information was shared then... the information came from his probations officer.*

The poor collaboration between Drive and health services is undoubtedly a reflection of the way resources are stretched within the NHS. It may also reflect the fact that

the Drive has not established the same mutual respect and understanding with (mental) health services as they have with police and probation services. The co-location with the police services helped, but key to establishing this relationship with the criminal justice system was Drive understanding the culture and expectations of the criminal justice services and communicating how they had added value for the sector. Establishing the same respect, understanding and clear added value with health services is likely to be key to building a collaborative relationship. That this relationship can be built is evidenced by what IRIS and IRS+ have achieved (see section 4.1.2).

Both in recognition of the challenges the Drive central team face in working with mental health issues, and to support their understanding of their approach, Drive has been provided with additional support around working with mental health issues, including regular case reviews with forensic psychologists, from HMPPS Wales. Deeper embedding needs a shared strategy with health services, something the Drive team were keen to establish. With good mental health representation on the MARAC in Cardiff (unlike in some other Drive localities), the opportunities for building the required relationship should be stronger.

An additional step that Drive Cardiff has taken around better supporting the mental health needs of their clients is the 'spot purchasing' of sessions with a counsellor who is experienced in working with DVA perpetrators, for some of their clients. One benefit of the involvement of the forensic psychologists is that space is potentially created for reflecting on the interactions with clients. Another suggestion that was made during this review was to create a shared reflective space with the counsellor around the clients they support.

For the success of any integrated multi-agency approach to domestic violence (perpetrator) services, the active involvement of social services is key. Despite the challenges CLEAR, for example, face in collaborating with social care (see 3.2), we encountered strong recognition of the need for this within social services:

> *It's just such a huge issue – when you look at our caseloads, I would probably say my current caseload would be 70% domestic abuse. That's just mine, if you look at the whole of children's services it would be a very high percentage of domestic abuse. You forget*

*when you're writing them up, you think 'which family is this?' because you've got four or five on your caseload at one time that are all active domestic abuse... It's a huge part of our job.*

For most of those families there is no intervention with the perpetrator, but a recognition of the need:

*"No, and we don't have time to do it. If they do go on the (child protection) register, they go over to the long-term team, but we manage it until then. The children are seen every ten days, maybe we could get a session then but that's* ***very*** *rare. That's not enough."*

While Drive also initially encountered challenges in building relationships with social services, this had changed – to the extent that there were attempts by social services to get Drive support by circumventing the usual referral routes (see section 4.4). Again, once mutual respect and understanding had been established, and it was clear that Drive could support social services in reducing the risk with some of their most concerning cases, a basis was established for strong collaboration. The fortnightly 'co-location' at MARAC meetings had probably supported this. And now there are daily DV daily discussions in Cardiff (a 'mini-MARAC' attended by representatives from Police, NPS, IDVA, Children's social services and the MARAC coordinator).

It was not just perpetrator services, like Drive working who came across barriers to collaboration. From victim services:

*"There is lots that needs to be improved with information sharing – particularly from addiction services, sexual health, mental health services. Many of these won't share information and won't give a clear reason for withholding it. Concerns around GDPR and safeguarding, potentially. We could benefit from clear guidance on situations in which information sharing is encouraged."*

There were signs of Drive strengthening collaboration with, for example, substance misuse and housing services.  We were given examples of how Drive had worked with these services around shared strategies. For housing services interventions are

limited and can easily escalate to eviction. This does not necessarily solve a problem if a perpetrator then moves to a new victim *with* housing, repeating the cycle. Perpetrators have been housed and supported to break this cycle – a strategy that works for housing, but which they are unable to achieve alone. This is then at the heart of collaboration: all the services involved achieving more, by working together.

## 5.5 The collaboration between perpetrator services – a joined-up model

The links between DVA perpetrator services are hampered by there being no linking service across medium-risk levels. Services find themselves at different ends of a spectrum. The connection with Drive was missed by staff working with lower risk perpetrators, who said that there had been "*no sharing of information or learning with DRIVE so far… and that they were not sure the appetite is there from DRIVE's end for working together*"

It is possible that the very different approaches from a largely public health perspective on one side, and a largely criminal justice perspective on the other, are creating barriers to engaging with each other. However, these very different perspectives also create great opportunities to learn from each other. It is also possible that two relatively new services in Cardiff, in focussing on establishing their client work and the relationships they need with other services, have not given enough priority to supporting each other.

Discussions with Drive staff about the work of IRIS+, as part of this review, also prompted a suggestion to explore collaboration between IRIS+ and Drive. Drive have found collaboration with GPs to be sometimes challenging:

> *We've taken service users to GP appointment, and they've been absolutely horrible to them. And this guy is opening up and telling the GP what's going on and he's not taking any notice at all. We get to the place where we say, "you need to open up and be honest, you need to tell your GP everything", and then the GP is very dismissive.*
>
> *We would welcome partnership-working with IRIS+ to help improve this.*

Despite the failure to establish it so far, the idea of greater collaboration within the sector was greeted on all sides with enthusiasm. The one concrete suggestion that was put forward, was a request from Drive to IRIS+ for help in their engagement with GPs. Exploring this could not only be potentially valuable for Drive but could also foster a deeper understanding of each other and how they engage with other

services. There is already the expertise within services to strengthen collaboration. This will need to be drawn on when medium-risk services are developed.

As we have highlighted earlier, medium-risk services are potentially some of the most complex services; there are big variations in risk levels, and variations in the other needs of service users. They need to work closely with a wide range of other services, sometimes supporting clients to engage with those services, sometimes just signposting. Also, it is likely that group work will be a part of these services, and that in itself also brings new possibilities, and challenges.

During discussions, the Domestic Violence Hub in Swansea became a focus (Swansea Council, 2020) in terms of Social Services led multi-agency working. The hub has similarities to the high-profile Hertfordshire Social Services model (Community Care, 2020) and to the One Front Door model, recently piloted by SafeLives in seven English local authorities (*Seeing the Whole Picture - An Evaluation of SafeLives' One Front Door*, 2019), in working as an integrated service focussing on the whole family. Staff that work with DVA perpetrators and victims work as a team together, with the involvement of other services:

> *We had a lot of police support, so we had offices within the police. We've now moved to a multi-agency office, a safeguarding hub; this is developing still. There will be two police based there, health, education, safeguarding, IDVAs.*

> *We did a multi-agency systems review. People would have to tell their stories six or seven times and we wanted to streamline that and what came out in this review was the lack of services for men. For lasting change, we need to treat the cause, we need to work with the men. Nobody even speaks to the man a lot of the time and the woman is having to do all the work…*

Having social services leading the work of a hub, like in Swansea, can have strengths and weaknesses:

> *that is a definite strength of ours, that we have access to information.*

And it looks like the service is working:

> *There has been a drop in repeat MARAC referrals for couples where there's children; we don't know whether there's any link, but the impression is that that's the impact of our work because other local authorities in the area haven't experienced that drop, and we are developing ways of capturing change and progress with Swansea University.*

But it has also resulted in a service that, for example, excludes men who do not (yet) have children. Truly integrated services have been a topic for some time; 'Co-locating domestic violence services and social work seems to offer a means of meeting ...the challenge of how to build domestic violence expertise into the day-to-day work of children's social services and specifically child protection.' (Blacklock & Phillips, 2015, p.203). But a truly collaborative service has yet to be developed:

> *Funding sources will dictate what the service looks like – it will look very differently if funded by police or by children's services... An integrated domestic abuse service, with a focus on the whole family, without being limited to referrals from children's services? I've not yet come across a true multi-agency response, where everyone has equal say and equal responsibility*

It seems that the success of such a service could rely on a model being co-created by commissioners, together with staff in services who know what the challenges are around truly collaborating. For while the idea of co-location was welcomed, it was not seen as a panacea: *"just because you're co-located, doesn't mean you're joined up."*

Among the discussions around a hub three other topics emerged:

1) The opportunities that a hub could provide for finding new ways to work with the complex families and couples that are discussed in section 4.6
2) The possibilities for joined up assessment processes. Both Drive and CLEAR had experienced challenges with their assessment process and the tools they use:
   a) CLEAR feel a need to review their assessment.

*We've gone with the Dash because it's used quite widely. It has a lot of weaknesses as a tool. We've had lots of discussions around that as well. It's a recognized tool... and together with the other things... I wouldn't use it alone but with all the other information we have....*

*The perpetrator version of the DASH is used to assess clients. DASH is the main tool at the moment, but they got to spend some time reviewing that. DASH isn't a fantastic fit for the lower risk men we're working with. It can be quite off-putting as an early intervention to introduce that early on in the program because it goes through things that might not be relevant. So, we're looking at other things like impact on kids to try and find something that's actually more relevant for the men that we were working with. DASH isn't that helpful for us or for them. The questions on the DASH could give the men the wrong idea about their problems; they could come away feeling "well actually I'm okay"; it can be counterproductive in some cases*

b) Drive have already been reviewing their assessment procedures. At the end of the RCT, new decision-making and assessment processes needed to be put in place.

Three tools seem to be in use:

*"A perpetrator version of DASH for risk assessment"* (though DASH has some serious short comings in terms of measuring risk).

For the decision-making at MARAC about which clients get taken on B-Safer (Kropp, et al., 2005) is being explored:

*Around the eligibility of potential Drive clients, we've got guidance but a lot of it is subjective. Are they in a relationship? Has a relationship just ended? We're looking at all those risk factors. In Cwm Taf we're trialling 'B-Safer', so if out of a MARAC of 30, eight can come to us, but we can only take four, then we'll use 'B-Safer' as a screening method. Then we can say we'll take these four opposed to that four and these are the reasons why. It's professional*

*judgement but it's structured professional judgement. I really like it, so I want to see that moving forward in Cardiff as well. What they ask is "why are you taking those instead of all the rest of these" and kind of smoking gun backwards, if one of those kills someone how can you argue.... Every single person coming through MARAC can potentially make it as a case for somebody to come to Drive. The hardest part of this job is sometimes having to decide not to take people on. But with 'B-Safer' our decision making around that is much more credible.*

And for a more in-depth assessment of high-harm clients SARA-V3 is being used:

*It's important we have defensible decision making. We're also trying the SARA-3. And people are taking us seriously, because it's a real risk assessment, people are taking us seriously when we are sharing that with our partners. So, the SARA-3 is only done on the riskiest clients.*

3) Exploring new opportunities for the transition from one DVA perpetrator service to another. This is especially interesting for Drive, looking for a way for some of their clients to move 'down' to a medium-risk service. What would that support need to look like through that transition?
4) It should be noted that although Drive team members were among those enthusiastic for the more joined up working that a DV hub could bring, being co-located with the police was a first priority.

## 5.6 The referral process for high-harm perpetrators

Currently in Cardiff all referrals of high-harm perpetrators to Drive come through MARAC, because a victim has been identified as being at serious risk. This model had been questioned because, with a focus on victims, there could be limits to the discussion space given to perpetrators. Also, case reviews for perpetrators are not built in, and MARACs may miss potentially important cases because of the referral process, which starts with a high-risk victim. Wider complexities in the family situation, for example (children with) disabilities may not come to the attention of a MARAC because the risk to the partner does not meet the threshold. Also, serial perpetrators whose multiple victims do not meet the threshold will be missed.

In some areas of the country Domestic Abuse Perpetrator Panels (DAPPs) have been established to create extra space to discuss perpetrators. This was proposed for the neighbouring Cwm Taf area but was rejected as being too resource intensive. We spoke to the MARAC / DAPP chair and others involved with the DAPP in Croydon, where there is also a Drive programme. There is a busy well-functioning MARAC and the DAPP seems to be a welcome addition to create space to discuss perpetrators, also for case reviews. We were told that a pre-requite for a good DAPP was a highly functioning MARAC. This pre-requisite does not seem to be being met in Cwm Taf. The fortnightly MARAC in Cardiff also benefits from being supported by DVA daily discussions - attended by representatives from Police, NPS, an IDVA, Children's social services and the MARAC coordinator. Cases can often be dealt with sufficiently there without having to go to the full MARAC.

Another model is being used in Sandwell in the Midlands, where the DAPP and local MAPPA have been combined. This structure would not work in Croydon, where the MAPPA is dominated by gang crime and would not have the capacity. A big advantage is that *“this led to some interesting system change work…has led to innovation… networks are strong…even if we’re not sitting on the same step we can talk and listen to each other”*

A huge adjustment for the team would be around who makes the decisions around taking a client on. Drive in Cardiff are working to structure this decision-making

more strongly using the B-Safer tool, but still tend to 'own' the decision-making. At DAPPs decisions tend to be shared by the whole panel.

The situation in Worcester, where there is also a Drive programme, seems to be similar to Croydon, in terms of a good functioning DAPP. The DAPP is Worcester is currently being evaluated by researchers from Worcester University.

The DAPP model still uses the MARAC referral route, which potentially misses some perpetrators. Because of this there was some enthusiasm locally for the MATAC model. With the MATAC model a Recency, Frequency & Gravity Model (RFG) analysis tool, based on a risk model established in Scotland, to reduce crime and anti-social behaviour is used (Davies & Biddle, 2018). Repeat DVA perpetrators are identified using a scoring mechanism that identifies the recency, frequency and gravity of offending, "using a range of specific and weighted criteria (e.g., previous offences, number of victims, interpersonal relationships, health issues and substance misuse) the RFG scores each perpetrator from 0-100 (100 being the most harmful). The top-four highest scoring perpetrators identified are selected for discussion at each MATAC area meeting…. All partner agencies are also able to refer perpetrators for consideration/into the RFG analysis tool" (p.14). MATACs have had disadvantages in not integrating behaviour change support sufficiently, but this is changing (see section 5.4). There is a risk that being led by services' evaluations of perpetrators that they are less victim-led. The model is currently being reviewed by Northumbria University. "Whilst we recommend the wider use of the MATAC approach, the many dynamics of community relationships will always be determined by the local context" (Davies & Biddle, 2018, p.30)

In South Wales the idea of bringing MARACs, DRIVE, WISDOM, MAPPA & MOSOVO together in a Co-ordinated (High-risk) Offender Management Hub linked to a Multi-Agency Centre / One Stop Shop (with Housing / Social Services involvement etc.) is being discussed. This is in line with proposed changes to legislation that would require MAPPAs to monitor *serial* and serious harm domestic abuse and stalking perpetrators (*Domestic Abuse Bill - Hansard*, 2020). Discussions are still at an early stage and are being, led by the police. This second aspect of this model has similarities to the DVA hub discussed above – but for high-harm perpetrators: *"a sort of MASH for perpetrators"*. The panel itself has the obvious

advantage of highlighting offenders who are both a significant risk in their community and in their personal relationships

An implementation group will be set up for this with reps from Probation, Prison etc. Any structure is going to need widespread buy-in. And, especially where there is innovation, good (University-led) evaluation processes.

Whatever structure is chosen:

- A strongly functioning MARAC is needed
- On all panels, representatives are needed who are able commit resources, at least to some extent.
- It needs to avoid situations where panel members are excessively coming and going, *"just being there for cases they are interested in"*
- It needs be ensured that DVA is not side-lined by other crime e.g., knife crime.
- Mechanism should be there for engaging with serial perpetrators, who may be particularly high risk (Monckton-Smith, 2012)
- There are advantages of a shared awareness of multiple types of offending
- Having structures like daily MARACs can be useful for filtering and focussing on the most appropriate cases
- Mechanisms should be built in for case reviews, in order, for example, ensure there is ongoing support post-Drive involvement, where needed.

This section is based on interviews with Drive in Cardiff, Croydon, Sandwell & Worcester, a MATAC representative in Northumbria and others involved in multi-agency conferencing in those areas (e.g., police, probation, and victim services)

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# 6 Conclusions and discussion

There are currently preventative, early intervention and high-harm DVA perpetrator services operating in Cardiff. IRIS+ is an innovative approach to engaging GPs in the identification of DVA perpetrators and victims. Its success in the identification of victims is already evidenced (Sohal et al., 2020), and with perpetrators it shows promise as an intervention model.

CLEAR, an early intervention model, also shows promise. CLEAR aims to flexibly meet changing needs while using an intervention that is primarily focused on awareness raising. Both IRIS+ and CLEAR are being evaluated (by the University of Bristol and London Metropolitan University, respectively). 'Trusted Professional' is another local service aiming to increase the identification of victims and perpetrators. It is itself at an early stage of rollout and will be evaluated by the same London Metropolitan programme as CLEAR. Both IRIS+ and CLEAR show promise. They could remain a valuable part of a range of interventions to identify and work with DVA perpetrators in Cardiff. They have both been built around evidence of what we know to be effective and are beginning to show results. At the early intervention end of services there also seems to be clear evidence for commissioning a court diversion programme. These relatively low-cost interventions can reduce domestic violence offending, and the impact of domestic violence on police forces.

At the high-harm end, Drive has shown itself to be a valued and effective service. It is making a real difference, evidenced by a recent strong evaluation (Hester et al., 2019). It is highly appreciated by the services it works in partnership with.

There are currently no DVA perpetrator services in The Vale of Glamorgan, though Cardiff Drive is set to expand into the area. There are also no medium-risk (DVPP) services in the region. We recommend that a DVPP programme is commissioned based on good practice. There are indications that badly designed DVPPs, with poorly trained staff may be ineffective, or do more harm than good. It is worth investing in a strong intervention. Combining group work with one-to-one work would increase the inclusivity of this service.

Possibilities were explored for the development of a domestic violence hub working with victims and perpetrators. Models like this, initiated by social services are

appearing. The Swansea DVA hub appears to be a strong and developing example. Their weakness so far lies in excluding couples without children. A broader model would need broad support for its development and ambitious collaboration, also at commissioning level. This could integrate preventative, early intervention and medium-risk services in the region, with input from high harm services (Drive). Social care needs to be at the heart of this, but we recommend a collaborative approach and the possibility of reaching people who would not come into contact with social services. A hub like this may create possibilities for stronger innovation and deeper collaboration, for example between victim and perpetrator services. It may for example create opportunities for exploring family system approaches; when working with complex family dynamics, where risk and safety allow.

Similar ideas for a hub are being explored for high-risk offenders. If both hubs develop, then we can envisage Drive having a foot in both. It is vital for Drive to maintain its strong links with police, but also vital to build them with other DVA perpetrator services. Linked to this hub, an integrated referral and monitoring structure is being explored, combining MARAC and Drive, WISDOM and MAPPA, and MOSOVO together. Any structure relies on several factors. Some of which we have set out. They include a strongly functioning MARAC, strong commitments from partners, and a broad reach, to include, for example, working with serial perpetrators.

The VAWDASV Perpetrator Standards have created a good baseline for perpetrator services in Wales, highlighting for commissioners and others, the characteristics of strong services and the need for these services to be accredited by Respect or CSAAP. We also recommend that these continue to develop, with clearer expectations of staff training and skills. There may be aspects of the accreditation processes for behaviour change staff in probation services that could be implemented or adapted for community services, with a requirement that staff are accredited. Clearer guidance around information sharing needs to be established, especially with (mental) health services, recognising the complexity of this for these services. And strong multi-disciplinary links to Universities are also to be encouraged. They help ensure successful innovation and learning.

Finally, services are currently non-existent in the Vale of Glamorgan. Cardiff and The Vale of Glamorgan are now one Police Basic Crime Unit, as well as one health board area. Also, council commissioning should, as much as possible, be a collaborative effort. Solutions need to be found that work across the whole area.

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# 8 Appendices

## 8.1 VAWDASV Perpetrator Service Standards

The tables below are based on the perpetrator service checklists, which have been designed to be used in conjunction with the Welsh Government Perpetrator Service Standards, as an aid to compliance assessment of any VAWDASV perpetrator service (early intervention, DVPP, or high-harm) by commissioners, service providers and service users. A shorter commissioning checklist is used if a service has not yet been accredited. We have used this checklist for CLEAR. Drive also has not yet been accredited but was at the time this review was written in an advanced stage of progress towards that accreditation. We therefore decided to do a full checklist.

Each item is RAG rated – Red (does not meet criteria), Amber (partially meets criteria), Green (meets criteria completely). Any Red items will indicate that the service has not met the standards and will need to address area and be reassessed. Any Amber areas should be reviewed within an agreed timeframe that gives the service opportunity to improve the item and move to Green status.

### CLEAR

| Question | Answer | Status |
|---|---|---|
| What is the need this service will meet? | Developed around gaps in existing service provision, to provide an early intervention service. Interviews and documentation. | Green |
| What is the evidence base? | CLEAR is part of the wider Change that Last programme that develops and pilots programmes based on consultations with local people and the needs that they express, rather than a focus on risk reduction. Interviews and documentation. | Green |

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|---|---|---|
| Who does the service target? | Men with early emerging concerns around their behaviour towards women, without entrenched behaviours or a record of violence. Interviews and documentation. | Green |
| What is the gap in service for this target cohort? | There are no services currently targeting men requiring an early intervention. Interviews and documentation. | Green |
| Is there another service offering this locally? | There are no other early intervention programmes in Cardiff and the Vale. Interviews and documentation, | Green |
| What are the outcomes for service users? Are they clearly defined? How will they be measured? | The aim is to prevent problematic attitudes and behaviours in relationships developing to the point where harm increases, and possibly statutory involvement would be necessary. Following up on this with police not yet possible, but practitioner's follow-up with the men themselves 6 weeks later, as well as their partners' support workers. For those whose behaviours are more entrenched, referral on to a more appropriate service would be the aim. This is currently not available for medium-risk, though one case passed on to Drive. Interviews and documentation, | Green |

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| What are the outcomes for the service itself? Are they clearly defined? How will they be measured? | The intention is to produce an evidence base, and a commissionable package, for the pilot intervention. Interviews and documentation. | Green |
| Is the approach trauma informed? How is this approach applied? | Yes. Staff are appropriately trained and aware of the impact of trauma. Interviews and questionnaire. | Green |
| How does the service demonstrate value for money? | This will only be clear once the evaluation by London Metropolitan University is completed | Amber |
| How will you audit/review this service? | In addition to internal evaluations, there is an external evaluation being conducted by London Metropolitan University | Green |
| How will the service achieve evaluation? Is the evaluation independent? | The service is being evaluated independently by London Metropolitan University. Documentation. | Green |

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| How is this service funded? When does the funding end? What is the sustainability plan? | The service is funded through a Home Office grant to Respect and WWA. The funding ends in October 2020, and the intention is to produce an easily commissionable package by the end of the pilot. Options for adaptation to a Court Diversion intervention are also being explored (PCC funding). Interviews and documentation, | Green |
| What is the model of change? How will the service demonstrate integrity to the model? | Focus is awareness raising, not a behaviour change programme., though there is staff experience of behaviour change work. CLEAR consists of seven sessions, which offer a combination of: an awareness-raising programme (violence and gender stereotypes); strength-based and solution-focused support to work on life goals. This is supported by a needs assessment and signposting. Interviews and documentation, | Green |

## Drive

| No | Standard | Findings & evidence | Status |
|---|---|---|---|
| 1.i, 1.ii, 1.iv, 1.v | What is the referral pathway? | A case must have progressed to MARAC in order to be considered for DRIVE. The programme has a single IDVA who is assigned to work with all victims. Interviews, including with IDVA | Green |
| 1.iii | Can you self-refer? How do you? | No, a self-referral pathway is not possible for high-harm or serial perpetrators. | Green |
| 2 | What are the eligibility criteria? | Now that the RCT is complete, selections are made by an *"intensive process"* exclusively from candidates brought to MARAC. Suitability and readiness for behaviour change are evaluated by gathering as data across agencies and workers. Because of disruptive interventions, DRIVE usually stay away from mutual partner violence. Decision-making processes around this are discussed in the review. Interviews & correspondence | Green |

| 3 | How is consent sought? | Drive's disruption work can take place without the consent or even the knowledge of the service user. Initial contact with the service user will only be made if and when it is judged not to increase risk. A consent process is then followed *"with some case-by-case discretion",* but the client is explicitly informed "*that we are working to protect vulnerable adults and children"*. Detail is not always supplied on Drive's activity, and referrals will sometimes be made without telling the client, in order to manage risk. Consent is sought unless this conflicts with safeguarding. Interviews | Green |
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|---|---|---|---|
| 4.i | What is the assessment tool being used? | The 'Drive-DASH' is the basic risk assessment tool, adapted from DASH and measures the "risk of significant harm from further DVA posed to the victim-survivor". DASH is widely used (e.g., by all police forces), which facilitates information-sharing. SARA-V3 is being trialled for the highest risk cases and B-Safer to support some decision-making, for example at MARAC – see review for more details. Input from an expert advisor and forensic psychologists is also available. A needs assessment is also completed. Interviews and recent service evaluation. | Green |
| 4.i | What research is behind this tool? | DASH has weaknesses in terms of confidently measuring risk, SARA-V3 & B-Safer have stronger research evidence. Drive team are aware of strengths and limitations of the tools. Interviews | Green |
| 4.ii, 4.iii | What training is available and implemented for assessors to use the tool? | All case managers are given specific training on the use of the DASH. As other tools are introduced training is included. Assessors have received all training required by the standards. Interviews | Green |

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| 4.iii.a | How does it cover motivational interviewing/engagement? | One hour of MI training was built into the original Drive training, staff report they could do with skills practice and a refresher. Testing with VASE-R indicated a need for more training. Interviews | Amber |
| 4.iv | How does the assessment consider risk? | The Drive-DASH is used, which *"helps to assess and create risk profiles... prompting the case manager to think about risk factors"*. DASH is an SPJ tool, supporting decision-making but not providing any reliable quantitative assessment of risk. Interviews and recent service evaluation. | Green |
| 4.iv | How does the assessment consider need? | A questionnaire is used to support the identification of need. Assessed needs are identified and can act as routes into working directly with perpetrator. Interview and recent service evaluation. | Green |

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| 4.iv | How does the assessment consider responsivity? | The balance of supportive and disruptive interventions is determined by readiness for behaviour change. Behaviour change interventions are adapted to the needs of clients. Case formulations can be adapted with input from forensic psychologists. Interviews with case reviews | Green |
| 4.v.a | How does the assessment reference official records? | The assessor gathers data from as many sources as possible (including police, probation). There are strong information-sharing agreements with these agencies. Interviews – including with police & probation. | Green |
| 4.v.b | How does it reference victim, survivor, and partner reports? | The dedicated IDVA is consulted on levels of abuse, impact of interventions and other changes on an ongoing basis. | Green |
| 4.v.c | How does it reference perpetrator interviews? | Case notes and case reviews feed into ongoing assessments. Interviews, including case reviews | Green |

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| 4.vi | How does the assessment inform an individualised service plan? | The Drive team have a lot of flexibility in the ways in which they can work with a service user. Assessment is used to decide between disruptive and supportive interventions. There are possibilities for external support with this from a supervisor, an external expert advisor, and forensic psychologists. Interviews | Green |
| 5.i, 5.iii | How are links to partner services made? | There is a 'Drive IDVA' at RISE Cardiff assigned to work with all victims of perpetrators whose cases are assigned to Drive. They are able to commence work with victims prior to Drive working with the perpetrator. Interviews (also with IDVAs) | Green |
| 5.ii | How can partner services access information about the intervention? | The Drive website describes the intervention in detail. Drive regularly gives presentations at partner organisations. High turnover of staff at some organisations, including RISE limits the effectiveness. Knowledge of some aspects of Drive's intervention was sometimes poor. Interviews. | Amber |
| 6.i | How are the groups staffed? | N/A | |

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| 6.ii | What is the evidence base/ model of change? | Drive makes use of the trans-theoretical model. High-Harm Toolkit of work to move perpetrators from pre-contemplation to contemplation. One-on-one work then has a focus on targeted behaviour change. Interviews. | Green |
| 7.i, 7.ii | When does re-assessment take place and does it include views of relevant authorities? | Assessment is performed at intake, regularly during engagement, and at case closure. Information from external agencies is included in this, especially from the IDVA for changes to levels of risk Interview and recent service evaluation. | Green |
| 8.i | What is the de-selection process? | The process involves other professionals and agencies and is the service manager's final decision. The process is exhaustive, and cases will not be closed while risk is still high without sufficient agreed case management by other agencies. Interviews | Green |
| 8.i.b | How does it consider minimum attendance? | N/A | |

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| 8.i.c, 8.ii | How does it consider engagement? Re-engagement? | Multi-agency working allows for information sharing on engagement. Numerous attempts to re-engage, de-selection only considered if there are no major opportunities for change. Interview and recent service evaluation. | Green |
| 8.i.d | How does it consider behaviour? | De-selection only considered if there are no major opportunities for change. Interview and recent service evaluation. | Green |
| 8.i.a | How does it consider re-offending? | Information about re-offending is immediately communicated to DRIVE by either the IDVA, or daily police bulletins. Interviews | Green |
| 8.iii, 8.iv | How does it consider risk management? | The Police, MARAC chair and partner agencies are all informed when de-selection occurs. Risk is assessed. Interviews | Green |
| 9 | What is the process for drop-outs? | See above information for de-selection. Dis-engagement does not mean termination of disrupt activities, Interviews. | Green |
| 10 | What is the process for progress assessment? | Regular re-assessment process, including expert advisor / forensic psychologists, if needed. | Green |

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| 11.i, 11.ii, 11.iii | What is the process for service evaluation? How often does this take place? | DRIVE was evaluated with a randomized controlled trial covering its first 3 years of operation. In 2019, there was a VAWDASV deep dive review of service users' journeys. Interview and recent service evaluation. | Green |
| 11.iv | Who is evaluating? Are they independent? Why were they chosen? | The University of Bristol evaluated the pilot. Recent service evaluation, | Green |
| 11.v | How does the service review and respond to an evaluation? | There are structures for ongoing learning with the central Drive team. Some processes have been adapted e.g., around assessment. Interviews | Green |
| 12.i, 12.ii | What criteria are applied to recruitment? (competencies, values, experience) | TO ADD | |
| 12.iii, 12.iv | How are DBS and vetting check applied? | There are strong procedures for this within Safer Merthyr Tydfil (SMT). Documentation | Green |

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| 13.i, 13.ii, 13.iii | What type of staff training and CPD are provided? | A training structure has been created for new staff by Drive Central. Ongoing training is responsive to expressed needs. Though this failed to identify needs for more MI training. Interviews, questionnaire & assessment of MI skills | Amber |
| 13.iii | How is training funded? | Funding from multiple sources including Drive Central. Interviews | Green |
| 14 | How do staff access clinical supervision? | Regular clinical supervision also supplemented by support from mental health expert advisor and case reviews with forensic psychologist so supervision can focus on issues raised by work. Interviews | Green |
| 15 | How do staff access separate confidential support? | EAP exists for Safer Merthyr Tydfil staff, but many were not aware of its existence. One member of staff reported using this support. Questionnaire & interviews. | Amber |
| 16 | What is the health & safety policy? | SMT Official Policy received and reviewed. | Green |
| 17 | What is the equality & diversity policy? | SMT Official Policy received and reviewed. | Green |

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| 18 | What is the complaints process? | SMT Official Policy received and reviewed. | Green |
| 19 | How does the environment suit workers and service users? | Staff very positive about environment within MOSOVO team. Service users are met at different locations, flexibly meeting risk management and service user needs. Interviews and visits to site | Green |
| 20 | What is the process for record keeping? | An adaptation of IIZUKA Case Manager was commissioned by SafeLives for Drive service providers to record, process, and share detailed case level information to support their work. Case Manager is ISO 27001 and Cyber Essentials plus accredited. Interviews and documentation. | Green |
| 21 | What is the protocol for information sharing? | There is a Welsh Information Sharing Protocol for MARACs that Drive (and all MARAC agencies) use (SafeLives, 2019) | Green |
| 22 | How are links formed with Children's Services? | Children's Services are present at MARAC, so are aware of all DRIVE service users. Regular discussions of individual cases. Interviews, also with social workers | Green |

**Note:** There were indications that previous victims of Drive perpetrators were not always traced. Drive Cardiff has recently improved its protocols around this.

## 8.2 Glossary

| Term / Abbreviation | Definition |
|---|---|
| BBR | Building Better Relationships. Only accredited programme for DVA offenders in Welsh criminal justice system. |
| B-SAFER | SPJ tool for assessing and managing risk for intimate partner violence. It is a simplified, brief version of the SARA-V3. |
| CAFCASS | Children and Family Court Advisory and Support Service. Looks after the interests of children involved in family proceedings. It is independent of the courts and social services. |
| CBT | Cognitive Behavioural Therapy. A short-term, goal-oriented therapy. Central principle is how thoughts, feelings and behaviour are linked. |
| CLEAR | Change that Lasts Early Awareness Raising. A DVA perpetrator early intervention programme that is part of the Change that Lasts (CtL) programme in Cardiff. |
| CRC | Police officers who attend incidents complete a Public Protection Notification document (PPN). This notice, which summarises the vulnerabilities of victims, goes to the PPU. |
| Criminogenic needs | Criminogenic needs are characteristics of an offender that directly relate to their likelihood to re-offend. |
| CSAAP | Correctional Services Accreditation and Advice Panel is non-statutory advisory body for the Ministry of Justice. Its main work is to accredit programmes for offenders and provide advice on audit and research issues brought to it. |
| CtL | Change that Lasts was developed by Women's Aid (England) and Welsh Women's Aid, with a focus on finding the earliest possible opportunities to intervene in VAWG. |
| Daphne III | An EU funding programme that aimed to contribute to the protection of children, young people, and women against all forms of violence. Often used to refer to a meta-analysis of DVA perpetrator programme studies funded by Daphne III and published as Lilley-Walker et al.'s (2018). |
| DAPP | Domestic Abuse Perpetrator Panels. Panels connected to MARACs to discuss associated perpetrators and plan interventions. |
| DASH | Domestic Abuse, Stalking and Honour Based Violence. A SPJ risk identification tool for DVA victims, used across all police services in the UK since 2009. There are adaptations for perpetrators. |
| Desistance theory | Approach focusing on which interventions show evidence of reducing offending behaviour. |
| Drive | An intensive intervention that works with high-harm and serial DVA perpetrators (see section 4.4). |

| Term / Abbreviation | Definition |
|---|---|
| Duluth | A model of working with DVA perpetrators that developed in Duluth, Minnesota in the 1980s. Grounded in feminist theory and an understanding of men abusing their female partners as intentional behaviour, driven by a need for power and control. The model has continued to develop, and has become broader, while remaining informed by gender. |
| DVA | Domestic violence and abuse. |
| DVPP | Domestic Violence Perpetrator Programme. Used here for community behaviour change programmes for DVA perpetrators that combine multi-agency risk management, behaviour change interventions that are often delivered in a group, and victim support. DAPP (Domestic Abuse Perpetrator Programme) is avoided as this is used in this report for Domestic Abuse Perpetrator Panels. |
| Emotion regulation | The ability to exert control over one's own emotional state |
| Emotion therapy | Emotion-focused therapy. Sees emotions as key to identity and central to individual choice and decision making. |
| Family system therapy | Sees the family as an emotional and behavioural unit. |
| GAM | General Aggression Model. A model that considers the role of social, cognitive, personality, developmental, and biological factors in understanding aggression. |
| GBV | Gender Based Violence. |
| Good Lives Model | A strengths-based approach to offender rehabilitation. Critical of RNRs ability to motivate and engage offenders in the rehabilitative process. |
| HMP / HMPPS | Her Majesty's Prisons / Her Majesty's Prison & Probation Service. |
| IDAP | Integrated Domestic Abuse Programme. Now replaced by BBR. |
| IDVA | Independent Domestic Violence Advisor. Specialised role that works to address the safety of victims at high risk of harm from intimate partners, ex-partners, or family members. |
| IOM | Integrated Offender Management. Programmes that target and prioritise the most dangerous or prolific offenders to disrupt their offending. Usually involves police, NPS, CRCs, Prison services, YOS, local authorities etc. |
| IPV | Intimate Partner Violence. |
| IRIS / IRIS+ | Identification and Referral to Improve Safety / Enhanced IRIS improves referrals of victims to DVA services from primary care / Enhanced also aims to improve referrals of perpetrators. |

| Term / Abbreviation | Definition |
|---|---|
| MAPPA | Multi-agency Public Protection Arrangements. Process by which IOM agencies work together to protect the public by managing the risks posed by violent and sexual offenders living in the community. |
| MARAC | Multi Agency Risk Assessment Conference. A victim focused information sharing, and risk management meeting attended by all key agencies. |
| MATAC | Multi-Agency Tasking and Coordination protocol. Regular meetings. led by police with key partners to target and disrupt serial perpetrators and/or support them to address their behaviour (in some areas of England and Scotland). |
| ME | Motivational Enhancement. A brief adaptation of MI, especially when used at the beginning of treatment. |
| MI | Motivational Interviewing. A counselling approach that combines client-centeredness with a directive, focused and goal-orientated style that aims to encourage change. |
| MOSOVO | Management of Sexual Offenders and Violent Offenders. A police team specialised in working with these offences. |
| Narrative therapy | Seeks to help patients identify their values and the therapist seeks to help the patient co-author a new narrative about themselves by investigating the history of those values. |
| Nested Ecological Model | A model of development that highlights circles of influence on an individual from individual level to cultural levels. |
| NICE | National Institute for Health and Care Excellence. Part of the Department of Health in England, which publishes health practice guidelines. |
| NPS | National Probation Service. Supervises offenders released into the community. |
| OOCD | Out of Court Disposal. A quick way for police to deal with 'low-level', often first-time, offending where there is an admittance of guilt, which could be resolved more appropriately without a prosecution in court. |
| PPU | Each police force has a Public Protection Unit (PPU). to assess risk. A marker is created relating to the individual victim on the online intelligence system to indicate the level of risk to that victim. |
| Primary prevention | Primary prevention aims to prevent a health problem before it occurs. |
| Psychodynamic therapy | A type of therapy that focuses on unconscious processes. |
| Psychoeducational | An intervention that provides information and support to better understand and cope with (mental) illness. |
| RCT | Randomised Control Trial. A study in which people are allocated at random to receive one of several clinical interventions. One of these interventions is the standard of comparison or control. |

| Term / Abbreviation | Definition |
|---|---|
| Respect | Respect is a third sector organisation that provides accreditation for two types of services: work with perpetrators and work with male victims. Respect is also a service provider. |
| Restorative justice | Restorative justice brings those harmed by crime and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. |
| RNR | Risk Need Responsivity. An offender rehabilitation model based on three principles: 1) risk can be predicted and interventions should be proportionate to risk level; 2) criminogenic needs are key in the design and delivery of treatment; and 3) responsivity principle - interventions should be tailored to each offender. |
| SARA-V3 | Spousal Assault Risk Assessment (Version 3). Used to help determine the degree to which an individual poses a DVA threat to his/her partner. |
| Secondary prevention | Secondary prevention aims to detect a health problem early and prevent it from getting worse. |
| SNA | Social Norming Approach. Focuses on strengths and building on individual's own norms, rather than pathologizing behaviour, as part of a motivational interviewing strategy. |
| Social learning | Social learning theory proposes that new behaviour can be learnt by observing and imitating others. |
| Solution Focused Therapy | Focusses on solution-building rather than problem-solving. |
| SPJ | Structured Professional Judgement. SPJ instruments like the DASH are proposed as guides to risk formulation, and therefore not a risk prediction tool per se. |
| SV | Sexual Violence. |
| Tertiary prevention | Tertiary prevention aims to reduce the impact of an existing health problem (we have included all behaviour change interventions, including early intervention at this level). |
| VASE-R | Video Assessment of Simulated Encounters – Revised. A video-based method for assessing respondent skill in MI. |
| VAWDASV | Violence Against Women, Domestic Abuse and Sexual Violence. An Act of the National Assembly for Wales to improve arrangements for the prevention of gender-based violence, domestic abuse, and sexual violence. |
| VAWG | Violence Against Women and Girls. |
| WISDOM | Wales Integrated Serious and Dangerous Offender Management. Welsh IOM programme, intended to compliment MAPPA by supporting the day-to-day management of offenders. |
| YOS | Youth Offending Services. Works with young people aged 10–18 years old that have got into trouble with the police or are in danger of getting into trouble. |