



Working with people who perpetrate domestic violence and abuse in families

Strategic briefing

About this briefing

This briefing discusses work with people who perpetrate domestic violence and / or abuse (DVA), with a specific emphasis on people who perpetrate DVA in families, involved with children’s social care. When delivered competently and confidently, and in a manner that is victim-survivor focused, perpetrator interventions can contribute to perpetrator behaviour and attitudinal change, increase perpetrator accountability, and reduce the harm posed to adult and child victim-survivors. Work with, and responses to, people who perpetrate DVA spans at least the last three decades and has grown in prominence in recent years. Within the limitations of this short briefing, the aim is to foreground insights from practice, research and lived experience that may be applied to, or inform thinking, in children’s social care work with people who perpetrate DVA.

The briefing does not endorse a particular model of perpetrator intervention, but it does suggest some key principles and messages that could apply to social work with perpetrators of DVA, based on the evidence and established good practice sector guidance. Among these are some messages which are hard to hear, but will be of little surprise to colleagues working in this field. Challenging messages regarding how professional interventions can make victim-survivors feel, for example, are consistently reflected in the available evidence from people with lived experience, practice and academic literature. But it is important not to apportion any individual blame, and instead recognise that these messages reflect the extent of the significant challenges facing the children’s social care sector and the need for wider systems and culture change, as regards to this highly complex area of practice. This strategic briefing seeks to explore some ways in which positive change might be achieved, so that policy, practice and strategy planning might be developed in order to improve outcomes for adult and child victim-survivors, as well as to expand the evidence base.

This briefing is aimed at strategic leaders and managers in children’s social care, and includes sections on:

- > The background and context of work with perpetrators of DVA 5
- > Different settings for, and types of, perpetrator programmes and interventions 8
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Sources used for this briefing

- > Data analysis from focus groups held with mothers with experience of DVA and children’s social care.
- > Data analysis from focus groups held with practitioners and leaders, working in the fields of DVA and children’s social care.
- > Learning from research on work with perpetrators of DVA based on a rapid literature review of the current evidence base (2008¹ – 2021), including practice models and approaches.
- > Practice insights shared during a Research in Practice national **Change Project on domestic abuse and child protection**.

1 Exceptions to this date cut-off have been made in a limited number of cases in order to include key foundational texts which continue to be relevant, or where they represent historical milestones in the evolution of, or foundations for, the current evidence base.

Summary of key messages

- > Evidence from research, practice and lived experience, together strongly underscore the need to reform current children's social care practices so that the responsibility and onus for protecting children and reducing risk is situated with the perpetrator of DVA.
- > Mothers often fear children's social care intervention, and the threat of child removal. These themes are reinforced from multiple sources and perspectives: children's social care is too often not experienced as a protective or supportive system by some mothers, but instead as one that is threatening and punitive.
- > Responses to people who perpetrate DVA in families have key implications for policy and practice within the domains of child protection. Greater efforts are required to hold perpetrators of DVA to account for their behaviour, as well as improving practitioners' safety, learning and development.
- > Social workers are uniquely placed to hold perpetrators of DVA to account, but this complex work requires appropriate learning and development opportunities which are nuanced, specialised and victim-survivor focused.
- > To operate confidently and ethically in this evolving field, practitioners require ongoing support, safe spaces and professional relationships within which to process the emotional impact of the work.
- > The task of refocusing practice attention onto perpetrators of DVA, and of partnering with victim-survivors by social care practitioners, requires substantial organisational and culture change which requires senior management support, advocacy and organisational infrastructure.
- > Work with perpetrators of DVA relies on multi-sectoral engagement and collaboration, particularly when working with whole families. This entails robust cross-agency working across adults' and children's social care, health, housing and criminal justice sectors, with perpetrator interventions undertaken in tandem with support for adult and child victim-survivors.
- > Evidence points to a lack of consensus regarding 'what works' when working with perpetrators of DVA, as well as a lack of diversity in programme and perpetrator services. This can present a substantive challenge for children's social care when working with families where there is a perpetrator of DVA.
- > There are a number of available programmes and approaches with several indicating positive outcomes for adult and child victim-survivors, as well as behaviour change among different cohorts of perpetrators of abuse, including serial and high-harm perpetrators of DVA.
- > There remains a shared responsibility involving services, commissioners, funders, policy-makers and the academic community to expand the evidence base on work with perpetrators of DVA.

Introduction

Domestic violence and abuse (DVA) is a global public health concern, a social justice issue and a human rights violation with significant implications for (physical and mental) health, wellbeing and social and economic participation (WHO, 2019). Statistics from the Office for National Statistics (ONS) indicate that 1.6 million women (aged 16 to 74), and 757 000 men (aged 16 to 74) reported experiencing some form of DVA in the 12 months to March 2020 in England and Wales (ONS, 2020) while the Children's Commissioner in England reported that 830, 000 children experienced DVA in their own homes (Children's Commissioner, 2020). An interim report from Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services describes how women and girls are being subjected to an 'epidemic' of violence that requires a 'radical and bold' shift in how crimes such as domestic abuse are addressed (HMICFRS, 2021).

Until relatively recently, greater emphasis has been understandably placed on victim-survivor intervention with less attention on addressing those that harm, certainly at a national level. This has diminished the accountability attributed to perpetrators of DVA and contributed to a tendency to victim-blame, which has become particularly pronounced in children's social care and private law family court settings (Coy et al., 2015; Ministry of Justice, 2020; Neale, 2018; SafeLives & Domestic Abuse Commissioner, 2021). Research documenting the benefits and importance of directly engaging people who perpetrate DVA in order to change their behaviour, as well as to prevent DVA, first emerged at least three decades ago (see for example, Dobash & Dobash, 2000; Gamache et al., 1988; Gondolf, 1987b, 1987a, 1997; Pence et al., 1993; Shepard, 1999; Shepard et al., 2002).

This evidence base continues to grow with an increase in interest and funding for services, research and evaluation in recent years. There is, however, a lack of consensus regarding perpetrator intervention efficacy (Akoensi et al., 2013; Hamilton et al., 2013; Kuskoff et al., 2021), particularly in terms of the outcomes achieved for people – typically, but not exclusively, women and children – who experience DVA (O'Connor et al., 2020). This arises from variations in methodological and analytical approach, the interpretation of data, and a lack of agreement around what constitutes 'success' (Westmarland et al., 2010). These issues are explored at greater length in the rapid literature review which accompanies this briefing.

Focus on victim-survivor safety and risk management

Work with perpetrators of DVA has the potential to increase the risk and harm posed to adult and child victim-survivors and consequently entails substantial responsibility. It is therefore essential that interventions always centre victim-survivor needs and safety, and that risk reduction is prioritised first and foremost (Respect, 2017; SafeLives, 2020c). While differences in perpetrator intervention implementation and methodology can make it difficult to talk conclusively about what works, and what does not, there is evidence of promising practice using a range of different models and approaches when working with perpetrators of DVA, across various settings.

This evidence underpins the Respect Standard third edition (2017) for accredited perpetrator programmes delivered in the UK (included later on in this briefing). A rapid review of the literature underscores the need to grow the existing evidence base, as well as develop greater consistency in understanding across sector providers regarding what constitutes 'success' when developing and implementing responses to perpetrators of DVA.

Context and background

How DVA is defined and understood strongly informs the ways in which practice responses and interventions for perpetrators of DVA, are formulated and delivered (Kelly & Westmarland, 2016). Historically, DVA has been conceptualised within a feminist framework of analysis. The feminist focus on power and control remains a defining characteristic of DVA and continues to be key in identifying who is most at risk, or for whom the 'space for action' is more limited (Kelly & Westmarland, 2016). DVA is understood as a specifically gendered issue which turns on the enactment of power and control. But as discussed in forthcoming sections, gender and gender inequalities intersect with other structural factors such as race, class, socioeconomic status, immigration status, and (dis)ability, which in turn fundamentally shape understandings and lived experiences of DVA (Imkaan & Ascent, 2016). This includes in some cases families' ability to access or engage with services (Day & Gill, 2020).

The statistics demonstrate that DVA is experienced in the majority of cases by women, and perpetrated in most cases, by men. Women, non-binary people and men can all be victim-survivors of DVA. But violence and abuse perpetrated against men does not usually stem from the same structural factors which foster the conditions for violence against women, nor is it rooted in patriarchal systems of oppression. Research regarding women perpetrators of DVA indicates that women do not typically create a context of fear and coercive control, in contrast to men perpetrators of DVA (Hester, 2013). The amount, severity and impact of DVA experienced by women is also substantially higher than that of men, and women are more likely to experience coercive controlling behaviours (Hester, 2013; Myhill, 2015, 2017), repeat victimization and serious injury (Walby & Towers, 2017). The presenting needs of men victim-survivors are distinct to that of women and it is important to recognise this distinction and the implications it has for service provision (Respect, 2019).

Coordinated community responses to domestic violence and abuse

First originating in the USA, Pence and Paymar's (1993) Duluth coordinated community response (CCR) model is possibly the most well-known, and historically dominant model for perpetrator intervention both in the UK and North America (Bohall et al., 2016). Many perpetrator programmes, particularly earlier ones, have their foundational roots in the Duluth CCR (Lilley-Walker et al., 2018). It is a multi-agency, systemic response which mobilises a gendered analysis of domestic abuse and addresses the ways in which patriarchal privilege manifests in the perpetration of violence against women and girls (Pence & Paymar, 2011). The CCR simultaneously addresses the needs of victim-survivors (Phillips et al., 2013), in order to ensure the safety of victim-survivors during the course of the perpetrator programme (McGinn et al., 2016) as well as develop and maintain perpetrator accountability (White & Sienkiewicz, 2018).

In the UK context, the CCR approach has been pioneered by the charity Standing Together for the last two decades. The CCR 'enables a whole system approach to a whole person' and shifts responsibility for safety away from individual victim-survivors and onto communities and services (Standing Together, 2020, p.6). It encompasses a broad response to DVA by addressing prevention, early intervention, crisis, changing levels of risk, and longer-term recovery. Made up of 12 key components, it brings services including social care, housing, health, criminal justice, and communities together in order to ensure local systems keep victim-survivors safe and hold perpetrators to account, as well to prevent DVA. Standing Together guidance was reviewed in 2020 to ensure local areas were prepared to respond to the new duties and changes brought in by the *Domestic Abuse Act 2021*, including statutory duties associated with Tier 1 and 2 Boards (Standing Together, 2020).

The Domestic Abuse Act 2021

The *Domestic Abuse Act 2021*, signed into UK law on 29 April 2021, sets out a statutory, gender-neutral definition of domestic abuse, which extends beyond physical violence. The new Act makes provisions to hold perpetrators of abuse to account by strengthening legal measures including the new Domestic Abuse Protection Notice (DAPN) and the Domestic Abuse Protection Order (DAPO) for longer term protection. The DAPO imposes both prohibitions and requirements on perpetrators, including such as to engage with mental health support or attend a behaviour change programme (Home Office, 2021b). The Act also extends the offence of coercive and controlling behaviours, recognises children as victims in their own right, and places new duties on local authorities, including the establishment of a multi-agency domestic abuse local partnership board. The new legislation has introduced a statutory duty on the Secretary of State to publish a DVA perpetrator strategy, as part of the wider holistic domestic abuse strategy, due in late 2021 (Home Office, 2021a).

Key messages

- > How domestic violence and abuse is defined and understood strongly informs how it is responded to, and the methods used to intervene in the behaviours of perpetrators of abuse.
- > A review of the literature substantiates the value of retaining a range of approaches and programmes to respond to perpetrators of DVA, in order to improve outcomes for adult and child victim-survivors.
- > Safe and effective interventions for perpetrators of DVA should be provided within the context of a coordinated community response, which includes the requisite support provision for victim-survivors, as set out in the Respect Standard third edition (2017) outlined below.
- > The *Domestic Abuse Act 2021* has precipitated a commitment from the UK to publish a dedicated perpetrator strategy, as part of the wider domestic abuse strategy.

Respect Standard third edition (2017) – principles

- 1. Do no harm:** Organisations take all reasonable steps to ensure that their services do not create additional risks for survivors of domestic violence and abuse.
- 2. Gender matters:** Organisations work in a way that is gender informed, recognising the gender asymmetry that exists in the degree, frequency and impact of domestic violence and abuse. They understand that men’s violence against women and girls is an effect of the structural inequality between men and women and that its consequences are amplified by this. A gender analysis includes violence and abuse perpetrated by women against men and abuse in same-sex relationships, and these also require a gender informed response.
- 3. Safety first:** The primary aim of work with perpetrators is to increase the safety and wellbeing of survivors and their children. The provision of an Integrated Support Service for survivors alongside the intervention for perpetrators is essential. When working with perpetrators it is important to recognise the need for behaviour change, but risk reduction should always be prioritised.
- 4. Sustainable change:** Organisations offer interventions that are an appropriate match to the perpetrator, considering the risks they pose, the needs they have and their willingness and ability to engage with the service offered. This will ensure that they are offered a realistic opportunity of achieving sustainable change.
- 5. Fulfilling lives:** Organisations are committed to supporting all service users to have healthy, respectful relationships and to lead fulfilling lives.
- 6. The system counts:** Domestic violence and abuse cannot be addressed by one agency alone and work with perpetrators should never take place in isolation. Organisations are committed to working with partners to improve responses as part of their local multiagency arrangements.
- 7. Services for all:** Organisations recognise and respect the diversity of their local community and take steps to respond to everyone according to their needs.
- 8. Respectful communities:** Organisations recognise that the environment their service users live in has an impact on their lives. They will make the links between individual change and the development of respectful communities.
- 9. Competent staff:** Organisations deliver a safe, effective service by developing the skills, well-being and knowledge of their staff through training, supervision and case work support.
- 10. Measurably effective services:** Organisations employ clear and proportionate measurement tools, which demonstrate both the individual benefits and the impact of interventions.

Domestic abuse perpetrator programmes as part of a coordinated community response

Perpetrator interventions can differ in terms of method, objectives and scope, but they generally share the common goals of stopping the violence or abuse, increasing the safety of adult and child victim-survivors, and holding the perpetrator of abuse to account (Callaghan et al., 2020; Pallatino et al., 2019), including to their children (Alderson et al., 2013). The **Respect Standard** third edition sets out requirements for safe and effective practice with perpetrators of DVA in the UK, which includes the requisite provision of integrated services for (ex)partners of men on the programme (Respect, 2017).

The most common intervention in the UK is the domestic violence perpetrator programme (DVPP) and there are examples of them being successfully co-located within children's social care settings (Phillips, 2012). DVPPs typically use cognitive behavioural, (pro)feminist, psychodynamic and / or psychoeducational models of intervention in a group setting (Akoensi et al., 2013; Phillips et al., 2013). They are generally divided into criminal justice or community-based/non-criminal justice programmes. Community programmes tend to receive referrals from social work child protection and family courts (Kelly & Westmarland, 2015).

The Mirabal evaluation of domestic violence perpetrator programmes: what counts as 'success'?

The Mirabal evaluation of Respect accredited DVPPs for men, examined programmes across 11 sites in the UK (Westmarland & Kelly, 2015). The evaluation assessed outcomes for victim-survivors and set out six measures of success (Westmarland et al., 2010), which extend beyond just the cessation of physical violence. These measures account for the possibility that the physical violence may stop, but that women and children may continue to live in a coercively controlling or threatening environment. The measures are defined as follows:

1. A better relationship between men on programmes and their (ex)partners, in which there was more effective communication and respect.
2. (Ex)partners had more 'space for action', which enabled them to have their voices heard as well as make choices, while also improving their wellbeing.
3. Women and children were safer and had more freedom from violence and abuse.
4. Safe, positive and shared parenting.
5. Men on programmes developed an awareness of self and others, which included understanding the impact DVA had on their partner and children.
6. Children had healthier childhoods in which they felt heard and cared about.

The evaluation also showed that DVPPs function as a mechanism for coordinated decision-making, and as a key reference point for agencies working to intervene in DVA, including children's services and the Children and Family Court Advisory and Support Service (CAFCASS). The evaluation underscored the importance of programme integrity, noting it is best achieved through robust monitoring processes, case and practice management, clinical supervision and reflection.

Addressing mental health and substance use needs

Analysis of domestic homicide reviews (DHRs) in England and Wales indicated that 49% of perpetrators of domestic homicide had a mental health diagnosis (Chantler et al., 2020) and analysis of DHRs involving people aged 60 and over, reflect this data (Benbow et al., 2019). Other studies lend support to incorporating mental health and / or substance use treatment in interventions for perpetrators of DVA (where relevant) (Isobe et al., 2020; Stephens-Lewis et al., 2019). This is bolstered by evidence highlighting the limited engagement with mental health issues in some programmes working with perpetrators of DVA (Greaves et al., 2016; Portnoy et al., 2020; Trevillion et al., 2015). These points are substantiated in the evaluation of Drive Project intervention for high harm perpetrators of DVA (Hester et al., 2017), discussed later, as well as in an evaluation of perpetrator programme efficacy (Cordis Bright, 2019).

These points were substantiated during the leaders' focus group with some discussing the prevalence of mental health and substance use need among the people they worked with:

'We have looked at how substance misuse and mental health is quite often prevalent [among perpetrators of DVA]; I think 80% of domestic abuse cases [in my local authority] have those co-existing issues, and then identifying what the best intervention is at that particular time is important as well, because you can make a referral through our third sector provider, and they don't necessarily have the skills to address dad's alcohol issues or mental health problems.'

'There needs to be recognition that these issues are very complex and include mental health and substance misuse in particular. So we are asking workers to be multi-skilled and be experts in those fields almost, and feel confident in being able to work with families where those issues are prevalent. And for that to happen and for them to build relationships they need time, and for them to have more time we need more staff, but to have more staff, we need money...'

Together, these studies suggest that mental health specialist services provide an important avenue for engaging people who perpetrate DVA, as well as to discuss the issue of DVA, in order to facilitate disclosure and much earlier intervention. These data also suggest there is a higher concentration of mental health need among people who perpetrate DVA, in comparison to the general population (Bhavsar et al., 2020). This does not imply a causal link, but recognising these factors could create more opportunities for earlier intervention with perpetrators of DVA, better risk reduction and improved safety outcomes for adult and child victim-survivors (Oram et al., 2013).

Multi-agency and cross-sector working between children's social care, adult social care and mental health and substance use providers offer opportunities to work with, and intervene in, the behaviours of perpetrators of DVA, as well as improving outcomes for children in the context of child protection practice. The family safeguarding model (Rodger et al., 2020), discussed in the section on Whole Family Practice, provides an example of how this might be done through use of motivational practice and facilitating cross-agency working through multidisciplinary teams which include adults' substance use, mental health and domestic abuse specialist practitioners in social work teams.

Information sharing

A key barrier to this type of collaborative working are anxieties on the part of health care professionals, regarding information sharing. **This resource provides helpful guidance** (Sidebotham et al., 2016).

Key messages

- > Evidence suggests that mental health and substance use treatment settings are key locations for DVA screening and earlier intervention, as part of a broader coordinated multi-agency response to perpetrators of DVA.
- > Earlier intervention in health and social care settings could enable any co-occurring or complex needs of people who perpetrate DVA, including those associated with trauma and / or substance use, to be identified and responded to, including within the context of a whole family intervention.
- > Multi-agency and cross-sector working between adult social care, children's social care and health care providers, can provide opportunities to work with, and intervene in, the behaviours of people who perpetrate DVA.
- > There are examples of whole family practice approaches which incorporate work to address any substance use and mental health needs among perpetrators of DVA, within the context of children's social care interventions, as well as in the context of other community-based approaches.

Dominant children's social care responses to perpetrators of domestic violence and abuse

Child protection work in the context of DVA is a highly complex, nuanced, and invariably challenging area of practice. During the focus groups held with victim-survivors and professionals, concerning messages emerged regarding how children's social care interventions can make victim-survivors feel, and which fundamentally shape families' engagement with professionals. These are also consistently reflected in the academic literature. But it is important to note that this is not a matter of individual blame, and instead recognise that these messages reflect the extent of the significant challenges facing the children's social care sector and the need for wider systems and culture change.

During focus groups victim-survivors spoke powerfully about their involvement with children's social care when experiencing DVA. Below are two women's accounts:

'All of the load and responsibility seems to be put on the mother, even though that is only part of the story. Going back to the perpetrator behaviour – what are they going to do about that? Which is often nothing!'

'It is always on the mother, it is never on the father who is the perpetrator, it is always on the mother to do better when she is the one at breaking point really, you are pushing this person to do better who can't, who is doing her absolute best, she has got all the things, she is trying her very best and it's just never, for me, [it] is never, for the father to do better. [...] Perpetrators need to do better, not the mother.'

These accounts chime with research indicating that child protection practices can inadvertently place disproportionate responsibility on mother victim-survivors (Coy et al., 2015; Cramp & Zufferey, 2020; Lapierre, 2009a; Morriss, 2018; Smith & Humphreys, 2019) and sustain the comparative absence of fathers (Lapierre, 2009b; Nygren et al., 2019; Strega et al., 2008). In this, mothers are held accountable for ensuring the perpetrator of DVA stops his abuse (Feresin et al., 2018; Holt, 2016; Humphreys & Absler, 2011), and for the fact that she and her children are in that situation (Coy et al., 2012). This tendency to focus on the victim-survivor as 'the only solution', with far too little attention on the perpetrator of abuse, was identified as a clear practice pattern, during a Joint Targeted Area Inspection (CQC et al., 2017). This is not to suggest that individual practitioners do not care, or are to blame; rather it highlights the constraints and limitations of the system in which practice operates.

Professionals acknowledged the concerns raised by women in the lived experience focus groups and recognised the need to shift the focus away from victim-survivors and onto perpetrators of DVA:

'It is about going back to making perpetrators accountable for and responsible for [their behaviour], so that as local authorities we are saying, we see the need, we see there is nothing really in place for perpetrators, what can we do as organisations? Because [...] as Children's Social Care, we do plough a lot into children and families, but if we want to see change we are going to have to be looking face to face and giving eye contact with our perpetrators [of DVA].' ~ **Leader's group**

'The reality is that it is still very much the fall-back stance: if someone is causing harm in the house they have to leave, and if they don't then the victim isn't protecting the children, and you hear it over and over again. You have got some sporadic engagement with social workers where they have bought in this non-judgemental practice and supportive stance with the victim to enable them. But there is just not the involvement with the people causing the harm that I would really like there to be. It is like, there is a phone call and if they don't engage "okay, never mind" end of. They are not expected to then engage.'

~ Practitioners' group

Case file analysis, as well as the accounts from mothers and professionals set out above, evidence the extent to which fathers are not routinely contacted, remain undocumented in case file notes, are often absent during assessments, and not regularly included in measures to support the family (Featherstone & Fraser, 2012; Nygren et al., 2019; Wild, 2020; Zanoni et al., 2013). This can create a strained and distrustful relationship between mothers and social care services (or individual social workers) (Devaney, 2009), particularly when DVA is seen by some practitioners as something to be 'overcome' rather than a trauma to be supported (Robbins & Cook, 2018). It can also lead to a reluctance among mothers to disclose abuse and can impede help-seeking, due to legitimate concerns that it may lead to children's social care proceedings and potentially the removal of children (Feresin et al., 2018; Morriss, 2018).

This research coheres with what several women told us during the lived experience focus groups:

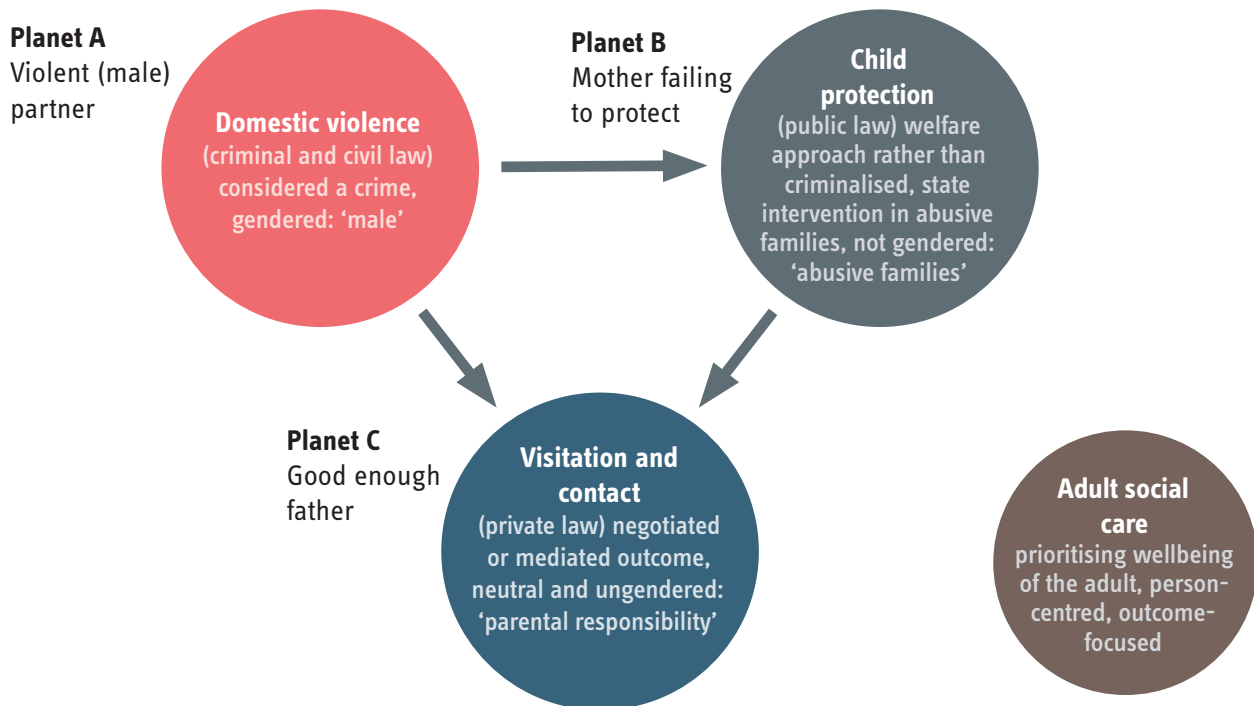
'I didn't want to seek help because I was scared [children's social care] would take my children away from me, so it comes down to an element of trust. So if you can't speak to social services, because all they want to do is take away your children from you, you need to do [that]. You are not going to speak to them and get the support that you need.'

'I think it is imperative to mention the fear factor. Striking fear into people who have been controlled for ages, so many people will tell you; "I went from being abused by that person to then being abused by the local authority, and controlled by the local authority." And I think that is really difficult for women because they need to understand when you come in, you need to come in to a nurturing place.'

These accounts illustrate the extent to which women often fear children's social care intervention, and the threat of child removal. These themes were reinforced from multiple sources and perspectives: children's social care is too often not experienced as a protective or supportive system by some mothers, but instead as one that is threatening and punitive. In some cases, the actions of children's social care are experienced as mirroring the behaviours of the perpetrator of DVA, as the women's accounts show. This is often coupled with a failure to recognise the tactics used by perpetrators of DVA, with women victim-survivors instead being viewed as complicit, sabotaging or a risk themselves.

The 'three planets' of domestic abuse

Hester's (2011) 'three planets' model provides a useful framework for analysis when thinking about the complexities associated with this area of practice. Each 'planet' encompass contrasting policies, practices and principles, including regarding work with people who perpetrate DVA (Hester, 2011).



Hester M (2011) The three planet model - towards an understanding of contradiction in approaches to women and children's safety in contexts of domestic violence. *British Journal of Social Work*. 41, 837-853.

The challenges of the current family and criminal court systems featured heavily in the focus groups with mothers, and it is a key area of focus for many social work academics. It is, however, beyond the scope of this briefing to discuss these complexities as well as the broader socio-legal considerations regarding the family and criminal court systems in circumstances of DVA, but further information can be found in the following resources:

Hunter, R., Burton, M., & Trinder, L. (2020). *Assessing Risk of Harm to Children and Parents in Private Law Children Cases*. Ministry of Justice.

SafeLives, & Domestic Abuse Commissioner. (2021). *Understanding court support for victims of domestic abuse: Mapping the provision of court-related domestic abuse support and advocacy across England and Wales on behalf of the Domestic Abuse Commissioner*.

Barriers to working with perpetrators of domestic violence and abuse in children's social care settings

Social workers are uniquely situated to hold perpetrators of DVA to account within the context of their child protection work. However, they report experiencing challenges when working with perpetrators of DVA (Donovan & Griffiths, 2015; Stanley et al., 2012). These challenges are complex and can occur at systemic, organisation and / or individual levels (Olszowy et al., 2020). A substantial barrier to working with people who perpetrate DVA in families rests with the fact that many social workers, particularly women, experience it as a highly uncertain and fear-inducing area of practice. This is primarily due to the potential risks associated with engaging with violent perpetrators of abuse, both for themselves as workers, as well as for the adult and child victim-survivors they are supporting (Bateson et al., 2017; Ewart-Boyle et al., 2015; Featherstone, 2017; Humphreys et al., 2020; Maxwell et al., 2012; Olszowy et al., 2020). These concerns coalesce with workers' anxieties regarding their ability to ensure the safety of all family members, fears that engagement with the person causing harm might present an obstacle to engagement with victim-survivors, as well as, concerns rooted in workers' own experiences of violence or abuse in some cases (Featherstone, 2017).

Social workers also describe the difficulties of working in a system in which dominant policy and practice paradigms emphasise the role of the mother as 'primary protector' (Mirick, 2014; Olszowy et al., 2020). Gendered discourses of parenting further embed this construction of the mother (Sinnott & Artz, 2016), with research conducted with social work practitioners corroborating the need for a gender-sensitive approach which incorporates a recognition of the contrasting expectations, sanctions, constraints and opportunities available to, and placed on, women and men as regards to their parenting (Philip et al., 2019).

Other studies signal how a lack of adequate resource (including longer-term capacity building across the workforce) in order to implement and sustain meaningful organisational culture or practice change mean that workers tend to revert back to holding mothers to account for managing DVA in the family (Ferguson et al., 2020; Wild, 2020).

During the focus groups, people with lived experience as well as professionals, reflected the concerns articulated in the literature regarding this being an uncertain and sometimes frightening area of practice. They also highlighted that children's social care practitioners do not always understand the complexity of domestic abuse and how to work effectively with families in which there is a perpetrator of DVA. Practitioners and leaders noted that many professionals may lack confidence in dealing with perpetrators of DVA in families, and there is often a concern that by intervening with the perpetrator, practitioners will do more harm than good. Their views chime with prior research which underscores the need for more specialist training and confidence building in this area of practice (Humphreys et al., 2018), along with opportunities for ongoing reflective supervision and a learning culture. While this sentiment was reflected across all focus groups, there was also an understanding among some professionals that learning and development alone is not the sole answer to improving responses to domestic abuse in families, as wider system challenges exist (set out on the next page).

Echoing research, women in the lived experience groups repeatedly spoke about the need for more comprehensive, specialised learning and development on DVA, to be made available to the children's social care workforce:

'The main thing that has to be done to change, is really training in domestic abuse for social services. [...] I can't help thinking if social workers were [...] better informed, before all of these things started, all of our cases might have ended up differently; we might not have ended up at family court. [...] There needs to be full, thorough training. [...] [I]t has to be something more than a five-minute safeguarding training because their lack of understanding is what tears people like us apart.'

'Maybe try and understand why she is not leaving ...[...] maybe social services need a bit of training and listen to more survivor stories and what they have gone through and how, why is it so hard [to leave]. [...] Everyone has a different story but you need to just understand why, not [tell people] we are going to do this - [ask] how can we help you?'

The discussion during the leader and practitioner focus groups reflected the women's concerns:

'We did a wide consultation with practitioners [...] and social workers were very honest and weary about the amount of domestic abuse they worked with. But they also told us that they felt that they could not work with men. [...] I think there is a culture that specialist services are the only ones that can work with men and they will make it worse, if they even say hello to the guy. [...] So somehow we have got social work where it's very women focused and that becomes women blaming.'

'We signpost the man; we are very female dominated career sadly at the moment, there is a fear element to that as well so it is easy to [just] signpost.'

'The big one for me is the concern of doing more harm than good, so at the intervention stage when [social workers] go out and they actually complete this work, they are opening a can of worms potentially, and then walking away from it. [...] I think a lot of our practitioners have that fear of opening a can of worms and not being able to address it, and [about] how they manage that risk.'

Both victim-survivors and professionals highlighted the fact that child protection work is highly individuated to the child, rather than seeing all members of the family as requiring intervention and support:

'I think the legislation and its focus on children, I think we all welcomed that when [...] the Children Act came in, and the focus on the child was important, but I think what that has meant is we are quite confused. When we see that the main person who is being hurt is an adult, we don't quite know how to work in that context. You will hear social workers saying, "I am not your social worker, I am the child's", not always in a sympathetic manner.' ~ Practitioners' group

'If you are looking at the priority of who do we support first, I sometimes think priority should be focused on the perpetrator because that is the concerning issue within the family unit. But actually we are social workers for children, and second to that comes keeping mum safe [...] that is the stance that we get from social care, and those are the barriers that we have needed to tackle and support.' ~ Practitioners' group

Evidence suggests that when social work practitioners are adequately supported and trained to 'hear' abusive men in the context of child protection work, it can create opportunities for them to validate and foreground women's experience of DVA (Heward-Belle et al., 2019). Further, other work corroborates the benefits of a gender-sensitive approach which incorporates a recognition of the contrasting expectations, sanctions, constraints and opportunities available to, and placed on, women and men as regards to their parenting (Philip et al., 2019).

Children's social care workforce

During focus groups, professionals identified barriers to improvement, rooted in the following workforce related issues:

- > For the social care workforce, engaging with perpetrators of DVA can involve a degree of 'mystery' and 'fear that they would make things worse'. Sometimes there is a belief among the workforce that only specialists are equipped to do DVA work.
- > Social workers, particularly women, often regard work with perpetrators of DVA as a fear-inducing area of practice, which they are ill-equipped to manage in their day-to-day practice.
- > The social care workforce are predominately women, and sometimes young and inexperienced. This was cited by professionals as both a barrier and an opportunity, with some arguing that the younger generation of colleagues can be more able than experienced staff to build relationships with families, and to employ strengths-based approaches. Others felt this inexperience or age, was an obstacle to engaging families.
- > High staff turnover was referenced as a challenging issue when attempting to embed new approaches and culture change, or building consistent methods of working. These areas of work require repeat training and messaging about the local authority's approach to working with families where domestic abuse is a concern, so high staff turnover can make this difficult.
- > Professionals highlighted social care's sometimes patchy engagement with the evidence base and with existing and emerging approaches to practice with perpetrators of DVA.
- > Disjointed or limited cross-sector and multi-agency working presented challenges for several of the local authorities present in the focus groups, sometimes impeding their ability to work holistically with families where there was a perpetrator of DVA with co-occurring needs associated with mental health or substance use.

Organisational context required for work with perpetrators of domestic violence and abuse

Humphreys et al (2020, pp. 22-24) worked with professionals in Communities of Practice supported by the Safe & Together Institute (discussed in forthcoming sections), to map the support social care practitioners require from their organisations, in order to develop and enhance their practice with people who use violence and abuse in families:

Senior management support

Senior managers have a vital role to play in creating the 'levers for practice change'.

This entails providing the leadership and policy necessary for enabling practitioners to change practice and influence their colleagues.

Refocusing attention onto perpetrators of DVA, and partnering with victim-survivors requires substantial organisational change as well as advocacy and support from senior managers.

Support for strong organisational collaboration

A single organisation does not have an exclusive hold on effective responses to domestic abuse. The work must be collaborative.

Robust interagency working, particularly between statutory child protection and specialist domestic abuse services, is essential and can enhance information sharing and build trust.

Collaborative working requires the support of senior managers.

Essential elements to support organisational development and to improve practice with people who perpetrate DVA in families

Combined training, coaching and supervision

Work with perpetrators of DVA is skilled work and workers often feel ill-prepared.

Training is therefore a key driver for improved practice. Everyone, not just social workers, working with people who perpetrate DVA in families, should receive training.

Coaching, resources and peer-to-peer support are also integral for learning and practice change.

Risk assessment and management to support worker safety

Work with perpetrators of DVA can mean practitioners fear for their safety or that of survivors.

More focus must therefore be placed on ensuring physical and psychological safety, taking into account the vulnerabilities of new and women workers in particular.

Quality supervision and debriefing are crucial to these processes.

Examples from practice

There are other examples of social work training being delivered in this context such as the **SafeLives Whole Picture cultural change programme** for those working in social care. An evaluation of the programme evidenced the substantial impact the training had in the way social care practitioners think and act as regards to DVA (SafeLives, 2020b). Safe & Together™ also provides a suite of tools and strategies for use by both statutory and non-statutory practitioners (Healey et al., 2018), as discussed in relation to Humphreys et al's (2020) work above.

The Make a Change (MAC) intervention, offers the Recognise, Respond and Refer (RRR) training to improve domestic abuse awareness among practitioners in public, voluntary and private sector organisations. An evaluation of the training indicated significant improvements in attendees' confidence in terms of their understanding of DVA, as well as in their ability to raise concerns regarding abusive behaviours (Callaghan et al., 2020, p.6).

Key messages

- Mothers are disproportionately held to account for DVA in families, with far too little focus placed on addressing the perpetrator of DVA and his behaviours, in child protection social work.
- Research provides compelling justification for working with men who perpetrate DVA in families in children's social care settings, not only to improve safety outcomes for mother and child victim-survivors, but also to hold perpetrators of DVA to account for their abuse.
- Women often fear children's social care intervention, and the threat of child removal, underscoring that children's social care is often not experienced as a protective or supportive system by some mothers, but instead one that is threatening and punitive.
- The actions of children's social care are experienced by some mothers as mirroring the behaviours of the perpetrator of DVA.
- Children's social care work with people who perpetrate DVA in families can be seen as an uncertain, frightening or cryptic area of practice and the workforce are often ill-equipped to respond appropriately to families in which there is a perpetrator of DVA.
- There is a need for more nuanced, specialised and comprehensive opportunities for learning and development for the social care workforce, coupled with senior management leadership and organisational support necessary to facilitate change by refocusing attention away from victim-survivors and onto perpetrators of DVA in families.
- Changing the way families in which there is a perpetrator of DVA are supported requires a fundamental shift in the ways in which DVA is understood by practitioners, as well as in relation to the impact it has upon all members of the family – including the perpetrator. Safe & Together and SafeLives' Culture Change Programme both offer key points of learning in this area.

Using an intersectional lens in social work with people who perpetrate domestic violence and abuse in families

Intersectionality

Intersectional thought is rooted in Black feminist scholarship (Alexander-Floyd, 2012; Mirza & Gunaratnam, 2014). Coined by Crenshaw (1989, 1991) intersectionality was first developed as a metaphor for understanding Black African and Caribbean women's experience of violence and abuse, as fundamentally shaped by various interlocking systems of gendered, racialised and classed oppressions.

An intersectional analysis of DVA accounts for the ways in which minoritised people must navigate a system of structural oppression (Brooks et al., 2021). In this, gender interacts with other structural oppressions and inequalities of race, ethnicity, class, age, sexuality, economic status and / or (dis)ability, which together fundamentally shape experiences of DVA (Ferguson et al., 2020; Hester, 2012; Nixon & Humphreys, 2010; O'Brien, 2016), both for victim-survivors and perpetrators of DVA (Chavis & Hill, 2008; Roguski & Edge, 2021). An intersectional lens in the design and delivery of programmes for perpetrators of DVA may therefore provide opportunities for more nuanced and responsive interventions which respond to family members' identities, and accommodate for structural inequalities or discrimination in the lives of people who perpetrate DVA and their families.

While the evidence remains limited regarding the overall efficacy of culturally or racially specific interventions for perpetrators of DVA more generally, an intersectional lens may offer opportunities to acknowledge and respond to race-related, cultural or religious needs among perpetrators (Brooks et al., 2021; Parra-Cardona et al., 2013; Thandi, 2012).

This type of culturally responsive provision can offer a platform upon which to build trust among communities, offer support, as well as opportunities to challenge ideologies regarding DVA, as evidenced in the successful implementation of Al-Aman, the Arabic speaking project of the Domestic Violence Intervention Project (DVIP) (DVIP, 2012).

Research from mothers and fathers involved in care proceedings exemplifies how intersectionality can also provide a lens with which to understand the intersection with socioeconomic status – lived experiences of both affluence and poverty – and how these operate in the lives of families who come to the attention of children's social care (Ferguson et al., 2020; Philip et al., 2021; Skafida et al., 2021) and the extent to which families are able to access or engage with children's social care support. This is particularly relevant in the case of parents who are involved in recurrent care proceedings (Philip et al., 2021).

Women in the lived experience focus groups discussed how children's social care responses to domestic abuse are intersected by both class, gender and socioeconomic status, as well as by cultural diversity:

'I think often what happens is, "We don't have a budget for this" or, "We don't have a budget for that" or, "I have to get it approved". There have been instances for a client I have supported, [who] has been promised money to travel to [child] contact and then I have had to, out of my own organisation, give her grants so she can access travel because funds are not being distributed to her [by children's social care] and it's just, lots of barriers which affect women in her situation. So, if [social care] could be a little bit more supportive in understanding the financial pressures that are in these families, and not make families feel bad because they won't come to you and ask you for help and push you deeper in to those really horrendous situations that you get stuck in.'

Victim-survivors noted that for some communities the role of the police in responses to domestic abuse and safety planning needs to be viewed through a cultural lens. They also discussed the need to be mindful of the impact of dominant language used to describe DVA, as the following account demonstrates:

‘There are cultural differences you know, in our community we wouldn’t necessarily want to go to the police, we wouldn’t necessarily [...] know how to find a support worker [...]. We need to work on more visibility, and for spaces for people like myself in the Black community that we can go to, because I didn’t know [...]. So I think that it is really important when they are thinking about [...] developing whatever you guys are working on, [...] that cultural overview – really look at the words that are being used. Like the word “perpetrator” that means nothing to people in my community, you know? What is a “perpetrator”?’

There is a broader point regarding the language that is used in child protection social work, which can be experienced as stigmatising and harmful by some parents, reflecting concerns regarding the current tendency to structure child protection work in circumstances of DVA as highly individuated to the child. The following from a practitioner reflects these concerns, as well as, emphasising the impact:

‘So it’s looking at more holistic ways of working with the survivor and the perpetrator to really support the children [...] and it has really turned it around for me especially, if we are talking about the language we use. [Like] when we say “non-engagement”, or the survivor is not working alongside us because they’re not engaging [...] But this Safe & Together training [...] really opened our eyes to the language we use in writing reports, the language that we use in interviews, raising our confidence in having those really hard discussions with perpetrators.’

The second account corresponds with research which foregrounds the experiences of African and Caribbean heritage people, which suggested that the language typically used to describe people that harm through DVA, such as ‘perpetrator’, while acceptable for most, may - for some - reinforce negative cultural stereotypes about race and criminality, and could function as a barrier to men’s engagement on behaviour change programmes (Adisa & Allen, 2020, p. 11). This emphasises the need to further examine the nuance and complexities associated with the dominant framing and language used in relation to DVA, in children’s social care settings.

Key messages

- People's experiences of DVA, in terms of both victimhood and perpetration, are shaped by their intersectional identities. As such, there is value in recognising the roles race, culture, religion, ethnicity, class, (dis)ability, sexuality, gender-identity, poverty and / or socioeconomic status may occupy in the lives of perpetrators of DVA and their families, and the ways these interact with responses to perpetrators of DVA.
- There is some evidence to suggest there is value in developing interventions which take account of intersectional inequalities in the lives of minoritised people who perpetrate DVA; there is a need to explore and expand this evidence base further.
- Research with families who have experienced recurrent care proceedings indicates the need to consider the role multiple adversities and / or the economic status of families occupy, and how these may shape their ability to engage with support, particularly in relation to children's social care.
- When delivering perpetrator interventions, it is important to be alert to the intersections of institutionalised racism and / or trans/bi/homophobia.
- Dominant understandings and responses to DVA are often too limited and therefore obscure the experiences of non-binary, lesbian, gay and bisexual people who both experience and perpetrate DVA; transgender people's experiences are especially underrepresented within this frame.

Working with perpetrators of domestic violence and abuse in families

The value of, and need to, work with all members of the family in which there is a perpetrator of DVA was discussed by participants in all the focus groups. There was also a consistent message that more should be done to directly engage the person causing harm within the context of child protection work, with some professionals citing particular models or approaches:

‘Yes okay children’s services are children’s based, and they are children focused but what you need to do is you need to support the whole family unit. [...] The victim can almost be targeted negatively, and what you need when you are in that position, you may be physically injured, you are probably traumatised for various reasons, you are psychologically in a bit of a mess, [...] [is] you need to support everybody not just the child, for the child to thrive...[...] You need to nurture everybody that is involved with the child, not just the child and I think that is a big part of it.’ ~ **Lived experience group**

‘We have tried to train all our DA [team] in that Engage whole family approach because there is that challenge that so many of our families want to stay together and having that traditional view that the victim needs to leave or the perpetrator needs to leave [...] [but that] just doesn’t happen in reality...’ ~ **Leaders’ group**

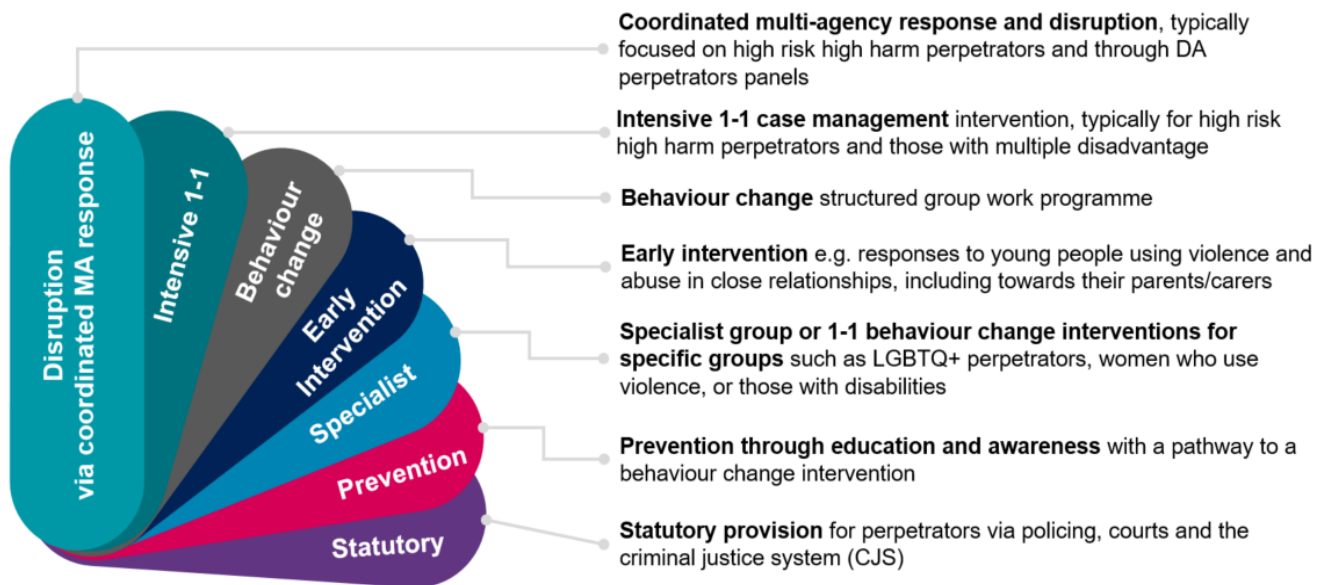
‘There is an over reliance on the survivor at times, but I think sometimes we forget that survivors have a strategy that we are not often aware of and we go in and we wag our finger and say, “You must keep your children safe”, where at times they are often doing that. [...] But the Safer Together model has made me reassess and think differently about how survivors do keep their children safe, how they do have clear strategies in place.’ ~ **Practitioners’ group**

‘We are beginning to see those green shoots of social workers being able to have those clear, frank and open discussions with perpetrators, not all the time, because in our experience perpetrators were often quite confrontational, [so] those conversations needed to be done in a safe space. We are mindful as well [of] the impact that has for the survivor afterwards, especially if they are living in the same household [...] We have just done a review and [audited files] [...] and you can see [...] when Safe & Together wasn’t involved, you can see the difference in how the assessments are now written, the way we are absolutely making sure perpetrators are accountable and taking responsibility. It is about constantly getting it embedded because unfortunately staff leave, staff go, staff turnover is really, really high.’

~ **Leaders’ group**

Community-based programmes and models of interventions

Community-based programmes and interventions for perpetrators of DVA, as part of a coordinated response, are wide ranging, and there are a number being run across the UK and elsewhere at any given time. This includes several **Respect Accredited programmes**. Interventions for perpetrators of DVA should be underpinned by support for victim-survivors, broad referral pathways and information sharing, good governance, culturally appropriate practice and quality assurance (Respect et al., 2021).



Source: Respect, SaferLives, Social Finance, 2021

On the next page are some examples, including parenting programmes which work with perpetrators of DVA who are fathers. It's important to acknowledge the differing aims of violence prevention programmes and those of parenting programmes. While they do frequently overlap, and are advantageous when combined, they are not the same, and do not function as a substitute for one another (Respect, 2013, p.10).

Name	About	Available evidence / evaluated outcomes	References for further reading
Caring Dads: Safer Children programme	<p>The Caring Dads programme was first developed in Canada by Scott and Crooks in 2004 and is a group parenting intervention for men who have been identified as having, or being at risk of, abuse or neglect of their children or of exposing children to DVA.</p> <p>The intervention entails contact with the child(ren)'s mother and coordinated case management in order to reduce risk posed to family members. The programme promotes child-centred fathering and focuses on enhancing men's motivation and ability to engage in respectful, non-abusive co-parenting practices with the child(ren)'s mother.</p>	<p>A UK evaluation of the programme found 'promising' evidence that the programme contributes to reducing risks to children, as well as indicating there was behaviour change and improved parenting practices among some participants of the programme, and increased feelings of safety among mothers.</p> <p>These findings are corroborated in an Australian evaluation which assessed behaviour change against six indicators including recognition of harmful behaviours and embedding positive fathering practices (Diemer et al., 2020). A Canadian study has also found significant child protection accounts over a period of two years, as a result of fathers' involvement in the programme.</p>	<p>UK evaluation (McConnell et al, 2017)</p> <p>Australian evaluation (Diemer et al., 2020)</p> <p>Canadian study on child protection outcomes (Scott et al., 2021)</p>
Drive Project intervention	<p>The Drive Project intervention launched in April 2016. It entailed the delivery of a ten-month intervention which engaged 506 perpetrators of DVA. It implements a whole systems, whole family approach using a multi-sectoral model of intervention and disruption. Focused on high-harm, high-risk perpetrators, including those considered serial perpetrators, the key aim of the project was to reduce numbers of child and adult victim-survivors through the deterrence of perpetrator behaviour.</p> <p>Drive has sought to embed new approaches to working with this cohort of perpetrators of DVA as well as to establish or expand existing provision in the localities in which it has been delivered.</p>	<p>Drive was piloted in three areas across England and Wales from 2016-2019. Findings were generated via a randomised control trial, which synthesised data from a range of qualitative and quantitative data sources. The evaluation assessed outcomes following the ten-month delivery and the 12 months thereafter, to assess whether change was sustained.</p> <p>Findings from the evaluation indicated the intervention was successful across various outcomes measures, including in reducing abusive behaviour, increased safety for victim-survivors, and a reduction of risk in three quarters of the cases over the period of the intervention. It also created increased opportunities for victim-survivor decision-making and in some cases, leave-seeking where this outcome was sought by the victim-survivor.</p>	<p>Drive Program Evaluation 2016 – 2019 (Hester et al., 2017)</p>

Name	About	Available evidence / evaluated outcomes	References for further reading
<p>Make a Change (MAC)</p>	<p>Make a Change (MAC) is an integrated model that addresses both organisational and community level responses to DVA, supports behaviour change among perpetrators of abuse, and provides support to (ex)partners. It aims to engage people who are concerned about their behaviour at an earlier stage than more typical perpetrator programme interventions. The intervention is designed to take place before behaviour escalates to the point where intervention is court-mandated or required by child protection orders.</p> <p>The MAC model permits referrals from any source and does not require a disclosure of abuse during the first phase of the model, prior to the intervention taking place. The removal of this requirement is understood as central to the programme. Like other programmes, the needs and safety of victim-survivors are prioritised.</p>	<p>A mixed methods evaluation assessed impact on client, service and implementation outcomes, involving focus groups and interviews. Data suggested the intervention supported positive change among perpetrators of DVA, including building insight into the nature and motivation of abusive behaviours, as well as fostering a commitment to change.</p> <p>Integrated support for victim-survivors increased safety and provided important opportunities for reflection and potential action and change.</p>	<p>Evaluation of implementation (Callaghan et al., 2020)</p>

Whole family practice

SafeLives Whole Picture Strategy

The **SafeLives Whole Picture Strategy** locates a whole family response within a risk-led model which incorporates work to address the needs, and rebuild the wellbeing, of every member of the family, including those that are perpetrating the abuse (SafeLives, 2020c). This approach underscores the need for effective risk assessment for each member of the family, tailoring responses to meet their specific needs and own individual circumstances, in line with that risk. There is an emphasis on seeing the whole person, as well as supporting people earlier and in more suitable, sustainable ways, and taking into account the contextual and systemic issues, such as those discussed earlier.

Whole family approaches aim to redress the imbalance regarding the management of risk in families, which is typically placed on the non-abusive parent, as well as to hold perpetrators of abuse to account. An evaluation of whole family programmes in England suggests there is a growing need and demand for these types of approaches which consider the needs of the whole family, and which take into account the wider context in which the DVA occurs (Boxford et al., 2020). Evidence suggests whole family approaches are more effective when multi-layered, multi-disciplinary, multi-agency and in operation across a range of settings including within homes, schools and healthcare settings (Boxford et al., 2020).

There is a diverse and growing range of practice models which fit into the ‘whole family’ category of intervention, including the following examples:

Name	About	Available evidence / evaluated outcomes	References for further reading
Connect/Engage Programme	This programme supports adult victim-survivors who wish to remain in, or who are still in, a relationship with the perpetrator of DVA. Some couples may have separated previously, or may separate in the future. The Engage IDVA, children’s caseworker and Engage case worker provide support that centres safeguarding and risk management for the family in which there is a perpetrator of DVA, with the aims of increasing victim-survivor safety, and building accountability and responsibility of the person causing harm. It also ensures appropriate support for children.	An evaluation was conducted after two years of service delivery. The evaluation demonstrated that victim-survivors received a range of support interventions associated with safety, parenting, housing, and mental health. Perpetrators of DVA also received parallel support in areas including mental health, substance use and parenting. Children also received a range of support interventions. Victim-survivors reported various outcomes, with the highest percentage reporting a cessation of physical violence and increased feelings of safety and wellbeing. All children engaged in the programme reported increased feelings of safety, while perpetrators of DVA reported significant outcomes associated with substantial behaviour change, improved understanding of the impact of their behaviour and better relationships.	Two-year service delivery evaluation (SafeLives, 2020a)

Name	About	Available evidence / evaluated outcomes	References for further reading
Family Safeguarding Model	<p>The <i>Family Safeguarding Model</i> is a whole-systems reform of dominant local authority child protection approaches. It brings together all the professionals working with a family together in one multi-disciplinary team (MDT). It uses motivational, strengths-based practice approaches to address compounding family vulnerabilities associated with DVA, parental substance use and parental mental health.</p> <p>The MDTs include specialist adult workers with expertise in substance use, mental health and DVA, who work within social work teams thereby bridging the separation between adults' and children's social care. The model facilitates an approach to DVA which focuses on supporting both adult and child victim-survivors, as well as offering interventions to support perpetrators of DVA to change behaviours.</p>	<p>The model was first delivered in Hertfordshire (Sanders et al., 2020), and has since been implemented in four other local authorities across England. Evidence following independent evaluation (Rodger et al., 2020) indicates that it is effective in preventing children from entering care and for reducing the numbers on child protection plans. These findings coincide with a reduction in police call-outs and in frequency of mental health crisis contacts. Evaluation data also indicated an ongoing demand for perpetrator support and intervention.</p>	
For Baby's Sake	<p><i>For Baby's Sake</i> whole family perinatal early intervention works with parents from pregnancy to two years postpartum, with the dual aims of disrupting cycles of DVA and enabling better outcomes for children. Infant mental health is a central focus. The programme combines DVA trauma-informed intervention, mental health and attachment-focused parenting support for both parents. It utilises a strengths-based model which responds to adverse childhood experiences and trauma among parents, and aims to promote emotional self-regulation.</p>	<p>It was first launched in 2015 in two English community settings. Evaluations of the programme highlight the associations between mental health and experiences of domestic abuse and substantiate the benefits of an individualised approach specific to each family.</p>	<p>Evaluation (Kings College London & The Stefanou Foundation, 2019)</p> <p>Further reading: (Domoney et al., 2019; Domoney & Trevillion, 2020)</p>

Name	About	Available evidence / evaluated outcomes	References for further reading
Growing Futures	<p>Doncaster's <i>Growing Futures</i> mobilises a whole family approach, as well as a typology-based conceptualisation of DVA. The programme convenes multiple agencies across the community and a key component of the model is the Domestic Abuse Navigator (DAN) role. The programme uses a partnership approach informed by Hester's (2011) 'three planet' model to address historically disjointed practice across the range of services working to respond to DVA in the locality.</p>	<p>An initial evaluation was conducted from 2015-2016 and assessed the impact on services and families, of the Growing Futures' domestic abuse navigators (DANs). The evaluation found that the DANs facilitated a more trusting relationship between families and professionals and improved multi-agency working in the context of a whole family approach.</p> <p>A second longitudinal follow-up evaluation (Boxford et al., 2020) assessed the longer-term outcomes associated with the model. It found the model had a sustained impact on the services received by children and families, while the whole family approach it espouses was sustained and impacted positively on family members.</p>	<p>Growing Futures initial evaluation (McCracken et al., 2017)</p> <p>Longitudinal follow-up evaluation (Boxford et al., 2020)</p>
Newham NewDAy programme	<p>Newham <i>NewDAy</i> is a non-statutory service available to families in which there is situational violence not connected with controlling behaviour. The multi-disciplinary, collaborative programme uses a model that is non-judgmental and consent based. It consists of four key elements including: short-term intervention for all members of the family including children, victim-survivor and perpetrator; the Caring Dads programme for the perpetrator of DVA; systemic sessions with both parents; and school-focused support for children and young people.</p>	<p>An evaluation of the programme indicated positive impact on outcomes for children and young people with a reduction in risk of harm, as well as positive outcomes for victim-survivors. It also indicated increased confidence among social care practitioners, as well as a change in culture among professionals working with families in which there was a perpetrator of DVA.</p>	<p>Evaluation (Langdon-Shreeve et al., 2020)</p>

Name	About	Available evidence / evaluated outcomes	References for further reading
Opening Closed Doors (Barnardo's)	Barnardo's <i>Opening Closed Doors</i> programme was set up to support children and families experiencing DVA, with an emphasis on helping to recover and build sustainable change. It was funded by the Home Office and employs a holistic approach to working with families, incorporating three strands of intervention: integrated women's support, Safety Trust and Respect programme for children and young people, and a domestic abuse perpetrator programme.	The programme was run in five Welsh local authorities in 2019. An evaluation cited the whole family approach as crucial to tailoring interventions to the needs of each family member. Findings indicated an ongoing, high demand for this type of service, which responded to a 'gap' in provision. The programme was assessed as achieving positive impact on families, with strong evidence for creating a safe and stable home environment, a reduction in children's emotional stress and enabling families to recover from DVA.	Programme evaluation (Institute of Public Care, 2020)
Oranje Huis (Orange House)	This model from the Netherlands offers an alternative whole family approach, situated within the refuge sector (de Jong, 2016). The <i>Orange House</i> model involves the provision of support within an 'open' setting at a closed location, in contrast to the typical refuge set-up which operates a strict secrecy policy. It also involves the whole family wherever possible. This includes working therapeutically with the perpetrator of abuse, and facilitating contact between fathers who perpetrate abuse, and their children. Cohering with other whole family models of working, Orange House, places a strong emphasis on parenting and the needs of the child. It also offers an integrated model of support with a range of services to support women and children experiencing DVA, all under one roof.	The Orange House methodology was evaluated in three phases (2018; 2019; 2020), and assessed the impact of the approach in terms of safety, trauma and service user wellbeing. The evaluation was conducted with women (with and without children) living in safe houses in two localities. The women reported increased feelings of safety and independence. Areas for improvement were identified around language support for non-Dutch speaking women and practice support for children while living in the safe houses.	Phase 1 evaluation summary report (Verwey-Jonker Institute, 2018) Further reading: (Blijf Groep, 2020; de Jong, 2016)

Name	About	Available evidence / evaluated outcomes	References for further reading
Safe & Together™	<p>An increasingly prominent whole family approach is the <i>Safe & Together™</i> model. It is a suite of tools and interventions designed for child welfare and allied professions. It exemplifies a perpetrator pattern-based approach, and was first developed in North America as part of the Greenbook Initiative. It frames domestic abuse as a negative parenting choice and challenges the ‘failure to protect’ paradigm referred to earlier. Using a strengths-based approach, it promotes an alliance with the non-abusive parent, and recognises the strategies implemented by the non-abusive parent to manage risk and safety in the context of DVA. It also responds to intersectional considerations such as race, class and sexuality, and is equipped to respond to substance use and mental health needs.</p>	<p>A range of sources evidence outcomes associated with the Safe & Together approach in practice. These include improved assessment practices among child protection and specialist domestic abuse services. Evaluations of the model implemented in multiple US states indicated various outcomes in relation to workforce practices, including; attitudinal change and a reduction in victim-blame, better screening and assessment of coercive control, better partnering with adult victim-survivors, increased attention on perpetrator engagement, and improved assessment and recording of the impact of perpetrator behaviour on children (Safe & Together Institute, 2018).</p>	<p>Evidence on the Safe & Together approach (Bocioaga, 2019)</p> <p>Safe & Together Institute: Overview and evaluation data briefing (Safe & Together Institute, 2018)</p> <p>Case reading as a practice tool (Humphreys et al., 2018)</p> <p>Further reading: (Humphreys et al., 2020; J. Scott, 2019)</p>
Steps to Safety	<p><i>Steps to Safety</i> was developed by the NSPCC in conjunction with the University of Oxford and the University of South Florida. Delivered by NSPCC social workers, it aims to respond holistically to families, while recognising multiple adversities.</p> <p>It is designed to stop ‘reactive violence’ among both same-gender and heterosexual couples who are expecting a child, or those with a child aged under five. The model applies to couples in which one or both partners are using violence in the context of escalating conflict, and in circumstances where there is no evidence of coercive control. It requires some evidence of a desire to change.</p>	<p>A feasibility conducted in 2017-2018 found that the majority of the families referred by social care were experiencing problems too severe to be suitable for conjoint work. Where conflict did not reach a critical threshold, couples sometimes lacked motivation or dropped out following assessment.</p> <p>The key lessons from the feasibility study included the need to develop referral pathways from a broader range of organisations and services who work with families before the escalation of violence (such as perinatal, GPs, midwifery etc.). There is also a need to work with couples not known to social care at an earlier stage, to build motivation for engagement.</p>	<p>Feasibility study: (Mcmillan & Barlow, 2019)</p> <p>Further reading: (Margolis et al., 2020)</p>

Developing and expanding responses to families in which there is a perpetrator of domestic violence and abuse

System-level changes

There is a need for evidence-informed practice

- > Victim-survivors strongly felt that perpetrators of DVA should be held to account for their actions and required to meet expectations around behaviour change, commensurate with requirements placed on victim-survivors.
- > Professionals noted the need for good quality evaluations of 'what works' when working with families in which there is a perpetrator of DVA, and specifically the need for more evidence regarding perpetrator intervention efficacy in children's social care settings.
- > Discussions indicated a need for greater awareness and understanding among children's social care professionals of the existing evidence base, as well as of children's social care's key role within a community coordinated response to address DVA.

'What I don't quite understand is why in 2021, we are in this situation where we haven't an agreed model in social work of how best to work with perpetrators after all the investment that has gone into domestic abuse, that we are still having these debates [...]. It worries me we can have a different view in the police, in the third sector, in the regional service, in the national service, and then locally. It worries me a bit that we do not have a joined up or a decision being made somewhere, that this is the approach that we should take.' ~ Leaders' group

'My service, as a new service, in order to identify what is the best intervention out there to buy "off the shelf", it's been quite tricky because there are so many. I was hoping that the Domestic Abuse Bill would lead to some really, really clear recommendations about the things that we think local authorities should be doing with families. And I am not sure that I have seen that yet. [...] That for me is a huge gap...' ~ Leaders' group

Domestic abuse needs to be given priority

- > In order to address domestic abuse, victim-survivors and professionals noted the need for domestic abuse to be given a degree of priority, and an acknowledgement of the degree to which children's social care work and domestic abuse are interlinked.
- > Professionals spoke about the challenges of embedding culture or practice change, against the backdrop of short-term or time-limited funded programmes for perpetrators and / or high workforce turnover.

'Our probation providers come in and provided some training a couple of years ago with managers on how to work with men or people that were harming and it was so well received and then it never really went anywhere and it never really expanded. [...] If you want to make a culture change then you need to be committed and look across the service and not just domestic abuse [...]. It is a huge part of [our work] and quite a large majority – a huge majority of the cases that come to social care have an element of domestic abuse, even if they don't always seem at first to be the primary cause. So I think it needs to be given priority and they need to change how they work, it needs to be given more focus.'

~ Leaders' group

Multi-agency working

- > There was an acknowledgment that in order for responses to domestic abuse and specifically the ability of services to work with perpetrators of harm, that a strong multi-agency response is essential.
- > Information sharing between health, police and social care was raised as an opportunity for services to understand the 'whole picture'. Comments from all groups highlighted that better joint working could allow effective responses rather than merely referring on or reporting concerns with limited intervention taking place.
- > Professionals also noted that effective multi-agency working afforded social workers the opportunity to 'share the risk' and that it was no longer just the social worker monitoring the perpetrator.
- > Crucially, victim-survivors repeatedly discussed how they felt they were solely responsible for monitoring the behaviour of the person causing the harm.

'It is the fears from other agencies – what social care is struggling with, what everybody is struggling with, when you speak to health, even the police, they are unequipped almost to support and deal [with perpetrators of DVA]. They know that when they go, for example there is an incident what they do – they will do a DASH with the victim, they remove the perpetrator. What do they actually do [with the perpetrator], do they do a perpetrator DASH? Do they review the risk the perpetrator presents? There is nothing there at the moment. Even from the first instance of response it is fed through. It's culture.' ~ **Leaders' group**

Practice-level changes

Intervention at an earlier stage

- > Professionals and victim-survivors discussed opportunities for services to intervene at an earlier stage to provide support and prevent domestic abuse from escalating.
- > One local authority explained how they had begun reviewing all 'front door' referrals to explore if domestic abuse was a concern, even if not the initial presenting concern, so that support and help could be offered as quickly as possible and by the most appropriate service.

Intervention that is specific and nuanced, rather than 'one size fits all'

- > Some professionals were aware that current practices allowed situations to deteriorate and even inadvertently escalated concerns because of generic or 'one size fits all' responses.
- > Some professionals also spoke about missing opportunities to provide appropriate pathways to support.
- > Victim-survivors echoed the concerns regarding a 'one size fits all' or generic approach which holds that women should 'just leave', without any due regard for the specificity of the family's circumstances, including taking into account the structural factors that may impede leaving.

'I think we miss a trick in terms of the "front door", that triaging at the front door, because I think if we handled that a bit more intelligently we would have very different pathways for some of these families. But at the moment we are terribly "one size fits all" and I think we do tend to drive families into corners where we escalate and we are setting that up some of the time, inadvertently.' ~ **Leaders' group**

'Where I struggled with the social care response, was the generic response, they have a 'one size fits all' response rather than a bespoke response to the situation and that is probably down to a lack of education and sometimes that compassion fatigue. They have seen so many "domestics" that they don't see the complexity of the particular domestic they are dealing with. They also don't see the complexity of the perpetrator. [...] Approaching anything relating to domestic abuse with a generic response is going to cause more harm than good. And that is the problem I have.

~ Lived experience group

'It is that one fits all - "you should leave". Well practically could she leave? I have not got this big pot of money in my back pocket. Practically I may be unable [to leave]. But you can move me, you can change my locks and you can do all of this, but you are not dealing with the root cause - that perpetrator is either going to draw me back in, or abuse again and it is that spotlight that social care are missing.'

~ Lived experience group

Relationships-based, strengths-based, individualised practice

- > Victim-survivors and professionals discussed the essential role of relationships in improving responses to domestic abuse by children's social care and that this requires time and therefore resources.
- > Professionals recognised that quality relationships could be built between families and a range of professionals, not exclusively social workers, in order to improve the outcomes of all family members.
- > This work is impeded when child protection social workers see their role as narrowly individuated on the child, rather than acknowledging the needs of adult victim-survivors, as well as recognising the strategies they deploy to keep their children safe. Joint working with adult social care would go some way to responding to this challenge.
- > Victim-survivors also wanted to communicate their story only once, rather than repeating it to several professionals during their journey through services. They also spoke of the need to recognise the nuances of people's individual, unique experience of abuse, and the ways in which their own coping mechanisms or triggers may shape their ability to engage with children's social care.

'In terms of how could it be better [...] is you have got to build a relationship, you have got to understand who the person is, you have got to know what their triggers are [...] Are they frightened? When you have been controlled by someone do you want someone coming around and looking in your cupboards the first time they come around? No you don't. You need to understand that person and the problem is people say 'but we haven't got time'. The problem is if you don't spend time, you won't get anywhere.' ~ Lived experience group

'It's relationships for me. I think if we could have a process of worker engagement with the whole family [...] if we could have that, that golden consistent relationship, some of these parents when you look at, "What was it about their experience with social care, [...] that helped you to change something?" What comes back is, "They were straight with me, they were honest with me, they came, they visited me, they helped me", not "Well I never see them, they don't come up, they tell lies". It is that thing about relationship. It is about a unique skill that people have an ability to empathise and work with somebody. [...] But also having the ability to resource that [and] also having an ability to do the signposting at the right points...'

~ Practitioners' group

'I should be treated like an individual like I am [my social worker's] only case. And I appreciate that people are under pressure in their work and that is tough, but when you are going through what you are going through you don't need to be told, "Oh well [...] why can't you just get on?" [...] Well hang on a minute, he is the perpetrator and my situation is my own individual situation. I am not in the book that you learnt. I am right in front of you, you need to help the person in front of you not necessarily what you have learnt.'

~ Lived experience group

Improving work with children

- > Victim-survivors felt that improvements could be made in how children's social care work with children where domestic abuse is present either as part of a current relationship, or in situations where the parents are separated.
- > This included the need to better recognise the complex traumatic impact of DVA in the lives of children, and understanding how this trauma might shape children's behaviours and presentations.

'What they say is "You need to draw a line under everything that has happened to you so that you can move forwards", so they completely dismiss any trauma that you or the children have experienced. They don't take a history from the children, or if they do, they have a generic, "one size fits all" form about wishes and feelings, I am sure everyone has had these done [...]. They don't attend to the problems and experiences of the children – and a big thing people are talking about is training. So my experience is they don't have sufficient experience in domestic abuse and they don't understand what coercive control or gaslighting is, and they don't understand children's trauma, so certain behaviours are taken as "bad parenting" or something different, but it is a trauma response.' ~ Lived experience group

Focus on perpetrators of domestic violence and abuse and hold them to account

- > Every focus group discussion included the need to improve responses by children's social care to those who perpetrate abuse by holding them to account for their actions and focusing on their behaviour (rather than that of the victim-survivor), in order to halt the cycle of harmful behaviour.
- > Professionals acknowledge a persistent lack of attention on, or interventions with, the person causing harm in families, which function to re-embed the feelings of victim-blame discussed during the lived experience focus group.
- > Limited awareness or understanding of how to work with perpetrators of DVA, coupled with a lack of learning or development opportunities to equip practitioners to do the work, impedes their ability to hold them to account.

'I think all of us are feeling that it is us that are interrogated, us that are questioned where actually time spent with the perpetrator is essential and that doesn't happen. They are seen once or twice if something serious is alleged [...], there has been a Section 47 assessment done, that lasted two weeks, they stopped contact in that time, didn't put anything in to ensure any safety and they reinstate contact again. So it is a tick box exercise rather than challenging the perpetrator on what has been alleged.'

~ **Lived experience group**

'[The response] is very compartmentalised and I get very frustrated with that because in a lot of [...] cases there is that lack of meaningful engagement with the perpetrator. And therein, a complete merry-go-round of violence that just doesn't stop. So either [the perpetrator] carries on being within the family that they are already involved with, or they move onto a different family, or they just move into a slightly different area, and then they bounce back, and there is no intervention and they may be on Probation, [...] or a different service but there is no real joint working.' ~ **Leaders' group**

'I think it is about acting on the allegations and directly challenging the perpetrator and involving other agencies to address the problems rather than leaving it at our door and then blaming us if we can't keep the children safe.' ~ **Lived experience group**

Implement a needs-led and trauma-informed approach with perpetrators of domestic violence and abuse

- > Professionals and victim-survivors spoke about the benefits of implementing a needs-led and trauma-informed approach with people who perpetrate DVA in families, which better recognises and responds to any co-occurring needs or histories of trauma and childhood sexual abuse (where relevant).
- > Participants in all groups highlighted how this would enable the responsibility to be diverted away from victim-survivors, particularly for the management and monitoring of risk, but that it is dependent upon the existence of good collaborative working.
- > This is coupled with measures to hold people to account for their behaviour, as well as making them aware of the impact of their behaviour upon the people they are harming.
- > Professionals spoke of the need to incorporate an acknowledgement and understanding of the role of shame in the lives of perpetrators of abuse, and how this may act as a barrier to engagement and / or behaviour change.

‘The only way to appropriately challenge [the perpetrator of DVA] is to offer [...] perpetrators the same services that victims could be offered with an IDVA, so what Drive currently do is they have a one-to-one worker to monitor the risk all the time. Because if someone isn’t monitoring that perpetrator, the victim is the only one in the centre with any understanding of the risk and is monitoring that daily and without that challenge from multiple services and social care actually talking to other services...’ ~ **Practitioners’ group**

‘I think if we can try to get there in the early stages more often and looking at [perpetrators] in a similar way [...] as we would a victim, giving them support as well. This has come from a place of healing and of doing a lot of work on myself. Sometimes we do need to treat perpetrators a little bit like a victim, because they have probably been through a mass amount of trauma in their early stages of life and, as a result, have then become this person as an adult - and they should be dealt with in that way. [...] Also in situations like this it is really important for perpetrators to know how much painful impact they are having on those they are harming.’

~ **Lived experience group**

‘Shame and what a barrier that is in being able to have conversations with the people that harm around their harmful behaviour, and if we can find a way to overcome that particular barrier, because shame causes really deep-seated emotions, “Guilt is what I do, shame is who I am”. How do we engage with that? [...] We want to be able to do the challenge but also do the support and recognise them as victimiser as well as victim and then deal with those historic difficulties as well as looking at their challenging behaviour that is presenting itself. [...] It is not really straightforward, there isn’t one thing to concentrate on when we are working with people who harm. There are multiple areas that we need to be thinking about.’ ~ **Practitioners’ group**

Conclusion

Evidence strongly underscores the need to reform current social work practices so that the responsibility and onus for protecting children and reducing risk is situated with the person causing harm in families. This refocusing of practice attention onto perpetrators of DVA, and partnering with victim-survivors by social care practitioners, requires substantial organisational and culture change which can only be achieved through senior management support, advocacy and organisational infrastructure. Responses to people who perpetrate abuse in families has key implications for policy and practice within the domains of child protection, so that greater efforts are made to hold them to account for their behaviour but also for worker safety.

Social workers are uniquely placed to hold perpetrators of abuse to account, but research suggests this is best undertaken as part of a multi-agency coordinated approach, and with appropriate learning and development opportunities which are nuanced, specialised and victim-survivor focused. There is also a strong case to be made for approaches which rely upon multi-sectoral engagement and collaboration, particularly when working with whole families. In practice this means ensuring that there is good cross-agency working across adults and children's social care, mental health services, police, probation, housing services and substance use provision (where applicable), with interventions undertaken with perpetrators of abuse, occurring in tandem with those of victim-survivor support provision. The division and limited joint working between adults and children's social care services represents a significant barrier to achieving these aims, coupled with a tendency by some children's social care workers to see their role as narrowly individuated on the child.

Available evidence points to a lack of consensus regarding 'what works' as well as a diversity in programme and perpetrator services, which can present a substantive challenge for children's social care when working with families where there is a perpetrator of DVA. But crucially, absence of evidence does not equate to evidence of ineffectiveness. There are a number of programmes and approaches with evidence indicating positive outcomes for adult and child victim-survivors, as well as substantive behaviour change among different cohorts of perpetrators of abuse, including serial and high-harm perpetrators of DVA, as discussed in this briefing and accompanying literature review.

There remains a shared responsibility, involving services, commissioners, funders, policy-makers and the academic community to improve this evolving evidence base. This work is complex, nuanced, and invariably challenging. To operate confidently and ethically in this evolving field, practitioners require ongoing support, learning opportunities, safe spaces and professional relationships within which to process the emotional impact of the work. Leaders of local services and systems play a crucial role in understanding and creating the conditions in which this kind of practice can flourish.

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