TREATMENT COMPLIANCE OF MALE PERPETRATORS OF INTIMATE PARTNER VIOLENCE

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Abstract

The issue of Intimate Partner Violence (IPV) has received an increasing amount of media, political and professional attention during the past 50 years. However, there has been mixed findings regarding the effectiveness of established treatment interventions for convicted IPV perpetrators. Practitioners have observed high attrition rates from community IPV treatment delivered by Probation services. The aim of this research was to contribute to the understanding of treatment compliance and behaviour change within male IPV perpetrators, attending such treatment following court referral. A systematic review and meta-analysis identified correlates and predictors of attrition for convicted IPV perpetrators, who had been court mandated into treatment. An analysis of 22 studies found a similar average rate of non-completion was consistent with the range in existing literature. There was evidence to support independent bivariate associations between some variables and dropout from treatment, for example: age, marital status, education level, level of income, employment status, previous recidivism and severity of IPV. However, due to the heterogeneity across study designs, delivery and evaluation, there was no agreement on how these variables may interact as a model of prediction for treatment attrition. Following these findings, an empirical study, comprising of two parts, was designed to identify predictors of court mandated IPV treatment attrition and to promote treatment compliance of an IPV community intervention. Part one investigated the characteristic differences between IPV treatment completers and dropouts. The sample was made up of 574 men court mandated into IPV treatment. A logistic regression model was developed to identify men that are more at risk of

dropping out of treatment. The analysis demonstrated that the model of significant predictor variables could correctly predict the criterion variable of treatment dropout with 75.8% correct classification of cases. Part two evaluated the use of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O; Campbell, Sellen, & McMurran, 2010), which was delivered as a single session pre-treatment intervention to motivate IPV perpetrators to attend a community IPV treatment. The sample consisted of 55 male IPV perpetrators court mandated to the IPV group intervention. Findings showed that participants that completed the PACI-O were 1.4 times more likely to complete the IPV intervention programme than the 574 men within the control sample that did not undertake the PACI-O. Further applications and limitations of the PACI-O were explored. These primary research studies, were followed by a single subject case study of a participant that completed a group IPV intervention but went on to receive a further IPV conviction. The case study highlighted the limitations of group treatment, within a management plan to reduce recidivism and these limitations were explored in relation to the practical implications for child contact matters. The administration of routine risk assessments was brought into question. Hence, a critical appraisal of the Spousal Assault Risk Assessment – Version 3 (Kropp & Hart, 2015) was carried out. This is the licenced risk assessment tool used with Probation service users with IPV convictions in England and Wales. The lack of routine implementation was found which suggested that the use of this risk assessment tool was a "hit and miss" affair and recommendations are made. The conclusion of this thesis details the forensic practice implications of the findings and how they may enhance the effective delivery of IPV treatment within community Probation settings.

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Glossary of Abbreviated Terms

ABI	Abusive Behaviour Inventory
AM	Adaptive Motivation
BAME	Black, Asian & Minority Ethnic
BBR	Building Better Relationships
BD	Borderline/Dysphoric
B-SAFER	Brief Spousal Assault Form for the Evaluation of Risk
CAFCASS	Children and Family Court Advisory and Support Service
CBT	Cognitive Behaviour Therapy
CDVP	Community Domestic Violence Programme
CI	Confidence Interval
CODC	Collaborative Outcome Data Committee Guidelines
CPS	Crown Prosecution Service
CRC	Community Rehabilitation Company
CSAAP	Correctional Services Advice and Accreditation Panel
CTS2	Conflict Tactics Scales-2
DA	Danger Assessment
DRS	Dropout Risk Screen
DVCVA	Domestic Violence, Crime and Victims Act 2004
DVRAG	Domestic Violence Risk Appraisal Guide
GLM	Good Lives Model
GVA	Generally Violent/Antisocial
HMPPS	Her Majesty's Prison and Probation Service
IDAP	Integrated Domestic Abuse Programme
IDVA	Independent Domestic Violence Advisors
IPV	Intimate Partner Violence
ITT	Intend to Treat
MARAC	Multi-Agency Risk Assessment Conferences
MORM	Multifactorial Offender Readiness Model
NOMS	National Offender Management
NPS	National Probation Service
OASys	Offender Assessment System
OBP	Offending Behaviour Programme
ODARA	Ontario Domestic Assault Risk Assessment

OGP	OASys General reoffending Predictor
OGRS3	Offender Group Reconviction Scale-3
OM	Offender Manager
OR	Odds Ratio
OVP	OASys Violence Predictor
PACI-O	Personal Aspirations and Concerns Inventory for Offenders
PAS	Propensity for Abusiveness Scale
PCI	Personal Concerns Inventory
PCI-OA	Personal Concerns Inventory-Offender Adaptation
PSM	Propensity Score Matching
RNR	Risk-Need-Responsivity Model
SAM	Stalking Assessment and Management
SARA-V2	Spousal Assault Risk Assessment Version 2
SARA-V3	Spousal Assault Risk Assessment – Version 3
SPJ	Structured Professional Judgement
SSAS	Spouse-Specific Assertiveness Scale
SSO	Suspended Sentence Order
TCC	Theory of Current Concerns
URICA	University of Rhode Island Change Assessment
URICA-DV	University of Rhode Island Change Assessment – Domestic Violence

Chapter 1: Introduction

Domestic abuse is a common but often hidden crime which is prevalent across the world. Findings from the Crime Survey for England and Wales estimated 2.4 million people aged over 16 years within England and Wales experienced domestic abuse in the year ending March 2019. This equates to a prevalence rate of approximately 6 in 100 persons (Office for National Statistics, 2019a). However, this figure represents the cross-government definition:

> "Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and emotional." (Home Office, 2012)

This definition is consistent with the five subtypes of violence within a family unit (maltreatment of child, sibling, parent, elder or partner) (Browne & Herbert, 1997). Refining this definition further to the abuse committed by intimate partners within current or previous adult relationships provides the focus for this research. Hereon in this will be referred to as Intimate Partner Violence (IPV).

Strategies to tackle the detection and recidivism of IPV are a priority for the criminal justice system. This is a shared responsibility of multiple services and agencies; however the initial role of the police is crucial. The police response to domestic abuse and IPV involves taking positive action in holding the perpetrator accountable through investigation and responding effectively to

victims. This has received scrutiny within thematic inspections (Her Majesty's Inspectorate of Constabulary, 2014, 2015; Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, 2017, 2019).

Within the year 2018 in the United Kingdom, 149 women were killed by men and 61% were killed by a current or ex-intimate partner (Long, Harvey, Harper, Ingala-Smith, & O'Callaghan, 2020). The World Health Organization estimated that globally up to 38% of murders of women are committed by a male intimate partner, whereas the prevalence for men murdered by female intimate partners is much lower at 6% (World Health Organization, 2013). Indeed, it is estimated that globally one in three women have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime (World Health Organization, 2014).

It is pertinent to note that female perpetrators of IPV exist and they also receive convictions. In the year ending March 2019, 16 male homicides were perpetrated by current or former partners within England and Wales (Office for National Statistics, 2020). The existing literature that explores female offending against male victims is overshadowed by the vast publications concerning male perpetrated IPV. There is seemingly an insufficient evidence base for the design of OBPs for female IPV perpetrators in England and Wales. Hereon in, only adult male heterosexual perpetration of IPV will be examined.

With lethality a distinct possibility, effective treatment and management of IPV perpetrators and victim safety strategies strive to address recidivism of further IPV. Multi-Agency Risk Assessment Conferences (MARACs) take place within

all localities in England and Wales to share information concerning parties that are deemed the highest risk of domestic abuse and IPV. Specialists from statutory and voluntary sectors attend and consider the safeguarding needs of each case and devise a coordinated action plan.

The criminalisation of IPV for adult perpetrations has a number of outcomes for the perpetrator of an IPV offence, such as no further action, conditional cautions and prosecution at criminal court. The latter can result in in a conviction or acquittal, but with both, the perpetrator can be made subject to a restraining order under the Protection from Harassment Act 1997, amended by the Domestic Violence, Crime and Victims Act (DVCVA) 2004. This restricts the perpetrator from pursuing a course of action towards the victim or significant other that lasts for the duration of the order.

If such a restraining order is not imposed by a sentencing court other protective orders can be requested after a criminal court case. Within England and Wales, non-molestation orders were introduced in part IV of the Family Law Act 1996. In order to protect victims, applications are made to civil court requesting the prohibition of a person from molesting another associated person or relevant child. Although the wording of the order does not give an exact definition of molestation, behaviours prohibited can include pestering, harassment, threats and intimidation. Breaching a non-molestation order became a criminal offence from 2007 after the implementation of the DVCVA 2004. Within the same legislation, an occupation order can specify the occupants of a family home and those that should be excluded. This may be appropriate if a victim feels unsafe living with a relevant other.

Even when there is not enough evidence to secure a conviction, and police in England and Wales deem there to be sufficient threat of violence from an IPV perpetrator a Domestic Violence Protection Notice and Domestic Violence Protection Orders are available within sections 24-33 of the Crime and Security Act 2010. These civil orders are time limited and aim to protect the victim and provide respite from the perpetrator.

This brief overview has highlighted the variety and complexity of the disposals available to services working with victims and perpetrators of IPV, however there are also interventions designed to address victimisation and perpetration of IPV. Perpetrator interventions can come in two distinct forms. In England and Wales, interventions can be voluntary or specified by civil court services, such as community-based group Domestic Violence Perpetrator Programmes. Mandatory treatment can be stipulated following a formal police conditional caution or upon sentencing by a criminal court, usually for an IPV offence.

Court mandated treatment interventions delivered by the Probation and Prison services are not new. However, from the 1990s greater emphasis was put on rehabilitation of convicted offenders using group treatment programmes, which could be subject to routine evaluation to monitor levels of effectiveness. Accredited Offending Behaviour Programmes (OBPs) were established through a National Probation Service Pathfinder pilot programme, which initially developed nine programmes that addressed general offending, drug and alcohol misuse, sexual offences and offences involving violence.

Underpinning these and later OBPs, was the "What Works" literature (McGuire, 1995), including the Principles of Effective Practice (Andrews, 1995, 2001), which gave 18 recommendations for the structured development of effective group treatment programmes that had the potential to reducing reoffending. In England and Wales, the OBP accreditation process is led by the Correctional Services Advice and Accreditation Panel. This proclaims to seek the gold standard for OBP design, selecting only those most likely to evaluate and achieve good outcomes in addressing dynamic risk and that can monitor standards of delivery. Further reading about general OBP delivery, list of available OBPs, the accreditation process and auditing requirements, can be found in the following resources (Day, Kozar, & Davey, 2013; Hollin & Palmer, 2006; Maguire, Grubin, Lösel, & Raynor, 2010; Ministry of Justice, 2020).

In addition, the Risk-Need-Responsivity (RNR) Model (Andrews, Bonta, & Hoge, 1990) promotes the delivery of treatment should be at the right dosage, it addresses the relevant criminogenic needs and uses an approach that engages offenders effectively. Best practice suggests the RNR model should be adhered to throughout offender rehabilitation and this has been associated with successful recidivism reduction (Andrews, Bonta, & Wormith, 2006).

In 2001, the Home Office piloted and then later rolled out the first nationally accredited community group work programme delivered to male IPV perpetrators across England and Wales, this was called the Integrated Domestic Abuse Programme (IDAP). It was closely followed by the Community Domestic Violence Programme (CDVP), both OBPs being delivered by Probation services. A further OBP, the Healthy Relationships Programme, was accredited

for delivery within prison settings. Further reading on the content and delivery of these OBPs can be found in Bullock, Sarre, Tarling, & Wilkinson (2010) and Bates, Graham-Kevan, Bolam, & Thornton (2017). In 2012, IDAP was replaced with the Building Better Relationships (BBR) programme, which is also delivered in prisons. A common theme for all these programmes is that they are reserved for male perpetrators that pose a medium to high risk of harm to their female current or former partners. With finite resources, the RNR Principles guide these higher intensity treatments to the perpetrators with the great risk of serious harm.

However, there has been mixed findings concerning the efficacy of the IPV treatment programmes. A study using meta-analysis found completion of male IPV programmes was associated with a "small" decrease in IPV recidivism (Babcock, Green, & Robie, 2004) and "modest benefits" from official reporting (Feder & Wilson, 2005; Feder, Wilson, & Austin, 2008). Figures vary, with studies reporting a range of 0% (Waldo, 1988) to 41% (Gondolf, 2000) of those that completed treatment remain free from committing further violence. In a two year follow up both IDAP and CDVP were evaluated to have small but significant effects in reducing IPV reoffending (Bloomfield & Dixon, 2015). There are limitations with using reconviction data, within any study, as it does not accurately quantify reoffending or more widely recidivism. For example, Dobash, Dobash, Cavenagh, & Lewis (1996) observed that some 'treated' men persisted in verbal aggression when physical violence had ceased. Furthermore, IPV is believed to be under-reported within the general population and as such it is harder to identify the propensity of IPV behaviour unless self or third-party disclosures are made and recorded. Babcock et al.,

(2004) suggested the many methodological inconsistencies within the studies examined, such as treatment attrition, may have confounded the overall findings. This issue was supported by Feder & Wilson (2005), which suggested some of the variance in outcome findings was influenced by the nature of the control groups and if they consisted of participants that were never offered treatment or those that started and dropped out prior to completing.

In addition to the human and emotional cost of IPV, there are financial costs to the statutory public and voluntary services in place for both victims and perpetrators of IPV. These services include the Criminal Justice System, healthcare providers, adult and child Social Care, housing and civil legal services as well as many others. The most recent estimate of the total economic and social cost of domestic abuse in England and Wales for the year ending March 2017 is £66 billion, this includes all the aspects mention above as well as lost economic output. Furthermore it is estimated that each domestic homicide can cost £2.2 million (Oliver, Alexander, Roe, & Wlasny, 2019).

Changes to Probation in England and Wales:

The research contained in the following chapters, was conducted during the implementation of both the Offender Rehabilitation Act 2014 and Transforming Rehabilitation in 2015 within England and Wales. The paper 'Transforming Rehabilitation: A Strategy for Reform' (Ministry of Justice, 2013) outlined the radical division of 35 former Probation Trusts in England and Wales, creating an additional privatised sector of provision. As a result, the singular National Probation Service (NPS) became responsible for the management of all high risk offenders and individuals with sexual convictions. The NPS became

responsible for the sole provision at Magistrate and Crown Courts and all Approved Premises. Whilst 21 privatised Community Rehabilitation Companies (CRCs) manage all low and medium risk offenders. The CRCs were allocated responsibility of the Unpaid Work provision, as well as having responsibility for the delivery of OBPs for all offences except those addressing sexual offences. This created as momentous reorganisation of staff, resource rebranding and physical office relocation. As such the cost pricing of all service delivery became a significant priority for revenue and performance measures.

IPV treatment delivered as OBPs is resource intensive due to the specialist staff training and materials required for delivery, supervision and evaluation; thus, treatment dropout can impact heavily on the monetary cost effectiveness of providing such interventions. More crucially, individuals that start but do not complete an OBP have been found to have a higher risk of reoffending than those that do not commence treatment at all. This has been found across a range of OBPs (Gondolf, 2002; Harder, 2005; McMurran & Theodosi, 2007; Miner & Dwyer, 1995). Across studies, levels of reoffending have been estimated between 10-62% for men that drop out from IPV treatment (Aldarondo & Fernando, 2002).

The IPV treatment dropout (attrition) rate was observed to be particularly high within the geographic locality where this research was conducted. This was consistent with existing IPV treatment literature which identified attrition rates of between 12.4-68%, (Lemire, Rondeau, Brochu, Schneeberger, & Brodeur, 1996), 22-99% (Daly & Pelowski, 2000) and 22-78% (Jewell & Wormith, 2010). Higher attrition rates have been observed when treatment delivery has

been within community settings, as well as dropout occurring prior to treatment commencing (Babcock & Steiner, 1999; Olver, Stockdale, & Wormith, 2011).

High treatment dropout rates became expected by the CRC responsible for the IPV intervention involved with this research. The issues with this were twofold. When there were too many dropouts, treatment groups were cancelled. This could impact on the positive emotional investment practitioners held for their delivery of such interventions. Yet to pre-empt the dropout, double the recommended group size could be accepted to the first treatment sessions. This had the capacity to assist with achieving adequate completion rates based on the expectation that half of the treatment group would fail to attend and as such dropout. However, the drawbacks to this method occurred when nearly all the invited individuals attended. All efforts to promote a therapeutic alliance could be undermined due to the discomfort of so many people crammed into a room. Anecdotal experiences of attendees, at these sorts of initial treatment sessions, reported feeling unwelcomed and this could influence their reluctance to return.

As stated earlier, the RNR model has a wide evidence base which supports the structure of OBP design and delivery. However, it also underpins the OBPs accessibility and opportunity for Probation clients. If the perceived risk threshold is not met or there is an absence of criminogenic needs, then Probation clients will not have certain OBPs or wider interventions offered to them, as research would suggest the outcome of recidivism reduction would be less comparable to that for more "risky" clients. It is pertinent to

acknowledge that a sentence may not be wholly representative of an individual's actions, as a court's decision can be subject to plea bargaining between legal teams for a less serious conviction. Whilst Probation services are required to manage the sentences of all Probation clients irrespective of risk, there can be barriers to sentence planning due to courts decisions and some inflexibility of the application of RNR principles. However, this is not new to Probation services and practitioners work within a rehabilitative culture that is inclusive to all.

Whilst Probation services' approach can target criminogenic needs, there is the understanding of the intergenerational context of crime, where a practitioner can case manage an individual and their offspring in years to come. Probation services understand that a probation client is a human with a complex array of personal strengths in addition to criminogenic factors. This is not new to Probation Services and underpinning this Probation practice are the principles of criminal desistance. This addresses the process of change that is meaningful to the individual rather than imposed societal expectations of how they should be living their life.

Maturation theories have historically provided some explanation for desistance from crime. However, it would be unrealistic for Probation Services to wait for an individual to 'grow out of crime' as they are accountable within the Criminal Justice Service to the general public. There are various perspective of desistance from crime within literature. The Social Control Theory suggests that when an individual develops or strengthens social capital, this can facilitate desistance. This is when an individual develops a bond between

themselves and societal institutions such as legitimate employment or marriage. Developing emotional attachments to societal goals, serves to somewhat constrain the propensity for criminality as an individual could lose out on something meaningful in their life if they were to reoffend (Laub & Sampson, 2001; Sampson & Laub, 1990).

Desistance is not merely taking a break from committing crime, indeed it has been described as the process of assuming the "role or identity of a 'changed person'" (Maruna, Immarigeon, & LeBel, 2004). The Cognitive Transformation Theory (Giordano, Cernkovich, & Rudolph, 2002) describes four factors associated with desistance: i) personal choice or agency which allows an individual to have cognitive openness to change; ii) exposure to "hooks for change" which can be include life interactions or events as stated above; iii) the re-evaluation of an individual's identity and constructing a 'replacement self'; iv) reinterpretation of an individual's criminality as incompatible with their new identity. The latter can prompt an individual to distance themselves from their past criminal identity (Vaughan, 2007). This gives rise to desistance being understood as an interaction between age and maturation, life transitions and development of social bonds, and the attitudes, motivations and narrative constructions that individuals have concerning their path in life (McNeill & Whyte, 2007). This has also being coined as the steps of transformation (Maruna, 2000). Such literature has had significant influence on Probation policy and practice, informing how practitioners can facilitate the 'pull' towards desistance, in which an individual can feel encouraged and adequately resourced for a lifestyle without crime (Serin & Lloyd, 2009; Serin, Lloyd, & Hanby, 2010).

Probation practice is embedded in reality, and due to the complexity of criminal desistance there is likely to be lapses and relapses. This is important for practitioners to manage their own expectations for their clients and sustain hope for desistance even when lapse does occur(Weaver & McNeill, 2007). These and additional principles underpin the context of this thesis and in particular the execution of the empirical research within chapter 3. Probation services are just one element within the societal context of desistance, yet they cannot achieve desistance from crime on behalf of their clients, despite this often being the expectation of wider society.

Aims:

The research in this thesis aims to contribute to the understanding of treatment compliance and behaviour change within community OBPs for male IPV perpetrators. This subject was chosen based on the experiences of the author, initially from the perspective as a Probation practitioner delivering IPV OBPs for four years. It was regularly observed that individuals' motivation for treatment could hold a crucial role for compliance within OBPs and low levels often contributed to deselection from treatment, as well as self-selected dropout.

Structure of the Thesis:

To begin with, chapter one provides an overview of key concepts and introduces the research context. Chapter two comprises of a systematic review

and meta-analysis identifying correlates and predictors of attrition for convicted perpetrators court mandated into treatment. This methodology resulted in the review and analysis of 22 studies.

An empirical study, comprising of two parts, is described in chapter three, which is designed to identify predictors of court mandated IPV treatment attrition and to promote treatment compliance of an IPV community intervention. Part one investigates characteristic differences between IPV treatment completers and dropouts. The sample is made up of 574 men who had been court mandated into IPV treatment. A logistic regression model is developed to identify men that may be more at risk of dropping out of treatment. Part two evaluates the use of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O; Campbell, Sellen, & McMurran, 2010) when delivered as a single session pre-treatment intervention to motivate the men to attend treatment. The sample consists of 55 male IPV perpetrators court mandated to IPV treatment. Further applications and limitations of the PACI-O are explored.

Chapter four presents a single subject case study of a participant that completed a group IPV intervention but went on to receive a further IPV conviction. The limitations of group treatment within a management plan to reduce recidivism is explored, with particular attention to the practical implications for matters relating to child contact.

A critical appraisal of the Spousal Assault Risk Assessment – Version 3 (Kropp & Hart, 2015) is explored in chapter five. This is the licenced risk assessment

tool used with Probation service users with IPV convictions in England and Wales. The concluding chapter six, collectively considers the findings from each of the previous chapters and the implications for future IPV treatment and research are discussed.

Conference Presentation from this Thesis:

- Oral presentation on Promoting Treatment Engagement of Intimate Partner Violence Perpetrators within Community Intervention. Paper presented at British Psychological Society – Division of Forensic Psychology Annual Conference, Newcastle (June 2018).
- Poster presented on Promoting Treatment Engagement of Intimate Partner Violence Perpetrators within Community Intervention and potential uses of The Personal Aspirations and Concerns Inventory- for Offenders (PACI-O). Poster presented at 3rd Annual Probation Practitioner Conference, London (July 2018).
- Oral presentation on Promoting Treatment Compliance of Intimate Partner Violence Perpetrators within Community Intervention – The Psychology Postgraduate Affairs Group Annual Conference, Huddersfield (July 2018).

Chapter 2: Non-completion of court mandated Intimate Partner Violence treatment programmes for men – A meta-analysis

A strategy to reduce attrition from Intimate Partner Violence (IPV) treatment programmes was the introduction of court mandated IPV treatment (Dutton, 1984; Hamberger & Hastings, 1989). A more recent study using meta-analysis identified IPV perpetrators court mandated to treatment were 16% more likely to complete than those not mandated (Jewell & Wormith, 2010). However, dropout still occurred and this chapter aims to identify correlates and/or predictors for attrition from court mandated treatment for convicted perpetrators, using a meta-analytic methodology. A further objective is to consider approaches addressing attrition as part of the treatment intervention.

A study using meta-analysis found completion of male IPV programmes was associated with a "small" decrease in IPV recidivism (Babcock et al., 2004). It was suggested the many methodological inconsistencies within the examined studies may have confounded the overall findings, such as treatment attrition. This issue was supported by a further meta-analysis study, which suggested some of the variance in outcome findings was influenced by the nature of the control groups and if they consisted of participants that were never offered treatment or those that started and dropped out prior to completing (Feder & Wilson, 2005). This shows the need to reduce treatment dropout rate in order to reduce recidivism and contribute to the wider public protection, as well as more effective treatment evaluation studies.

Inclusion criteria:

Participants: The target population includes convicted male adults aged 18 year or older, serving custodial or community sentences for IPV related offences against a female current or ex-partner, whom start but do not complete offered treatment to address their IPV behaviour.

Interventions/Exposure: Identification of target participants that have started IPV treatment but not finished, also termed non-completers.

Comparators: Participants who have successfully completed IPV treatment.

Outcome measures: Identification of recidivism measures, including documented at risk behaviours, re-offending and re-conviction. Included studies must contain a comparison between treatment completers and non-completers for correlates or predictors of non-completion.

Exclusions criteria: Exclusion of narrative, reviews, editorials or commentary papers. Exclusion of non-offenders and voluntary attendance or pre-trial interventions such as court diversion programmes. Exclusion of studies that do not report attrition data.

Information sources:

The search strategy was conducted using electronic searches of the databases: PSYCHINFO, PUBMED, ASSIA as well as Cochrane Library and The Campbell Collaboration Library. In addition, the following E-Theses portals were searched: Nottingham E-Thesis, Birmingham eTheses Repository and Proquest Dissertations and Theses. Hand searches were conducted on specific Journals such as the Probation Journal and Forensic Update, also the reference lists of previous systematic reviews were reviewed (Babcock et al., 2004; Feder &

Wilson, 2005; Jewell & Wormith, 2010). Research registers were also searched such as the National Offender Management (NOMS) research register and National Criminal Justice Reference Service. This search strategy was non-discriminative against language or country of research origin. No limits were placed on publication dates. The planned search took place in January 2019.

Search strategy:

The following search syntax was used within the search strategy and modified to individual database requirements where appropriate. The searches were restricted to title, abstract and keywords.

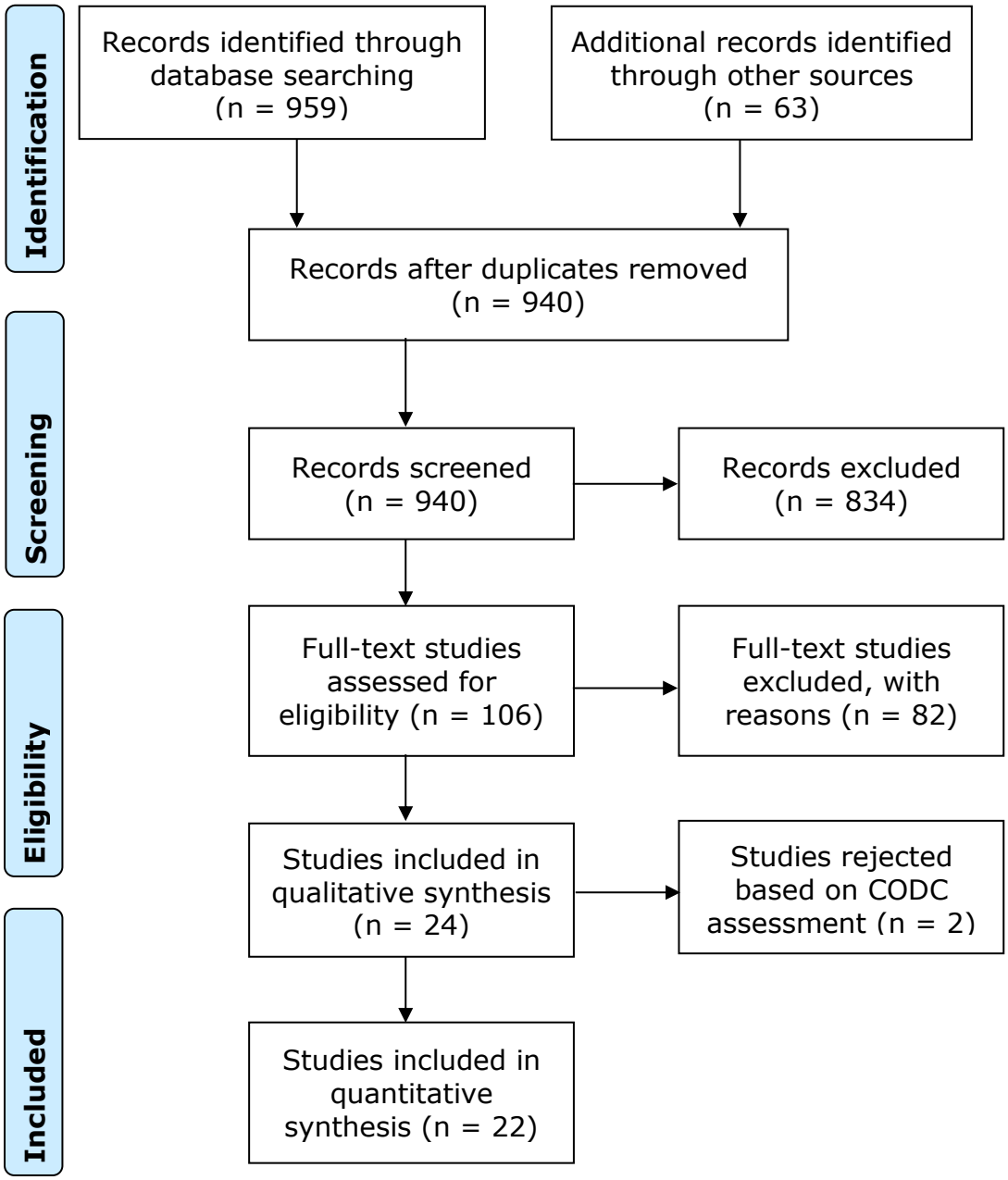
> (Batterer* or Offend* or Perpetrat* or criminal* or convict* or felon*) AND (Domestic abus* or Domestic violence or Intimate Partner Violence or Spous* abus*) AND (Attrition or dropout or treatment termination or premature termination or non-completion or non-attendance or non-compliance or discontinuation or early withdrawal)

Selection process:

All records identified through implementation of the search strategy were managed using EndNote software. Duplicate and irrelevant records were excluded and multiple publications of an evaluation or data set were treated as a single study to reduce inappropriate weighting of results. The preliminary screening of record titles and abstracts was completed by the lead author using the above inclusion/exclusion criteria. A PRISMA flow diagram (Moher, Liberati,

Tetzlaff, Altman, & the PRISMA Group, 2009) illustrates the study selection (figure A).

Figure A: PRISMA flow diagram of search results and study selection



Risk of bias and quality assessment of individual studies:

The assessment of methodological quality was applied to the full text of all the studies that met the inclusion criteria to consider the common forms of bias, such as sampling bias, measurement bias, performance bias and attrition bias in the actual design and conduct of each study. Examined studies were rated as: 'rejected', 'weak', 'good' or 'strong' based on the analysis of 20 items (or 21 items if relevant to cross-institutional designs) of methodological quality using the Collaborative Outcome Data Committee Guidelines (CODC; Collaborative Outcome Data Committee, 2007a, 2007b). Originally, the CODC was designed to study sexual offender treatment outcome studies. This was deemed transferable to analyse the methodology of IPV treatment studies as these guidelines have also been used with drug treatment studies (Gutierrez & Bourgon, 2012).

Data Extraction:

Data extraction was completed using a pre-designed template to elicit study information and outcomes (Appendix I). The characteristics of the included studies are summarised in Table 1, specifying the author(s) and date of publication, country of origin, sample size, treatment curriculum, format, location and duration, study definition of non-completion, attrition rate, and correlates of non-completion significant at $p<0.05$. As treatment programme completion data contains proportions, the Cohen *h* statistic is used to calculate an effect size index from the percentage proportions between treatment dropouts and treatment completers (Cohen, 1988; Rosenthal, 1994). MedCalc

software version 19.1.3 was also used to explore the heterogeneity of study data, as well as publication bias and dropout proportion variance.

Results:

Figure A shows the breakdown of literature search. Of the 106 full-text articles screened, 64 did not meet the inclusion criteria. Reasons for exclusion were due to the lack of differentiation of court mandated participants, samples containing women and young men under 18 years, individual treatment modality and conference proceedings without data. Three studies were excluded as they shared the same data set. In order to not bias the results in this study, the most recent article of each of the duplicate data was used. Finally, 15 articles were excluded as they did not specify attrition data.

The remaining 24 studies were reviewed and given a global rating of study quality using the CODC guidelines. Following this, two studies were rejected from this review due to low confidence in their findings and some required information was missing. Of the included studies three were categorized as having strong study quality, twelve as good and seven were assessed as weak quality. An independent assessor reviewed and coded risk of bias for 18.2% of the papers selected for eligibility. There was 100% agreement of the global ratings of study quality assessments (Appendix II).

The 22 studies remaining for this analysis were predominantly dated post-millennium, with the exception of two studies from 1989 and 1991. The majority of studies took place in North America and four were from Europe.

One study was written in Spanish and translation services were utilised to ensure inclusion of this study.

Most of the studies were designed as evaluations of specific IPV treatments, however some were exploratory of treatment non-completion. There were a mix of methodologies including quasi-experimental designs as well as non-equivalent comparisons or no comparison groups at all. One study was conducted with an incarcerated sample (Stewart, Gabora, Kropp, & Lee, 2014), whilst the rest were in community-based settings. Sample sizes varied between studies, from n=83 to n=1702. When pooled, this totalled 6331 participants across the 22 studies.

The treatment duration ranged across studies, from eight bi-weekly sessions to 78 weekly sessions. One study did not specify exact treatment duration (Bennett, Stoops, Call, & Flett, 2007). Some studies explored multiple treatments, so a total of 30 treatment groups are considered in this review of varying lengths and curricula.

All IPV treatment delivered within these studies had a group treatment format and most had additional individual pre-treatment assessment sessions. There was a variance in the treatment curricula of the interventions. These included Cognitive Behaviour Therapy (CBT), Feminist or Duluth informed (Pence & Paymar, 1993) and Ecological Model (Dutton, 1995b; Heise, 2011) approaches. One study evaluated a Mind-Body Bridging programme modified to IPV treatment that focusses on wellbeing and regulation of the mind and body. Four studies did not specify their treatment approach.

Successful completion was defined by some studies as participants' full attendance at all sessions, whilst others deemed up to three missed sessions were acceptable. However, despite stating a maximum of three sessions could be missed, one study's authors noted due to treatment facilitator discretion, the mean number of sessions was 16 out of 24 for participants who were classified as completers of treatment (Bowen & Gilchrist, 2006). Eight studies did not specify any definition of treatment completion. This is pertinent as attrition from treatment can be multifaceted, occurring post-referral but also prior to assessment, after assessment but before treatment commences and finally during the treatment (Gondolf & Foster, 1991).

Table 1 shows the above studies' characteristics and the IPV treatment non-completion (attrition) rates, which ranged from 16.7% - 60.0%. The mean dropout rate for all 22 studies (total n=6331) is 36.56%. Three studies' samples were purposely selected to comprise of 50% completers and 50% non-completers from archive data (Buttell & Carney, 2002, 2008; Carney, Buttell, & Muldoon, 2006). Therefore, omitting these three studies, the mean treatment dropout rate for the remaining 19 studies (total n=4378) is 34.71%.

Nearly all the studies included bivariate analyses, some also had multivariate analyses such as logistic regression to identify predictor variables relating to specific outcome measures e.g. treatment completion. Treatment non-completion was not the sole focus for each of these studies and some focused more on recidivism outcomes. However, based on the data included in each study it was possible to identify variables associated with non-completion.

The following will summarise the statistical analyses of such variables under four categorical headings: demographic variables, violence-related variables, intrapersonal variables and non-client variables, as identified by Daly & Pelowski (2000) and Jewell & Wormith (2010).

Demographic variables:

Non-completion was significantly associated with younger aged participants (Bowen & Gilchrist, 2006; Buttell & Carney, 2002, 2008; DeMaris, 1989; Stewart et al., 2014), nonattainment of further or higher education levels (Beldin, 2008), unemployment (Bennett et al., 2007; DeMaris, 1989) and lower incomes compared with treatment completers (Buttell & Carney, 2008; DeMaris, 1989; Lila, Gracia, & Catalá-Miñana, 2018). Having more than high school education was a significant demographic variable (OR 4.25, $p = 0.000$), which accurately predicted 60.3% completion (Beldin, 2008). Treatment non-completers were significantly less likely to be married (Bennett et al., 2007; Bowen & Gilchrist, 2006; CarnIey et al., 2006; DeMaris, 1989) and had shorter relationships with their victim (Buttell & Carney, 2008). Non-completers had significantly younger partners (DeMaris, 1989). There were some conflicting findings regarding ethnicity, the majority of studies found ethnicity had no significant association with non-completion of treatment. However, one study identified non-completers were significantly more likely to be African American/Black (Eckhardt, Holtzworth-Munroe, Norlander, Sibley, & Cahill, 2008). Being Latino was a predictor variable for treatment completion (Bennett et al., 2007).

Violence-related variables:

Treatment dropouts were significantly younger at their first ever conviction (Bowen & Gilchrist, 2006), had significantly more previous arrests (DeMaris, 1989), specifically significantly more previous IPV arrests (Gordon & Moriarty, 2003), had more previous IPV convictions (Gordon & Moriarty, 2003) and had significantly more previous custodial sentences (Bowen & Gilchrist, 2006). Only one study focused on exploring adverse childhood experiences of treatment participants. They found treatment non-completers reported significantly more childhood abuse, witnessed significantly more sibling abuse, witnessed significantly more parental violence, had a significantly more distant paternal relationship and that their parents were significantly more likely to be divorced (Cuevas & Bui, 2016). This indicates a possible predisposition for the acquisition of violent attitudes and behaviours when dealing with conflict, possibly based on social learning theory (Bandura, 1973). The following psychometric measures were used in a minority of studies to examine violence-related behaviours; the Spouse-Specific Assertiveness Scale (SSAS; O'Leary & Curley, 1986), the Conflict Tactics Scales-2 (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996), the Propensity for Abusiveness Scale (PAS; Dutton, 1995a) and Abusive Behaviour Inventory (ABI; Shepard & Campbell, 1992). Treatment dropouts had significantly higher passive/aggressive scores using the SSAS (Buttell & Carney, 2002), were significantly more likely to have used a least one severe sexual coercion tactic using the CTS-2 (Carney et al., 2006) and were significantly more likely to chronically use minor sexual coercion tactics using the CTS-2 (Carney et al., 2006). In addition, treatment dropouts reported significantly lower levels of psychological and physical partner abuse using the ABI (Bowen & Gilchrist, 2006). However, two studies

by the same authors identified conflicting findings. One found treatment dropouts had significantly higher PAS scores (Buttell & Carney, 2002), yet the other showed treatment completers had significantly higher PAS scores (Buttell & Carney, 2008).

Intrapersonal variables:

Treatment dropout was associated with drug and alcohol use. Treatment non-completers were significantly more likely to drink alcohol (DeMaris, 1989) and were significantly more likely to be problematic drinkers (Catalá-Miñana, Lila, Conchell, Romero-Martínez, & Moya-Albiol, 2013; Lila, Gracia, & Catalá-Miñana, 2017). Treatment non-completers were significantly more likely to be substance users and specifically more likely to have higher marijuana use (Buttell & Carney, 2008). One study found treatment non-completers were significantly less likely to be suffering with depression at intake (Bowen & Gilchrist, 2006). When professionals delivering IPV treatment assessed participants as an 'active changer', in relation to transtheoretical model (J. O. Prochaska & Di Clemente, 1982); this was a predictor variable for treatment completion (Bennett et al., 2007). Treatment dropouts were considered within the IPV typology by Holtzworth-Munroe & Stuart (1994) and were significantly more likely to be Generally Violent/Antisocial (GVA) and Borderline/Dysphoric (BD) subtypes (Eckhardt et al., 2008). Treatment dropouts had significantly lower motivation to cease abuse (DeMaris, 1989). Finally, using scores from the Spousal Assault Risk Assessment (Kropp, Hart, Webster, & Eaves, 1995) treatment non-completers had significantly higher baseline levels of risk of IPV recidivism (Lila et al., 2018).

Non-client variables:

The language of treatment delivery was found to have an association with dropout, in that significantly more native Spanish speaking dropouts participated in spoken English treatment rather than treatment conducted in spoken Spanish (Hudak, 2000; Trebow, Berkanovic, & Harada, 2015). Participants were significantly more likely to drop out of longer duration programmes in studies that compared more than one treatment (Davis, Taylor, & Maxwell, 2000; Stewart et al., 2014). Having received additional mandated mental health treatment was significantly associated with IPV treatment completion (Gondolf, 2009). Finally, two studies examined the referral route for IPV treatment (Buttell & Carney, 2002; 2008). They found that referral to IPV treatment after arrest was significantly associated with treatment completion.

It is important to note that one study only examined the association of treatment outcome with a single variable, which was found to be non-significant (Gondolf, 2008).

Table 1: Study characteristics and correlates of court mandated IPV treatment outcomes (22 studies)

No	Study and location	Sample	Treatment approach and duration	Treatment completion definition	Dropout %	Correlates/predictors of significant treatment outcome at $p<0.05$
1	Beldin (2008) USA	n=184 community Tx completers (n=102); Tx dropouts (n=82)	Unspecified, Group A: 24 weekly group sessions; Group B: 36 weekly group sessions	Completed all sessions	44.6	Tx completers had more than a high school education, ($\chi2 = 13.167$, $p = .000$)
2	Bennett et al., (2007) USA	n=549 community Tx completers (n=413); Tx dropouts (n=136)	Unspecified, unspecified	Unspecified	24.8	Tx completers were Latino (OR = 1.81, CI: 1.03 to 3.19), an 'active changer' (OR = 2.34, CI: 1.49 to 3.66) Tx dropouts were more likely to be unemployed (OR = .31, CI: .19 to .50) and being single (OR = .32, CI: .34 to .96)
3	Bowen & Gilchrist (2006) UK	N=120 community Tx completers (n=81); Tx dropouts (n=39)	Duluth psycho-educational, 24 group sessions, 1 induction session, 5 monthly follow-up sessions	Completed a minimum of 21 of 24 group sessions (Actual mean session completed 16 of 24 based on facilitator discretion)	32.5	Tx dropouts were significantly younger, were significantly younger at the time of their first conviction and had significantly more previous convictions ($p<0.05$). Tx dropouts were more likely to have previous custodial sentences, ($\chi2 = 8.694$ $p<0.01$), were less likely to be married, ($\chi2 = 4.113$ $p<0.05$), less likely to be suffering with depression at intake ($\chi2 = 3.909$ $p<0.05$), report lower ABI psychological and ABI physical scores ($F(1,114) = 12.669$, $p < .01$; ($F(1,114) = 5.415$, $p < .05$)
4	Buttell & Carney (2002) USA	N=137 community Tx completers (n=77); Tx dropouts (n=60)	CBT approach, 16 weekly group sessions	Completed all sessions	43.8	Tx completers were older ($t = -3.796$, $p< .01$) and more often referred after arrest ($\chi2 = 5.855$, $p <.01$) Tx dropouts were more passive/aggressive in responding to their partners ($t = 2.601$, $p< .01$) and had a greater propensity for abusiveness score ($t = 2.128$, $p < .05$).

KEY: Tx - Treatment, OR - Odds Ratio, CI - Confidence Interval, CBT - Cognitive Behavioural Therapy, MBB - Mind-Body Bridging, FCS – Family & Child Services, FCC – Family Crisis Centre, SADVC – Sexual Assault and Domestic Violence Centre, IMP – Individualised Motivational Plan, MMPI-2 – Minnesota Multiphasic Personality Inventory-2, ABI – Abusive Behaviour Inventory

No	Study and location	Sample	Treatment approach and duration	Treatment completion definition	Dropout %	Correlates/predictors of significant treatment outcome at $p<0.05$
5	Buttell & Carney (2008) USA	N=1702 community Tx completers (n=850); Tx dropouts (n=852)	CBT approach, 26 weekly group sessions	Completed all sessions	50.1	Tx completers were older (t = 4.863, p =.000), reported higher monthly incomes (t = 4.159, p = .000) and longer relationships with their victim (t = 2.077, p = .038), and they were more often referred after arrest ($\chi2$= 29.222, p = .000) and less likely to report any marijuana usage ($\chi2$= 4.605, p = .032). Tx completers had a greater propensity for abusiveness score (t = 2.225, p = .026)
6	Buttell & Pike (2002) USA	N=83 community Tx completers (n=61); Tx dropouts (n=22)	CBT approach, 12 weekly group sessions	Completed all sessions	26.5	None identified
7	Carney et al., (2006) USA	N=114 community Tx completers (n=56); Tx dropouts (n=58)	CBT approach, 16 weekly group sessions	Completed all sessions	50.9	Tx dropouts more likely unmarried p = .05, more likely to have used at least one severe sexual coercion tactic (t = 2.208, p = .03) and more likely to chronically use minor sexual coercion tactics (t = 2.374, p = .03)
8	Catalá-Miñana et al. (2013) Spain	N=166 community Tx completers (n=126); Tx dropouts (n=40)	Nested ecological perspective, weekly group sessions over 9 months	Unspecified	24.1	Tx dropouts more likely to be problematic drinkers ($\chi2$ = 5.198, p < .05) and dropout was associated with alcohol consumption (OR = 1.073, CI 1.018 to 1.131)
9	Cuevas & Bui (2016) USA	N=180 community Tx completers (n=79); Tx dropouts (n=101)	Duluth approach, 52 weekly group sessions	Completed 49 of 52 sessions	56.1	Tx dropouts experienced more childhood abuse ($\chi2$ = 13.185, p < .01), witnessed more sibling abuse ($\chi2$ = 12.515, p < .01), witnessed more parental violence ($\chi2$ = 18.573, p < .01), have a more distant relationship with father ($\chi2$ = 13.151, p < .01) and whose parents were divorced ($\chi2$ = 4.55, p < .05)
10	Davis et al., (2000) USA	N=190 community Tx completers (n=76); Tx dropouts (n=114)	Duluth approach, 8 biweekly group sessions or 26 weekly group sessions	Unspecified	60.0	Tx dropouts more likely assigned to 26-week group ($\chi2$ = 27.72, p < .001)

No	Study and location	Sample	Treatment approach and duration	Treatment completion definition	Dropout %	Correlates/predictors of significant treatment outcome at $p<0.05$
11	DeMaris (1989) USA	N=295 community Tx completers (n=214); Tx dropouts (n=81)	Feminist psycho-educational approach, 12 group sessions	Completed 11 of 12 sessions	27.5	Tx dropouts are more likely to be younger (t = 2.849, p = .005), have lower incomes (t = 2.538, p = .012), have younger partners (t = 2.115 p = .035) were unemployed ($\chi2$ = 5.009, p = .025), previously arrested ($\chi2$ = 5.117, p = .024), drinks alcohol ($\chi2$ = 3.981, p = .046), lower motivation to cease abuse ($\chi2$ = 4.508, p = .034), have unmarried partners ($\chi2$ = 4.56, p = .033), premarital onset of abuse ($\chi2$ = 11.139, p = .004)
12	Eckhardt et al., (2008) USA	N=186 community Tx completers (n=110); Tx dropouts (n=76)	Unspecified, 24 weekly group sessions	Completed all sessions, with up to 3 excused absences, and exit interview attendance	40.9	Tx dropouts were more likely to be African American/black ($\chi2$ = 12.06, p < .002) and more likely to be GVA and BD violence subtypes ($\chi2$ = 26.79, p < .001)
13	Gondolf (2008) USA	N=684 community Tx completers (n=370); Tx dropouts (n=314)	CBT approach, 16 weekly group sessions	Completed all sessions	45.9	None
14	Gondolf (2009) USA	N=479 community Tx completers (n=271); Tx dropouts (n=208)	CBT approach, 16 weekly group sessions	Completed all sessions	43.4	Subsample of n = 148 Tx completers were more likely to have received additional mental health treatment (p < .05)
15	Gordon & Moriarty 2003) USA	N=132 community Tx completers (n=81); Tx dropouts (n=51)	Feminist psych-educational approach, Group A: 20 weekly sessions; Group B: 24 weekly sessions	Completed all sessions	38.6	Tx completers were less likely to have prior IPV arrests (t = −2.14, p < .05), less likely to have prior IPV convictions (t = −2.269, p < .05)
16	Harrell (1991) USA	N=107 community Tx completers (n=84); Tx dropouts (n=23)	CBT approach, FCS group: 12 weekly sessions; FCC group: 8 weekly sessions; SADVC group: 12-18 weekly sessions	Unspecified	21.5	None

No	Study and location	Sample	Treatment approach and duration	Treatment completion definition	Dropout %	Correlates/predictors of significant treatment outcome at $p<0.05$
17	Hudak (2000) USA	N=91 community Tx completers (n=56); Tx dropouts (n=35)	Unspecified, 52 weekly group sessions in English or Spanish	Unspecified	38.5	English speaking Tx dropouts were more likely to have higher MMPI-2 Scale 4 scores (t(50) = -2.410, p = .02), unemployed ($\chi 2$ (3) = 14.466, p < .01), lower than $12000 annual income ($\chi 2$ (5) = 13.478, p < .05)
18	Lila et al., (2017) Spain	N=286 community Tx completers (n=206); Tx dropouts (n=80)	CBT approach, 30-32 weekly group sessions	Unspecified	28.0	Tx dropouts were more likely to have alcohol abuse problems, ($\chi 2$ = 6.011; p < .05; $\varphi 2$ = .15) and dropout was associated with Alcohol abuse (W = 5.93; [OR] 1.92, CI 1.14, 3.23)
19	Lila et al., (2018) Spain	N=160 community Tx completers (n=123); Tx dropouts (n=37)	CBT approach, Standard: 35 weekly group sessions, Standard & IMP 35 weekly session plus 8 additional sessions	Unspecified	23.1	Tx completers reported higher levels of income (t = -1.95, p < .05; d = .37) and lower levels of baseline risk of recidivism (t = 2.46, p < .05; d = .45)
20	Stewart et al., (2014) Canada	N=246 prison Tx completers (n=160); Tx dropouts (n=86)	Nested ecological model approach, Medium intensity: 25 group sessions, High intensity: 78 group sessions, both delivered 3-5 times per week	Completed all sessions	35.0	Tx dropouts were more likely to be younger (t=9.50, p<.05)
21	Tollesfson & Phillips (2015) USA	N=90 community Tx completers (n=75); Tx dropouts (n=15)	MBB approach, 16 weekly session; Eclectic approaches, 20 weekly sessions	Completed all sessions	16.7	Tx completers more likely to be from MBB treatment (p=.05, one-sided Fisher's Exact Test)
22	Trebow et al., (2015) USA	N=150 community Tx completers (n=102); Tx dropouts (n=48)	Feminist psycho-educational approach, 52 group sessions	Completed all sessions	32.0	Tx completers more likely to be in Spanish language group ($\chi 2$ = 9.93, p = .002) and (B = 1.55, SE = .361, p = 000, Exp (B) = 4.71, CI 2.32 to 9.54); Tx dropouts were associated with having Drug & alcohol Probation conditions (B = -1.04, SE = .49, p = .035, Exp (B) = .35, 95% CI [0.13, 0.93]

Predictor model variables:

Seven studies utilised logistic regression to examine the predicted likelihood of treatment completion or dropout based on a combination of independent variables (predictors) (Table 2). Collectively, these models were composed of 49 predicator variables, ranging in number from three to fourteen per model. Albeit there was overlap of some variables between these models, as such 33 distinct variables appear to contribute to the model predictive efficacy for treatment completion in these seven studies. This indicates a wide diversity of factors associated with IPV treatment completion and dropout, ranging across the demographic, violence-related, intrapersonal and non-client variables from the four categories posed above (Daly & Pelowski, 2000; Jewell & Wormith, 2010).

Within these seven models, twelve predictor variables were significant. The demographic variables included: Age (Bowen & Gilchrist, 2006; Buttell & Carney, 2002, 2008; DeMaris, 1989), Education above high school (Beldin, 2008) and Average income (Buttell & Carney, 2008); violence related variables were: Previous custodial sentence (Bowen & Gilchrist, 2006), Self-reported ABI physical abuse score (Bowen & Gilchrist, 2006), SSAS assertiveness subscale score (Buttell & Carney, 2002), Propensity for abusiveness (PAS) score (Buttell & Carney, 2008), CTS2 sexual coercion prevalence score (Carney et al., 2006), CTS2 sexual coercion frequency score (Carney et al., 2006) and CTS2 injury prevalence score (Carney et al., 2006). The only intrapersonal variable was Crack/cocaine use (Buttell & Carney, 2008) and the only non-client variable was Referral to treatment after arrest (Buttell & Carney, 2002, 2008).

However, there were conflicting findings as some models identified five of these variables as non-significant predictors. Some authors contradicted their own findings as two models were by the same authors, and a further model by one of these authors; Age, PAS score, SSAS assertiveness subscale score and Crack/Cocaine use were deemed non-significant predictors (Buttell & Carney, 2002, 2008; Carney et al., 2006). In addition, yearly income was found to a further conflicting non-significant variable (DeMaris, 1989).

Although contributing to the predictive model, the remaining 21 variables were found to be non-significant: Currently employed (Buttell & Carney, 2002; DeMaris, 1989), Race (Beldin, 2008; Buttell & Carney, 2008), Education below high school (Beldin, 2008), Level of education (Buttell & Carney, 2008), Relationship length (Buttell & Carney, 2008), Marital status (Buttell & Carney, 2008), Victim is wife (DeMaris, 1989), SSAS passive/aggressive subscale score (Buttell & Carney, 2002, 2008), Control of Partner Scale (Follingstad, Rutledge, Polek, & McNeill-Hawkins, 1988) score (Buttell & Carney, 2002, 2008), CTS2 physical assault frequency score (Carney et al., 2006), CTS2 injury frequency score (Carney et al., 2006), Ever arrested (DeMaris, 1989), Motivation to cease IPV (DeMaris, 1989), Four individual partner violence subtypes: Generally Violent/Antisocial, Family only, Low-Level Antisocial, Borderline/Dysphoric (Eckhardt et al., 2008), Alcohol use (Buttell & Carney, 2002, 2008; DeMaris, 1989), Trouble due to alcohol use (DeMaris, 1989), Marijuana use (Buttell & Carney, 2002, 2008) and Prescription drug use (Buttell & Carney, 2002).

Table 2: Logistic regression models for treatment completion and dropout (7 Studies)

Study	% Correct classification	Variance proportion explained by model	Model statistics and number of variables in model
Beldin (2008)	**60.3%** 3.3% improvement over chance (breakdown not stated)	Nagelkerke R^2= .113	Log likelihood = 228.853, model χ2 not stated p < .05 1 significant predictor variable of 3 variables in model
Bowen & Gilchrist (2006)	**78%** % improvement not stated (correctly predicted 88% of completers & 59% of dropouts)	Not stated	Log likelihood not stated, model χ2 (3) =129.253; p < .001 3 significant predictor variables of 3 in model
Buttell & Carney (2002)	**74.8%** 33% improvement over chance (correctly predicted 46.9% completers & 27.8% dropouts)	Not stated	Log likelihood = 124.443, model χ2 (11) = 31.827, p <.001 3 significant predictor variables of 11 variables in model
Buttell & Carney (2008)	**60.3%** 10.7% improvement over chance (correctly predicted 28.9% completers & 31.4% dropouts)	Not stated	Log likelihood = 2208.65, model χ2 (14) = 86.965, p <.001 5 significant predictor variables of 14 variables in model
Carney et al., (2006)	**59.3%** 8.9% improvement over chance (correctly predicted 29.2% completers & 30.1% dropouts)	Not stated	Log likelihood = 140.785, model χ2 (6) = 15.857, p <.05 3 significant predictor variables of 6 variables in model
DeMaris (1989)	**64.8%** 12% improvement over chance (correctly predicted 62.7% completers & 70.5% dropouts)	Pseudo R^2 = .0829	Log likelihood not stated, model χ2 = 20.53; p = 0.0085 1 significant predictor variables of 8 variables in model
Eckhardt et al., (2008)	**69.2%** % improvement not stated (breakdown not stated)	R^2 = .17	Log likelihood not stated, model χ 2 (5) = 23.12, p < .001 Zero significant predictor variables of 4 variables in model

Evaluating the effectiveness of these models requires examination of the overall model and associated statistics. Missing data was acknowledged in one study (Beldin, 2008) and was in the acceptable range for logistic regression models (Hair, Anderson, Tatham, & Black, 1992). Zero missing data was identified in the other six models. However, five models excluded proportions of their study's participant sample, as follows: 27.6% (Bowen & Gilchrist, 2006), 23.1% (DeMaris, 1989), 16.1% (Buttell & Carney, 2002), 2.7% (Buttell & Carney, 2008) and 0.9% (Carney et al., 2006). Using a smaller sample may limit the efficacy of the predictive model and generalisability to each study's wider sample. Bowen & Gilchrist (2006) utilised a sample of n = 88 in their model, compared to n ≥ 113 in the other six models.

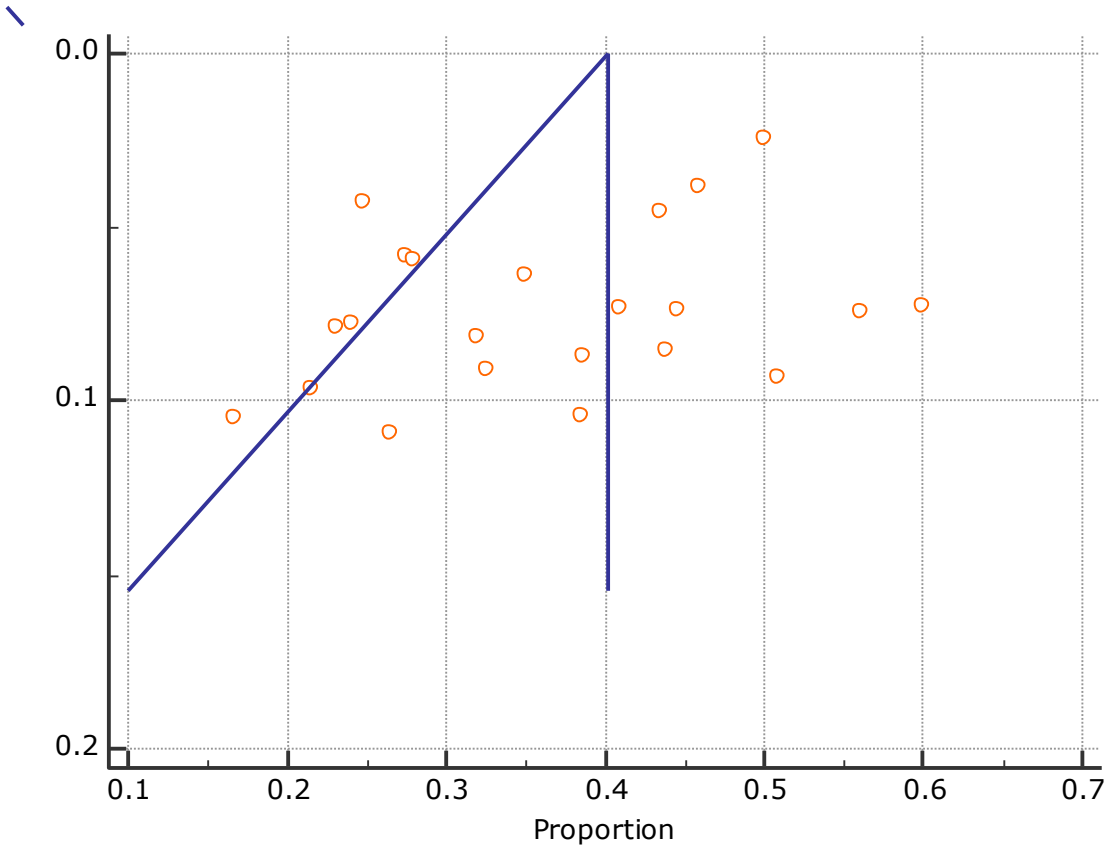
The percentage of accurate overall classifications from these seven models ranged from 59.3% (based on three predictor variables) to 78% (based on six predictor variables). However, percentage of improvement on the null hypothesis varied from 3.3% to 33% for five models and two did not make any reference to this (Bowen & Gilchrist, 2006; Eckhardt et al., 2008). Due to the variation in type and number of predictor variables as well as sample sizes used in each model, the comparability of the models is limited. Buttell & Pike (2002) attempted two logistic regression models to predict treatment completion. However, both models were found to be non-significant, for example 0% of treatment dropouts were classified accurately. These models were based on a sample of 83 participants which may have limited the predictive efficacy.

Finally, it is worth contrasting these finding with The Dropout Risk Screen (DRS; (Nunes, Cortoni, & Serin, 2010). Whilst the DRS has been designed to identify individuals at risk of dropout or expulsion from generic Offending Behaviour Programmes (OBPs), it is a screening tool that has been shown to have good predictive validity (AUC = .70) within an Australian offending sample. The five significant factor are Statistical Information on Recidivism – Revised 1 (Nafekh & Motiuk, 2002) risk scores, age, level of motivation for treatment, marital/family problems, and attitudes indicative of concerns about living a law-abiding life. There is little overlap of variables in the DRS and this chapter's findings. Again, this highlights the heterogeneity of variables examined within the existing literature.

Publication bias:

Figure B shows a funnel plot of all 22 studies. Some symmetry is visible which indicates low publication bias. This was supported in this review through the inclusion of unpublished studies and non-peer reviewed reports of IPV treatment outcomes.

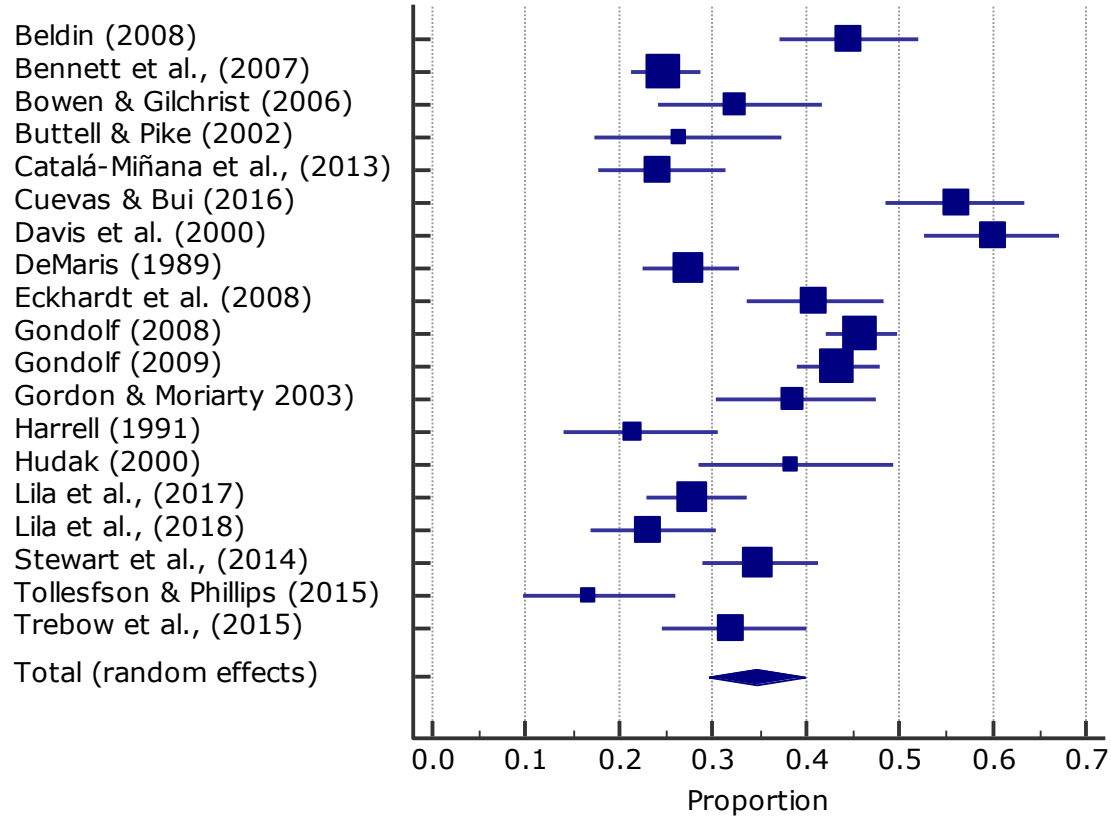
Figure B: Assessing publication bias (22 studies)



Heterogeneity:

Heterogeneity across the 22 studies' treatment outcome findings was analysed using the I^2 statistic, which was calculated to be 93.75% [95% CI 91.74%, 95.25%]. This shows a high level of variability in the dependent variable of treatment dropout outcome. As a result of this, a meta-analysis of proportions using the Freeman-Turkey transformation was conducted under the random effects model. Furthermore, three studies were excluded from the comparison of the proportions of treatment dropout (Buttell & Carney, 2002, 2008; Carney et al., 2006). This was due to the sample proportions of treatment completion and dropout being selected by their respective authors to approximate 50%. The forest plot produced illustrates the variance within the remaining 19 studies (Figure 3).

Figure C: Forest plot of treatment dropout proportions (19 studies)



There appears to be minimal consistency across studies of the particular variables subject to investigation; seemingly related to each study's aims. For some studies, treatment dropout was secondary to the aims. Only eight of 25 variables were examined for association with treatment completion in half of the studies in this review. It appears that data from demographic variables and violence-related variables were more readily examined in relation to treatment completion (see Table 3).

Utilising the Cohen's *h* statistic, the effect sizes of dropout proportions were analysed, in order to explore if there were any underlying trends between certain variable types. Stratifying the studies by quality assessment rating,

treatment curricula and sample size, show medium to large effect sizes of the proportion of dropouts within the 19 studies (see Tables 4, 5 & 6). This did not appear to discriminate any particular trends.

Table 3: Variables examined to be associated with treatment completion outcomes with all 22 studies

Variable	Significant	Non-significant	Not considered
Age	5	13	4
Ethnicity	2	15	5
Marital status	4	13	5
Education level	1	13	8
Alcohol use	3	10	9
Employment status	3	9	10
Psychometric measures	2	9	11
Income level	3	8	11
Drug use	1	9	12
Previous arrests	2	8	12
Severity of violence	2	8	12
Mental health symptoms	1	6	15
Adverse Childhood Experiences	1	4	17
Additional treatment or support	2	3	17
Previous custodial sentences	1	3	18
Relationship length with victim	1	2	19
IPV Risk level	1	2	19
Motivation to change status	1	2	19
Treatment length	2	1	19
Age of first conviction	1	1	20
Language of treatment	1	1	20
Referral following arrest	2	0	20
Age of partner	1	0	21
IPV typology	1	0	21
Level of motivation to cease IPV	1	0	21

Table 4: Treatment dropout mean effect sizes stratified to quality assessment rating

	Strong	Good	Weak
Studies (n)	2	10	7
Pooled dropout group (n)	123	710	755
Pooled full sample (n)	406	1998	1974
Cohen's *h* Effect size mean	0.873	0.687	0.688
Cohen's *h* Effect size SE	0.262	0.130	0.154
Confidence Level (95.0%)	3.329	0.295	0.376

Table 5: Treatment dropout mean effect sizes stratified to treatment curricula

	CBT	Feminist/ Duluth	Other	Unspecified
Studies (n)	6	6	3	4
Pooled dropout group (n)	684	434	141	329
Pooled full sample (n)	1799	1067	502	1010
Cohen's *h* Effect size mean	0.778	0.582	1.053	0.528
Cohen's *h* Effect size SE	0.184	0.104	0.245	0.184
Confidence Level (95.0%)	0.473	0.268	1.056	0.586

Table 6: Treatment dropout mean effect sizes stratified to sample sizes

	≥200	Between 100-200	<100
Studies (n)	6	10	3
Pooled dropout group (n)	905	611	72
Pooled full sample (n)	2539	1575	264
Cohen's *h* Effect size mean	0.657	0.658	0.968
Cohen's *h* Effect size SE	0.153	0.119	0.287
Confidence Level (95.0%)	0.393	0.270	1.234

Discussion, conclusion and recommendations:

The main findings are summarised in relation to the limitations and strengths of the study design. Furthermore, recommendations about the application of the findings to clinical practice and future research follow.

The IPV treatment non-completion (dropout) rates ranged from 16.7-60.0%. The mean rate of non-completion across 19 of the 22 studies was 34.7% (omitting three studies' samples purposely selected to comprise of 50% completers and 50% non-completers (Buttell & Carney, 2002, 2008; Carney et al., 2006)). This is consistent with the ranges previously identified by Lemire et al., (1996), Daly & Pelowski (2000) and Jewell & Wormith (2010).

The study designs ranged from quasi-experiments, some utilising randomised allocation of samples, to retrospective cohort designs. Some studies reported

charging participants fees for the treatment provided (Beldin, 2008; Davis et al., 2000; Gordon & Moriarty, 2003; Harrell, 1991; Tollefson & Phillips, 2015; Trebow et al., 2015). Payment of mandatory fees was routine within the USA, although details fees were not specified in all US studies. Other studies paid for participation (Eckhardt et al., 2008; Harrell, 1991). It is unclear if the ability to pay for treatment or being paid to participate has influenced treatment completion rates within these studies nor if initial intake into treatment has been affect. For example, one study suggests payment for treatment is an investment for an individual as well as a deterrent from further involvement with the legal system as an associated with lower follow up recidivism was identified. However this study also identified that 0.5% of the sample chose imprisonment in preference to engaging in treatment (Beldin, 2008).

Furthermore, despite the criteria for participants for this meta-analysis, the study samples were varied in nature (see table 1). Two studies only accepted first-time convicted perpetrators in community treatment (Lila et al., 2017, 2018), whereas another study's sample was made up of imprisoned perpetrators (Stewart et al., 2014). Whilst the sample from the latter study may have included men convicted for the first time, it was likely that imprisonment represented a sample with heightened severity or frequency of IPV. This may indicate a variation in typology of perpetrator. Samples were obtained from across North America and two countries in Europe, in which there are variations in IPV criminal legislations as well as cultural and ethnic diversity. This was of particular interest for two studies. For example, the study by Harrell (2000) only included men of Hispanic ethnicity and the study by Gondolf (2008) comprised only African-American men. However, ethnicity was

examined in 17 studies and only two found significant findings pertaining to minority groups. As such this cultural diversity appears to have had only a small association with overall treatment dropout.

The length of treatment varied between and within studies, especially where different treatment curricula were being compared. Whilst all these treatments aim to decrease future IPV, there are variations with the underpinning psychological theory and content of the treatments. As indicated in table 5, the most prevalent curricula: CBT and Duluth/feminist both had medium effect sizes for treatment dropout, using Cohen's *h* statistic. In more recent years, IPV treatment has expanded from the traditional curricula. Within this review's identified studies, treatment has been delivered from a Mind-Body Bridging approach, using the Nested Ecological Model (Dutton, 1995b) and holistic approaches which incorporate treatment or support for other offender issues, e.g. mental health, alcohol use and cultural differences. Whilst there is no well supported evidence for the superiority of a particular approach for reducing recidivism (Babcock et al., 2004), the impact of curriculum type on treatment attrition is yet to be more thoroughly investigated. It is recommended that treatment content and integrity measures should be explicitly described in future studies. In addition to treatment duration and frequency of delivery, detailed references should be made to the content or treatment manual, the training and supervision of staff delivering treatment, and integrity checks verifying that treatment was delivered as intended.

The aim of this study was to identify variables associated with treatment non-completion of court mandated male IPV perpetrators. Findings were

comparable to the meta-analysis conducted by Jewell & Wormith (2010), with the exception of inclusion of voluntary treatment. Whilst there is evidence from this present study to support independent bivariate associations between some variables and dropout from treatment, for example age, marital status, level of education, employment status, level of income, previous recidivism and severity of IPV, there was no agreement on how these variables may interact as a model of prediction for treatment attrition. This is most likely due to the sample heterogeneity, the handling of missing data, and a lack of comparable variables within the studies in this review that developed predictor models. Half of the studies included in this review failed to consider 17 variables in relation to treatment dropout. There was variation in the type of psychometric tools used within the included studies such as measures of general aggression or violence (Novaco, 1994; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), IPV (Dutton, 1995a; O'Leary & Curley, 1986; Straus, 1979; Straus et al., 1996), substance misuse (Babor & Grant, 1989; Mayfield, McLeod, & Hall, 1974), social desirability (Crowne & Marlowe, 1960; D. Paulhus, 1998), temperament (Radloff, 1977; M. Rosenberg, 1979) amongst others. The use of IPV specific risk assessments was infrequent. Overall, there was an absence of an aggregate IPV or generic risk score within the included studies.

Treatment dropout may be considered as clients' psychological reactance (J. W. Brehm, 1966), which is more readily recognised within the field of psychotherapy. It has been suggested that when situational threats to freedom exist, an individual may elicit motivation to restore freedom (S. S. Brehm & Brehm, 1981); in this case resisting court mandated IPV treatment. This should be acknowledged by the providers of court mandated interventions through

the delivery and execution of treatment. However in this chapter, non-client variables were frequently overlooked as factors that may impact on compliance. This suggests a presumption from researchers that treatment non-compliance is predominantly due to individual characteristics. This seems to be a limitation of the research presented, as well as suggestive of a somewhat arrogant perspective that a treatment provider has a minimal impact on this important outcome. The practical elements of treatment that may influence treatment include: the time and distance needed to access treatment, treatment location, the day and time of when treatment takes place, the group size, space for breaks and refreshments. Regardless of an individual's characteristics, attending group treatment can be daunting and if the venue has limited accessibility or is not welcoming, then this may impact on dropout before treatment has even had opportunity to be meaningful.

It would be unwise to neglect the impact of the practitioners delivering treatment. Whilst some studies in this chapter examined the spoken language of treatment, this seemed to be the only variable in relation to the extent of practitioners' influence on treatment. The practitioner training required for treatment delivery may influence the quality and integrity of the content of treatment. If treatment delivery is perceived to be poor in quality, this may discourage group members from completing. This can relate to the confidence group members have in the expertise of practitioners. It would not be uncommon for episodes of ongoing intimate partner conflict to be shared by group members as part of treatment. However, if a practitioner is overly condemning or condoning in their response, this may impact on group members' willingness to comply with treatment. Such a practitioner skill is not

taught from a prescriptive manual but rather from observation of other practitioners based on their expertise working with IPV perpetrators, as well as individual/peer supervision practices. It is commonplace to have two practitioners deliver IPV treatment, which can allow for more experienced practitioners being paired with newly trained staff, which may mitigate for some inexperience if the organisation structure allows.

Another factor related to the relational aspect of group interventions, is the degree of client-practitioner therapeutic alliance impacting on or moderating other variables associated with attrition. Having a sense of positive cohesion with other group members and practitioners can support a strong alliance that can reinforce treatment attendance. The use of motivational interviewing skills may foster the development of therapeutic alliance, however such use is frequently underreported in treatment evaluation unless it is the main subject of investigation. However, therapeutic alliance is a complex concept to investigate as it can be influenced by the organisational structure of a treatment provider. Organisational strengths can be having an overarching ethos where the treatment setting and practitioners have both a desistance-informed and trauma-informed approach. This can provide a rehabilitative culture that is supportive and accommodating to individual's needs. This may instil some optimism and recognition for recidivism reduction; whilst understanding the circumstances and background of each individual rather than the label given by society. However, organisational issues may negatively impact on the degree of such a rehabilitative culture. Disruptions in staff resourcing, office relocations, significant legislation changes can impact on the morale of practitioners and their willingness to remain in their roles. The loss

of experienced staff may impact on the quality of treatment as stated above. If a practitioner is directed to deliver group treatment rather than electing themselves into such a role, then this may adversely impact on their quality and commitment to deliver treatment. Ultimately, having an operational ethos on key performance targets, has the propensity to inhibit a client centred approach. IPV literature is beginning to explore how non-client variables, such as positive therapeutic alliance, can moderate other variables associated with attrition (Babcock et al., 2016; Bowen, Walker, & Holdsworth, 2019).

Only six studies provided an explanation for participant's non-completion of treatment. Examples included: gaining further charges/conviction, exceeding the number of acceptable absences, relocation and prioritisation of other treatment needs, amongst others. Classification of the reasons for treatment non-completion has been recommended across offender treatment literature (McMurran & Theodosi, 2007; Wormith & Olver, 2002). On the one hand, this can inform responsivity issues from the treatment provider or client that may be contributing to the non-completion, in which by addressing these may impact to reduce dropout rates. On the other hand, such information can differentiate legitimate reasons for non-completion, such as entering employment/education, that may support desistance from offending. Where treatment dropout occurs, it is recommended to record the quantity of treatment an individual completes, the reason for departure and any resulting sanction.

It is worth considering at what part in treatment did a study participant dropout. As there was a variation in the definition of dropout (see table 1),

some non-completers may have completed large parts of treatment compared to others that may have failed to start or had numerous failed attempts. This brings into question the appropriateness of comparing such completer and non-completer groups, if potentially some had similar doses of treatment. One study attempted to differentiate between no attendance, some attendance and full completion (Davis et al., 2000), another recorded the number of sessions attended (Beldin, 2008), however no significant findings were identified. This could suggest an adjustment to the research question, to investigate predictor variables associated with individuals who start but do not complete treatment compared with others fail to start at all. This is a limitation in data available for this review, in that variable differences are overlooked by grouping participants solely as 'non-completers'. However, one of the studies rejected from this review examined participants reinstated back into treatment following initial dropout (Scott, King, McGinn, & Hosseini, 2013). Findings showed participants that were reinstated back into treatment shared more characteristics with men who failed to complete compared with those who completed on their first attempt. Whilst this is only one study, further research may inform on the effect of treatment exposure for partial treatment completers. This is particularly relevant to treatment evaluation literature, which would require a clear differentiation of treatment or evidence that the comparison sample did not receive any treatment or alternative service (Cheng, Davis, Jonson-Reid, & Yaeger, 2019).

Included studies required samples to be court mandated, however there was little information regarding the actual sanctions for study participants failing to complete treatment. This may have impacted as a possible deterrent for

dropout. The low attrition rate in the study by Buttell & Pike (2002) was attributed by the authors to the strong judicial support, who had the option of 30-90 day imprisonment if a perpetrator was returned to court for treatment non-completion. However, findings on this are inconclusive. One study found the degree of the threat of sanction from non-compliance was not predictive of treatment compliance (Dalton, 2001). Further research into the effects of enforcing such sanctions may inform the possible non-client extrinsic motivators that are at play with commencing court mandated treatment. In the study by Davis et al. (2000), participants agreed to the treatment with the convicting judge and prosecutor. The authors suggest participants were sufficiently motivated for treatment over alternative sentence options. In contrast, this implies that some perpetrators are less motivated and as stated earlier, at least one study identified individuals who actively chose imprisonment over completing IPV treatment in the community. Some included studies did attempt to measure the degree of motivation to change, some using informal single item assessments from treatment staff (Bennett et al., 2007), others used validated measures such as using the University of Rhode Island – Domestic Violence (URICA-DV; Levesque, Gelles, & Velicer, 2000) (Eckhardt et al., 2008; Stewart et al., 2014). It is important to consider that an individual's self-reported level of motivation may contrast with a practitioner's assessment their motivation for treatment. It has been identified that treatment cannot be expected to be effective if it occurs against an individual's will (Rosenfeld, 1992). Indeed, motivation for treatment features as one of the five significant factors within the predictive model underpinning the Dropout Risk Screen (Nunes et al., 2010).

It has been suggested to tailor treatment to an individual's stage of change in order to improve treatment outcomes (Norcross, Krebs, & Prochaska, 2011). Based on this, it may be impractical to design different treatments to each stage of change due to fluidity of motivation as a concept. As such a number of included studies evaluated the use of additional strategies to promote treatment readiness. Significant findings were low from the culturally sensitive intensive case management studies such as Gondolf (2008) but showed improved completion rates with responsivity to language preference (Trebow et al., 2015). However, additional intervention before or during treatment produced conflicting findings. Completion rates were improved with the incorporation of additional interventions for mental health (Gondolf, 2009), however the implementation of additional motivational strategies showed limited improvement to completion rates (Lila et al., 2018). This finding was in contrast to significant findings from wider literature utilising motivational interviewing techniques (Miller & Rollnick, 1991) in a single session or six week interventions (Crane & Eckhardt, 2013; Scott, King, McGinn, & Hosseini, 2011). Other types of offender treatment are now designed to include a specific module bespoke to promoting motivation and engagement in treatment, prior to addressing treatment risk and need (Tew & Atkinson, 2013).

Aside from treatment motivation, use of supportive or preparatory intervention may also address the variables that are associated with attrition so that they have less impact when treatment is commenced. Such variables can include marital status, employment and age. These stake in conformity variables represent the degree of attachment with society an individual has, which is inversely related to lifestyle instability (Toby, 1957). Whilst age and marital

status are static factors, addressing employment, accommodation etc. needs can support an individual to have a greater stake in a nonviolent society which in turn may result in having more to lose by dropping out of treatment (Feder & Dugan, 2002).

In the wider literature, there has been exploration of the expense and resource incurred with reinstating treatment dropouts. Scott et al. (2013) estimated for a particular type of IPV treatment, this cost approximately US$2000 for the professionals' time and correspondence efforts with each reinstated completer. It would be useful to identify costings for pre-treatment motivation enhancement interventions to evaluate the cost-effectiveness compared with reengaging with dropouts.

To date, there have be a number of IPV typologies suggested, relating to the perpetrator gender, underlying motivation for violence, personality traits, physiological responses and violence frequency and severity (Holtzworth-Munroe & Stuart, 1994; Johnson, 1995, 2000; Johnston & Campbell, 1993). Only one study in this review incorporated reference to IPV typology (Eckhardt et al., 2008) however, none of the typology clusters predicted treatment attrition. A more recent study has identified that in line with Holtzworth-Munroe & Stuart's (1994) theoretical model, individuals clustered within the Generally Violent-Antisocial typology had significantly higher dropout and recidivism rates. Personality traits may be relevant to treatment engagement, as Anti-Social Personality Disorder was associated with low overall treatment readiness in three UK offender treatments, including one for IPV (Shaw & Edelmann, 2017). It is yet to be examined if particular treatment curricula are better

suited to certain typology groupings. However, this may be related to the methodology involved with identifying each typology from the three dimensions of Holtzworth-Munroe & Stuart's (1994) theoretical model: severity of marital violence, generality of violence and psychopathology; the latter requiring a measure of personality dimensions. This clinical application of the IPV typology to practice has been examined with a small sample of practitioners and provisional findings have been unclear of the benefits (Boxall, Rosevear, & Payne, 2015).

Overall, it is vital to address and reduce attrition rates because this can have a confounding effect when evaluating the effectiveness of IPV treatment and restrict an individual's ability to address their IPV, which may ultimately result in further IPV recidivism (Babcock et al., 2004). This meta-analysis, has contributed to the exploration of factors associated with IPV treatment attrition. Recommendations, if implemented in future research, may assist treatment providers with identifying potential individuals that may dropout from treatment. By doing so, additional practical resources may be designed and implemented to support such individuals to engage fully. Furthermore, this research can be developed in order to ascertain if individuals that dropout of treatment are more likely to recidivate. Whilst some of the included studies did explore recidivism, the variation in type of recidivism and follow up length, was inconsistent for comparison and some data did not specifically differentiated the individuals that dropout from treatment. There has been some preliminary findings that the variables associated with attrition have similarities with IPV recidivism (Jewell & Wormith, 2010). Further analysis of the recidivism of

dropouts within IPV treatment studies may reinforce the urgency of utilising strategies to reduce treatment attrition.

Chapter 3: Assessing treatment dropout and promoting treatment compliance of Intimate Partner Violence Perpetrators within a community group intervention in England

Introduction:

Chapter two has identified variables such as age, marital status, education level, employment status, level of income, previous recidivism and severity of IPV, that are associated with attrition from court mandated Intimate Partner Violence (IPV) group treatment. However, predictive models of dropout were inconclusive due to the heterogeneity of variables and the sample types considered.

IPV Offending Behaviour Programme (OBP) treatment dropout or attrition was a key concern for the treatment service provider where this research was conducted. As stated in the introductory chapter, this attrition has an impact on the financial cost-effectiveness of this treatment delivery. This is in addition to the heightened risk of further offending that individuals that start an OBP and do not complete present, compared with those that do not commence treatment at all (Gondolf, 2002; Harder, 2005; McMurran & Theodosi, 2007; Miner & Dwyer, 1995). Levels of reoffending have been estimated to be between 10-62% for men that drop out from IPV treatment (Aldarondo & Fernando, 2002). The practical implications of these findings present an ethical issue. In that, by failing to address and reduce treatment dropout, are treatment services indirectly contributing to the increased risk of further IPV perpetration?

Research has examined and identified various variables to be associated with OBP completion for IPV perpetrators. Studies have found such indicators are: age, education level, being employed, mental-wellbeing, history of substance use, number of children, being in a stable relationship, violence in the family of origin, prior arrests, lack of court sanctions and having motivation to change (Bennett et al., 2007; Bersani & Chen, 1988; DeHart, Kennerly, Burke, & Follingstad, 1999; DeMaris, 1989; Gondolf, 1999; Grusznski & Carrillo, 1988; Hamberger & Hastings, 1989; Pirog-Good & Stets, 1986; Saunders & Parker, 1989).

Suggested ways of promoting motivation to change in IPV perpetrators are using motivational interviewing techniques (Kistenmacher, 2001), building and maintaining a therapeutic working alliance (Taft, Murphy, Elliott, & Keaser, 2001), having a motivational enhancement therapy approach (Miller, Zweben, DiClemente, & Rychtarik, 1992), and focussing on parenting roles (Baker, Perilla, & Norris, 2001; Israel & Stover, 2009).

A lack of motivation has been identified as an attitudinal factor associated with dropping out from group IPV treatment (Daly & Pelowski, 2000). Motivation for treatment and/or readiness to change plays a crucial role within many psychotherapeutic interventions. This is applicable with IPV perpetrators and it is important to consider this the context of a court mandated intervention. Should offender motivation be considered a criterion for treatment selection or as a treatment need in itself? It could be quite appealing to only select the most highly motivated perpetrators for treatment, this could have a positive effect on attrition and therefore increase successful treatment completion.

However, criminal courts do not convict motivated perpetrators only, they convict guilty parties and within these there are fluctuating levels of motivation to change. As such, motivation should be a treatment need throughout all aspects of Probation supervision, but it could be a contributing factor for treatment selection, in that those deemed least motivated may benefit from an additional intervention prior to commencing the main IPV treatment specified in an individual's sentence plan, such as an OBP.

Self-identification of the need for treatment has been identified as a predictor for IPV treatment compliance (Cadsky, Hanson, Crawford, & Lalonde, 1996), as well as the perception of IPV treatment as important (DeMaris, 1989). So enhancing perpetrators attachment to treatment may assist with reducing attrition and subsequently positively impact on the recidivism reduction associated with OBP completion (Adams, 1985; Gondolf, 1987; Scott, 2004). Having a strength-based approach can also promote motivation to engage and change (Bennett et al., 2007). This is consistent with the greater emphasis within public and private sector Probation service to manage offenders utilising the principles from Desistance research (Maruna, 2000; Maruna et al., 2004; McNeill & Weaver, 2010), and the Good Lives Model (GLM) of offender rehabilitation (Ward & Brown, 2004; Ward & Stewart, 2003).

Offenders' motivation to change has received scrutiny within academic literature. The main theories and models of motivation to change have evolved from addiction literature: the Theory of Current Concerns (TCC; Cox & Klinger, 1988, 2004, 2011), the Stages of Change model (James O. Prochaska & DiClemente, 1983) Self-Determination Theory (R. M. Ryan & Deci, 2000), the

Multifactorial Offender Readiness Model (MORM; Ward, Day, Howells, & Birgden, 2004) and the Readiness to Change Framework (RCF: Burrowes, 2006). It is not possible to explore each of these in this overview, however a comprehensive overview of these can be found in McMurran, (2010); and McMurran, Sellen, & Campbell, (2011). The second part of this study explores the goal-directed perspective of offender motivation in order to promote IPV perpetrators' engagement with treatment.

One such goal-oriented strategy to assess offender motivation for treatment and meaningful change is the Personal Aspirations and Concerns Inventory for Offenders PACI-O; Campbell, Sellen, & McMurran, 2010). This is underpinned by the TCC (Cox & Klinger, 1988, 2004, 2011) and has been developed from adaptations of the Personal Concerns Inventory (PCI; Cox & Klinger, 2000) and the PCI-Offender Adaptation (PCI-OA; Sellen, McMurran, Cox, Theodosi, & Klinger, 2006). All of these measures refer to the cognitive and affective process that underlie active goal pursuit and addresses the social context of an individual's motivation.

These measures involve identifying personal goals and incorporates a strengths based approach of rating them in terms of their perceived value, attainability, controllability, achievability, commitment and expected affective change if goal were achieved. This is comparable to the Barriers to Change Model within the RCF. The PACI-O design streamlined the life areas of the previous measures, in which people are likely to have current concerns into six distinct categories: (i) Past, current and future living arrangements, (ii) Close personal relationships, (iii) Physical or mental health issues, (iv) Recreation, (v) Self-

changes and personal improvement, and problems with anger/violence, and (vi) Employment, training and financial situation. Also incorporated was the identification of goal obstacles and possible conflicts between goals.

Overall the PACI-O, delivered as a semi-structured interview, is shorter to administer than its PCI and PCI-OA predecessors. It has shown potential as a pre-treatment motivation enhancer, which improved treatment engagement for offenders completing custodial OBPs (Sellen, Gobbett, & Campbell, 2013). The PACI-O, if delivered as a brief motivational intervention, has the capacity to enhance treatment motivation through the following mechanisms. Identifying goals can assist with exploring the function or dysfunction of an individual's choices within the eight life areas. Goal identification features in the MORM (Ward et al., 2004) as volition and within the RCF (Burrowes, 2006). This is an individualised approach without judgement of goal choice.

The expected affective change of a particular goals is framed within the PACI-O as the degree of happiness an individual may expect to feel following goal attainment. This may be a welcome contrast with the negative emotions such as distress, shame and guilt associated with their offending, which are described in the MORM as influencing on treatment readiness.

On the one hand, the question about how probation may help or hinder their goals can highlight to an individual the supportive nature of the Probation input of them as a whole person, not just concerning their offending. On the other hand, the responses to this question can be indicative to the assessor of particular cynicism or hostility that can be addressed within future client

contact. This may be suggestive of client expectations from treatment and this has been positively associated with treatment outcome (Arnkoff, Glass, & Shapiro, 2002). This also relates to the behaviour internal component of the MORM, in that an individual can recognise they may need support for an issues and furthermore, appraise their ability to engage with the support that is available. This item can be indicative of the external (MORM) or environmental (RCF) factors. These may include concerns about the delivery of treatment, the expertise of the staff, support for individual needs e.g. literacy, and the practicality of timing and location of treatment.

The question about how offending may help or hinder their goals, provides the individual opportunity to contemplate a non-offending identity (Bowen et al., 2019). This may have particular relevance when describing the relationships life area as they can consider a non-violent role within their meaningful relationship. Such a cognitive shift may support the desistance from offending. This item assists the individual to analyse the costs and benefits of offending compared with life goals.

The identification of the personal barriers to goal attainment can assist with formulating strategies of removing or reducing such barriers. This features within motivational approaches in making change palatable, whilst pre-empting the costs of change (Miller & Rollnick, 1991). In addition, the PACI-O is based on the life domains within the GLM (Ward & Brown, 2004; Ward & Stewart, 2003), and consideration of an individual's life as a whole can provide a broader perspective of possible conflict or cohesion between goals. This can assist with the prioritisation of some or perhaps the modification of others.

The PACI-O requires individuals to consider their own self-efficacy in relation to their goal attainment. This may support their ability to feel more in control of their next steps and sense of achievability, and is associated with enhancing motivation and performance (Bandura & Locke, 2003). Within the initial PACI-O pilot, the authors identified a positive orientation towards the PACI-O from respondents. They commented that it helped them to "think straight" and think "about how different things will affect my plan" (J. Campbell et al., 2010).

The psychometric properties have been explored and investigation of the structural validity of the PACI-O as a measure of motivation, found the most robust factor structure uses the rating scales common to the PCI and PCI-OA rather than incorporating the PACI-O adapted rating scales (J. Campbell, McMurran, & Sellen, n.d.). Findings for the construct, Adaptive Motivation (AM), have been shown to have good internal consistency (Cronbach's alpha = .72), however further investigation of convergent and predictive validity are required for the PACI-O.

The most recent research using the PACI-O has focused on custodial samples (Kearney & Sellen, 2013; Sellen et al., 2013). Thus the second part of this chapter details the examination of the applicability of the PACI-O within community samples to contribute to the empirical evidence evaluating interventions to enhance motivation for treatment compliance. The methodology of this project is influenced by recommendations of previous PACI-O research. The PACI-O was deemed suitable for use with IPV perpetrators based on its commonality with findings from a study exploring the

role of self-determined goals in predicting recidivism with IPV perpetrators (M. Y. Lee, Uken, & Sebold, 2007). The authors identified that goal specificity, goal commitment and goal agreement could negatively predict recidivism, with the level of confidence to work on the goals being a mediating factor for IPV perpetrators engaged in treatment.

Part one aim:

To identify the factors associated with treatment attrition in a community IPV intervention.

Part two primary hypothesis:

Administration of the PACI-O to offenders before the completion of community IPV intervention will give better treatment completion rates in male IPV perpetrators under Probation supervision, compared to offenders that have not undergone the PACI-O pre-treatment.

Part two secondary hypothesis:

Within the experimental group, participants with high Adaptive Motivational scores will have a higher rate of IPV intervention completion.

Part one method:

Data collection:

Part one involved the analysis of data collected by a Community Rehabilitation Company (CRC) Probation service OBP team in northern England. At referral, basic demographic information was taken and stored in an electronic database

by the treatment provider. This included age at referral, ethnicity, type of court order, geographical district, allocation to public or private sector Probation management, completion status and number of invitations offered to individuals which indicated the number of attempts to start treatment. In addition, the Offender Group Reconviction Scale 3 (OGRS3; Howard, Francis, Soothill, & Humphreys, 2009) scores were recorded at point of referral. The OGRS3 give two scores, of percentage prediction of re-offending after one and two years. The scores are based on the static factors: age, gender and criminal history. The database was then updated with the progress of each individual in terms of their allocation and engagement with a treatment intervention. Any missing data was sourced from an additional computer system. To comply with ethical requirements, the data was anonymised upon sharing from the IPV intervention referrals database with the primary author. It was known anecdotally that clients' employment status, relationship status and child access could change throughout their supervision. As such, the recording this information on statutory electronic Probation systems was dependent on Probation practitioners inputting such information. Such recording was typically inconsistent, and when this information was documented, it was not always clear if the information was relevant pre-, per- or post-treatment. As such this information was uncollectable for the purpose of this study.

The IPV intervention:

This OBP was designed in response to the high demand for IPV intervention for male perpetrators that posed medium risk of violence specifically towards female intimate partners using the Offender Assessment System (OASys;

Home Office, 2002) and Spousal Assault Risk Assessment Version 2 (SARA-V2; Kropp, Hart, Webster, & Eaves, 1999).

This OBP was cognitive-behavioural in approach and comprised of two phases: (i) group orientation session and individual intake interview (two sessions) and (ii) psychoeducational weekly group sessions and one mid-treatment individual session (14 sessions). The group sessions consisted of approximately 8-12 perpetrators and met one night each week for 2-2.5 hours. The programme content aimed to develop insight into use of violence and support IPV perpetrators to take responsibility for their thoughts, feelings and behaviours within intimate relationships. The psycho-educational sessions included developing emotional respect, responsible parenting and committing to change. The content also included interpersonal skill development such as communication, handling conflict and self-control skills. A comprehensive treatment manual structured the intervention delivery and overall structure.

This intervention was delivered by two OBP facilitators, best practice supported the mix of male and female staff allocated to each treatment group but due to a higher ratio of female staffing levels, this was not available to all treatment groups. Four days of formal training was required before staff were assessed as competent in delivering this intervention and supervision processes were in place for each treatment group delivered. The latter incorporated regular integrity checks by a trained treatment manager to ensure the treatment was being delivered as intended and to provide feedback to delivering staff following the review and evaluation of video recorded sessions.

Within the 12 month study period, 24 treatment groups were delivered across five geographical districts served by this study's treatment provider. District 1 had the smallest civilian population of 210,082 people, and District 5 had the highest population of 789,194, with Districts 2, 3, and 4's populations increasing sequentially in between (Office for National Statistics, 2019b). The treatment provider delivered two treatment groups in District 1, four in District 2, three in District 3, five in District 4 and ten in District 5.

Definition of treatment completion:

Intervention completion was defined as attendance at 15 sessions comprising of two individual sessions and 13 group sessions. An initial group orientation session was not mandatory. Failing to attend two consecutive session without any acceptable reason given would result in deselection of an individual from treatment. Up to two non-consecutive session could be missed if a legitimate reason was provided to an individual's Probation Offender Manager. However, the content of each missed session had to be completed as a condensed hour-long session prior to the delivery of the next session. It was possible to have up to three attempts for completing the intervention. If an individual dropped out from treatment and they had sufficient time remaining on their sentence, they could be invited up to two more times to attend and potentially be classed as a treatment completer if they completed all 15 sessions. Consequently, intervention dropout was classified as an individual who fails to complete more than one of the 15 sessions. When this occurred an individual's Offender Manager was notified, who could recommend reengagement with intervention, return the individual to court or dismiss the matter.

Participants:

The sample comprised of 574 male IPV perpetrators, aged over 18 years and subject to criminal sentence for an IPV related offence (Table 7). Each had been referred to a community IPV group intervention delivered by a CRC Probation service OBP team, in a twelve month period from 29th June 2014.

Table 7: Demographic information of participants in part one

	Variable	Part one (N = 574) Completed Intervention (N = 211)		Not completed Intervention (N = 363)	
Median Age (IQR)		31	(15)	30*	(12)
Ethnicity (%)	White	167	(79.1%)	299	(82.4%)
	Asian	21	(10%)	33	(9.1%)
	Black	8	(3.8%)	18	(5%)
	Mixed	12	(5.7%)	10	(2.8%)
	Other/Not stated	3	(1.4%)	3	(0.8%)
Order Type (%)	Community Order	155	(73.5%)	252	(69.4%)
	Suspended sentence	37	(17.5%)	70	(19.3%)
	Custodial sentence	19	(9%)	41	(11.3%)
Management (%)	CRC	187	(88.6%)	307	(84.6%)
	NPS	24	(11.4%)	56	(15.4%)
Geographical District (%)	District 1	25	(48.1%)	27	(51.9%)
	District 2	36	(46.8%)	41	(53.2%)
	District 3	49	(41.2%)	70	(58.8%)
	District 4	36	(31.0%)	80	(69.0%)
	District 5	65	(31.0%)	145	(69.0%)
Median OGRS3 Year 2 (IQR)		38.5†	(29)	55‡	(35)
Median days bet. Order start & Referral (IQR)		24	(36)	24	(37)
Number of invites (%)	1 invite	159	(75.4%)	122	(33.6%)
	2 or more invites	52	(24.6%)	224§	(61.7%)

KEY: * Missing data for 35 participants; † Missing datum for 1 participant; ‡ Missing data for 36 participants; § Missing data for 17 participants

Data analysis plan:

Statistical analysis involved the use of Chi-square, Mann Whitney U tests, correlations and logistic regression. The statistical methods were chosen based

on tests of normality finings. All collected data was entered and analysed with SPSS version 24. The outcome of treatment dropout was subject to bivariate statistical analysis with each of the variables listed in Table 7. Any variables that were found to be significantly associated with treatment outcome were explored in combination, in order to ascertain if they contributed to any capacity to predict treatment dropout. Correlations were run for independent variables included in the logistic regression model in order to check for collinearity issues. Due to small cell sizes related the ethnicity, this variable was dichotomised in "white" and "BAME" categories. In addition, the unusual distribution of the continuous variables: age, OGRS3 scores, and number of days between start of order and referral to treatment, was addressed through recoding using visual binning. The variables were recoded into the following categories: quintiles, quartiles and quartiles, respectively. Logistic regression was selected for this analysis, based on the proportion of categorical data collected, as it does not require the assumption of multivariate normality and equal variance (Hair et al., 1992; Hosmer & Lemeshow, 1989). The variables were entered into the logistic regression simultaneously in one step. Outcome was coded as: 0 for completed and 1 for not completed.

Part one results:

The treatment dropout rate for this sample was comparable to those within established literature, as 63.2% failed to complete this IPV intervention.

Bivariate analyses found no significant differences between completers and non-completers for the following variables: sentence type, private/public

sector Probation management, ethnicity or length of time between start of order and referral to treatment, see Appendix III. However, such analyses did identify variables that significantly differed between individuals that completed treatment and those that did not, these were:

- Geographical District – The more rural (lower populous) the geographical district of treatment, the more likely an individual was to complete, χ^2 (4, N = 574) = 11.854, p = .018. Anecdotally this was well known and more rural areas hosted fewer IPV interventions, as stated above, compared with more urban areas. Consequently men in rural areas completed treatment in these locations more frequently as the alternative would require them to travel to a different district to attend IPV treatment.
- Offender Group Reconviction Score version 3 (OGRS3) – Treatment completion was associated with lower OGRS3 Year two (Y2) scores. This actuarial assessment calculates the percentage likelihood of reconviction within two years. A Mann-Whitney U test indicated that the OGRS3 Y2 score was significantly higher for treatment dropouts (Mdn = 55) than treatment completers (Mdn = 38.5), U = 23424.500, z = -6.219, p < .001.
- Number of attempts at the treatment – Those that required more than one attempt to attend treatment were less likely to complete. Measured through number of invites given to each individual to attend IPV intervention, 64.7% of treatment non-completers had been given two or more opportunities to start treatment but then went on to dropout, whereas 75.4% of treatment completers only required one attempt at treatment to completed, χ^2 (1, N = 557) =84.292, p < .001.
- Age at the time of referral to treatment - A Mann-Whitney U test indicated that age was significantly lower for treatment dropouts (Mdn = 30) than

treatment completers (Mdn = 31), U = 29293.500, z = -3.012, p =.003. A linear-by-linear chi-square analysis identified a significant trend of increasing age of an individual that completed treatment than those who did not complete treatment, χ^2 (1, N = 539) =9.808, p = .002.

Table 8: Logistic Regression Analysis of 524 Referrals for IPV treatment

							95% C.I. for EXP (B)	
	B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Treatment attempts(1)	1.842	.212	75.277	1	.000	6.311	4.162	9.568
OGRS3 2 Yr score	.028	.005	31.922	1	.000	1.029	1.018	1.039
Geographical Districts			7.873	4	.096			
Geographical Districts(1)	-.151	.366	.170	1	.680	.860	.420	1.761
Geographical Districts(2)	-.785	.325	5.838	1	.016	.456	.241	.862
Geographical Districts(3)	-.401	.277	2.102	1	.147	.669	.389	1.152
Geographical Districts(4)	.070	.299	.055	1	.814	1.073	.597	1.926
Constant	-1.549	.305	25.771	1	.000	.212		

Variables entered on step 1: Treatment attempt, OGRS 2 Year and Geographical Districts Log Likelihood = 568.677 Nagelkerke R Square = .311, Hosmer and Lemeshow test was not statistically significant demonstrating predictive capacity of the model.

The logistic regression was performed to ascertain the predictive efficacy of the effects of treatment attempts, OGRS3 Year 2 score, Geographical district and age on the likelihood that perpetrators would not complete IPV treatment. This was based on data from 91.3% of the sample due to 50 missing cases. When these four variables were combined, age was no longer a significantly contributing factor. As stated, age does have a significant linear trend if binned into quartile ranges and if age is modelled alone against treatment outcome it is a significant predictor variable within a binary logistic regression. However, such a model is insufficient as there is a 1.5% decrease in predictive capacity. The predictive capacity of age was explored further by completing logistic regression analyses modelling age with each of the above three variables independently. The only non-significant association of predictor variables was age with OGRS3 2 year score. Age was also found to have a significant negative

correlation with OGRS3 2 year score, r = -.400, p < .001. This indicates that age and OGRS3 2 year score have some collinearity that is likely caused by the OGRS3 scores being calculated using age components.

Table 9: Classification accuracy of model in classifying individuals who dropped out or stayed in treatment (n=524), the observed and predicted frequencies, with the cut-off of .50

	Predicted		
Observed	Non-Completion	Completion	% Correct
Non-completion	258	56	82.2%
Completion	71	139	66.2%
Overall % correct			75.8%

False positive = 21.6%, False negative = 28.7%

As such, the final logistic model for characteristics associated with treatment non-completion, when age was excluded (Table 8), was statistically significant (χ^2 = 136.962, df = 6, p < .001). The model explained 31.1% (Nagelkerke R^2) of the variance in treatment non-completion and correctly classified 82.2% (sensitivity) of cases that did not complete treatment and 66.2% (specificity) of cases that did complete treatment. This gave an overall percentage correct classification rate of 75.8% of cases (Table 9). The applied model resulted in a 15.9% improvement over chance (59.9% versus 75.8%) in the prediction of treatment dropout for the sample. Individuals that required two or more attempts at treatment were 6.76 times more likely to not complete treatment than those who had one attempt at treatment. Increasing OGRS3 year 2 score was associated with an increased likelihood of not completing treatment.

Part one discussion:

The treatment non-completion rate for this sample was 63.2%, which was just outside the range of 16.7-60.0% as identified in chapter 2. However, the rate was consistent with the wider literature (Daly & Pelowski, 2000; Jewell &

Wormith, 2010; Lemire et al., 1996). This may indicate the population served by this treatment provider has more problematic attrition from this particular IPV intervention.

The findings from this study identified a low number of demographic, violence-related and non-client variable differences between treatment dropouts and completers. This is likely due to the limited data recorded by the treatment service. However, the data analysis suggested treatment dropouts, when compared with treatment completers, are younger, have a higher OGRS3 score, require more attempts at treatment and are located in more urban districts with higher general populations.

The OGRS3 score is made up of a collective of variables and the two scores are calculated from the interaction between age, gender and criminal history factors. The latter factor encompasses current offence category, sanction history, number of previous sanction and time between current and first sanction. The predictive validity of the OGRS3 as a prediction of proven reoffending is deemed to be strong with an Area Under Curve statistic of .75 (Howard, 2015). A higher OGRS3 score would indicated heightened risk that requires intervention based on RNR principles (Andrews et al., 1990). However, this study found a higher OGRS3 score was associated with treatment dropout. Thus this would suggest that the men most in need for this intervention are the same men that are likely to drop out.

It would make sense that treatment non-completers would require more frequent attempts at treatment due the dropping out from their first attempt.

Only 24.6% of treatment completers required two or more attempts to complete the intervention and 61.7% of non-completers had 2 or more unsuccessful attempts at treatment. Indeed reinstating men back into treatment can be costly to the treatment provider. A Canadian study attempted to quantify the financial cost to a treatment service for re-engaging an IPV perpetrator back into treatment. They identified 16.8% of treatment completers required two or more treatment attempts whilst 39.4% of treatment dropout received two or more treatment attempts. The authors quantified the staffing cost involved with telephone contact, administration, addition meetings and additional intervention session totalling US$2,094 per reinstated completer. This suggests the importance of making the first treatment attempt successful (Scott et al., 2013).

The key finding from this study was the logistic regression model. This had a 75.8% accurate overall classification of treatment dropouts and completers. Using the variables in the model provided a 15.9% improvement in prediction of treatment dropout over chance. This predictive model was comparable with the range of predictive efficacy in seven logistic regression models reviewed in chapter 2 (Beldin, 2008; Bowen & Gilchrist, 2006; Buttell & Carney, 2002, 2008; Carney et al., 2006; DeMaris, 1989; Eckhardt et al., 2008). Indeed, this predictive model shares similarities with the Dropout Risk Screen (DRS; Nunes, Cortoni, & Serin, 2010) in that being younger and having a higher risk score was predictive of increase risk of dropout.

The practical application of these findings can lie within identifying individuals that are most likely to drop out of IPV treatment. Identifying such men at point

of referral may allow sufficient time for the implementation of additional support to promote treatment compliance as this is crucial to the successful outcome of the OBP (McMurran & Ward, 2010). Indeed, use of pre-treatment motivation strategies have been investigated in relation to IPV perpetrators and shown promising results in reducing attrition rates (Crane, Eckhardt, & Schlauch, 2015; Lila et al., 2018).

Whilst this study utilised scores for percentage reoffending risk, there was no specific IPV risk assessment documented for this population. This may have been decided by the treatment provider because the criteria for acceptance into treatment was a medium risk of violence towards an intimate partner. However, there was seemingly no post-treatment risk assessment recorded in the data. This is a limitation of the current study as measures of IPV behaviours have informed other predictive models (Bowen & Gilchrist, 2006; Carney et al., 2006).

A strength of this study was the exploration of the non-client factor of geographic location to treatment interventions and the impact of treatment availability. This seemingly has had limited investigation in the existing treatment attrition literature. As such this would benefit from further exploration. This model was based on the entire population of individuals referred to this particular IPV intervention in a twelve month period. As such, these findings are generalizable to future populations referred to this intervention in this geographic location.

The data provided from the treatment service did not detail any reasons why individuals dropped out of treatment. This may have provided a qualitative exploration of the wider pressures experienced by IPV perpetrators undergoing community group treatment. Furthermore, employment data was not available for this sample. This could have had some confounding effect, as unemployment and lower education attainment has been association with treatment dropout (DeMaris, 1989; Rooney & Hanson, 2001; Saunders & Parker, 1989).

Part two method:

Data collection:

Part two of this study took place with the same CRC Probation service that provided the same IPV treatment intervention as stated in part one. As such the same definitions of treatment completion and dropout applied to part two of this study. However, part two had a different methodology and utilised an experimental design for recruiting and interviewing participants.

Participants:

This sample comprised of male IPV perpetrators, aged over 18 years, who have been referred to community IPV intervention delivered by a CRC Probation service OBP team. Out of 533 individual referrals 115 individuals were identified for participation in the study interview. Using a random number generator, participants were selected from groups of 5-30 perpetrators referred consecutively to treatment. Recruitment took place over a twelve month period, from 29th June 2015, in order to reduce any confound of

seasonal differences in referrals. Participants were excluded if active mental health symptoms or limited level of spoken English would likely impair their engagement with an IPV group intervention and if they had completed the same IPV intervention 24 months prior to current referral. Each potential participant was offered an interview following a joint meeting with their Offender Manager (OM) and the lead author, to confirm suitability for IPV intervention. 38 individuals failed to attend this appointment, 22 of the remaining 77 attended but declined study participation, leaving 55 participants that were successfully recruited into this study's experimental group (see Appendix IV for the demographic breakdown for the experimental sample).

The data from part one of this study was utilised as a control sample for the purpose of a comparison with the experimental sample from part two. See Table 10 for demographic breakdown of experimental and control samples.

Ethics:

This study commenced upon ethical approval being granted from the National Offender Management Service (NOMS) National Research Committee and the University of Nottingham Research Ethics Committee, Appendix V. As the PACI-O is predominately strengths focussed in design it was unlikely that it would evoke past adverse experiences. None of the 55 participants disclosed or appeared distressed post-interview. However support agency information was included in the participant information sheet if required following participation.

Interpreters and translator services were not utilised within this study. This was due to the requirement of all individuals requiring a sufficient level of

English to commence into the IPV intervention. It was explained to each participant that entry into the study was entirely voluntary and that their Probation supervision was not affected by their decision. In the event of their withdrawal from the study it was explained that their data collected up to the point of withdrawal would still be included in the final analyses where appropriate.

It is pertinent to note that the author was employed by the treatment provider in which the research was conducted and in this role, contributed to the partial delivery of 4 of the 24 IPV treatment groups delivered in the data collection 12 month period. Whilst the author was involved in the delivery of all the PACI-O interviews, conflict of interest was minimised by the author not being involved in the day to day decisions or management of the IPV treatment service. Indeed, it was arranged with the IPV treatment manager that the author would be not be allocated to deliver individual IPV treatment sessions with any of the group members participating in the PACI-O study; thus reducing any potential bias concerning the IPV treatment integrity.

In addition, the author held a number of years' experience working with probation clients and as such had developed a vested interest concerning the benefits of strength-based approaches and applying a desistance approach within everyday Probation Practice. However, this could be contained within the delivery of the PACI-O, which itself reinforced these principles. Furthermore, all the practitioners involved in the delivery of the IPV treatment received training in Motivational Interviewing skills as part of the standardised

training programme. The application of this approach was incorporated when conducting the PACI-O interviews.

Procedures:

This was a multi-centre study, with interviews taking place across nine different Probation offices within the five geographic locations. A private interview room was utilised in each Probation office. All were fitted with attack alarms and safe working practice guidelines were observed.

Written informed consent was obtained. The Consent Form, Appendix VI, was signed and dated by each participant in the experimental group before they completed the study interview. No additional consent was required from other agencies as this sample comprised of adults with full capacity. The main author explained the details of the study and provided an Information Sheet, Appendix VII, ensuring that each participant has sufficient time to ask questions, understand exceptions to confidentiality and consider their participation.

The semi-structured PACI-O interview was conducted with each participant, guided by six life areas on a Response Sheet, Appendix VIII, and a Scoring Booklet, Appendix IX, used to record the participants' responses. Interviews lasted between 20-80 minutes. An additional stimulus booklet, Appendix X, was shared with the participant throughout the interview to give a visual representation of the category areas as well as each rating scale being visible.

No audio recordings were required for this study and upon completion each participant was debriefed establishing if support was required in response to

any adverse impact on wellbeing. The end of the data collection occurred when the outcome of treatment completion for the final participant had been substantiated. No follow-up contact was required.

Table 10: Demographic information of Experimental and Control samples

Variable		Sample Experimental (N = 55)	Control (N = 574)
Median Age (IQR)		30 (12)	30 (13)*
Ethnicity (%)	White	48 (87.3%)	466 (81.2%)
	Asian	6 (10.9%)	54 (9.4%)
	Black	0	26 (4.5%)
	Mixed	1 (1.8%)	22 (3.8%)
	Other/Not stated	0	6 (1.0%)
Order Type (%)	Community Order	37 (67.3%)	407 (70.9%)
	Suspended sentence	12 (21.8%)	107 (18.6%)
	Custodial sentence	6 (10.9%)	60 (10.5%)
Management (%)	CRC	45 (81.8%)	494 (86.1%)
	NPS	10 (18.2%)	80 (13.9%)
Geographical District (%)	District 1	7 (12.7%)	52 (9.1%)
	District 2	7 (12.7%)	77 (13.4%)
	District 3	5 (9.1%)	119 (20.7%)
	District 4	17 (30.9%)	116 (20.2%)
	District 5	19 (34.5%)	210 (36.6%)
Median OGRS3 Year 2 (IQR)		42 (27)	46 (34)†
Median days bet. Order start & Referral (IQR)		16 (24)	24 (35)
Median days bet. Referral & PACI-O Interview (IQR)		69 (78)	-
Number of invites (%)	1 invite	32 (58.2%)	281 (50.4%)
	2 or more invites	23 (41.8%)	276 (49.6%)‡

KEY: * Missing data for 35 control participants, † Missing data for 37 control participants, ‡ Missing data for 17 control participants

Measures:

The PACI-O was adapted to make it relevant for Probation clients by incorporating Probation terminology and removing prison specific content.

These modification were authorised by the PACI-O correspondence author Dr Joselyn Sellen, former Senior Lecturer, Department of Applied Psychology, Cardiff Metropolitan University. The Adaptive Motivation (AM) score was calculated from the mean scores of six rating indices: importance, likelihood, control, achievability, happiness and commitment (Campbell, McMurran, & Sellen, Unpublished).

Part two results:

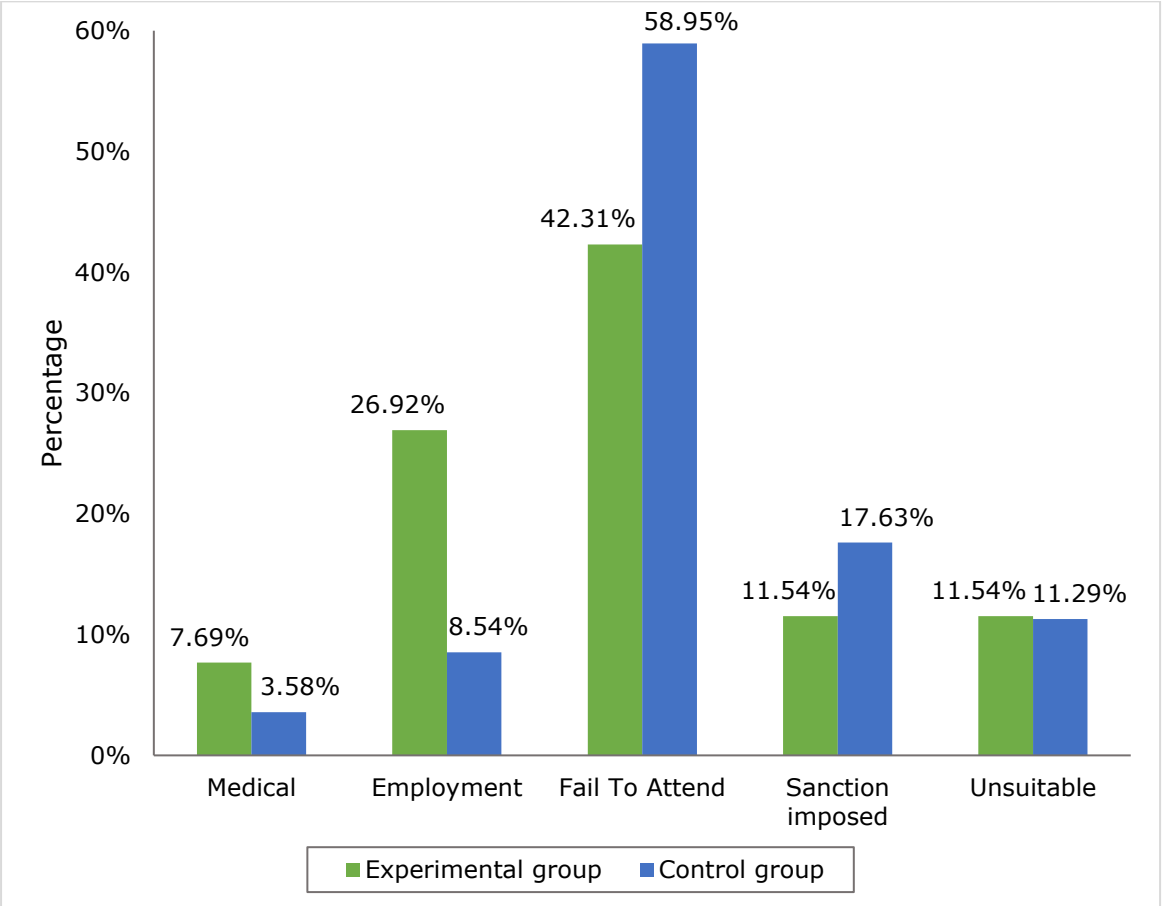
The treatment dropout rate for the experimental sample was comparable to attrition rate within established literature, as 47.3% failed to complete this IPV intervention.

Within the experimental sample, five categories were identified as reasons for treatment attrition. The first category was Medical related reasons for non-completion, including physical ailments, mental health related symptoms and increased problematic alcohol and/or drug use. The second category was when individuals gained employment or their current employment limited their ability to attend weekly intervention sessions consistently. The third category was due to individuals Failing to Attend two consecutive session without any acceptable reason given. The fourth category was when a criminal sanction was placed on an individual, including recall to prison for individuals subject to licence from custody conditions, returning to court for breaching an existing order, being remanded or sentenced to custody for further offences. The fifth category for non-completion was when an individual was reassessed as unsuitable, reasons included: limited understanding of English in a group setting, refusal to attend

a group setting, refusal to engage in the intervention content and maintaining innocence during the intervention.

The most frequent reason for treatment dropout in both samples was failing to attend without an acceptable reason and least frequent reason for dropout was for medical reasons. For statistical analysis, a Fisher's Exact test was necessary due to a low cell count for some of the category data. This found a significant association between sample groups and reason for attrition, p = .031. Being in the experimental group and not completing the intervention due to employment has the largest impact on this statistical significance as this held the largest percentage difference between samples, of 18.38%, see Figure D.

Figure D: Reasons for attrition: a comparison of within sample percentage



Univariate analyses found no significant differences between intervention completers and non-completers in the experimental sample, for the following variables: age, geographic district, sentence type, private/public sector Probation management, ethnicity, length of time between referral to treatment and PACI-O interview and SARA-V2 ratings (see appendix XI). It is important to note that there was a high proportion of missing data for the SARA-V2 summary rating for risk of violence towards a partner in the experimental sample, see Table 11. As such, it was not possible to identify any significant changes in IPV risk over time nor associated with treatment completion. However, such analyses did identify variables that significantly differed between individuals from the experimental group that completed treatment and those that did not, these were:

- Treatment completion was associated with lower OGRS3 two year scores. An independent-samples t-test indicated that OGRS3 2 year scores were significantly lower for treatment completers (Mn = 38.38, SD = 18.292) than for non-completers (Mn = 50.19, SD = 18.823), $t(55) = -2.359$, $p = .022$, $d = 0.636$.
- Number of attempts at the treatment was measured through number of invitations given to each individual to attend IPV intervention. So those that required more than one attempt to attend the IPV intervention were less likely to complete treatment. 65.4% of treatment non-completers had been given two or more opportunities to start treatment, but then went on to dropout, whereas 79.3% of treatment completers only required one attempt at treatment to completed, χ^2 (1, N = 55) =11.256, $p = .001$.

Table 11: Frequency table for SARA-V2 Summary Risk Ratings pre & post-intervention in experimental sample

	Risk of violence towards partner			
	Pre-intervention	(%)	Post-intervention	(%)
Low	3	5.5%	2	3.6%
Medium	39	70.9%	20	36.4%
High	2	3.6%	1	1.8%
Missing	11	20.0%	32	58.2%
Total	55	100%	55	100%

These findings suggested some commonality of the experimental sample data with that of the sample from part one. As such this indicates that both samples were comparable in relation to their demographic characteristics and the following analyses detailed this relationship further.

Univariate analyses found no further significant differences between the experimental and control samples for the following variables: age, geographic district, sentence type, private/public sector Probation management, ethnicity, OGRS3 2 year score and number of treatment attempts (see appendix XII). However, two variables showed significant differences between the samples. The experimental sample was associated with a significantly shorter time period between an individual's order commencing and a referral being received for the IPV intervention. A Mann-Whitney test indicated that time period between order start and referral to IPV intervention was significantly lower for the experimental sample (Mdn = 16 days, IQR = 24) than for control sample (Mdn = 24 days, IQR = 35), U = 11748.5, p = .020. This was explored further with two additional Mann-Whitney tests that examined between sample group differences split between intervention completers and non-completers. Individuals that completed the intervention from the experimental group had significantly shorter time period (Mdn = 15 days) compared with intervention

completers in the control group, U =2009.0, p = .003. There was no significant differences between sample groups for individual that did not complete treatment.

The other variable which significantly differed between the two samples was intervention completion. Using chi-square analysis, table 12 shows participants in the experimental group, who had completed the PACI-O interview, were 1.4 times more likely to complete the IPV treatment than individuals in the control group (χ^2 (1, N=629) =6.718, p = .020). This finding provided further support to the existing literature that the administration of the PACI-O appears to be associated with increased treatment completion.

Table 12: Sample comparison of intervention completion rates

		Intervention		
		Not Completed	Completed	Total
Sample	Control	63.2% (N=363)	36.8% (N=211)	100% (N=574)
	Experimental	47.3% (N=26)	52.7% (N=29)	100% (N=55)

Odds Ratio of Completion for experimental vs control group [95% CI] = 1.9189 [1.1006, 3.3455]
Risk Ratio of Completion for experimental vs control group [95% CI] = 1.4344 [1.0925, 1.8833]

The interview length of the PACI-O (Probation amended) took between 20-70 minutes in total with the participants in the experimental sample. Goals were identified in each of the life areas, see Table 13. Eight participants requested to take a copy of the life areas worksheet after the interview. The life area with the highest frequency of goals identified was Close Personal Relationships and the lowest frequency was the life area Recreation.

There was no significant difference Adaptive Motivational scores for experimental sample completers (Mdn 53.800) and non-completers (Mdn 54.417), Mann-Whitney *U* test = 359.500, *p* =.768. Interestingly, this was the inverse of the findings from the only two published papers examining the PACI-O as a measure of motivation. This is not fully conclusive as there are only two papers published exploring such scores and their finding were based on custodial samples, so not an ideal comparison with this study.

However, further analysis considered if the participants that dropped out of treatment because of employment commitments may have skewed these results. This is because their motivation to change may have been more relevant to employment rather than treatment compliance. The previous analysis was repeated with these 7 participants removed, and although still no significant difference was identified between completer scores (Mdn 53.800) and non-completer scores (Mdn 54.333) for the experimental group, the data showed more of a similarity to established research, Mann-Whitney *U* test = 266.000, *p* =.841.

Table 13: Frequency of goals identified in each life area and rating indices averages

Life area	No. of concerns per life area	Mean Importance (SD)	Mean Likelihood (SD)	Mean Control (SD)	Mean Knowledge (SD)	Mean Happiness (SD)	Mean Commitment (SD)	Mean Effect of Probation (SD)	Mean Effect of offending (SD)
Past, current & future living arrangements	29	8.86 (1.620)	8.83 (1.605)	7.59 (3.333)	9.34 (1.203)	9.31 (1.168)	9.1 (1.520)	5.55 (2.720)	0.62 (1.474)
Close personal relationships	38	9.47 (1.156)	8.08 (2.019)	6.42 (2.489)	7.53 (2.102)	9.42 (1.130)	9.26 (1.349)	6.97 (2.060)	0.61 (1.462)
Physical & mental health issues	30	9.57 (0.898)	8.03 (2.470)	8.5 (2.713)	9.00 (1.983)	9.77 (0.817)	9.53 (1.252)	5.97 (2.327)	2.90 (3.284)
Recreation	19	8.74 (1.661)	8.16 (2.218)	8.89 (1.729)	8.53 (2.632)	9.47 (1.219)	8.79 (1.988)	5.21 (1.988)	0.79 (2.507)
Self-change & personal improvement	26	9.38 (1.267)	8.46 (1.749)	8.35 (2.058)	9.19 (1.386)	9.63 (0.983)	9.31 (1.050)	6.73 (1.710)	0.38 (1.359)
Employment, training & finance	31	9.32 (1.514)	8.42 (1.945)	8.55 (2.127)	9.16 (1.530)	9.13 (1.910)	8.84 (2.099)	6.00 (2.176)	0.48 (1.981)

Part two discussion:

The main finding from part two showed an increase in treatment completion for IPV perpetrators was associated with the sample of participants who had completed the PACI-O. Part two primary hypothesis was accepted but the secondary hypothesis rejected. Although, as stated in part two results the analysis of the Adaptive Motivation scoring should be considered with caution, the results are inconsistent with two other studies using the PACI-O (Kearney & Sellen, 2013; Sellen et al., 2013).

To determine if treatment completion was attributable to the PACI-O, potential confounding variables were examined within the control and sample group characteristics. Data analysis using Propensity Score Matching (PSM) was considered but rejected as there was no indication of the experimental and control groups being overly imbalanced as only one measured characteristic was statistically different. This was the number of days between the perpetrator's order starting and a referral to IPV intervention being submitted. It is possible that unmeasured confounders could have influenced the overall findings however PSM cannot account for such characteristics if unmeasured. Traditional statistical analyses were utilised as no particular advantage for PSM could be identified (Sainani, 2012; Winkerlmayer & Kurth, 2004). A randomisation technique was implemented to select participants. Despite this, sampling bias could still have impacted on the findings as 52.2% of the 115 participants selected either failed to attend or declined the PACI-O interview, this may have created an imbalance of initial motivation levels, as those that failed to attend may have had hugely insufficient motivation to engage in treatment, however it was not possible to measure this.

This brief pre-treatment motivation enhancing intervention adheres to the NOMS values and purpose, by working collaboratively with offenders, whilst acknowledging their individuality and supporting their rehabilitation to a more pro-social lifestyle. By improving compliance with OBP interventions this can be beneficial to overall sentence completion for offenders. This has two further benefits. Firstly by having higher completion rates this represents improved cost-effectiveness e.g. the allocation of resources, such as cost of staffing, as well as addressing lowered staff morale from high attrition rates (Klein, Stone, Hicks, & Pritchard, 2003; McMurran, Huband, & Overton, 2010). Secondly, individuals that complete treatment have had the opportunity to gain new learning and develop skills that address their criminogenic risk factors. As such, successful completion of an intervention represents a significant element in the reducing re-offending strategy.

The PACI-O life area concerning close personal relationships had the highest frequency of goals associated with it. This appeared consistent with the experimental sample being IPV perpetrators whose offending has negatively impacted on intimate and/or parental relationships. In addition, the highest mean effect of Probation was also for the close personal relationship life area. This was not surprising as participants were all interviewed prior to being allocated into IPV treatment. This indicated some belief that Probation can assist with achieving goals in this domain and this can be indicative of the interaction between intrinsic and extrinsic motivation as seen in the MORM about positive relational change (Ward et al., 2004).

The findings for Adaptive Motivation (AM) were inconsistent with the two studies that have explored this measure of motivation (J. Campbell et al., 2010; Sellen et al., 2013). Possible reasons for this are that sample size was insufficient to draw inference from this measure and that AM may be confounded with other variables relating to motivation to participate in this study, treatment completion or from being a community sample. For the latter, goals are more attainable as an individual has more capacity to make their goals a reality compared with custodial limitations, such as difficulty acquiring accommodation, difficulty building and maintaining relationships, or gaining long-term employment opportunities etc. Therefore, it is unsurprising that indices ratings would differ and potentially give a varied mean compared with the custodial populations.

Part two was not without limitations in the design and execution. Firstly the small sample size of the experimental group limits generalisability to the wider population. It may have been an overestimation on behalf of the lead author to alone recruit and interview so may participants across nine different offices within five geographical districts with a total population of 2,320,214; when employment responsibilities within the CRC Probation service were prioritised. Sellen, Gobbett, & Campbell (2013) suggested that between-group comparison studies should require a minimum of 52 people, for power of 0.80, medium effect sizes and $\alpha<0.05$. However, this was perhaps too low of an estimation based on the results of this study. Secondly, the use of the generic OGRS3 scores was a late amendment as the SARA-V2 could have been more indicative of IPV related risk, which would be more relevant to the experimental sample. As stated earlier, too much data of the final risk ratings was missing to

incorporate into statistical analysis, eight participants has no SARA-V2 assessment throughout their sentence for an IPV offence. Anecdotal explanations of this related to lack of staff training to complete the assessment and lack of time to complete them to a standard that would amount to more than just scores in a box with minimal comments to evidence any scoring that might be present. This was similarly found in other studies exploring IPV interventions (Bloomfield & Dixon, 2015). Thirdly, it was evident in table 13 that a high proportion of participants scored most of their indices at the highest rating of 10. Initial refection, related this to participants being over ambitious with their perception of their goals or wanting to impress the researcher. In hindsight, adding a social desirability measure may have revealed this as a possible confounding effect. However, some participants asked to take a copy of the filled in answer sheet away with them, indicating personal gain from their participation rather than the conscious need for positive impression management. The final limitation relates to the possibility that due to sampling the most motivated participants engaged with the study and those least motivate declined participation. This could have amplified the perceived effect of the PACI-O (Haggård, Freij, Danielsson, Wenander, & Långström, 2015).

Conclusion:

This chapter has provided a preliminary strategy to identify potential dropouts from a community IPV treatment group intervention using a logistic regression model containing three variables. Whist OGRS3 incorporates age and gender, it also quantifies criminal history factors. This can indicate an antisocial behaviour history, which if present, also contributes to the prediction of

criminal recidivism as defined within the framework known as the central eight (Andrews & Bonta, 2010). As such this model may need further refining to facilitate improved prediction of treatment dropout with IPV perpetrators referred to this treatment provider. Indeed, the collection of further data, such as levels of education, income and employment status; relationship history with victim and marital status; problematic use of substances; use and severity of IPV behaviours; and personality factors, could be more informative on dropout prediction. The samples used in this study were all subject to NPS/CRC Probation supervision and the standardised assessment used with all such clients could qualitatively inform on all these factor, with the exception of personality factors. However, this would be dependent on the degree of accuracy and detail of the assessing practitioner. Indeed from part two of this study, the accuracy of record accessed was uncertain in relation to five reasons for treatment dropout. For example, a participant could be assessed as failing to attend with no acceptable reason, however this may be subject to being changed to one of the other four reason after follow up contact. If there is not follow up it is unknown if the non-attendance was for any other reason. The use of psychometric measures has been used by this treatment provider to inform on treatment efficacy. As such, if these were implemented before or at the point of a referral to IPV treatment, then this information could inform on the suitability for treatment as well as contributing to the study of the risk of attrition from treatment.

It was not possible to run the logistic regression with the experimental sample data to inform on the generalisability of the predictive model of dropout, due to the small sample size.

Overall, the finding from part two indicate the PACI-O can be utilised as a 'catalyst for change' (Burrowes, 2006) rather than a measure of motivation. This is due to the process of engaging with the PACI-O may support an individual to actively re-evaluate their goals. The process of engaging individually with a client has the capacity to build therapeutic alliance whilst moderating for resistance or psychological reactance. The initial PACI-O interview can provide an individual an awareness of what to expect from a rehabilitative OBP. The use of the PACI-O as a brief intervention, has begun the expansion of the evidence base for enhancing offender motivation within the community as recommended by McMurran & Ward (2010). Therefore, future directions could involve the training of Offender Manager (OM) practitioners to implement the PACI-O within their everyday Probation practice. The PACI-O could be imbedded in the initial stages of induction when an offender is commencing their supervision to reinforce an individualised therapeutic alliance. If the PACI-O was routinely implemented, it could also assist with the collection of data suggested above to contribute to a further refined predictive model of treatment dropout. Further utilisation of the PACI-O prior to other OBPs could inform the generalisability of findings from this study. Another potential domain for implementation of PACI-O into Probation practice is with offenders released from custody into community Approved Premises, formerly known as bail hostels. Evidence of how Approved Premises can impact on motivation has been explored using the PCI-OA (Rawsthorne, 2008) and a follow up of PACI-O could consolidate this approach.

As for developing psychometrically robust assessments of offender motivation, this remains inconclusive based on the PACI-O AM scores being insignificant. However goal perspectives do appear to support the conceptualisation of motivation in offenders, goals can give an individual some meaning and purpose in their life, even if only on an implicit level (Cox & Klinger, 2011; McMurran & Ward, 2004; Michalak & Holtforth, 2006). Further implementations within both community and custodial settings, follow up empirical evaluations could incorporate other measures of motivation to explore construct validity, for example, The Treatment Motivation Questionnaire, (R. M. Ryan, Plant, & O'Malley, 1995), the University of Rhode Island Change Assessment (URICA McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983) or the URICA-Domestic Violence (URICA-DV; (Levesque et al., 2000). Further exploration is required as there may be fundamental differences in motivation structure between custodial and community samples, most likely related the attainability and achievability of goals, which may account for this shortcoming in the comparison of findings.

Chapter 4: When further offending occurs after treatment: a case study of a male perpetrator subject to Probation supervision

Reconviction after treatment for offending can be problematic for rehabilitative services within the Criminal Justice System and more so where such measure are key for performance and payment by result targets. This case study examines a single participant from the empirical study featured in chapter 3. Their history is described and their PACI-O (J. Campbell et al., 2010) interview is summarised as well as their engagement within IPV treatment. The imposition of a non-molestation and indefinite restraining orders, as well as the further conviction received by the case study participant, is examined in the context of the continued treatment needs and the wider scope the interaction of the criminal and family justice processes. Particular attention is given to the impact on the best interests of the children.

Introduction:

Client overview:

On 22nd July 2015, Vic received a 24 month Suspended Sentence Order (SSO) for one count of assault occasioning actual bodily harm against his then wife. He was subject to supervision under the National Probation Service by the sentencing Crown Court, he had already separated from his wife and moved out of the family home. Vic had fully engaged with two Probation offending behaviour programmes addressing Intimate Partner Violence (IPV) and binge drinking of alcohol. He received positive feedback about his learning and

contributions from both interventions. Vic is a pseudonym to maintain client anonymity.

Initially, Vic maintained contact with his two young daughters, seeing them every weekend. Children's Social Care completed an assessment with the family as a result of the initial offence but required no further involvement beyond this. Vic and his ex-wife were on amicable terms, however this deteriorated and his contact with his daughters decreased prior to a non-molestation order being imposed prohibiting Vic from having contact with his ex-wife. On 3rd August 2017, Vic received a further sentence of two months custody for Breach of a Non-Molestation Order committed in May-June 2017 and seven months custody for breach of SSO, running consecutively. Upon this re-sentencing, Vic was also made subject to an indefinite Restraining Order. Following release from the custodial part of his nine month sentence, Vic no longer had parental responsibility for his children and due to the indefinite Restraining Order, any child contact had to be sought via a Contact Order which was classed as a private law matter. Vic's last contact with his daughters was prior to the non-molestation order being implemented when they were aged two and four years respectively.

Background Literature:

As stated in chapter one, domestic abuse is deemed a global major health problem, in which up to 38% of murders of women are committed by a male intimate partner (World Health Organization, 2013). With lethality a distinct possibility, effective detection and protection strategies are necessary to protect victims and intervene with perpetrators to reduce recidivism. Multi-

agency working between statutory and voluntary services feature within the England and Wales' provision of services. For a comprehensive overview of the current approaches see the Transforming the Response to Domestic Abuse: Consultation Response and Draft Bill (HM Government, 2019).

Aside from the economic cost of domestic abuse, the human and emotional cost of IPV not only affects the perpetrator and victim, but there are also detrimental effects of children's exposure to IPV. As such, tackling IPV is also priority for the family justice system. Research has shown that exposure to parental conflict arising from a relationship breakdown is associated with negative psychological outcomes for children (Hetherington, Bridges, & Insabella, 1998). The likelihood of relationships separation is more likely to be repeated when witnessed in childhood (Amato & Cheadle, 2005).

Research has identified the effects of children exposed to IPV have a higher likelihood of developing emotional and behavioural problems that other children (Humphreys, 2006). It is pertinent to note the heterogeneity of experiences of exposed children can include witnessing direct violence, hearing violent acts and seeing the aftermath of violence. The degree of adverse childhood experiences can vary depending on the age at which exposure occurred and gender (Cunningham & Baker, 2004).

Infants and toddlers that are exposed to IPV may experience disturbed sleep, irritability, fear of being left alone, tantrums, anxiety and delays with language and toilet training (Cunningham & Baker, 2004; Lundy & Grossman, 2005; Osofsky, 1999). This can be associated with compromised attachments that

have been affected with a child's undermined developmental need for safety (McIntosh, 2002). Direct exposure to IPV can be detrimental to neurodevelopment, which may be predisposing of impulsive and aggressive behaviours (Perry, 1997).

Prepubescent children that experience exposure to IPV may experience trauma-like symptoms such as hypervigilance, flashbacks, nightmares and regression to earlier developmental stages (Graham-Bermann & Levendosky, 1998). In line with their cognitive development, children's reasoning skills encompass the exposure to IPV. Children may try to blame themselves or to justify the violence seen. This risks the development of their own antisocial attitudes. As such, children may become sensitive to aggressive cues in which they display aggressive behaviour responses or conversely become avoidant and risk being a victim of bullying from peers (Cunningham & Baker, 2004).

Adolescents' exposure to IPV can further impact on developing avoidant and insecure attachments, which is problematic to socialisation with peers. The likelihood of problems with academic and social development is heightened (T. E. Moore, Pepler, Mae, & Michele, 1989). Maladaptive coping strategies may develop such as truancy, substance misuse, onset of IPV and criminality (Buel, 2002). As a strategy to exert some control, adolescents may try to intervene with the IPV they witness or take a parenting role which both may heighten distress and even direct anger at either parent (Goldblatt, 2003; M. Hester, Pearson, & Harwin, 2000).

Children's experiences of conflict and violence can continue post-separation, particularly when violent fathers remain in contact with their children (Forssell & Cater, 2015; Scott, Francis, Crooks, Paddon, & Wolfe, 2007). Perpetrators may indirectly expose their child to behaviours that blame, undermine or alienate the other parent. This can limit the child's ability to process and cope with the separation as well as create conflicts of loyalty (Bancroft & Silverman, 2002). Georgsson, Almqvist, & Broberg (2011) found that significantly more girls than boys self-reported mental health problems when remaining in continued contact with an IPV parent. It has been proposed that fathers that perpetrate IPV, inadequately model effective emotional management skills and healthy and nurturing relationship skills to their children (Bancroft & Silverman, 2002; Cummings, Iannotti, & Zahn-Waxler, 1985). Long-term IPV exposure can result in poor adult social adjustment that may perpetuate the intergenerational continuation of IPV (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996; Zeanah et al., 1999).

Taking all this into consideration, IPV can be a significant cause of adverse childhood experiences; so prohibiting an IPV perpetrator parent access to their children may be necessary. However, the impact of the absence of a parent can also be detrimental to a child and a high proportion of children exposed to IPV continue contact with a perpetrator parent (Salisbury, Henning, & Holdford, 2009). Hereon in, this case study with refer to an IPV perpetrator as the father in a family unit, in line with the family dimension of the case study participant.

The Children Act 1989 stipulates parental responsibility for children and Section eleven of the Children and Families Act 2014 emphasise that children should

have a relationship with each parent following family breakdown except for reasons of safety. This is reinforced from articles three and nine of the United Nations Convention on the Rights of the Child, which prioritises all decisions and actions, including remaining in contact with both parents after separation, should be made in the best interests of the child unless this could cause them harm. Paternal engagement has been found to be positively associated with children's social, behavioural and psychological development (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008), however this is in the context of a father or father figure cohabiting in family unit without the presence of IPV.

Concerning families with histories of IPV, it has been identified that preschool children can develop internalisation problems when they are prevented from seeing their fathers. However, this is reduced when weekly paternal contact occurs, which indicates the power of a child's attachment to their father (Stover, Van Horn, Turner, Cooper, & Lieberman, 2003). A small scale qualitative study found that Latina female teenagers are more at risk of having low self-esteem, incomplete education, engaging in risky sexual behaviour, having unplanned pregnancy and divorce in later years, all associated with inconsistent paternal involvement (Lopez & Corona, 2012). The quality of father-daughter relationships has been found to be positively associated with the ability to cope with psychosocial stress in peer relationships, as well as prepare a young girl for maturity and a secure sense of identity (Byrd-Craven, Auer, Granger, & Massey, 2012; Guardia, Nelson, & Lertora, 2014). In addition, as children enter adolescence in the absence of paternal contact, any unresolved issues with parents can become externalised (Scott & Crooks, 2004).

Thus, child contact arrangements need careful consideration in the aftermath of IPV, to minimise the risk of further harm to mother and children, whilst making attempts to include fathers within the child's developmental needs.

The interventions designed to address the perpetration of IPV come in two distinct forms. An individual can undertake community-based group programmes voluntarily or as specified by family courts or children's services. Otherwise, Criminal courts can mandate an individual to complete group Offending Behaviour Programmes (OBPs) that form part of criminal sentencing options.

The effectiveness of group treatment including OBPs that address male IPV has received frequent attention, usually by way of follow up measures using official reconviction data. Figures vary, with studies reporting a range of 0% (Waldo, 1988) to 41% (Gondolf, 2000) of those that completed treatment remain free from committing further violence. In a two year follow up both the Integrated Domestic Abuse Programme (IDAP) and the Community Domestic Violence Programme (CDVP), delivered within England and Wales, were evaluated to have small but significant effects in reducing IPV reoffending (Bloomfield & Dixon, 2015). Such modest effects of reducing reoffending were supported within a broader meta-analytic study (Babcock et al., 2004). Indeed, this meta-analysis showed no significant differences between the Duluth or Cognitive Behavioural Therapy (CBT) intervention types on recidivism. Indeed, further reviews have found inconclusive finding of the effectiveness of IPV interventions, often confounded with methodological issues (Feder et al., 2008;

Vigurs, Schucan-Bird, Quy, & Gough, 2016). However the What Works literature continues to be advocated for the utility of group intervention for offender rehabilitation (Andrews, 1995; Andrews & Dowden, 2005; Ministry of Justice, 2019).

Following OBP completion, recommendations can be proposed for an individual that support continued skill development and application. However, recommendation for repetition of the same OBP after further offending is uncommon and not considered good practice. However, alternative treatment pathways can be dependent on the localised resources of the statutory services involved.

Case study aim:

- Conduct file review of Vic's history, supervision and treatment designed to reduce future IPV behaviour, and consider if this can contribute to assessments of best interest for his daughters as well as identifying any shortcomings

Case study objective:

- Explore Vic's IPV typology and consider how this relates to parenting ability regarding re-establishing contact with his daughters and possible future communication with the victim and further IPV treatment needs

Design:

Initially, this case study was designed and planned to explore the psychometric properties of the PACI-O. However, this was adapted when Vic and two other PACI-O participants were no longer available for or declined follow-up interviews for this study. As Vic had already provided written informed consent for this case study (Appendices XIII & XIV), a retrospective file review of Vic's case history and Probation supervision was conducted for the content of this study.

Method:

Family history:

Vic was brought up in the suburbs of a Northern English city. He had no siblings and lived predominantly with his mother after her marriage with Vic's father broke down when he was approximately four years old. Although he could not recall witnessing any intimate partner violence between his parents, he stated there was frequent verbal conflict between them as he grew up. Vic described his relationship with his mother to be fractured at times, although he acknowledged that his basic needs were met and could not recall social care intervention occurring. He recalled being "a bit of a tearaway" as a child, he related this to his mother calling him "stupid" or "thick". He stated his mother could find it hard to manage and due to this he reported being keen to move out when aged sixteen years. Vic reported having an active social life made up of similar aged peers from the local area. Growing up, he stated his contact with his father could be infrequent due to his father working across the UK and who eventually moved the south of England when Vic was aged approximately

eleven years old. Vic stated he became more distant from his father over time, due to physical distance and his father beginning a new family.

Education and employment:

Vic reported achieving his developmental milestones and attended mainstream education. He left secondary school early, without gaining any qualifications, after falling behind with school work relating to what he describes as dyslexia type symptoms. He later attended college and became a certified electrician and has remained working in this trade ever since. Vic has had several temporary employments, often leaving them due to poor wages or there not being enough work.

Physical and mental health:

Vic was documented to have no physical health concerns growing up as well as no incidents of self-harm or suicide attempts. However, Vic reported being stressed and depressed as an adult, which he attributed to financial pressures at times of employment instability. He stated he consulted his GP about this once. However, he reported never taking his prescribed anti-depressant medication because he had to pay for the prescription.

Substance use:

After leaving home at 16 years of age, he stated that he started misusing drugs. He reported mixing with negative associates and recreationally used cannabis with them. He stated he began using ecstasy and cocaine would often binge drink alcohol at these time, whilst out socialising and whilst at home.

Relationships:

Vic reports his first significant relationship contained violence that lasted for several years, directed at him by his then girlfriend. However, there was one documented police call out concerning this relationship, identifying Vic as the perpetrator. At 19 years of age he received his first caution for common assault against this girlfriend. He reports this was in retaliation from being stabbed in the arm by her. However, he did not report to police this alleged stabbing, nor other violent incidents he stated she committed against him. Vic also described disliking this girlfriend's brother due to subject to bullying behaviour. At various times during this relationship, Vic reported he was using illicit drugs to excess. He has one child from this relationship but has no contact. He said he does not want contact until she is ready for contact.

Vic had been in a relationship with the victim of the index offence for four and a half years and for two of these years they were married. They had two daughters together, born in 2012 and 2014. There had been no Child Social Care involvement prior to the index offence and they had been reportedly asleep in their upstairs bedrooms for the duration of the assault. This relationship had one documented police call out regarding the couple having a verbal dispute on New Year's Day in 2015.

Vic provided financially for his family though his employment income. At the time of the offence he and the victim were struggling financially and were paying off significant arrears from their wedding as well as other existing debts. He reported having a good work ethic, and at times would work long hours

such as at evenings and weekends in addition to his regular working hours. He stated that this had caused some tension in his marriage.

The relationship began to breakdown three months prior to the assault. The victim reports Vic became verbally abusive and constantly criticised her appearance and parental ability. She was allegedly suffering from postnatal depression and taking anti-depressant medication. The couple had longstanding tensions concerning Vic's contributions to domestic chores, allegations of his infidelity, being inconsiderate of the victim's depression and limited finances. Due to the frequent arguments, Vic and the victim separated and she moved into her mother's home with their two children. Whilst there she received numerous text messages from Vic, some asking to reconcile and others being abusive. She returned to the family home after a week, and the assault took place on the night of her return. Vic reported they were attempting to reconcile when the offence took place, however the relationship difficulties had not been resolved.

Vic reported having a brief relationship since his marriage broke down, but this new partner was described as "too clingy" and wanting more commitment than Vic was prepared to give, so he has since remained single.

Forensic history:

Vic had no previous convictions until the commission of his index offence. Vic's recollection of the index offence was limited due to intoxication. The account he gave differed in some details from the Crown Prosecution Service (CPS) papers. He recalled on the day of the offence he had returned from work and

began consuming alcohol and using cocaine with the victim and they had sex together. It then appears matters began to deteriorate, as old tensions re-emerged. He stated they continued to drink alcohol and he began to say hurtful things about the victim to which she allegedly responded likewise. Unlike the CPS papers, he states he was grabbed by the hair and a glass of red wine was allegedly thrown at him by the victim which sprayed the wall. He identified from the CPS papers about the victim calling him a poor father for allegedly letting a sex offender around his daughter, which he refuted. He explained this may have been a key trigger for his violent response in relation to his fathering ability being questioned. During the assault the CPS papers refer to Vic dragging the victim off the sofa and her head landing on a glass, and then him stamping on her head and repeatedly punching her. Despite not recalling this, he has not sought to deny responsibility for these actions, accepting the CPS's version of events, albeit being surprised at his behaviour. He says he must have suddenly lost his self-control and assaulted her. There is no indication that the assault was pre-meditated, rather an impulsive response following an initial reconciliation.

Vic acknowledged his relationship was over and stated he was on civil terms with the victim. During Probation supervision he reported seeing his daughters regularly and they stayed over with him every weekend. He reported making financial contributions for their upbringing. In early 2017, the victim stopped contact between Vic and their daughters. In Vic's opinion this was due to him not giving her money during a period of unemployment. He stated he became frustrated and once threatened to go to the school to see them. Due to him saying this, his ex-wife approached family court for a Prohibited Steps Order.

Her solicitor recommended she apply for a Non-Molestation Order against Vic, which was granted in March 2017. This initially lasted for two months, however the victim had this extended to twelve months.

Consequently, family court proceedings commenced to evaluate what contact Vic should have with his daughters. It is reported that Vic gave most of his wages to the victim in order to look after their daughters. This was seemingly done with the best of intentions, however the Children and Family Court Advisory and Support Service (CAFCASS) assessor reported that this often left him with limited finances for groceries. As such, the victim brought food to his property on occasions. Vic commenced text message contact with his victim, who initially did not deem this problematic as she felt the messages were not abusive. The allocated CAFCASS advisor encouraged the victim to report any further contact to the police.

Vic went on to breach the non-molestation order by sending four text messages to the victim over two dates (see Appendix XV). During police interview, Vic acknowledged he should not have contacted her and he reported the context of the first message was that he was "in a mess" referring to his emotional state. He stated the second and third messages were old messages in his phone's outbox that were unsent until a Wi-Fi connection was established on his way to work. CAFCASS ceased their assessment of child contact upon Vic entering custody without any recommendations being made. The children have never been subject to children in need proceedings.

Upon release from custody, Probation documentation records the victim had reported to Child Social Care that Vic has no parental responsibility, however the legal implications of this are not verified. Vic frequently missed Probation appointments citing he forgot about the appointment or was working out of district so could not attend the office but received no sanctions for this. In the last six months of this supervision, Vic only attended two out of seven appointments, three were rearranged and two were deemed failed appointments with no further action. There was minimal involvement with the victim and the NPS. She declined contact with the NPS victim services and as Vic was not mandated to the Building Better Relationships (BBR) OBP, there was no allocation of a Partner Link Worker (PLW). If in place, the PLW can gain an important insight into the changing dynamics between the perpetrator and their (ex) partner where there is still contact, during the course of IPV treatment. This can provide additional insight into the perpetrators behaviour and guide and inform risk management. Finally, there was no documented victim involvement with an Independent Domestic Violence Advisor (IDVA).

Assessment and formulation of IPV offending:

Table 14: Case Study Predictor Scores percentages

	Probation OASys assessments in:			
	2015		2017	
	1 year %	2 Year %	1 year %	2 Year %
OGRS3 Probability of proven reoffending	18	31	19	33
OGP probability of proven non-violent reoffending	8	14	8	14
OVP probability of proven violent-type reoffending	13	22	9	16

Risk assessments were conducted though supervision of both Vic's sentences to assess risk of harm and future offending. A Probation Offender Assessment System (OASys) report identified the public and the named victim were deemed to be at medium risk of harm, specifically physical and emotional harm relating to IPV. In addition, Vic was deemed to pose medium risk of harm to children of an intimate partner, through indirect exposure to IPV. He was deemed to pose low risk to staff. The actuarial risk assessments show Vic to be in the low risk category for Offender Group Reconviction Scale version 3 (OGRS3), OASys General reoffending Predictor (OGP) and OASys Violence Predictor (OVP) scoring, see table 14.

Interestingly, no specialist IPV risk assessment was conducted within the Probation supervision of his first sentence for the index offence. However, a Spousal Assault Risk Assessment version 2 (SARA-V2; Kropp, Hart, Webster, & Eaves, 1995) was completed in his second sentence by his Probation offender manager for the breach offences. This assessed Vic to pose medium risk of violence towards a partner, but low risk of violence towards others. No items within the assessment were deemed to be critical to risk. For the purpose of this case study, the Spousal Assault Risk Assessment – version 3 (SARA-V3; Kropp & Hart, 2015) was conducted in December 2017. This summarises the risk that Vic may pose to intimate partners, concerning the nature of IPV factors (table 15), perpetrator factors (table 16) and victim vulnerability factors (table 17). For a more detailed overview of the SARA-V3 see Chapter 5.

Table 15: SARA-V3 Summary of nature of IPV factors

Nature of IPV (seriousness) Factors	Rating	
	Prior to 2017	Within 2017
N1. Intimidation	Not present	Not present
N2. Threats	Not present	Present
N3. Physical Harm	Present	Not present
N4. Sexual Harm	Not present	Not present
N5. Severe IPV	Present	Not present
N6. Chronic IPV	Partially present	Not present
N7. Escalating IPV	Present	Not present
N8. IPV-Related Supervision Violations	Not present	Present

Table 16: SARA-V3 Summary of perpetrator factors

Perpetrator Factors	Rating	
	Prior to 2017	Within 2017
P1. Intimate Relationships	Present	Present
P2. Non-Intimate Relationships	Partial	Not present
P3. Employment Finances	Present	Present
P4. Trauma/Victimization	Partially present	Not present
P5. General Antisocial Conduct	Not present	Not present
P6. Major Mental Disorder	Not present	Not present
P7. Personality Disorder	Not present	Not present
P8. Substance Use	Present	Not present
P9. Violent/Suicidal Ideation	Not present	Not present
P10. Distorted Thinking About IPV	Partial	Not present

Table 17: SARA-V3 Summary of victim vulnerability factors

Victim Vulnerability Factors	Rating	
	Prior to 2017	Within 2017
V1. Barriers to Security	Partially present	Partially present
V2. Barriers to Independence	Partially present	Partially present
V3. Interpersonal Resources	Not present	Not present
V.4 Community Resources	Not present	Not present
V.5 Attitudes or Behaviour	Not present	Partially present
V.6 Mental Health	Partially present	Not present

Using the structure of the SARA-V3 guidelines, a risk formulation of Vic's IPV is detailed below in the template known as the 5Ps (Weerasekera, 1996). This summarises risk and protective factors relevant to Vic's use of violence within intimate relationships.

Presenting problem:

Vic's use of violence towards current or former intimate partners.

Predisposing factors:

Vic had experienced being called "stupid" or "thick" by his mother, when she did not agree with the possibility of him being dyslexic. He stated that this resulted in him feeling belittled and this may have become further manifested as hypervigilance to criticism from women. He reported he was bullied in a previous relationship by the brother of his former girlfriend. This targeting impacted on his self-esteem and he stated feeling helpless to stand up for himself. Conflict within relationships was normalised to Vic he witnessed this between his own parents and it featured in both of his long-term relationships. He was also physically abusive within his past relationship. However, he stated he remained on good terms with his ex-partner, this may indicated that there was little consequence to such abusive behaviour. Similarly, Vic experienced no initial consequence to communicating with his victim following the non-molestation order being in place, as the victim did not consider the communication to be abusive and so did not report it. Vic experienced no consequence for failing to attend his last Probation appointments. He self-reported having a low tolerance for alcohol and becoming easily intoxicated. The use of substances and alcohol stemmed from him associated with negative peers after he left home, which indicates he could be impressionable and beginning to use such substances as avoidant coping. His reoccurring financial problems were an indication of limited problem solving skills and consequential thinking.

Precipitating factors:

At the time of the index offence, he reported that he was being accused of infidelity, and being a poor father and husband. This criticism became

intolerable to contain and he retaliated initially with verbal insults. Upon him perceiving a glass of wine being thrown at him, he acted upon this with physical violence. This type of retribution parallels assaultive behaviour in a previous relationship following him describing being physically injured by a former girlfriend. Vic reports experiencing high levels of stress relating to financial issues as well as tension with his victim. This ongoing emotional strain has likely reduced Vic's ability to adequately manage his emotions and subsequently impacted on increasing his level of impulsivity and failure to consider consequences. He recognised he would be verbally abusive and say "nasty things" to his victim, which indicated limitation with his perspective taking in understanding his victim's postnatal depression and his effect on her. He acknowledged that he would binge drink, often with his victim as well as taking cocaine together. It is known that the use of alcohol and cocaine is associated with risk for violent recidivism among IPV perpetrators (Capaldi, Knoble, Shortt, & Kim, 2012). In addition, Vic believed that sex could appease the marital problems was likely to be his underestimation in the lead up to the index offence. Perhaps this may have worked in the past but it further demonstrated the limitation of his problem-solving skills. Related to this, was the further breakdown in his co-parenting with the victim, in which he felt he was losing control of the contact he was having with his children and so threatened that he would implement his strategy of taking the children from school. This indicated continued failure to consider alternative strategies to situations.

Perpetuating factors:

His failure to successfully resolve ongoing conflict with his victim appears to have perpetuated his negative feelings towards her. This was further highlighted within treatment, as he failed to articulate how she and their daughters were affected by the index offence. All this may have justified the costs of him using verbal abuse and violence. His coping skills appeared to be insufficient for the level of stress he described and excessive drinking of alcohol and cocaine use likely reinforced his strategy of briefly escaping such issues rather than deal with them. There was a continuation of dependency following the relationship with the victim ending. Vic was keen to ensure he provided for the family and gave them a large proportion of his earnings. This may have served to reinforce his perceived status as a provider for his family, however this then created a reliance on his victim to provide him food. This may have been a conscious attempt to maintain some regular interaction with his victim and children, or a further demonstration of limited financial planning skills.

Protective factors:

Vic completed the Personal Aspirations and Concerns Inventory for Offenders (PACI-O; Campbell, Sellen, & McMurran, 2010). His adaptive motivational score was calculated to be 57 from the PACI-O rating indices out of a maximum of 60. This indicated he considered his goals as important and that he was committed and in control of being able to realistically achieve goals that would bring his future happiness. Both of his goals were associated with what he considered needed addressing to reduce further offending. He identified two goals, which were concerning Physical and mental health issues and Self-change and personal improvements. He specified that he desired to stop drinking alcohol and using illicit drugs. He identified this had caused problems

in his relationship and he did not like his behaviour when under the influence. He identified that an obstacle to this goal would be if he rekindled the relationship with the victim as they would previously drink alcohol to excess and use drugs. He stated that engaging with Probation would help him achieve this goal, as he reported this was the first time he felt he could talk to anyone about the relationship with his victim. He stated for nine weeks following the offence his abstained from any alcohol use due to the shock of his behaviour when intoxicated. Within his Probation supervision there was no indication that his alcohol or substance misuse became problematic and he successfully completed an intervention to address binge drinking.

His other goal was to improve his coping skills in relation to stress, he identified this had a physical impact such as losing weight from not eating and experiencing hair loss. Similarly, he stated that being in a relationship with the victim would be an obstacle to managing his stress. He stated that his Probation supervision would neither help nor hinder achieving this goal as he considered this goal was only in his hands. Vic completed an IPV Offending Behaviour Programme intervention, detailed in chapter 3. This was cognitive-behavioural in approach and incorporated psychoeducation and interpersonal skill development and practice. He received positive feedback from his post-intervention report. Vic was reported to be more able to develop his understanding of emotional awareness and management, he acknowledged that was brought up to not show his emotions and that he needed to "re-evaluate some of his beliefs" about expressing masculinity. He appeared more able to recognise his behaviours that were abusive and the indirect effect of this on his daughters, however wanted to establish himself as a better role

model to his children and be a positive part of their life. He identified alternative behaviours that could improve his relationships in the future. There was minimal disclosure or evidence of Vic being preoccupied with violence. Recommendations for future treatment within Probation supervision included actively developing his assertiveness skills when dealing with conflict. He declared new relationships to his Probation supervisor and reported he has ended these amicably when they came to an end. Upon release from custody, due to completing all the above interventions in his first sentence, no further intervention was sequence for Vic. As such he completed his latter sentence in full, with no further charges or convictions. He was reportedly patient with the lack of contact with his daughters but continued to request support to re-establish contact.

Summary judgement:

In summary, Vic's relationship had featured verbal aggression over a three month period that included accusations from the victim of Vic's infidelity. The index offence appeared to be an isolated incident that stemmed from a particular situation and contained limited anger control and conflict resolutions skills. The addition of alcohol to the situation may have contributed to the increased severity of violence, through the disinhibition of his self-control. Overall, Vic's offending behaviour showed consistency with situational couple violence typology of IPV (Johnson, 1995, 2000), which has some similarity to male-controlled interactive violence (Johnston & Campbell, 1993). Contrary to coercive controlling typology (Kelly & Johnson, 2008), there had been no prior reports of violence between the couple nor any clear pattern of non-violent control or coercion tactics. However it is known that IPV is under-reported and

official records may only reflect a small proportion of this occurring (Garner & Maxwell, 2009). Vic did not express misogynistic attitudes nor have evidence of supporting personality difficulties that impacted on his daily functioning. His actions did not appear to limit the liberty of the victim as she had temporarily moved out from the family home prior to the offence and agreed that separation was the best option afterwards. A cognitive behavioural approach, which featured in the IPV intervention, is deemed compatible with situational couple violence IPV typology as this approach is known to focus on affect-regulation and interpersonal skills.

Findings:

Although Vic's daughters did not witness the index offence, they are likely to have been exposed, at least indirectly, to verbal disputes documented in the months prior to the index offence. As children's appraisals of conflict can be complex, this may have created some confusion and ambivalent feelings about Vic. It is imperative for abuse to not continue after separation or for this to lead to child maltreatment and the proportionality of shared parenting is in the best interests of the child (Jaffe & Crooks, 2007). However, the literature has already been summarised of possible detrimental effects of daughters in particular being separated from their fathers.

There is clearly a disparity regarding Vic's perceived risk to his victim and children. On the one hand, after the index offence he maintained contact with all and had unsupervised contact with his daughters, in which Child Social Care required no involvement. This was maintained for 20 months, however after

Vic and the victim had a disagreement, she sought a prohibited steps order to restrict Vic from taking their eldest daughter out of school rather than restricting all contact. However, a two month non-molestation order was imposed by the family court that would commence and end prior to the suspended sentence completing. This appeared realistic to give respite to all parties and recommence contact whilst Vic was under statutory Probation supervision. However, this was extended to 12 months upon appeal from the victim's solicitor. An indefinite restraining order was imposed by the criminal court after the breach of non-molestation order. This seemed disproportionate in comparison to the timescale of the non-molestation order, as Vic had not committed any further acts of violence against his victim. Initially, his partner was not averse to text message contact as she deemed it not to be abusive; however she was told by an involved professional to report all contact to the police. There was no evidence or suspicion that Vic had ever been physically abusive to his daughters and the couple had never been referred to the MARAC regarding IPV concerns, before or after the index offence.

It is hypothesised that the differing perspectives of family law and criminal judges may account for the disparity of a two month no-molestation order followed by an indefinite restraining order being imposed respectfully. This may indicate some risk aversion relating to the indefinite restraining order appearing disproportionate to the further offending and this may be due to a difference of IPV understanding. Indeed, findings show that female victims are often good at judging risk posed by perpetrators to themselves and their children (Weisz, Tolman, & Saunders, 2000). Thus, this restraining order was not consistent with the wishes of the victim, who initially only requested a

prohibited steps order and did not consider text messages she later received from Vic to be abusive. There had been no further disclosure from the victim that she was in fear of her safety.

Such orders eliminate any form of direct attempts for mutual contributions to a parenting plan or mediation which is commonly used in child contact disputes. Since entering custody Vic had no contribution to the upbringing of his daughters, despite being able to do so during his first sentence and upon release this could not be reinstated without Vic seeking out his own legal advice. There appears to be a reluctance from statutory services to implement mediation type interventions with parents that have engaged in IPV. This is because of the possibility that an unhealthy power dynamic imbalance, consistent with the controlling and coercive IPV typology, could be maintained and reinforced. This might result in a continuation of victim fear that leads to hesitancy or a reluctance to raise concerns of further victimisation (Grillo, 2006; Schulman & Woods, 1983).

However, research suggests that for some parents with the appropriate professional facilitation and support, mediation may be effective in establishing the pathway for shared parenting and future contact arrangements, even when IPV has featured in the relationship (Ellis & Stuckless, 1996). Vic's parental ability with his daughters had not been brought into question during either sentence. However, the IPV risk was directly related to the ability to communicate with the victim which remained prohibited. Despite the IPV intervention, from the first sentence, promoting the development of Vic's conflict resolutions skills with his victim, he was no longer able to put these

into action due to the indefinite restraining order being imposed in his second sentence. Not only is this obstructive for shared parenting but it may reinforce avoidance strategies for conflict management to the children.

Conclusion:

In conclusion, it appears the criminal external controls within Vic's second sentence may have overlooked the best interest of his daughters for maintaining contact with both parents. This is a more common focus for family courts however Peled (2000) promotes IPV perpetrators should actively participate in parenting interventions to support their children's recovery and healing and play a positive role in their lives. Even when restraining orders impact on the father's involvement, T. A. Moore (2016) recommends supervised contact could be appropriate. This may safeguard the likelihood of an IPV parent using their children to further perpetrate violence against the other parent (Holden, 2003).

Establishing prosocial relationships are considered protective in nature for future risk of harm. Following the completion of OBPs, Vic was reported to have developed his interpersonal skills and recommendations were to further build on these. Some research has found that perpetrators engaged in group interventions have articulated that their children are motivation to improve their relationship skills (Mandel, 2003). In addition, perpetrators from a small scale study considered their paternal role was a source of "re-entry into the moral community" (p.p 137; (Fox, Sayers, & Bruce, 2002). It is important to note that Vic had requested support from Probation to establish contact with

his children throughout his second sentence. A pertinent comment from Vic's final sentence review, following a year of Probation supervision, recorded "Vic appeared fed up with the situation remaining unchanged and so the charity details of 'Fathers for Justice' [had been] given to him".

The IPV treatment appeared to serve Vic's needs whilst he was in contact with the victim. His need for maintaining healthy family ties was not met following the imposition of the extended non-molestation order and then the restraining order. This chapter clarifies that treatment with the approach of 'one size fits all' does not meet the need for all individuals. It is clear that whilst Vic engaged with treatment that had one session addressing parenting, this did not meet his need of understanding and navigating family law. This is indicative of the limitation of relevant available treatment for IPV perpetrators with children. Whilst expanding the content of OBPs to target such needs might not be appropriate for those IPV perpetrators that do not have children; it indicates that Probation practitioners need a more holistic approach to support the needs of individuals subject to their supervision.

This case study highlights the impact of seemingly risk-avoidant criminal justice decisions. It is useful to contrast with the Department of Health approach to 'positive risk-taking' within mental health services that serve to improve patients' quality of life (Hope, 2004; Ramon, 2004). To achieve a desired change may involve professionals acting to enable positive opportunities to overcome problems (Morgan, 2004). This may be more apparent in higher risk IPV cases that require defensible decision-making through statutory multiagency working, which can deliberate on shared

responsibility, partnership working, plans and contingencies, be strengths focussed as well as have access to necessary resources. The emotional and physical harm from IPV must remain paramount, however practitioners' fear of blame and society's blame culture can create defensive practice within all types of safeguarding and intervention practices (C. Lee, Hartley, & Sharland, 2017; Parton & O'Byrne, 2000). However, this focus on risk averse decision-making may be detrimental to good clinical judgement for rehabilitation and in this case the best interests of Vic's children.

There are limitations with this case study. Professional bias cannot be overlooked as the main author was involved within assessment and intervention. This involved facilitating Vic's desistance from further IPV offending. Vic's progress was seemingly visible for Probation practitioners and documented within both periods of supervision. Indeed it has been found that such practitioners working directly with IPV perpetrators are generally more open to support a father-child relationship that practitioners that work solely with victims (Lessard et al., 2010). This is related to the familiarity with the perpetrator and the likelihood of observing progression of developing offence insight and parenting ability. Indeed, a further limitation is that this case study focusses on one perspective and the contributions of the victim and Vic's daughters were not sought. Best practice in child custody promotes the interviewing of children to include their wishes and feelings for safe contact.

Future directions / clinical & research implications:

IPV is a heterogeneous in nature and Vic's family situations as detailed in the case study is not synonymous with all IPV perpetrators and their children. This case study aims to encourage the reader to consider the importance and utility of IPV typology, which can better inform sentencing decisions as well as treatment plans. This would give criminal agencies a similar foundation for IPV assessments that CAFCASS utilise for IPV family risk assessments. Ultimately this may provide practitioners confidence with defensible decision making rather than defensive decisions, when considering the risks of future IPV with the benefits of supporting an IPV perpetrator's opportunity to improve his personal relationship, whilst not overlooking the best interests of a child.

Chapter 5: Critique of the Spousal Assault Risk Assessment – Version 3 (SARA-V3)

Introduction:

When an IPV perpetrator has been found guilty or pleaded guilty in criminal court, Criminal Justice System professionals have to consider the likelihood of future violence, who may benefit from community or custodial management and types of appropriate treatment. With finite resources, a methodology is required to match the appropriate resource to those most in need, such as the Risk-Need-Responsivity (RNR) principles (Andrews et al., 1990; Bonta & Andrews, 2007) especially when lethality is a distinct possibility. IPV risk assessments assist with the exploration of the nature of IPV and are informative on the management of IPV future risk.

Such risk assessments have evolved over time. Most people have a perspective on IPV and could make a judgement on the risk posed by an individual based on their previous professional or life experiences. However, this unstructured method is reliant on profession discretion which may be subjective. Thus, different professionals may produce very different evaluations of the same risk, this then brings into question which judgement is valid or is the most representative of risk posed by an individual. Such unstructured decision making lacks reliability when there is a wide disparity of evaluations of the same risk.

It is important to consider the utility of assessments by professions. The risk of harm posed to current or future partners can be integral to criminal and family courts for decision making about supervisory or monitoring

requirements as well as child contact, as discussed in chapter four. As such, a mathematical approach, based on scores of variables associated with violence, have become widely used as they are deemed to have a greater predictive capacity than unstructured assessments of risk. Such assessment tools are termed actuarial risk assessments and have been developed based on empirical research in order to provide a prediction of future harm using a statistical foundation. Such tools relating to IPV include: Ontario Domestic Assault Risk Assessment (ODARA; Hilton et al., 2004), Domestic Violence Screening Inventory (Williams & Houghton, 2004) and the Danger Assessment (DA; Campbell, 1986; Campbell, Webster, & Glass, 2009). By comparing an individual with a particular reference group, a numerical estimate of the likelihood of future IPV can be provided. The use of categories of risk posed, such as low, medium and high can be somewhat arbitrary and largely depends on the makeup and size of the comparison group. Reliability is increased using actuarial methodology, however the dynamic nature of risk is deemed to be overlooked due to the reliance on static risk variables. This can result in the over-prediction of future risk of harm. Such error cannot be eliminated, but the actuarial method does not inform assessors of those individuals that do not conform to the statistical algorithms.

Indeed, scores do not provide a context to risk severity or the circumstance that aggravate or mitigate such risk. The limited practical utility of actuarial methods brought about the creation of Structured Professional Judgement (SPJ) risk assessment tools. These have moved away from a total numerical score approach to prediction but rather, they are a set of guidelines also based on empirical research for trained assessors to make judgements about the risk

that an individual poses. Examples of SPJs related to IPV are the Spousal Assault Risk Assessment – Version 3 (SARA-V3; Kropp & Hart, 2015) and Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005, 2010). This approach is more flexible than actuarial methodology, yet strives to maintain consistency of risk judgements. The practical utility of the SPJ is integral as it elaborates beyond prediction of risk but rather informs on the nature of risk prevention. Assessors are invited to identify and comment on particular factors that may be dynamic or changeable, so that management strategies to contain and reduce risk can be tailored to an individual and their circumstances. Timescales are specified by assessors which can be significantly shorter than those prescribed in actuarial measure, which may require a 5-10 years window for likelihood of further risk. Overall, SPJ assessment tools are not mathematical in nature and the emphasis is on making guided judgements based on the qualitative information collected. As such caution must be given when literature reduces such a tool to a numerical score as this may not be adequately representative of the purpose or utility of the tool.

Review aims:

The purpose of this review is to critically evaluate the SARA-V3. An overview of the tool is described, then the scientific properties are reviewed, and the application to forensic populations and research uses within England and Wales are considered. The limitations of the previous versions and further research avenues will be discussed.

Overview of SARA-V3:

The SARA-V3 was derived from two previous SARA versions with amendments (Kropp, Hart, Webster, & Eaves, 1994; Kropp et al., 1995, 1999), and was initially designed to provide a tool that could assess risk of spousal violence when no other validated non-actuarial procedure was established (Kropp & Hart, 2000).

The intended target population comprises of male or female adults, over the age of 18 years that pose a risk of actual, attempted or threatened physical harm of a current or former intimate partner. The risk posed can be alleged and encompasses persons with an established or suspected history of IPV. The SARA-V3 is designed to be versatile and can be utilised with perpetrators of same sex relationships and with differing cultural factors.

The authors offer the principal of this risk assessment is to be preventative rather than purely predictive as the latter is influenced by numerous factors and potentially ambiguity, as the range of IPV is multifaceted and contextual. The purpose of the SARA-V3 is *"to introduce a systematic, standardised and practical framework for gathering and considering information when making decisions about IPV risk"* (Kropp & Hart, 2015, p.7).

The development of SARA-V3 was driven by four factors. The updated version accommodates responses to feedback from practitioners that routinely conduct IPV assessments. In addition, the updated version was inclusive of current empirical literature on the nature of IPV, already incorporated within the Brief

Spousal Assault Form for the Evaluation of Risk (B-SAFER; Kropp, Hart, & Belfrage, 2005, 2010). Related to this, further victim vulnerability factors supplemented and enhanced the risk analysis and safety planning within this version. This is comparable to the B-SAFER and the Guidelines for Stalking Assessment and Management (SAM; Kropp, Hart, & Lyon, 2008) which are inclusive of such factors. Finally, there was an incorporation of new developments in the SPJ approach already accommodated in other assessments of risk, for example: Risk for Sexual Violence Protocol (Hart et al., 2003), SAM guidelines and the Historical, Clinical, Risk-20, version 3 (HCR-20 V3; Douglas, Hart, Webster, & Belfrage, 2013).

SARA-V3 guidelines encompasses a total of 24 IPV risk factors separated into three domains. These are relating to the Nature of IPV (eight N items), Perpetrator Risk Factors (ten P items) and Victim Vulnerability Factors (six V factors). This was one the main changes from previous versions, which contained 20 risk factors split into two parts: General Criminal and Psychosocial adjustment (ten items) and Spousal Assault (ten items). All the risk factors from the previous versions remained but some were renamed or combined see Table 18.

Table 18: Comparison of SARA-V2 and SARA-V3 individual factors

SARA-V2	SARA-V3
Part 1: Psychosocial Adjustment	**Nature of IPV**
1. Past assault of family members	N1. Intimidation
2. Past assault of strangers or acquaintances	N2. Threats
	N3. Physical harm
3. Past violation of conditional release or community supervision	N4. Sexual harm
	N5. Severe IPV
4. Recent relationship problems	N6. Chronic IPV
5. Recent employment problems	N7. Escalating IPV
6. Victim of and/or witness to family violence as a child or adolescent	N8. IPV-related supervision violations
	Perpetrator Risk Factors
7. Recent substance abuse/ dependence	P1. Intimate relationships
	P2. Non-intimate relationships

8. Recent suicidal or homicidal ideation/intent
9. Recent psychotic and/or manic symptoms
10. Personality disorder with angry, impulsivity, or behavioural instability

Part 2: History of Spousal Assault

11. Past physical assault
12. Past sexual assault/sexual jealousy
13. Past use of weapons
14. Recent escalation in frequency or severity of assault
15. Past violations of "no contact" orders
16. Extreme minimization or denial of spousal assault history
17. Attitudes that support or condone spousal assault
18. Severe and/or sexual assault
19. Use of weapons and/or credible threats of death
20. Violation of "no contact" order

P3. Employment/finances
P4. Trauma/victimization
P5. General antisocial conduct
P6. Major mental disorder
P7. Personality disorder
P8. Substance use
P9. Violent/suicidal ideation
P10. Distorted thinking about IPV

Victim Vulnerability Factors

V1. Barriers to security
V2. Barriers to independence
V3. Interpersonal resources
V4. Community resources
V5. Attitudes or behaviour
V6. Mental health

Administration of the SARA-V3 consists of a six step process. The first step involves the assessor gathering relevant information, second comes the rating of the presence of each risk factor using a 3-point scale (present, possible/partially present, or not present). The presence of factors are further analysed as occurring recently (within twelve months prior to assessment) or in the past (any time prior to the last twelve months). A rating can be omitted if there is not information available for rating. In the third step, assessors rate each factor's relevance to risk management planning, again using a 3-point scale (yes, possible/partial or no). A further option of omit is included as mentioned above. Step four requires the assessor to propose varied IPV risk scenario plans and step five involved the production of a risk management plan addressing the identified risk factors. The SARA-V3 has no outcome numerical scoring as it is not an actuarial tool, thus the final step consists of making a series of summary judgments using a 3-point scale (low, moderate or high) concerning: case prioritisation, risk of serious physical harm and imminence of violence. In addition, if other risks are identified, separate from IPV, these

should also be highlighted for further specific assessment. Finally the authors recommend documenting a date to review the assessment. The authors make clear that the 'absolute probability' or 'specific likelihood' of future IPV is not estimated for an individual from this assessment.

SPJ assessments require expertise and training and the SARA-V3 is designed for professionals with expertise in IPV and assessments. Such professions are most likely based within criminal justice, civil justice or health care services. Although no formal training programme is specified, the authors recommend scrutiny of the user manual and advances of IPV risk assessment literature, as well as practice case assessments initially under supervision or in collaboration with experienced colleagues.

Reliability:

There has been limited published findings regarding the reliability of the SARA-V3 since its publication. One such study involved an analysis of 30 IPV archive case files, rated using steps 1-3 and 6 of the SARA-V3, by two assessors working independently (T. J. Ryan, 2016). Categorical ratings of individual factors and summary ratings were converted to numerical scores (Present/Relevant = 2, Possible or partially present/relevant = 1, Not present/relevant = 0). Numerical scores for the Nature and Perpetrator domains were created by summing the applicable risk factor ratings, however due to a paucity of information available, the rating of Victim factors was limited and not reported in detail. This study investigated the interrater reliability of SARA-V3 using Intraclass Correlation Coefficients and their 95%

confidence intervals, based on the methodology of Shrout & Fleiss (1979). Two-way random effects model, absolute agreement convention was used for both single rater ICC (2,1) and averaged multiple rater ICC (2,2). It is important to note that the observer agreement interpretive guidelines utilised broad evaluative ranges described by Landis & Koch (1977).

Using ICCs, the interrater reliability was considered in terms of single and averaged rater agreement. This showed the level of reliability for the nature domain presence scores ranged between moderate to almost perfect, ICC values were .73 [CI .51, .86] and .84 [CI .68, .93] respectively. For the perpetrator domain presence scores, reliability ranged between substantial to almost perfect, ICC values were .89 [CI .78, .95] and .94 [CI .88, .97]. For the nature and perpetrator domain combined total presence scores, reliability ranged between substantial to almost perfect, ICC values were .85 [CI .71, .93] and .92 [CI .83, .96]. Finally, the perpetrator domain relevance scores had reliability ranging between substantial and almost perfect, the ICC values were .87 [CI .75, .94] and .93 [CI .86, .97]. Based on these ICC results, this study concluded that the interrater reliability for the total numerical scores is moderate to almost perfect.

There was more variance found in the ICCs for the presence and relevance of each individual risk factor. The reliability ranged between poor and almost perfect. The lower band extreme ICC scores were attributed to a lack of variability amongst the sample case file subjects.

The interrater reliability for the numerical scoring of summary risk ratings converted from the categories High, Medium or Low was also explored using ICCs again for single and averaged rater agreement. For case prioritisation rating, ICC values were .40 [CI .05, .66] and .57 [CI .09, .80] respectively. For serious physical harm ratings, ICC values were .68 [CI .44, .83] and .81 [CI .61, .91]. For imminent violence risk ratings, ICC values were .41[CI .07, .67] and .58 [CI .13, .80]. This showed the reliability of the ICCs and their confidence intervals for these summary risk ratings ranged between slight and almost perfect. This difference in rater agreement was attributed to the limits of having a 3-point scale. Yet when further explored, the variance was of no more than one category difference of risk rating and the majority of the cases were assessed as medium risk, thus indicating the sample had an inherent lack of variance.

Consideration of methodological limitations is warranted. First, the sample of cases was 30 in total and only two rater were involved with this study. This is below the required minimum as specified by Koo & Li (2016). It is suggested that the sample was not particularly heterogeneous as the low ICC values were attributed by the author to a lack of sample variance. Secondly, the author acknowledged the completion of each SARA-V3 within the sample did not conform to the specifications of the manual instructions. For example, a case file for each subject was examined rather that the gaining further information from interviews and additional materials. As a result, a number of individual factors were omitted from assessment due to lack of information, this was particularly relevant to the factors within the victim vulnerability domain, as such interrater reliability was not considered for this domain nor did this

contribute to the overall total scores for interrater reliability. Thirdly, the SARA-V3 manual prescribes the assessment of the presence of factors should be differentiate between the past and more recent. This was completed but results were not presented. Instead this study amalgamated these into one presence score of 'ever present' for 'simplicity of analyses'. Finally, the source of variance in ratings between the two rates was not identified. The author postulated that differences between rater, sample cases and time may have contributed or unknown confounding variables.

There is no current literature concerning test-retest reliability for SARA-V3. The Ryan (2016) study deemed the SARA-V3 as a reliable tool based on the above interrater reliability analyses. However generalisability is restricted to the characteristics of the sample.

Validity:

Despite the SARA-V3 being published in 2015, there has been little empirical exploration of the various aspects of its validity. Again, Ryan (2016) offers a comprehensive preliminary exploration of the concurrent validity of the SARA-V3 using analyses of correlations with other IPV risk assessments. For this, the sample was made up of 84 reviewed archive cases of IPV male perpetrators.

Initially, Ryan (2016) identified large associations of corresponding assessment areas of the SARA-V3 and SARA-V2. The SARA-V3 P domain had a strong positive correlation with SARA- V2 Part 1 as many of the risk factors overlap (r = .74, $p \leq .001$). The SARA-V3 total numerical scores of N and P domains had

a strong positive correlation with the SARA-V2 total numerical scores (r = .66, p ≤ .001). In line with the author's hypothesis, the SARA-V3 P domain has no correlation with SARA-V2 Part 2 as the risk factors in the latter corresponded to those within the N domain of the SARA-V3 (r = .10, p > .05), indicating some discriminant validity. A corresponding strong positive association was identified between SARA-V3 N domain and SARA-V2 Part 2 (r = .59, p ≤ .001). A weak to moderate positive correlation was identified between the SARA-V3 and SARA-V2 summary risk ratings. Although these correlations were statistically significant, it is important to note that SARA-V2 had only one rating whereas the third version had three summary risk ratings analysed.

A further analysis was conducted by Ryan (2016), this compared the SARA-V3 and the B-SAFER (Kropp et al., 2010). The B-SAFER assessment was designed for IPV risk assessing by police personnel and was adapted from the SARA-V2 by the same lead authors. A total of 97 archived cases made up this sample of male IPV alleged perpetrators. The SARA-V3 P domain had a strong positive correlation with B-SAFER Section II (Perpetrator Risk Factors: Psychosocial adjustment) as many of the risk factors overlap (r = .69, p ≤ .001). The SARA-V3 N domain had a strong positive correlation with B-SAFER Section I (Perpetrator Risk Factors: Intimate Partner Violence) (r = .69, p ≤ .001). In accordance with the author's expectations, the SARA-V3 N domain had no correlations with the B-SAFER Section II (r = .02, p > .05). A moderate to strong positive correlation was found between the SARA-V3 and B-SAFER summary risk ratings. Both assessment tools had corresponding summary risk rating categories and all correlations were statistically significant. There is an expectation that the SARA-V3 would correlate with the SARA-V2 and B-SAFER

as they are derivatives of each other, authored by the same parties and ultimately are similar measures.

Thus, examination of true concurrent validity requires comparisons with other IPV assessment tools. Using a sample of 97 archive cases, as described above, Ryan (2016) analysed scores from the actuarial assessment: Domestic Violence Risk Appraisal Guide (DVRAG; Hilton, Harris, Rice, Houghton, & Eke, 2008), Ontario Domestic Assault Risk Assessment (ODARA; Hilton et al., 2004) and the Danger Assessment (DA; Campbell, 1986; Campbell, Webster, & Glass, 2009). The SARA-V3 N domain showed weak to strong positive correlations with the actuarial instruments, the strongest correlation being with the DA (r = .51, p ≤ .001). Similarly the SARA-V3 P domain had weak to strong correlations, the instrument that had the strongest correlation was the DVRAG (r = .62, p ≤ .001). Overall, the summed SARA-V3 N and P domain scores had a moderate to strong positive correlation with these actuarial instrument total scores. The strongest correlation was with the DVRAG (r = .57, p ≤ .001). These actuarial instruments have been previously validated and the findings from Ryan's (2016) study show preliminary evidence concurrent validity. There have been no findings from predictive validity studies published yet for the SARA-V3.

Norms:

It is pertinent to note that some studies concerning the previous versions of the SARA require some caution regarding the generalisability of their findings. This is largely due to SARA administration inconsistencies and biased gender

samples. For example, only one study included female perpetrators in their sample (Wong & Hisashima, 2008). Although the SARA-V3 is not an actuarial instrument, a previous exploration of applying percentile distribution for total numerical scores and number of factors present was suggested in the 1999 SARA manual. The normative data consisted of male IPV perpetrators from Probation and custodial population within North America (Kropp & Gibas, 2010; Kropp & Hart, 2000). The aim was to encourage assessors to consider these distributions when assigning the overall summary risk ratings. However, this adaption was discontinued within the development of the SARA-V3.

Limitations:

The acknowledged SARA-V3 limitations from the authors include the lack of a profile-fit of a typical perpetrator of IPV due the heterogeneity of this population. Although the literature around typologies of IPV perpetrators attempts to classify categories of IPV perpetrators, this is not the aim of the SARA-V3. Likewise, the authors describe the SARA-V3 as limited to typical IPV only and will not address other forms of violence, for example, child abuse, sexual violence. Thus it is recommended that additional risk assessments should complement the SARA-V3. Finally, the authors instruct the tool should not be used for investigation and identification of historic IPV.

There are also some limitations of the research described in this critique. Ryan (2016) did not follow manual recommendations of using multiple information sources, but rather only reviewed archive case files. In relation, this study identified a paucity of information on victims' circumstance factors, which

ultimately underrepresented the V domain in all numerical scoring. The issues with this are twofold, calculations for reliability and validity are not accurately represented and furthermore this may be indicative of lacking victim information available to assessors/practitioners in general. Again this may impact the clinical utility of adequate victim safety planning for known victims. Finally, the interrater reliability ICC scores were only based on two raters measurements of a small sample of 30 IPV cases, however having at least three raters is recommend (Koo & Li, 2016). Relating to the summary risk ratings, there was lower rater agreement for case prioritisation and risk for imminent violence. It is suggested that such inconsistent interpretations by assessors is specific to the narrowness of a 3-point scale (Hilton, Carter, Harris, & Sharpe, 2007; Mills & Kroner, 2006).

Utility in forensic practice:

Use of previous versions of the SARA is widespread across at least 15 countries and translated into more than ten languages (Kropp & Gibas, 2010). Its application has been across criminal justice systems, civil justice systems and within healthcare. However, the SARA-V3 was published in 2015 and there is a need for literature indicating the effectiveness of applying this measure within such clinical settings.

Within England and Wales, the SARA-V2 is licenced for routine use within the electronic Offender Assessment System (OASys; Home Office, 2002), for persons subject to a criminal sentence or presentence assessment that pose a risk of IPV. Her Majesty's Prison and Probation Service (HMPPS) is licenced to

use SARA-V3, however this is limited to psychologists and Offending Behaviour Programme (OBP) staff in some prison establishments for the purposes of referral into interventions. For example, the Building Better Relationships OBP accepts men with an IPV related index offence and who are assessed as having moderate to high imminent risk of violence towards a partner. This clearly relates to the summary risk rating from early SARA versions. The newest version has not been integrated into general Probation practice due to difficulties aligning this within the OASys constructs. Further reviews are ongoing but no timescale for implementation are published.

An inspection of Community Rehabilitation Company (CRC) Probation services' response to IPV identified that the SARA documents added little value to assessment and planning(Her Majesty's Inspectorate of Probation, 2018). This was based on inconsistent completion with relevant IPV perpetrators, too few being shared from court services to CRC teams and those that were evidenced had little attention to detail. An earlier study, reviewed 1093 prison and Probation practitioners' views and experiences of OASys. This found 34% of responding practitioners felt specialist risk assessments such as SARA did not link well within the OASys, compared with 28% who felt it neither fit well or not and 38% considered it fit very/fairly well (Pike & Smith-Yau, 2015). Some suggested other parts of the OASys adequately covered the nature of IPV but other practitioners felt when IPV was indicated there was insufficient supporting evidence documented. There appears to be some disinclination for the clinical use of the SARA to its full entirety. This was also evident in chapter's three and four. Further exploration may assist with understanding if this is related to service resourcing or consequential of using an outdated tool. There

are no published SARA-V3 evaluations from criminal justice systems or healthcare settings at this time.

Conclusion:

This review has identified the significant developments of the SARA-V3 from its previous versions. The SARA-V3 was developed using updated empirical evidence. Research by Cooke & Michie (2003) aided the revision and re-categorisation of the N and P domains using a factor analysis of the established SARA-V2 risk factors. This also informed SARA-V2 factors that could be amalgamated to within one factor in the SARA-V3. A key development was from the identification of three SARA-V2 items being non-predictive of IPV violence (Grann & Wedin, 2002; Hilton et al., 2004; Wong & Hisashima, 2008). A criticism of the SARA-V2 was its unacceptably low interrater agreement for ratings of 'critical' items (Kropp & Hart, 2000). Instead this was converted to the step of assessing relevance of each factor in the SARA-V3. Clarification regarding the time periods for the presence of factors was made, in order to evidence changes for individuals serving lengthy custodial sentences. This reduces the likelihood of having a dichotomised scores, which can decrease predictive power (Hunter & Schmidt, 1990). A clearer definition of imminent risk also supported the improvements within the SARA-V3. The inclusion of victim safety planning, risk formulation, scenario planning were the specific SPJ steps added in this SARA version as well as a comprehensive worksheet to structure the final summary judgement.

In summary, there is still further research necessary to supplement the preliminary literature concerning the psychometric properties of the SARA-V3. Such research must address the highlighted issues, such as sample size, male gender bias and author bias. Regarding the latter, the Ryan (2016) study was produced under the supervision of the SARA authors. It would be surprising if future findings did not establish the SARA-V3 to be sound in psychometric foundation as it maintains similar empirical principles as the SARA-V2. Further independent research is beneficial in reducing author bias as well as examining the applicability to populations that have a more accurate representation of gender and ethnicity. It would be advantageous to source data from field implemented SARA-V3 assessments rather than solely research purposes. This allows for more diverse experience and training of assessors and improves generalisability of findings.

Within HMPPS in England and Wales the SARA-V3 has limited application and evidence-base. Three possible avenues for future research and service development could be considered. First, is to improve the use of the existing SARA (previous versions) through further training and evaluation, as the SARA-V3 currently has a limited evidence base. The SARA-V2 has demonstrated adequate to good interrater reliability and concurrent validity, but caution was recommended regarding the use with female offenders due to the lack of empirical research. There is argument to continue with a previous SARA version which does have some evidence base even if its predictive accuracy is deemed moderate compared with other risk assessments (Helmus & Bourgon, 2011). Further evaluation could include conducting retrospective studies including data from reconviction records, serious further offending reviews and

practitioner quality assurance audits. Practitioner focus groups could identify reasons for SARA non-completion for relevant perpetrators and training could potentially address identified shortcomings.

Second, is for all HMPPS practitioners and assessors to routinely implement the SARA-V3. Many of whom have previously received training following the publication of the third version. This would require the adaptation or removal of the SARA component from the electronic OASys software and/or an alternative platform to be available. The initial implementation of the SARA-V3 could contribute towards further reliability studies.

Finally, a further option is to source and implement an alternative IPV risk assessment tool. Should the implementation of SARA-V3 prove to be too complex for the statutory services, there could be scope to conduct feasibility studies of the implementation of actuarial or more concise IPV risk assessments, such as DVRAG (Hilton et al., 2008), ODARA (Hilton et al., 2004) or B-SAFER (Kropp, Hart, & Belfrage, 2005; Kropp et al., 2010).

As stated, it is vital to improve the range of source information for any SARA version. Within England and Wales, where information sharing agreements permit, partnerships exist that can provide contextual and additional information on victims and the wider context of IPV. For example, Multi-Agency Risk Assessment Conferences (MARAC), Multi-Agency Public Protection Arrangements, Independent Domestic Violence Advisers (IDVA), OBP Partner Link Workers (PLW) and Police Integrated Offender Management amongst others. These hold particular relevance when a victim does not support

prosecution or declines contact. Even if the information is not available and risk factors need omitting from assessment, an explanation is required indicating the limitation of the overall assessment. Future validation studies could utilise existing data sources within HMPPS. Comparisons could be made with the OASys Violence Predictor (Howard & Dixon, 2011) and the Risk of Serious Recidivism score (Ministry of Justice, 2014) in order to further examine predictive accuracy of IPV recidivism as well as possible discriminant validity.

In conclusion, there appears to be benefits for private and public sector criminal justice services to utilise the SARA-V3, as is already the case for some personnel. Further research is needed but the SARA-V3 has utilised current IPV literature within its development and has addressed crucial limitations of earlier versions. By incorporating the V domain factors, this may positively influence the communication and collaboration with other professionals across multiple services. Any reviews from practitioners currently using the SARA-V3 could assist future implementation within England and Wales.

On a final note, although IPV typology literature is not directly referenced within the SARA-V3, the factors contained within the Nature of IPV and Perpetrator domains can be implicitly representative of such IPV categorisation. This may become more applicable, if only linguistically at first, as Controlling or coercive behaviour in an intimate or family relationship has been created as an offence under section 76 of the Serious Crime Act 2015 across England and Wales. Thus within criminal law, perpetrators of this offence may become distinctive from other IPV perpetrators as the law gets further implemented. The SARA-V3 acknowledges the heterogeneity of IPV

perpetrators and advocates that the risk management strategies should creatively reflect the needs of each perpetrator and victim, especially when there is a risk of lethality. Within England and Wales, access to current OBPs is largely based on OASys and OGRS3 risk levels. This can provide a quantifiable approach to the allocation of national resources in line with the RNR model. However, the SARA-V3 can contribute to this as it has the capacity to direct and influence treatment design on an individual level but also on an organisational level by identifying themes of treatment needs, if subject to research. There is the potential to use the formulation derived from the analysis of all the SARA-V3 factors, which can identify the function of IPV behaviours (Ward & Carter, 2019). Designing and accessing treatment that is responsive to the function of IPV behaviours may be better tailored to the individual than an aggregate risk score.

Chapter 6: General discussion

This thesis has aimed to explore the nature of dropout from treatment addressing Intimate Partner Violence (IPV). The focus was on convicted male IPV perpetrators that were mandated to such treatment by Criminal Justice Services. The methodology for this thesis included a meta-analytic review, empirical research involving statistical analysis of archive data and an experimental field study, a single subject case study and a critique of an IPV risk assessment. Each chapter has provided a unique contribution to the literature on IPV treatment compliance.

This research has practice implications for the field of court mandated IPV treatment with regard to treatment compliance and overall risk management. Recommendations are discussed below within the context of the examined limitations highlighted within each chapter.

Summary of findings:

After Chapter one defined Intimate Partner Violence (IPV) and described the work of the Probation services with IPV perpetrators in England and Wales, Chapter two presented a systematic review and meta-analysis exploring the correlates and predictors of IPV treatment dropout. Strict inclusion and exclusion criteria were applied, resulting in a quantitative analysis of relevant studies controlled for risk of bias. The outcomes did not appear to be affected by publication bias. The finding identified 25 variables associated with treatment dropout across the 22 included studies. This indicated a lack of consistency of the variables investigated as only half of the studies explored a

maximum of eight such variables. Nevertheless, there was evidence to support that some IPV perpetrator characteristics have the potential to predict dropout from treatment, for example age, marital status, education level, employment status, level of income, previous recidivism and severity of IPV. However, due to the heterogeneity across study designs, delivery and evaluation, there was no agreement on how these variables may interact within a model of prediction for treatment attrition. The findings from this review can be generalised within western culture as the included studied were sources from North America and Europe.

IPV dropout was further investigated in the empirical studies in chapter three, in relation to a sample of 574 men court mandated into IPV treatment run by a Community Rehabilitation Company (CRC) located in Northern England. Associated variables were identified to inform this treatment provider that treatment dropouts are likely be younger in age, have a higher Offender Group Reconviction Scale-3 (OGRS3; Howard, Francis, Soothill, & Humphreys, 2009) score, have more than one previous treatment attempt and be from a more rural geographical location. A logistic regression model was developed based on the interaction of three of these variables, to identify men that are more at risk of dropping out of treatment. The analysis demonstrated that the model of three significant predictor variables could correctly predict the criterion variable of treatment dropout with 75.8% correct classification of cases. This showed the importance of non-client variables, but should be conducted again with a further exploration of more variables than available within this study.

A further aim of the empirical studies was to investigate the potential of the utility of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O; Campbell, Sellen, & McMurran, 2010) as a motivation enhancer to promote treatment completion. The sample consisted of 55 male IPV perpetrators court mandated to the IPV treatment. Findings showed that participants that completed the PACI-O were 1.4 times more likely to complete an IPV intervention programme than the 574 men within the control sample that did not undertake the PACI-O. This significant increase in treatment completion was evidenced following the engagement of participants with the PACI-O brief intervention. Using a goal based framework to explore an individual's personally meaningful goals is suggested to be motivation enhancing (Karoly, 1993) and the assimilation of such goals with treatment aims may support treatment compliance. However, this study did not find any evidence for the PACI-O to be a measure of motivation. Further evaluations of treatment compliance could give consideration for the use of the PACI-O as pre-treatment motivation enhancing intervention.

The case study in chapter four identified some limitations of group treatment on wider aspects of the aftermath of IPV within a family context. Whilst an individual can be motivated to engage in and complete treatment, if this does not address their criminogenic risk factors, there is still a likelihood for further offending (Andrews et al., 1990). For example, R. E. Dobash, Dobash, Cavanagh, & Lewis (1999), in their book *Changing Violent Men*, describe how some IPV perpetrators who have completed treatment have been reported by the partners as no longer physically victimising the family but continuing to control family members through coercive behaviour and

psychological/emotional abuse. This can be impactful in terms of the propensity for adding to adverse childhood experiences of young family members. In relation to this, there was a significant lack of input from the victim and young family members in the IPV risk assessments conducted by the treatment provider which is contrary to best practice of the completion of Structured Professional Judgement guidelines. The discrepancy of perceived risk between civil and criminal courts was also evident within this study and as such, further research is needed into the viability of access to couple mediation or therapy to address such treatment needs (Karakurt, Whiting, van Esch, Bolen, & Calabrese, 2016). Thus, the Case Study highlighted the limitations of current group treatment, within a management plan to reduce recidivism. It challenges the "one size fits all" approach to offender rehabilitation. Therefore, thorough risk assessment is essential, especially in relation to the practical implications for child contact. Using a more holistic approach to assessment, more contextual treatment needs can be identified and therefore can inform on a more nuanced management plan tailored to the individual's needs.

Chapter five set out to critically evaluate the psychometric properties of the Spousal Assault Risk Assessment – Version 3 (SARA-V3; (Kropp & Hart, 2015). This is the licenced risk assessment tool used with Probation service users with IPV convictions in England and Wales. IPV risk assessments assist with the exploration of the nature of a perpetrator's IPV and are informative on the management of IPV risk, by specifying suitable treatment interventions to reduce the likelihood of further IPV recidivism. Due to rehabilitation services having finite resources, risk assessments can contribute to the implementation of the RNR Principles (Andrews et al., 1990) to identify and direct the

perpetrators with the greater risk of serious harm into higher intensity treatments. Also, use of risk assessments are a strategy to monitor any changes in the risk dynamic and can contribute to the evaluation of treatment effectiveness. As this critique took place four years after the release of this measure, there was found to be a stark paucity of literature that referenced the use of the SARA-V3 and fewer investigating the constructs of reliability or validity. Despite the limited findings regarding the SARA-V3, the public/private Probation services are licenced to use and deliver training in the use of the SARA-V3. Furthermore, routine use of such risk assessments may provide a shared definition of IPV risk, which can provide effective communication between and with Criminal Justice Services, which could be beneficial for issues raised in chapter four. Nevertheless, the lack of routine implementation was found in chapter three, which suggested that the use of this risk assessment tool was a "hit and miss" affair and recommendations for changing this need to be made.

Limitations:

Limitation from each chapter generally related to incomplete or missing data for samples under investigation. The main limitation was related to the primary empirical research studies. Research interviews took place over 65 individual dates over a 12-month period in order to interview the Intend To Treat (ITT) sample comprised of 115 individual participants. However, only 55 participants were successfully recruited into part two of the empirical study. It was not easily possible to rearrange research interviews if the potential participant failed to attend as these took immense logistical planning for the single author to travel across nine Probation offices within five geographical districts. Having

further practitioners trained to deliver the PACI-O (J. Campbell et al., 2010) interview would have supported the collection of further data. If one practitioner was trained in each geographical district and could deliver the same quantity of PACI-O interviews, this would increase the ITT sample to 575. This would have the potential to deliver the PACI-O single session intervention with the total population for this particular IPV intervention, based on the number of 2014-2016 annual referrals with this treatment provider. As part two of the empirical study identified participants that completed the PACI-O were 1.4 times more likely to complete an IPV intervention, this would provisionally forecast an increase in successful treatment completion for 92 additional individuals out of the hypothetical sample of 575. Whilst the PACI-O was not found to be an effective measure of motivation using the adaptive motivation scores, nor associated with treatment completion, this may have related to the small experimental sample size. Therefore, expanding the delivery of the PACI-O to a larger sample, may allow further exploration of the structural and psychometric qualities of the PACI-O, for example construct validity could be explored using existing motivation measures.

Future directions:

Considering this thesis as a whole, it is apparent that further research is needed regarding the exploration of the nature of treatment compliance and motivation with IPV perpetrators. This has a number of possibilities. Firstly, expanding the range of variables under routine scrutiny, then replication and further adaptations to the research featured in this thesis.

A treatment outcome that was not focused on in this thesis was recidivism. This is features heavily in treatment evaluation studies as an indicator in the reduction of risk to the wider public. However, there is a disparity in the sources of information to measure such an outcome. Recidivism can included perpetrator self or partner disclosure of further IPV, police arrest records for an IPV-related offence, or official reconviction data for an IPV-related offence. This could be expanded further for non IPV-related offending. In addition, there is inconsistency across studies with the length of follow-up for such data collection. The follow-up length of time has to be evaluated as adequate to detect recidivism and that the sources of such information are credible. One recommendation is that a follow-up period of five years would equate to high confidence for recidivism detection whilst less than 36 months would provide poor confidence (Collaborative Outcome Data Committee, 2007b). However, a two year follow-up would be congruent with the OGRS3 scoring. An extended follow-up methodology may also risk the loss of participants due to the time periods, which can impact the study validity if the data loss is too great. Thus, a further study could follow-up the participants from part one of the research in chapter three. Cross-referencing the outcome measure of reconviction with treatment completion may assist with quantifying the association between risk of recidivism and treatment dropouts.

Within the current literature, there is inconsistency with the use of psychometric scales and measures. There are numerous measures such as those for Measuring IPV behaviours, for example: Abusive Behaviours Inventory (Shepard & Campbell, 1992); Control of Partner Scale (Follingstad et al., 1988) Conflict Tactics Scale 2 (Straus et al., 1996); those measuring

temperament and attitudinal trait measures such as Attitudes Towards Correctional Treatment (Baxter & Tweedale, 1995), the Inventory of beliefs about Wife Beating (Saunders, Lynch, Grayson, & Linz, 1987) Rosenberg Self-Esteem Index (Morris Rosenberg, 1965) State Trait Anger Expression Inventory 2 (Spielberger, 1999), Ambivalent Sexism Inventory (Glick & Fiske, 1997); those for measuring social desirability such as (Crowne & Marlowe, 1960; D. L. Paulhus, 1999) amongst many others. Furthermore, the use of psychometric scales and measures could assist with identifying additional variables associated with treatment attrition but could also be readily used directly within the treatment of a perpetrator and may be better suited in supporting the formulation of the IPV typology.

A replication of part two of the research in chapter three would assist with the generalisability of utility of the PACI-O. This brief intervention can be implemented by clinicians without specialist forensic training. As stated in the introductory chapter, the findings from chapter three were shared at three national conferences. Eleven practitioners provided contact details to this thesis author for further information of how they could consider the utility of embedding the PACI-O within their respective services. In addition, this could potentially benefit other treatment interventions and the wider supervision of Probation clients, not just with IPV perpetrators. Such implementation of the PACI-O could also be evaluated in terms of the resources needed for delivery and compared in terms of cost-effectiveness with the resources involved in re-engaging with treatment dropouts and supporting further attempts at treatment.

It would be useful to further explore the non-client variables that may be associated with treatment dropout. The empirical research in part two of chapter three identified a significant non-client variable of physical location of treatment. The impact of situational variables such as treatment alliance and gender of treatment facilitators in relation to treatment attrition has receive little investigation. Analysis of such factors could identify supportive practices that could improve the overall treatment completion rates.

However, these future directions relate to improving the numbers of IPV perpetrators completing treatment. What is missing from this research is the evaluation of the current IPV treatment being successful in reducing recidivism. As stated in the introduction there are monitoring processes in place to evaluate the effectiveness of Offending Behaviour Programme (OBP) treatment within England and Wales. There is a need for more transparency from the Ministry of Justice regarding the prompt sharing of treatment evaluations based on the vast amount of data that is collected for participants attending accredited OBPs. For example, the Building Better Relationships OBP has been in existence since 2012 and at this time there is no suggestion of an evaluation being shared. This may ultimately inform on the consideration of wider services such as seeking further evaluations of couple-based therapy and the consideration of voluntary treatment rather than court mandated treatment. Further transparency of the Correctional Services Advice and Accreditation Panel (CSAAP) meetings could provide confidence for practitioners, commissioning services and the wider public, that IPV OBPs are being designed and evaluated as effective in reducing recidivism.

Conclusion:

A research journey is represented within this thesis. The initial conception arose from the observations from delivering IPV group treatment programmes within a community Probation setting, targeted at male perpetrators from heterosexual relationships. Whilst reciprocal IPV exists and there are female perpetrators, there is significant asymmetry in the IPV modality, severity and prevalence. Research from an English sample indicates whilst men and women can display a similar range of IPV behaviours, the severity and intensity of abusive behaviours from men is, on the whole, much more extreme than that posed by female perpetrators (Marianne Hester, 2013). The heightened repeat perpetration posed by men has created a high volume of research exploring ways to understand, address and reduce IPV. Mandating treatment as part of a court order reflects the societal demand for justice for the devastating effects of this crime. Dropping out from such treatment has been associated with posing a heighten risk of reoffending, in comparison with no treatment being offered (McMurran & Theodosi, 2007). This has guided the formation of each chapter, using intensive investigation of existing literature and research. In addition, the research took place in the backdrop of changes within the statutory services that supervise and monitor convicted IPV perpetrators and the more recent draft proposal of the Domestic Abuse bill 2019-21.

The thesis set out to explore the nature of dropout from court mandated IPV group treatment with particular focus on the constructs of motivation and readiness for such treatment, as a strategy to address treatment attrition. Findings from the systematic review and the empirical research indicate treatment motivation plays a part in supporting an individual to comply with

IPV group interventions. However, there are limitations to this in that the completion of treatment does not always inhibit reoffending, as shown in the case study.

The focus of a vast proportion of existing literature had been on modifying the client in order to comply with treatment. A disproportionately few number of studies evaluated in the systematic review focused on non-client factors, referred to in the Multifactor Offender Readiness Model (MORM; Ward, Day, Howells, & Birgden, 2004) as external or contextual factors in relation to treatment readiness conditions. Whilst the empirical research expanded on this, in terms of the impact of geographic location and accessibility of treatment, there is need for further examination of how the nature of treatment can impact on compliance or dropout. This raises the question of why this domain is under analysed in the literature. Perhaps this relates to the assumption of interventions providing an unquestionable 'gold standard' if reviewed and endorsed by groups such as the CSAAP (Lipton, Thornton, McGuire, Porporino, & Hollin, 2000). As a result there may be an implicit bias from researchers that problems with treatment compliance and engagement are solely client-rooted.

As stated, the MORM stresses the importance of the external factors that are associated with the readiness for treatment. These can include: treatment accessibility and availability, quality of treatment, credentials of practitioners delivering treatment, and presence of professions that will support and encourage the client through the process of treatment. Since the part privatisation of the Probation services, consideration of the marketing of

treatment to a court mandated clients and their Offender Manger has been given more attention. This is due to National Probation Service (NPS) accessing treatment for the clients they supervise and manage, from the privatised Community Rehabilitation Companies (CRCs). This is achieved by use of a 'rate card' which lists services, such as OBPs, that are purchasable from the CRCs for NPS clients. The efficacy of treatment has been an ongoing subject of research and evaluation, however due to the CRC culture of 'payment by results' being implemented since 2015, the efficiency of treatment services is now subject to scrutiny. In order to provide cost-effective service, there may be more opportunity to examine how the context of treatment and its environment can be associated with the rates of treatment dropout.

The provision of current OBPs is largely based on an IPV perpetrator's level of risk using assessments such as the Offender Assessment System (Home Office, 2002b)2002 home office, OGRS3 and SARA-V3. An aggregate risk level may be helpful in allocating the proportion or type of resources for rehabilitation, however some commentators suggest "that offender's behaviour is best described by subcategories" (Dixon & Browne, 2003). IPV typology theories group offending behaviours into categories and is suggestive of the expected range of perpetration and victim types for each (Holtzworth-Munroe & Stuart, 1994; Johnson, 1995, 2000). The Holtzworth-Munroe & Stuart (1994) typology classification requires the identification of personality traits. This would be an uncommon practice for the CRC that was involved with the research contained in this thesis, making this typology less accessible to Probation practitioners. Indeed, IPV typology does not overtly feature within the treatment programmes discussed in this thesis. IPV perpetration is heterogeneous in

nature and all perpetrators may not be easily 'pigeonholed'. There is an expectation that a perpetrator's modality of offending may alter rather than remain static within one typology grouping, particularly when a perpetrator is subject to monitoring, supervision and treatment. This is shown in risk assessors' use of 'Twist', 'Escalation' and 'Improvement' risk scenarios in Structured Professional Judgement assessments, such as the SARA-V3. IPV typologies may assist in understanding the descriptive nature and range of IPV, but an advancement of this could categorise behaviours based on their function. Using a tool such as the PACI-O can assist in exploring an individual's motivational structure underpinning their goal directed behaviours. This can then contribute to the formulation of IPV behaviours as featured as an assessment step within the SARA-V3. This can ultimately direct the development of risk management strategies and treatment targets tailored to the individual, rather than a collective group.

In conclusion, this thesis has achieved its overall aim of contributing to the existing literature concerning IPV treatment compliance and provided further evidence of the utility of the PACI-O as a brief motivational intervention. The meta-analytic review built on the existing literature to identify a diverse interplay of factor that are associated with IPV treatment dropout. The empirical research put forth a predictive model that incorporates treatment service variables and tested the feasibility of using the PACI-O with a community sample to increase treatment compliance. The case study highlighted the complexity of IPV and demonstrated the limitations of OBPs, which may not address all treatment needs for an individual. The critique of the SARA-V3 identified evidence of reliability and validity is lacking for this risk

assessment, which may be indicative of the limited uptake on its utility, certainly within the public/private Probation provision in England and Wales. Overall, the research presented in this thesis can assist researchers and practitioners with progressing the evolution of "what works" in community IPV group treatment.

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Chapter 1

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Appendices

Appendix I: Data extraction form

Article Citation [Author, Date & Title]:	
1 Type of study:	
2 Country of origin:	
3 Sample size:	
4 Number of treatment completers:	
5 Number of treatment dropouts:	
6 Did the author state reasons for attrition?	
7 Treatment curriculum:	
8 Treatment duration:	
9 Treatment completion definition;	
10 Did participant pay for treatment?	
11 Was there a participation payment?	
12 Did the author test for baseline group equivalence?	
13 Correlates or predictors of significant treatment outcomes at $p<0.05$:	
14 Any predictive models and full details?	
15 Length of follow-up period:	
16 Type of recidivism measures:	
17 Any issues with generalisability?	
18 Other:	

Appendix II: Quality Assessment ratings using CODC guidelines for included studies

Study Number:	1			2			3			4			5			6			7						8		
	Rater 1			Rater 1			Rater 1			Rater 1			Rater 1			Rater 1			Rater 1			Rater 2			Rater 1		
	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D
1. Defining Treatment	0			0			0			1			1			1			1			1			0		
2. Defining Comparison	0			0			0			0			0			0			0			1			0		
3. Miscellaneous Incidental Factor		1	?		1	?		2	0		2	0		2	0		2	0		2	0		2	?		2	0
4. Experimenter Involvement		2	0		2	0		2	0		2	0		2	0		2	0		1	?		2	+		2	0
5. Blinding in Data Management		1	?		1	?		1	?		X	0		X	0		X	?		1	?		0	?		1	?
6. Sample Size of Treatment	1			2			1			1			2			1			1			1			1		
7. Sample Size of Comparison	1			1			0			1			2			0			2			2			1		
8. Cross Institution Design Sample Size	X			X			X			X			X			X			X			X			X		
9. Subject Selection		2	0		2	0		2	0		2	0		2	0		2	0		2	0		2	0		1	+
10. Program Attrition		0	?		1	?		1	?		X	0		X	0		1	0		0	-		0	-		1	0
11. Intent-to-treat		**1**	0		1	0		1	0		1	0		1	0		1	0		**1**	0		0	0		1	0
12. Attrition in Follow-up		2	0		2	0		X	?		X	?		X	?		X	?		X	?		X	?		X	+
13. A Priori Equivalence of Groups		1	0		1	?		0	?		1	0		1	0		0	?		1	?		1	?		1	0
14. Adequacy of Search for Differences	2			2			2			2			2			1			2			2			2		
15. Findings on Group Equivalence		X	?		X	?		X	?		X	?		X	?		2	?		X	?		X	?		0	?
16. Length of Follow-up	0			0			0			0			0			0			0			0			0		
17. Validity/Reliability of Recidivism	1			1			X			X			X			X			X			X			0		
18. Equivalence of Follow-up		2	0		2	0		X	X		X	?		X	?		X	?		X	X		X	X		0	?
19. Data Dredging	2			2			2			2			2			2			2			1			2		
20. Effectiveness of Statistical Controls	2			1			2			1			1			1			2			2			2		
21. Compute Least Bias Comparison		2	0		2	0		1	?		1	?		1	?		1	?		2	0		1	0		1	+
GLOBAL CONFIDENCE	1			1			1			1			2			1			2			2			1		
GLOBAL QUANTITY OF BIAS	2			2			1			2			2			2			1			1			1		
GLOBAL DIRECTION OF BIAS	?			?			?			?			?			?			?			?			Increases		
GLOBAL RATING	**Good**			**Good**			**Weak**			**Good**			**Strong**			**Good**			**Good**			**Good**			**Weak**		

9			10			11			12			13			14			14			15			16			17			18			19		
Rater 1			Rater 1			Rater 1			Rater 1			Rater 1			Rater 1			Rater 2			Rater 1			Rater 1			Rater 1			Rater 1			Rater 1		
C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D
0			0			0			0			0			1			1			0			1			1			1			0		
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	X	?		2	0		X	?		2	0		2	0		2	0		2	0		1	0		2	0		1	+		X	?		1	+
	X	?		1	0		1	?		X	?		1	+		1	?		1	0		2	0		1	0		0	?		1	?		1	0
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	X	X		1	?		X	X		2	0		2	0		2	0		2	+		2	0		2	0		2	0		X	X		1	+
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	?			?			?			?			Increases			Increases			Increases			Increases			?			Increases			?			Increases		
Good			**Good**			**Good**			**REJECT**			**Good**			**Weak**			**Weak**			**Weak**			**Weak**			**Weak**			**Good**			**Weak**		

20						21			22			23						24		
Rater 1			Rater 2			Rater 1			Rater 1			Rater 1			Rater 2			Rater 1		
C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D	C	B	D
2			2			0			2			2			2			1		
2			2			0			2			2			2			1		
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2			2			1			1			1			1			1		
X			X			X			X			X			X			X		
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	2	0		2	0		X	?		2	0		2	0		2	0		2	0
	2	0		2	0		1	?		1	0		2	0		2	0		1	?
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	2	0		2	0		X	?		?	X		X	?		0	?		0	+
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2			2			0			2			1			1			1		
2			2			2			2			2			2			2		
Increases			Increases			?			?			?			?			?		
Strong			**Strong**			**REJECT**			**Strong**			**Good**			**Good**			**Good**		

Appendix III: Statistical analyses confirming the null hypotheses of no significant variable associations between treatment completers and non-completers in the sample for part one

Variable tested	**Result**
Ethnicity all responses	A chi-square test found no association between ethnicity type and completers vs non-completers, χ^2 (4, N=574) = 6.864, *p* = .143
Ethnicity (white vs Black, Asian, Minority Ethnic (BAME))	A chi-square test found no association between ethnicity type (white vs BAME) and completers vs non-completers, χ^2 (1, N=574) =1.298, *p* = .255
Type of sentence	A chi-square test found no association between the type of sentence and completers vs non-completers, χ^2 (2, N=574) = 1.195, *p* = .550
Probation management private/public sector	A chi-square test found no association between type of management agency and completers vs non-completers, χ^2(1, N=574) =1.827, *p* =.176
Number of days between start of order & referral to treatment	A Mann-Whitney test indicated no significant difference between no. days from start of order & referral and completers vs non-completers, *U* =37423, *p* =.648, *r* =.019
Number of days between start of order & referral to treatment quartile ranges	A chi-square test found no association between no. days from start of order & referral and completers vs non-completers, χ^2 (3, N=574) =3.649, *p* = .302

Appendix IV: Demographic information of the experimental sample

	Variable	Experimental (N = 55)	
		Completed Intervention (N = 29)	**Not completed Intervention (N = 26)**
Median Age (IQR)		33 (17)	30 (8)
Ethnicity (%)	White	25 (79.1%)	23 (88.5%)
	Asian	4 (13.8)	2 (7.7%)
	Black	0	1 (3.8)
	Mixed	0	0
	Other/Not stated	0	0
Order Type (%)	Community Order	19 (65.5%)	18 (69.2%)
	Suspended sentence	7 (24.1%)	5 (19.2%)
	Custodial sentence	3 (10.3%)	3 (11.5%)
Management (%)	CRC	25 (86.2%)	20 (76.9%)
	NPS	4 (13.8%)	6 (23.1%)
Geographical District (%)	District 1	5 (17.2%)	2 (7.7%)
	District 2	6 (20.7%)	1 (3.8%)
	District 3	2 (6.9%)	3 (11.5%)
	District 4	9 (31.0%)	8 (30.8%)
	District 5	7 (24.1%)	12 (46.2%)
Median OGRS3 Year 2 (IQR)		38 (23)	49.5 (30)
Median days bet. Order start & Referral (IQR)		15 (14)	17 (32)
Median days bet. Referral & PACI-O Interview (IQR)		85 (108)	57.5 (55)
Number of invites (%)	1 invite	23 (79.3%)	9 (34.6%)
	2 or more invites	6 (20.7%)	17 (65.4%)

Appendix V: Ethics approval letter

The University of Nottingham

Faculty of Medicine and Health Sciences

Research Ethics Committee
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham
NG7 2UH

[redacted]

15th June 2015

[redacted]

Dear [redacted]

Ethics Reference No: W16042015 SoM PAPsych DFP – please always quote
IRAS ID: 171828
Study Title: Promoting Treatment Engagement of domestic violence perpetrators within community Safer Relationships Activity (SRA) – evaluating the use of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O) as a motivational tool
Chief Researcher/Academic Supervisor: [redacted] Assistant Professor in Forensic Psychology/Consultant Forensic Psychologist, Division of Psychiatry & Applied Psychology, School of Medicine
Other key researchers/student: [redacted] Trainee Forensic Psychologist, Doctorate Forensic Psychology Student.
Duration of Study: June 2015-30 June 2016 12mths
No of Subject: 288 (18+yrs)

Thank you for submitting the above application which has been reviewed and the following documents were received:

Effectiveness of PACI-O motivational tool with DV perpetrators:

- FMHS Research Ethics Committee Application Form version 01, 02 April 2015
- NOMS Research Application Form version 1.0 09/01/2015
- National Offender Management Service (NOMS) - request for further information letter dated 23rd February 2015: NOMS-Research ref: 2015-016.
- Letter of response to NOMS request for further information 02/04/15
- Participant Information Sheet Version 01: 02/04/2015
- Consent Form version 01: 02/04/2015
- Personal Aspirations and Concerns Inventory for Offenders Tool: Answer Sheet
- Personal Aspirations and Concerns Inventory for Offenders Tool: Review Sheet

These have been reviewed and are satisfactory and the study has been given a favourable opinion.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

1. Please can you submit the letter of approval from the NOMS- National Research Committee and a Sponsorship approval letter when these are available.

2. You must follow the protocol agreed and inform the Committee of any changes using a notification of amendment form (please request a form).

3. You must notify the Chair of any serious or unexpected event.

4. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

5. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Dr Clodagh Dugdale
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix VI: Part 2 consent form

The University of Nottingham
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[redacted]

CONSENT FORM
(Version 02: 15/04/2015)

Title of Study: Promoting treatment engagement of domestic violence perpetrators within community Safer Relationships Activity (SRA) - evaluating the use of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O) as a motivational tool

REC ref: W16042014 SoM PAPsych DFP

Name of Researcher: [redacted]

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version 02 dated 15/04/2015 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my probation supervision or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that relevant sections of my probation notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant & 1 for the project records

Appendix VII: Part 2 information sheet

[redacted]

Participant Information Sheet
(Version 02: 15/04/2015)

Title of Study: Promoting Treatment Engagement of domestic violence perpetrators within community Safer Relationships Activity (SRA) - evaluating the use of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O) as a motivational tool

Name of Researcher(s): [redacted]

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

This study will aim to help your participation and engagement for the Safer Relationships Programme (SRA) by using a motivational tool called the PACI-O.

Why have I been invited?

You are being invited to take part because you have been referred to the Safer Relationships Activity. We are inviting 144 participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Once you have understood the purpose of the study and given consent to take part, you will be asked to take part in an interview about any issues or goals you may have in different areas of your life. This will be a one time only interview which will last up to 80 minutes. Firstly, you will be asked to pick out any issues or goals you have. Secondly you will be asked to choose numbers that best describe how you feel about each of these issues, eg rate on a scale of 0 to 10. Finally you will be asked to consider how each goal might affect your other goals.

Your responses will be noted and personal information will the collected from probation records, such as age, sentence type and SRA completion information. You will be assigned a study identity code number so you will not be identifiable from your responses in any publication.

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[redacted]

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

It is likely this appointment will be arranged before or after a probation appointment as such any inconvenience of your time will be kept to a minimum. You will be asked about areas of your life that you might like to develop or improve, as such this may cause you to feel some discomfort or upset if you are unhappy with certain aspects. If you feel down after the interview you can be directed towards support services such as your probation officer, GP or Samaritans.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help you to better understand the goals you are working towards and you may be able to identify how probation group work can assist you with your goals. By participating in this study you are helping to inform probation staff on ways to better engage with service users.

What happens when the research study stops?

This research will constitute my doctoral thesis in Forensic Psychology studied at the University of Nottingham. I will then aim to publish the findings in a relevant journal. I will also share my findings within [redacted] as this research has potential to develop working practices that can support the reduction of drop out rates for SRA.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: [redacted].

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of your probation records and the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the probation offices will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

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[redacted]

Your personal data (address, telephone number) will be kept for 4 weeks after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

Who is organising and funding the research?

This research is being organised by the University of Nottingham without funding.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by NOMS National Research Committee (NRC), as well as the University of Nottingham Ethics Committee.

Further information and contact details

[redacted]

Appendix VIII: PACI-O response sheet

Printed as
A3 sheet
Double sided

Review Sheet

Ok, this is now the final part.
Let's look at the issues you've talked about and if each goal supports or clashes with your other life goals.
In summary you said…(Fill in boxes Goal #1, #2, #3 etc)

Lets now review each goal and tell me on a scale of 0-10 how much achieving each goal would affect your other goals.

0 5 10
(this goal greatly clashes with my other goals) ..... (this goal supports my other life goals)

	SCORE 0 (clashes) - 10 (supports)
Past, Current and Future Living Arrangements Goal #1 is...	
Close Personal Relationships Goal #2 is...	
Physical or Mental Health Issues Goal #3 is...	
Recreation Goal #4 is...	
Self Changes and Personal Improvement Goal #5 is...	
Employment, Training and Financial Situation Goal #6 is...	

Thank the participant

Record if SU requests a copy of PACI-O circle: YES / NO

Record if SU would mind being contacted at a later date: YES / NO

OFFICAL SENSITIVE

Initial of Service user:		Date of birth:	
Name of Offender Manager:		CRN:	
Name of Interviewer:		Participant number:	
Date of Interview:		Information sheet & consent form given?	

Explain Task:
You will be asked to think carefully about what you may want to change in your life or changes you are already working on. These may be goals you want to achieve or problems to overcome.

I will read through a number of Areas of Life in which you may pick out these issues. Use the booklet which will help highlight different aspects of each area.

In some of these Areas of Life, you might have only one issue or no issues at all. In other Areas of Life, you might have two, three, or more issues. Share only what you are comfortable with. I will then ask you to describe how you would like things to turn out.

I will ask you to choose the numbers that best describe how you feel about each of the issues that you have described. This is using rating scales of 0 to 10 also in the booklet. Turn the pages when we change life events.

I will be making a note of what you say in the Answer Booklet & Sheet as we go along. I will review what I have written with you to check if this is correct so you can add or change anything you have said.

Please stop me at anytime if you want to ask questions or would like to stop for a break. Do you have any questions before we begin?

PACIO – Probation amended

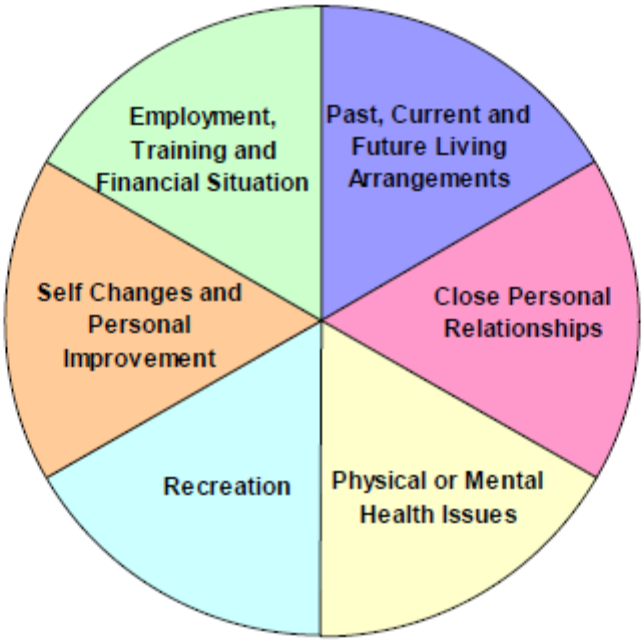
Appendix IX: PACI-O scoring booklet

OFFICIAL SENSITIVE

Initial of Service user:		Date of birth:	
Name of Offender Manager:		CRN:	
Name of interviewer:		Participant number:	
Date of interview:			

Answer sheet

6 areas of life



Think of anything you want to change in each life area such as problems you want to overcome
OR
goals you want achieve

When problems, goals and obstacles have been identified on A3 sheet, ask the following questions whilst prompting the participant to refer to the scales in their booklet.

1) Past Current and Future Living Arrangements
Home & Household Issue

	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal? ⇨	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal? ⇨	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

2) Close Personal Relationships

Friends, Family, Partner, Love & Intimacy

	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal?	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal?	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

3) Physical or Mental Health Issues
Health, Medical Matters & Substance Abuse

	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal?	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal?	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

4) Recreation

Hobbies, Pastimes & Spiritual Matters

	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal?	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal?	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

5) Self- Changes and Personal Improvement

Changes to Yourself, Re-offending, Anger & Violence

	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal?	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal?	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

6) Employment, Training and Financial Situation
Jobs, Training, Money & Education

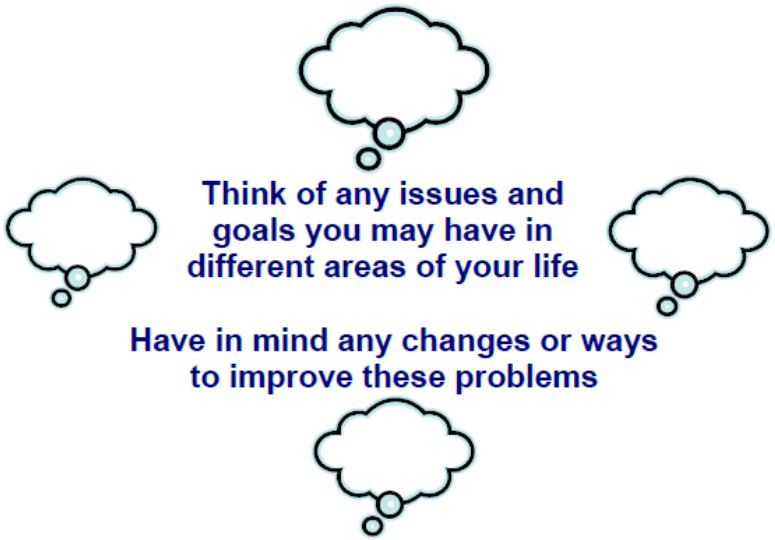
	SCORE (out of 10)
How **IMPORTANT** is it to you for things to turn out the way you want? 0 (not important) 10 (very important)	Importance:
How **LIKELY** is it that things will turn out the way you want? 0 (not likely) 10 (very likely)	How likely:
How much **CONTROL** do you have in causing things to turn out the way you want? 0 (no control) 10 (full control)	Control:
Do you know **WHAT STEPS** to take to make things turn out the way you want? 0 (don't know what to do) 10 (know exactly what to do)	Achieve:
How much **HAPPINESS** would you get if things turn out the way you want? 0 (no happiness) 10 (full happiness)	Happiness:
How **COMMITTED** do you feel to making things turn out the way you want? 0 (not committed) 10 (fully committed)	Commitment:
WHEN will it happen? (Is it something you can achieve in the foreseeable future or not until far into the future)	(Circle): Stm / Inter / Ltm
Think about and LIST any ways in which being on probation may either get in the way or help you with achieving this goal?	
How will the experience of being on probation **AFFECT** you being able to achieve this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Probation affect:
Think about and LIST any ways in which reoffending in the future may either get in the way or help you with achieving this goal?	
So overall if you were to offend in the future how would this **AFFECT** you achieving this goal? 0 (completely gets in the way) 10 (helps achieve)	**SCORE** Offending affect:

Appendix X: PACI-O stimulus booklet

Printed as A5 booklet

Thank you for taking part!

PACIO – Probation amended



Think of any issues and goals you may have in different areas of your life

Have in mind any changes or ways to improve these problems

First you will be asked to pick out these issues

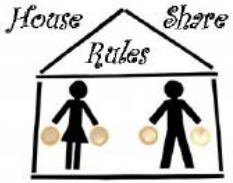
Next you will be asked to choose numbers that best describe how you feel about each of these issues, eg rate on a scale of 0 to 10

Finally you will be asked to consider how each goal might affect your other goals

- You can stop or ask questions at any time

1) Past Current and Future Living Arrangements

Home & Household Issue



Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

2) Close Personal Relationships

Friends, Family, Partner, Love & Intimacy

Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

3) Physical or Mental Health Issues

Health, Medical Matters & Substance Abuse

Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

4) Recreation

Hobbies, Pastimes & Spiritual Matters

Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

5) Self- Changes and Personal Improvement

Changes to Yourself, Re-offending, Anger & Violence

Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

6) Employment, Training and Financial Situation

Jobs, Training, Money & Education

Not important..... Very Important
0 1 2 3 4 5 6 7 8 9 10

Not likely.....Very Likely
0 1 2 3 4 5 6 7 8 9 10

No Control ..... Complete Control
0 1 2 3 4 5 6 7 8 9 10

Don't Know What To Do..... Know Exactly What to Do
0 1 2 3 4 5 6 7 8 9 10

Very Unhappy ..... Very Happy
0 1 2 3 4 5 6 7 8 9 10

Not Committed ..... Fully Committed
0 1 2 3 4 5 6 7 8 9 10

Probation:
Completely
gets in the way..... Probation Helps
0 1 2 3 4 5 6 7 8 9 10

Offending:
Completely
gets in the way.....Offending Will Help
0 1 2 3 4 5 6 7 8 9 10

Appendix XI: Statistical analyses confirming the null hypotheses of non-significant variable associations between treatment completers and non-completers in the experimental sample

Variable tested	**Result**
Age at referral to intervention	A Mann-Whitney test indicated no significant difference in age between completers vs non-completers, U =305.000, p =.224, r =.164
Age at referral to intervention quintile ranges	A Fisher's exact test found no association between age grouped in quintiles and completers vs non-completers, p=.115
Ethnicity all responses	A Fisher's exact test found no association between ethnicity type and completers vs non-completers, p=.909
Geographical district	A Fisher's exact test found no association between the geographical district and completers vs non-completers, p=.200
Type of sentence	A Fisher's exact test found no association between the type of sentence and completers vs non-completers, p=.917
Probation management private/public sector	A Fisher's exact test found no association between type of management agency and completers vs non-completers, p=.490
OGRS3 2 year score quartiles	A chi-square test found no association between OGRS3 2 year scores grouped in quartiles and completers vs non-completers, $\chi^2(3, N=55) = 5.405$, p=.144
Number of days between start of order & referral to treatment	A Mann-Whitney test indicated no significant difference between no. days from start of order & referral and completers vs non-completers, U= 301.5, p=.202, r= .172
Number of days between start of order & referral to treatment quartile ranges	A chi-square test found no association between no. days from start of order & referral and completers vs non-completers, χ^2 (3, N=55) = 4.057, p = .255
Number of days between referral to treatment & PACI-O interview	A Mann-Whitney test indicated no significant difference between no. days from start of order & referral and treatment non-completers from both samples, U = 291.000, p =.147, r = .196.
SARA-V2 Summary Risk of violence towards partner rating pre-intervention	A Fisher's exact test found no significant association between SARA-V2 pre-treatment partner score and completers vs non completers, p = .233
SARA-V2 Summary Risk of violence towards partner rating post-intervention	A Fisher's exact test found no significant association between SARA-V2 post-treatment partner score and completers vs non completers, p = 1.00

Appendix XII: Statistical analyses confirming the null hypotheses of non-significant variable associations between experimental and control samples

Variable tested	**Result**
Age at referral to intervention	A Mann-Whitney test indicated no significant difference in age between samples, U =14435, p =.749, r =.013
Age at referral to intervention quintile ranges	A chi-square test found no association between age grouped in quintiles and sample groups, $\chi^2(4, N=594) = .120$, p=.998
Ethnicity all responses	A Fisher's exact test found no association between ethnicity type and sample groups, p=.517
Ethnicity (white vs BAME)	A chi-square test found no association between ethnicity type (white vs BAME) and sample groups, $\chi^2(1, N=629) = 1.245$, p=.176
Geographical district	A chi-square test found no association between the district location and sample groups, $\chi^2(4, N=629) = 6.963$, p=.138
Type of sentence	A chi-square test found no association between the type of sentence and sample groups, $\chi^2(2, N=629) = .372$, p=.830
Probation management private/public sector	A chi-square test found no association between type of management agency and sample groups, $\chi^2(1, N=629) = .737$, p=.390
OGRS3 2 year score	A Mann-Whitney test indicated no significant difference in OGRS3 2 year score between samples, U =13265.0, p =.214, r =.051
OGRS3 2 year score quartiles	A chi-square test found no association between OGRS3 2 year scores grouped in quartiles and sample groups, $\chi^2(3, N=592) = 3.844$, p=.279
Number intervention invites	A chi-square test found no association between the frequency of intervention invites and sample groups, $\chi^2(1, N=612) = 1.198$, p=.274
Number of days between start of order & referral to treatment (non-completers only)	A Mann-Whitney test indicated no significant difference between no. days from start of order & referral and treatment non-completers from both samples, U = 4049.5, p =.227, r = .061

Appendix XIII: Case Study research consent form

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

[redacted]

CONSENT FORM
(Version 1.0: 22/11/16)

Title of Case Study: A case study exploring the effectiveness of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O) as a pre-treatment motivational intervention to enhance engagement within community Safer Relationships Activity (SRA)

Name of Researcher: Anna Thompson

Name of Participant: [redacted]

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.0 dated 22.11.16 for the above study and have had the opportunity to ask questions. [redacted]

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my probation supervision or legal rights being affected. I understand that should I withdraw then the unidentifiable information collected so far cannot be erased and that this information may still be used in the project analysis. [redacted]

3. I understand that relevant sections of my probation notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the researcher's supervisors and regulatory authorities where it is relevant to my taking part in the study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish anonymous information obtained from my participation in this study. I understand that my personal details will be kept confidential. [redacted]

4. I agree to take part in the above study. [redacted]

[redacted]	29/11/16	[redacted]
Name of Participant	Date	Signature
Anna Thompson	29/11/16	[redacted]
Name of Researcher	Date	Signature

2 copies: 1 for participant & 1 for the project records

Appendix XIV: Case Study research information sheet

[redacted]

Participant Information Sheet
(Version 01: 22/11/2016)

Title of Case Study: A case study exploring the effectiveness of the Personal Aspirations and Concerns Inventory for Offenders (PACI-O) as a pre-treatment motivational intervention to enhance engagement within community Safer Relationships Activity (SRA)

Name of Researcher(s): [redacted]

This is an invitation to take part in a research case study. Before you decide it is important for you to understand why the research is being done and what it would involve for you. Take time to read the following information carefully. Please ask if there is anything that is not clear or if you have any questions.

What is the purpose of the study?

This study will aim to explore how your completion of the PACI-O tool helped your participation and engagement in the Safer Relationships Programme (SRA).

Why have I been invited?

You are being invited to take part because you consented to being contacted at a later date after completing the PACI-O interview in May 2016.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

Once you have understood the purpose of the study and given consent to take part, the interview will last up to 45 minutes. Firstly, you will be asked to review any issues or goals in different areas of your life that you identified in your initial research interview from May 2016. Secondly, you will be asked to review the ratings you chose which described how you felt about each of these issues, eg rate on a scale of 0 to 10. Thirdly, you will be asked to review how each goal affects your other goals. Finally you will be asked some general questions about your experiences committing to the SRA programmes and to complete a 26 item questionnaire exploring your motivation for engaging with SRA.

Your responses will be noted and personal information will the collected from probation records, such as age, sentence type and SRA completion information. You will be assigned a study identity code number so you will not be identifiable from your responses in any publication.

[redacted]

Expenses and payments

Participants will not be paid to participate in the study.

What are the possible disadvantages and risks of taking part?

It is likely this appointment will be arranged before or after a probation appointment as such any inconvenience of your time will be kept to a minimum. You will be asked about areas of your life that you might like to develop or improve, as such this may cause you to feel some discomfort or upset if you are unhappy with certain aspects. If you feel down after the interview you can be directed towards support services such as your probation officer, GP or Samaritans.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help you to better understand the goals you are working towards and you may be able to identify how probation group work can assist you with your goals. By participating in this study you are helping to inform probation staff on ways to better engage with service users.

What happens when the research study stops?

This research will constitute my doctoral thesis in Forensic Psychology studied at the University of Nottingham. I will then aim to publish the findings in a relevant journal. I will also share my findings within [redacted] as this research has potential to develop working practices that can support the reduction of drop out rates for SRA.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting: [redacted], details below.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of your probation records and the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the probation offices will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

[redacted]

All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

Who is organising and funding the research?

This research is being organised by the University of Nottingham without funding.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by NOMS National Research Committee (NRC), as well as the University of Nottingham Ethics Committee.

Further information and contact details

[redacted]

[redacted]

Appendix XV: Communication record between Vic and the victim

On the 19th of May 2017 the victim receives a message via the WhatsApp messaging service. Sent at 21:49 – "HI CAN WE TALK PLZ"

On the 12th of June the victim received three further messages:

Sent at 08:01 – "U NO WHAT [redacted] FUCK WHAT ANYONE SAYS. U WAS RIGHT IN EVERY TXY"

Sent At 08:09 – "TXT I DON'T DESERVE THEM GIRLS U HAVE TOLD ME SO MANY TIMES ITS UNREAL I SHOULD HAVE GROWN UP. U WERE THE BEST THING THAT'S EVER HAPPENED TO ME AN I DONE NOWT BUT BE A LITTLE BOY AN TREATED EVERYONE LIKE SHIT WELL CAN I JUST SAY I'M SORRY [redacted]. I DON'T DESERVE U OR YOUR STUNNING GIRLS. U ARE EVERYTHING I'VE EVER WANTED… I'M SO SORRY… AN I COULDN'T CAR IF I GET LOCKED UP NOW CAUSE YOUR ALL I HAVE [redacted] I LOVE U [redacted] SO MUCH"

The victim has replied telling him not to text and that she will report it to the Police and solicitors.

A further message is received saying "OK SO DO I [redacted]… MY GIRLS DON'T BURN THERE SELF BY ACCIDENT"