Briefing note 1: June 2023

REPROVIDE Development

A modified Delphi consensus process

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reprovide
Reaching Everyone Programme of Research On Violence In diverse Domestic Environments

Respect

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Table of contents

Introduction

The REPROVIDE study is a randomised controlled trial designed to test the effectiveness and cost-effectiveness of a domestic abuse perpetrator programme (DAPP) (sometimes referred to as domestic violence perpetrator programmes, DVPPs) for male perpetrators.

In order to develop the DAPP, in June 2016, a panel of experts and stakeholders was invited by the REPROVIDE research team and collaborators at Respect (https://www.respect.uk.net/) to contribute to a modified two-stage Delphi consensus process.* The invited panel included practitioners from domestic violence services, the criminal justice system, general practice and academic researchers. Of the 30 experts originally invited, 13 participated in the full process (in both stages), although 16 experts completed the first stage.

The original design was a five-stage Delphi process to enable the gathering of views from experts without direct confrontation while allowing the opportunity to provide their reasoning and to reflect on their responses[2]. The modified version used by REPROVIDE followed a similar rationale restricted to two stages, whilst still allowing for responses from the first round to be considered and developed[3].

*Respect is the national, UK-based domestic abuse organisation which sets standards for, and accredits, domestic abuse perpetrator programmes.

The REPROVIDE Delphi process

Timepoint 1 (June 2016)

The first stage of DAPP development involved a meta-summary of existing domestic abuse perpetrator programmes to identify their key ingredients[4]. The basis of this meta-summary was used to inform a series of 57 statements (see Appendix 1) on good practice for perpetrator programmes and some areas of uncertainty around evaluation such as the best outcome measures to use. We asked our experts to score these statements on a 9-point scale (see Box 1). Statements focused on a range of topics including:

- the setting for a DAPP
- the theoretical framework and components of a DAPP
- the intervention delivery
- the format of the intervention
- the population and inclusion/exclusion criteria for a DAPP
- support for current or ex-partners
- additional issues relating to the research and outcome measurements.

Box 1: Example REPROVIDE Delphi statement

Setting

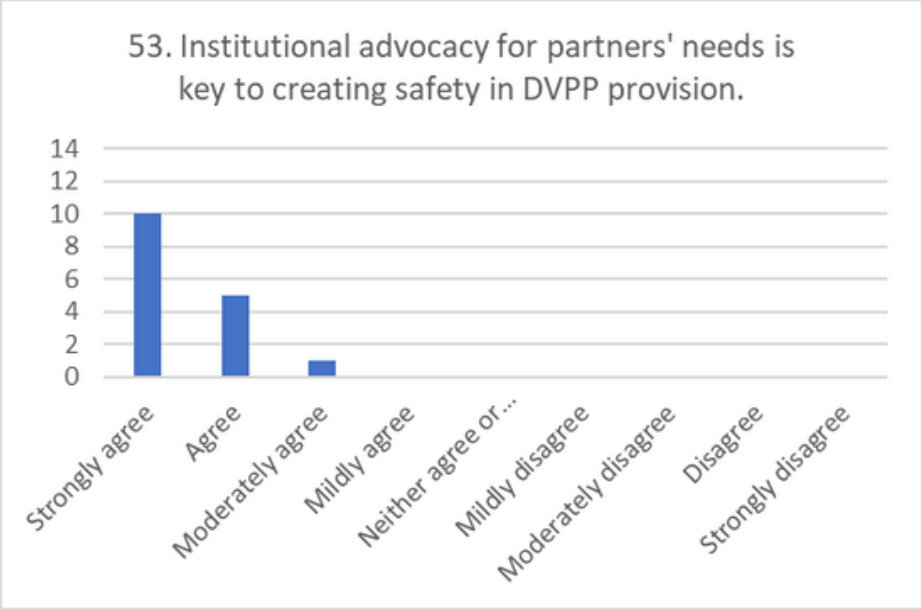
A health setting such as ahealthy living centre located next to GP practice is an appropriate setting for a perpetrator group to be run.

- strongly agree
- agree
- moderately agree
- mildly agree
- neither agree nor disagree
- mildly disagree
- moderately disagree
- disagree
- strongly disagree

The expert panel was invited to score the statements independently of each other, using an online survey via a unique weblink (Research Electronic Data Capture (REDcap) hosted by the University of Bristol)[5,6]. The scoring was then analysed with descriptive statistics to determine which were the most contentious issues relating to DAPPs and these were discussed at a face-to-face meeting attended by the experts.

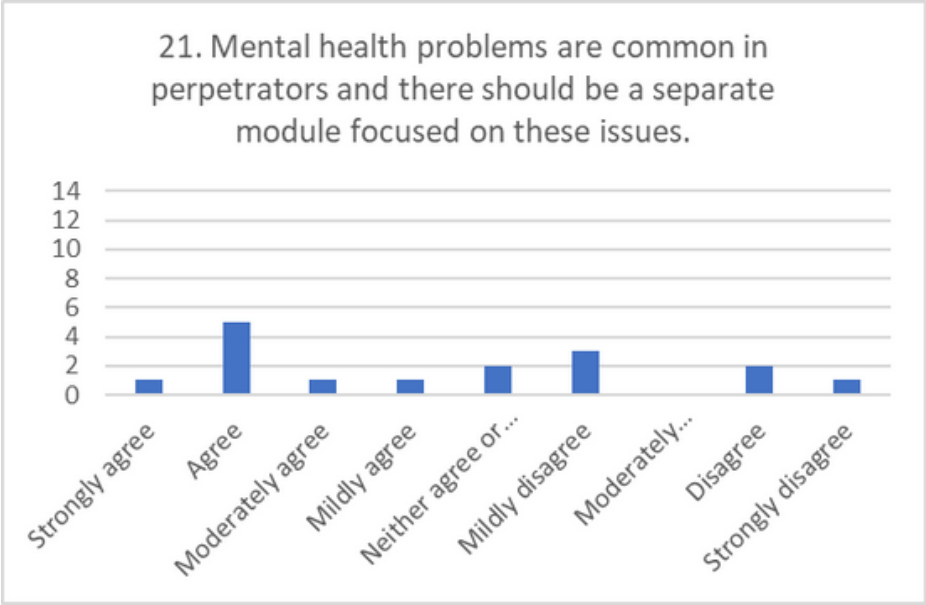
After the first round of statements, some were found to produce broad agreement amongst the experts. For example, Box 2 shows that all the experts agreed (Strongly agree - Moderately agree) that advocating for partners' needs was key to ensuring safety in DAPPs.

Box 2: Agreed statement



Other statements, however, showed much more disagreement (Strongly agree – Strongly disagree) as indicated in Box 3 which asked experts about providing a separate mental health module for perpetrators.

Box 3: Disagreed statement



Once all statements from the first round were scored, 38 were found to be non- or only mildly contentious. These involved several statements relating to the theoretical framework and components: drivers for change, the support of partners and ex-partners, and the delivery of the intervention (Appendix 2).

Areas of contention (16 statements as set out in Appendix 2) included the shape of the research study itself (for example what the control arm of the randomised controlled trial should consist of), how to support men with specific issues such as mental ill-health, or substance or alcohol misuse, and specific components of the intervention including trauma focus, anger management and whether men should be given 'homework'.

In preparing the statements and taking into account the advice of our collaborator, Respect, and the standards already established for accredited DAPPs, some elements of perpetrator programmes were taken as 'established' and not put forward for debate. These included:

- The DAPP will be held weekly for at least 26 weeks.
- A male and female facilitation pair is the optimal model for a DAPP.
- The facilitators will have regular practice and clinical supervision.
- DAPP service providers will work towards establishing positive working relationships with relevant agencies.
- DAPP providers will have inter-agency working protocols with other organisations which address issues such as information sharing, joint working arrangements etc.
- Information sharing with the women's support worker will occur regularly.
- Partners / ex partners of men in the intervention will be offered ongoing individual support in line with the Respect service standard.

Furthermore, after the experts had responded to the statements at the 1st timepoint, three of these (set out in Table 1 below) were also deemed to be taken as 'established' ideal scenarios (depending on funding availability) and therefore not necessarily subject to further debate.

Table 1: Statements deemed to be 'established'

Statement no.	Statements
37.	Optimal DVPP group size should be between 8 and 12 participants.
38.	The maximum DVPP group size should not exceed 15 participants.
39.	A children and young people's worker focused on the needs of the children connected to DVPP participants is key to reducing men's abusive behaviour.

Note: The acronym DVPP (for Domestic Violence Perpetrator Programmes) was used in the consensus statements. We later switched to referring to DAPPs to better reflect the range of non-physical abusive behaviours addressed by such programmes.

Discussion phase: 'Best bet' DAPPs

At a full-day face-to-face meeting held in July 2016, the experts were grouped onto tables of 5 or 6, with each group consisting of a combination of those who worked with perpetrators and/or survivors, academics and other stakeholders, and a facilitator. The aim was to understand what our experts felt what a best-bet model of a DAPP should look like. Within their groups, the experts were invited to discuss the consensus statements before wider plenary sessions pulled together all contributions.

The meeting generated nuanced and insightful discussion. Statements which had been most contentious at the 1st timepoint were discussed in detail. This resulted in some clarification of key issues which had a bearing on the differing opinions. For example, the statement 'The interruption and awareness raising techniques frequently used in anger management are important in supporting behaviour change in [DAPPs]' highlighted that anger management should be incorporated within a DAPP in order to address necessary behaviour change. However, it also became clear that context is important and that a focus purely on anger management might increase other forms of violence, so facilitators need a good understanding of techniques in addressing anger management.

Furthermore, the experts raised the point that partners and ex-partners need to understand what is happening on groups. If a perpetrator is learning techniques to control his anger, the affected victim/survivor needs to be aware that this is happening and that his behaviour may change.

Although there was increased consensus on most statements, there were a few where experts' disagreements continued, and for a few statements the disagreements became more marked. These areas of contention mostly related to trauma and to mental health or substance abuse issues. For example, the statement 'Men with moderate mental health problems need additional one-to-one support' which was moderately contentious at timepoint 1, became more so at timepoint 2, with over half our experts agreeing with the statement while two experts selected 'Mildly disagree' or 'Disagree'. At the consensus meeting, it became clear that some experts felt that facilitators should be able to deal with at least some indications of mental ill-health. Also, there were some definitional issues as to what might constitute 'mental health problems' especially given the nature of the service-users, many of whom present with and/or identify as having mental ill-health.

We also asked our experts to discuss elements specific to running a randomised controlled trial such as what the control arm should look like if the intervention is to be a weekly group programme. It was suggested that it might be very hard for some men to take a first step toward change but to then be put in the control group where they receive no intervention but are still asked to fill in questionnaires. One suggestion made as an alternative to providing no intervention was for control men to receive a monthly phone call, to be provided by someone trained to talk and listen but not intervene (much like a Samaritans worker). However, it was agreed that this would be too much of an intervention over and above researcher involvement to collect follow-up data.. It was, however, reiterated that we would need to be clear in recruitment literature that only some men would be allocated a place on the intervention and the remainder would be in a control arm where they would receive nothing.

The experts were asked for their views on which outcome measures should be collected. There were mixed responses, but the general agreement was that a need to consider severity and frequency of abuse, take into account issues relating to sexual respect, and consider financial and controlling behaviour. It was noted that if a victim/survivor felt safe enough to leave the relationship, this could be an indication of a successful programme and also that an expanded space for action is a good way of conceiving successful outcomes for women[7]. In order to help triangulate outcome measures, it was pointed out that police records could be important as a separate indicator of perpetrator behaviour, and that there would need to be some integration of outcome measures from both perpetrators and victim/survivors. The importance of qualitative data in the form of interviews was highlighted.

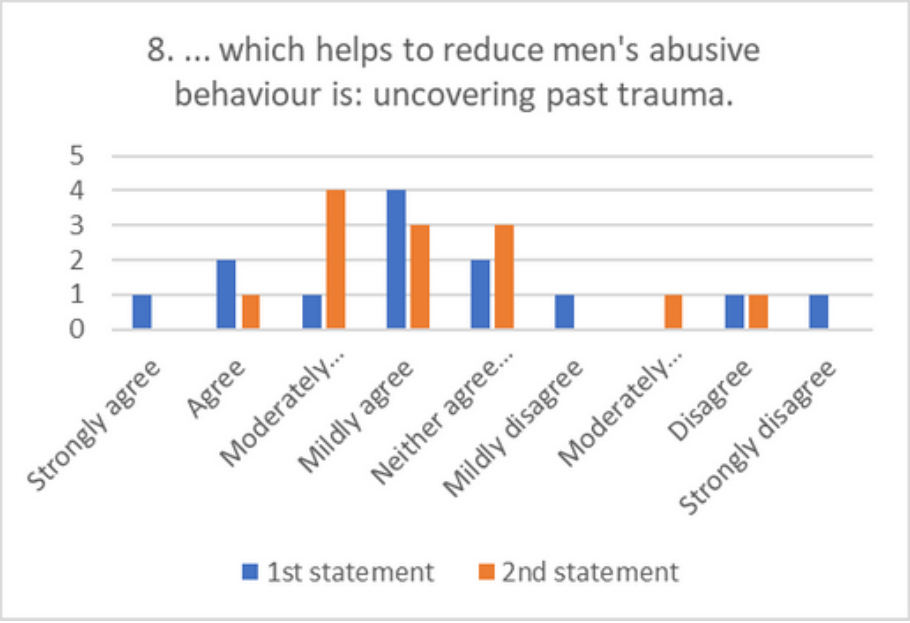
At the end of the process, attendees were asked to independently re-score all questions, again using their unique weblink on the REDCap online survey tool.

Timepoint 2 (July 2016)

Statements completed at the 2nd timepoint were compared with those from the 1st timepoint. Most statements now showed a higher level of consensus, with 17 statements showing considerably more consensus. Appendix 3 shows how the statements changed at the second stage, giving the median scores and standard deviation at each time point (T1 is the 1st stage timepoint and T2 is the 2nd stage timepoint). As discussed above, there were some statements where the experts still disagreed following the discussion process. Seven statements including one about men with mental health issues requiring 1:1 support resulted in slightly less consensus at the second stage.

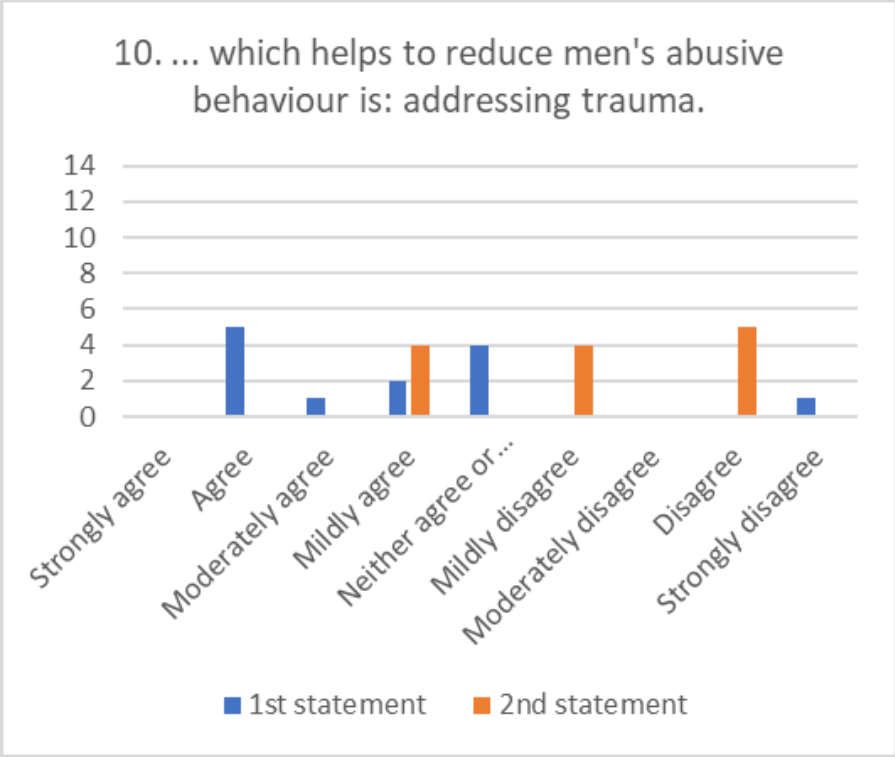
An area which was particularly difficult to reach agreement on related to trauma and opinions were somewhat polarised. Statements 8, 9 and 10 all asked about trauma as indicated in Appendix 1. Statements 8 (about uncovering past trauma) and 10 (about addressing trauma) were particularly controversial, whereas statement 9 (responding to trauma in a supportive way) was only mildly controversial. As can be seen in Box 4 below, responses remained polarised at both the first and second statement rounds. However, at the 1st timepoint, responses ranged between 'Strongly agree' and 'Strongly disagree' with most responses falling in the 'Mildly agree' range. By the 2nd timepoint, responses ranged between 'Agree' and 'Disagree' with most responses in the 'Moderately agree' range – indicating slightly more consensus in the second round and a shift towards agreeing with the statement that a key driver to reducing men's abusive behaviour is uncovering past trauma.

Box 4: Past trauma



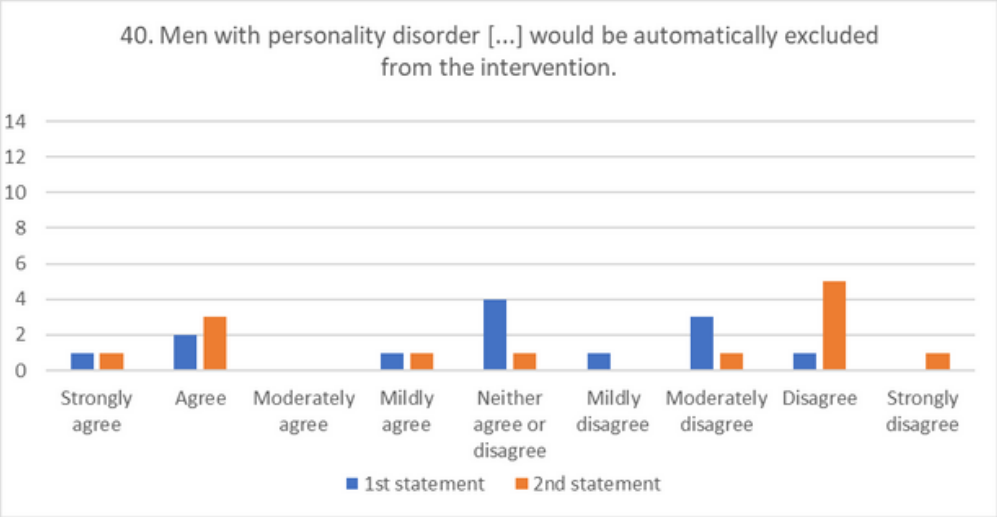
Box 5, on the other hand shows that while again, there was slightly more consensus, here there was more of a shift to disagreeing with the statement that a key driver to reducing men's abusive behaviour is addressing trauma. In this case, at the 1st timepoint, responses ranged between 'Agree' and 'Neither agree nor disagree' but with one expert indicating that they 'Strongly disagree'. After the face-to-face meeting and trauma-related discussions, responses at the 2nd timepoint were split between 'Mildly agree', 'Mildly disagree', and 'Disagree'.

Box 5: Addressing trauma



Experts at the face-to-face meeting, felt that it could be difficult to address past trauma on a DAPP and that although this should be acknowledged, it may be best approached in-depth by other services. There were also concerns that past experiences should not be used as an excuse for current abusive behaviour and that focusing on individual trauma may distract from other aims of the intervention. Some experts felt that it would be better for perpetrators to receive appropriate trauma-informed support before attending a DAPP. They felt that a trauma focus can be useful but can also increase harm to the perpetrator, increase risk both for the perpetrator himself and for victim/survivors, may affect the group setting, and increase feelings of being wounded. Others made the point that it is in a DAPP group that an attendee may, for the first time, make a disclosure of (for example) sexual or violent childhood experiences. However, it is not always possible to ensure that there is the relevant therapeutic competence to deal with such disclosures within the group. Consequently, it was felt that supporting perpetrators to focus on building empathy and better relationships in the light of their own experiences rather than facilitators attempting to adopt a healing approach, could be more useful.

Box 6: Contentious statement on exclusion / mental health



Responses which were polarised at the 1st timepoint (ranging between 'Strongly agree' to 'Disagree' became even more so at the 2nd timepoint (Strongly agree' to 'Strongly disagree'). The consensus meeting had focused on the importance of including other services, especially mental health services, in intervention delivery with such individuals – but there was also a recognition that other services are usually too busy to provide this type of support. It was felt that cases may need to be dealt with on an individual level, with a willingness to engage and to change behaviour being demonstrated and particularly high-risk men being excluded. For men who may be neurodivergent, it was felt that if the other men on the group were supportive, the facilitators would be able to work with this and where necessary provide additional 1:1 support. It may, therefore, be extra work to include such men in a group but this should not be a reason to exclude them. Some men may not receive a diagnosis, or mental ill-health may not be apparent, until after they have started on a group. In these cases, a decision would need to be made about how they were engaging and their ability to continue. For this statement, one reason for the polarisation and lack of consensus lies in the ambiguity of the statement. Many domestic abuse perpetrators may present with indications of personality disorder or pathological jealousy, for example. The main consideration, therefore, seemed to be whether or not the facilitators would be able to work safely with them.

Where it was apparent that there was no clear agreement on best practice in DAPPs, issues were taken forward to be discussed in more detail with Respect and with our Programme Executive Group. For example, the statement that 'programme completion should be defined as men attending at least 75% of the sessions' was slightly contested and this was discussed at the programme executive meeting following the scoring of the second round of statements. They agreed that we needed a clearer picture of what might count as a 'sufficient dose' (attendance) for the randomised controlled trial. The extent to which it was feasible to provide children's support within a DAPP in addition to the integrated victim-survivor support was also discussed at this executive meeting.

Consultants from Respect (Kate Iwi and Chris Newman), both experienced at facilitating DAPPs and developing interventions[8], incorporated what is already known about the drivers for behaviour change, the impacts of early trauma and neglect, risk factors which need to be addressed, the consensus findings, and elements already taken as ‘established’ into a ‘best bet’ manualised DAPP, consisting of a 23-week weekly group programme[9] with a minimum of three 1:1 sessions (depending on need) with each attendee. It was this version of the manual which provided the basis for the intervention which was then tested in a pilot feasibility trial[10].

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Appendix 1

REPROVIDE Delphi Consensus Statements*

1. A health setting such as a healthy living centre located next to GP practice is an appropriate setting for a perpetrator group to be run.
2. The interruption and awareness raising techniques frequently used in anger management are important in supporting behaviour change in DVPPs.
3. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: enabling participants to recognise their own abilities and capacity for change.
4. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on respectful communication skills in relationships.
5. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: an expectation for participants to reflect on the work they are undertaking outside of the programme and setting additional activities for them to complete.
6. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on sexual respect.
7. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: exploring gender-based expectations of self and others.
8. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: uncovering past trauma.
9. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: responding to trauma in a contained supportive way.
10. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: addressing trauma.
11. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: taking responsibility for abusive behaviour.
12. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: helping men to develop enhanced empathy for the impact of their behaviour.
13. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: full disclosure of the nature and extent of their abusive behaviour.
14. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a commitment to being accountable for their own behaviour.
15. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on the use of controlling and coercive behaviour.
16. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: discussing the adverse effects of violence on children.
17. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: the use of motivational interviewing.

18. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a supportive group process where participants challenge each other's behaviour.
19. Social, community or organisational leverage to address abusive behavior is key to change in DVPPs.
20. Flexibility in the delivery of the intervention to respond to participants' needs within the framework of the intervention are core principles.
21. Mental health problems are common in perpetrators and there should be a separate module focused on these issues.
22. Men with mental health issues and substance misuse problems are not suitable for DVPPs and should be referred to other agencies.
23. Substance misuse problems are common in perpetrators and there should be a separate module focused on these issues.
24. The facilitators' ability to establish trust and rapport with men on a DVPP is key to bringing about change.
25. The facilitators' experience at running DVPP groups is key to bringing about change.
26. Modelling values such as respectful prosocial communication is key to making change happen within a DVPP.
27. High quality practice supervision is key to bringing about change in DVPPs.
28. The intervention model needs to have sufficient flexibility to respond to the variations in risk, and the needs of participants.
29. Participants' risks and needs must be reviewed regularly throughout and the intervention adjusted in the light of this information.
30. The DVPP should include one-to-one sessions for all men with one of the facilitators.
31. Men with moderate mental health problems need additional one-to-one support.
32. Men with substance abuse issues need additional one-to-one support.
33. One-to-one support is an unnecessary addition and the group format of the DVPP alone should be sufficient for most men.
34. DVPP 'top ups' (i.e. groups held monthly following the intervention) are unnecessary for most participants.
35. DVPP 'top ups' (i.e. groups held monthly following the intervention) are essential to support and ensure that change is sustained.
36. Each DVPP group session should be at least 2 hours long.
37. Optimal DVPP group size should be between 8 and 12 participants.
38. The maximum DVPP group size should not exceed 15 participants.
39. Men will be automatically excluded from the intervention if they have a pending criminal justice case relating to domestic violence and abuse or a case pending regarding contact proceedings.
40. Men with personality disorder, active psychosis, pathological jealousy or displaying manic symptoms would be automatically excluded from the intervention.
41. Having a developmental disability would mean automatic exclusion from the intervention.
42. Mental health screening can be carried out by the facilitators using screening tools and asking men to self-report.

43. Drug and alcohol use screening can be carried out by the facilitators using screening tools and asking men to self-report.
44. Men with drug or alcohol problems would be included in the intervention if their use of drugs/alcohol does not impact significantly on their ability to benefit from the intervention.
45. Including participants whose level of risk and need is high reduces the effectiveness of the intervention for all.
46. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call by one of the group facilitators for no more than half an hour in duration.
47. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a weekly telephone call by one of the group facilitators for no more than 5 minutes in duration.
48. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call for no more than half an hour by someone trained in male offenders and domestic violence but who isn't one of the group facilitators.
49. Timely and persistent partner contact is key to creating change in DVPPs.
50. All partners should have information and staff time to talk through the intervention and what it means for them.
51. Key elements of the intervention should be flagged and explained to partners or ex-partners.
52. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: safety planning and risk management with partners.
53. Institutional advocacy for partners' needs is key to creating safety in DVPP provision.
54. Support for partners and ex-partners should mirror the principles underlying the intervention for men and this is key in reducing men's abusive behaviour.
55. A children and young people's worker focused on the needs of the children connected to DVPP participants is key to reducing men's abusive behaviour.
56. As self-referral is a strong indication of being motivated to change, research recruitment should be encouraged through the use of media advertisements.
57. Programme completion should be defined as men attending at least 75% of the sessions.

Appendix 2

REPROVIDE Delphi Consensus Timepoint 1

Consensus and agreed statements

Statements	
Statement number	**Contentious statements**
1	A health setting such as a healthy living centre located next to GP practice is an appropriate setting for a perpetrator group to be run.
2	The interruption and awareness raising techniques frequently used in anger management are important in supporting behaviour change in DVPPs.
8	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: uncovering past trauma.
10	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: addressing trauma.
21	Mental health problems are common in perpetrators and there should be a separate module focused on these issues.
22	Men with mental health issues and substance misuse problems are not suitable for DVPPs and should be referred to other agencies.
23	Substance misuse problems are common in perpetrators and there should be a separate module focused on these issues.
34	DVPP 'top ups' (i.e. groups held monthly following the intervention) are unnecessary for most participants.
35	DVPP 'top ups' (i.e. groups held monthly following the intervention) are essential to support and ensure that change is sustained.
39	Men will be automatically excluded from the intervention if they have a pending criminal justice case relating to domestic violence and abuse or a case pending regarding contact proceedings.
40	Men with personality disorder, active psychosis, pathological jealousy or displaying manic symptoms would be automatically excluded from the intervention.
42	Mental health screening can be carried out by the facilitators using screening tools and asking men to self-report.
43	Drug and alcohol use screening can be carried out by the facilitators using screening tools and asking men to self-report.
46	An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call by one of the group facilitators for no more than half an hour in duration.
47	An appropriate 'control arm' or comparison for men who do not get the group intervention should be a weekly telephone call by one of the group facilitators for no more than 5 minutes in duration.
48	An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call for no more than half an hour by someone trained in male offenders and domestic violence but who isn't one of the group facilitators.

Mildly contentious statements	
5	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: an expectation for participants to reflect on the work they are undertaking outside of the programme and setting additional activities for them to complete.
9	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: responding to trauma in a contained supportive way.
13	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: full disclosure of the nature and extent of their abusive behaviour.
33	One-to-one support is an unnecessary addition and the group format of the DVPP alone should be sufficient for most men.
36	Each DVPP group session should be at least 2 hours long.
45	Including participants whose level of risk and need is high reduces the effectiveness of the intervention for all.
56	As self-referral is a strong indication of being motivated to change, research recruitment should be encouraged through the use of media advertisements.
57	Programme completion should be defined as men attending at least 75% of the sessions.
Agreed statements	
3	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: enabling participants to recognise their own abilities and capacity for change.
4	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on respectful communication skills in relationships.
6	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on sexual respect.
7	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: exploring gender-based expectations of self and others.
11	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: taking responsibility for abusive behaviour.
12	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: helping men to develop enhanced empathy for the impact of their behaviour.
14	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a commitment to being accountable for their own behaviour.
15	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on the use of controlling and coercive behaviour.
16	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: discussing the adverse effects of violence on children.
17	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: the use of motivational interviewing.
18	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a supportive group process where participants challenge each other's behaviour.
19	Social, community or organisational leverage to address abusive behavior is key to change in DVPPs.
20	Flexibility in the delivery of the intervention to respond to participants' needs within the framework of the intervention are core principles.

24	The facilitators' ability to establish trust and rapport with men on a DVPP is key to bringing about change.
25	The facilitators' experience at running DVPP groups is key to bringing about change.
26	Modelling values such as respectful prosocial communication is key to making change happen within a DVPP.
27	High quality practice supervision is key to bringing about change in DVPPs.
28	The intervention model needs to have sufficient flexibility to respond to the variations in risk, and the needs of participants.
29	Participants' risks and needs must be reviewed regularly throughout and the intervention adjusted in the light of this information.
30	The DVPP should include one-to-one sessions for all men with one of the facilitators.
31	Men with moderate mental health problems need additional one-to-one support.
32	Men with substance abuse issues need additional one-to-one support.
41	Having a developmental disability would mean automatic exclusion from the intervention.
44	Men with drug or alcohol problems would be included in the intervention if their use of drugs/alcohol does not impact significantly on their ability to benefit from the intervention.
49	Timely and persistent partner contact is key to creating change in DVPPs.
50	All partners should have information and staff time to talk through the intervention and what it means for them.
51	Key elements of the intervention should be flagged and explained to partners or ex-partners.
52	Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: safety planning and risk management with partners.
53	Institutional advocacy for partners' needs is key to creating safety in DVPP provision.
54	Support for partners and ex-partners should mirror the principles underlying the intervention for men and this is key in reducing men's abusive behaviour.

After the first timepoint, and before proceeding to the second timepoint, it was decided that three of the original statements could be taken as 'established'. This did not necessarily mean that they were agreed statements, but that they did represent models for what was currently known about DAPPs. All three statements were re-scored at the second timepoint (See Appendix 3).

Statements taken as 'established'	
37.	Optimal DVPP group size should be between 8 and 12 participants.
38.	The maximum DVPP group size should not exceed 15 participants.
55.	A children and young people's worker focused on the needs of the children connected to DVPP participants is key to reducing men's abusive behaviour.

Appendix 3

REPROVIDE Delphi Consensus Timepoint 2

	Consensus statements. Changes between timepoint 1 and timepoint 2	T1i Medianii SDiii
Statements where there is considerably less consensus at T2. (n = 0)	N/A	N/A
Statements where there is slightly less consensus at T2. (n = 7)	20. Flexibility in the delivery of the intervention to respond to participants' needs within the framework of the intervention are core principles.	T1: Median: 1 SD: 0.66 T2: Median: 1 SD: 0.88
	29. Participants' risks and needs must be reviewed regularly throughout and the intervention adjusted in the light of this information.	T1: Median: 1 SD: 0.48 T2: Median: 2 SD: 0.58
	31. Men with moderate mental health problems need additional one-to-one support.	T1: Median: 2 SD: 1.32 T2: Median: 2 SD: 1.88
	36. Each DVPP group session should be at least 2 hours long.	T1: Median: 2 SD: 2.15 T2: Median: 2 SD: 1.45
	40. Men with personality disorder, active psychosis, pathological jealousy or displaying manic symptoms would be automatically excluded from the intervention.	T1: Median: 5 SD: 2.18 T2: Median: 7 SD: 2.96
	55. A children and young people's worker focused on the needs of the children connected to DVPP participants is key to reducing men's abusive behaviour.	T1: Median: 3 SD: 1.42 T2: Median: 3 SD: 1.44
	57. Programme completion should be defined as men attending at least 75% of the sessions.	T1: Median: 3 SD: 1.82 T2: Median: 3 SD: 1.88
Statements where there is no change in consensus at T2. (n = 2)	18. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a supportive group process where participants challenge each other's behaviour.	T1: Median: 1 SD: 0.65 T2: Median: 1 SD: 0.65
	53. Institutional advocacy for partners' needs is key to creating safety in DVPP provision.	T1: Median: 1 SD: 0.66 T2: Median: 1 SD: 0.66

Statements where there is slightly more consensus at T2. (n = 31)	1. A health setting such as a healthy living centre located next to GP practice is an appropriate setting for a perpetrator group to be run.	T1: Median: 3 SD: 2.32 T2: Median: 3 SD: 2.03
	2. The interruption and awareness raising techniques frequently used in anger management are important in supporting behaviour change in DVPPs.	T1: Median: 3 SD: 1.93 T1: Median: 2 SD: 1.50
	4. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on respectful communication skills in relationships.	T1: Median: 2 SD: 0.95 T1: Median: 1 SD: 0.63
	7. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: exploring gender-based expectations of self and others.	T1: Median: 1 SD: 0.87 T2: Median: 1 SD: 0.44
	8. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: uncovering past trauma.	T1: Median: 4 SD: 2.29 T1: Median: 4 SD: 2.03
	10.[iv] Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: addressing trauma.	T1: Median: 4 SD: 2.04 T1: Median: 6 SD: 1.72
	11. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: taking responsibility for abusive behaviour.	T1: Median: 1 SD: 0.85 T2: Median: 2 SD: 0.65
	14. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a commitment to being accountable for their own behaviour.	T1: Median: 1 SD: 0.77 T2: Median: 1 SD: 0.48
	16. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: discussing the adverse effects of violence on children.	T1: Median: 1 SD: 0.96 T2: Median: 1 SD: 0.63
	17. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: the use of motivational interviewing.	T1: Median: 3 SD: 1.03 T2: Median: 2 SD: 0.73
	19. Social, community or organisational leverage to address abusive behaviour is key to change in DVPPs.	T1: Median: 2 SD: 1.36 T2: Median: 2 SD: 0.95
	21. Mental health problems are common in perpetrators and there should be a separate module focused on these issues.	T1: Median: 5 SD: 2.22 T2: Median: 8 SD: 1.95
	22. Men with mental health issues and substance misuse problems are not suitable for DVPPs and should be referred to other agencies.	T1: Median: 6 SD: 2.06 T2: Median: 8 SD: 1.75
	23. Substance misuse problems are common in perpetrators and there should be a separate module focused on these issues.	T1: Median: 4 SD: 2.53 T2: Median: 8 SD: 2.08
	24. The facilitators' ability to establish trust and rapport with men on a DVPP is key to bringing about change.	T1: Median: 1 SD: 0.66 T2: Median: 1 SD: 0.27
	25. The facilitators' experience at running DVPP groups is key to bringing about change.	T1: Median: 2 SD: 0.93 T2: Median: 2 SD: 0.63

	26. Modelling values such as respectful prosocial communication is key to making change happen within a DVPP.	T1: Median: 2 SD: 0.73 T2: Median: 1 SD: 0.66
	28. The intervention model needs to have sufficient flexibility to respond to the variations in risk, and the needs of participants.	T1: Median: 1 SD: 0.66 T2: Median: 1 SD: 0.51
	32. Men with substance abuse issues need additional one-to-one support.	T1: Median: 3 SD: 1.89 T2: Median: 2 SD: 1.76
	35. DVPP 'top ups' (i.e. groups held monthly following the intervention) are essential to support and ensure that change is sustained.	T1: Median: 2 SD: 1.96 T2: Median: 3 SD: 1.62
	37. Optimal DVPP group size should be between 8 and 12 participants.	T1: Median: 2 SD: 1.48 T2: Median: 2 SD: 0.76
	38. The maximum DVPP group size should not exceed 15 participants.	T1: Median: 1 SD: 2.00 T2: Median: 1 SD: 0.51
	39. Men will be automatically excluded from the intervention if they have a pending criminal justice case relating to domestic violence and abuse or a case pending regarding contact proceedings.	T1: Median: 4 SD: 1.86 T2: Median: 4 SD: 1.85
	41. Having a developmental disability would mean automatic exclusion from the intervention.	T1: Median: 7 SD: 1.45 T2: Median: 8 SD: 1.33
	42. Mental health screening can be carried out by the facilitators using screening tools and asking men to self-report.	T1: Median: 4 SD: 2.29 T2: Median: 4 SD: 1.78
	43. Drug and alcohol use screening can be carried out by the facilitators using screening tools and asking men to self-report.	T1: Median: 4 SD: 2.42 T2: Median: 3 SD: 2.02
	45. Including participants whose level of risk and need is high reduces the effectiveness of the intervention for all.	T1: Median: 6 SD: 2.20 T2: Median: 8 SD: 1.61
	46. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call by one of the group facilitators for no more than half an hour in duration.	T1: Median: 5 SD: 1.98 T2: Median: 8 SD: 1.80
	47. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a weekly telephone call by one of the group facilitators for no more than 5 minutes in duration.	T1: Median: 6 SD: 1.98 T2: Median: 8 SD: 1.63
	51. Key elements of the intervention should be flagged and explained to partners or ex-partners.	T1: Median: 1 SD: 0.78 T2: Median: 1 SD: 0.60
	52. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: safety planning and risk management with partners.	T1: Median: 1 SD: 1.35 T2: Median: 1 SD: 1.13

Statements where there is considerably more consensus after T2. (n = 17)	3. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: enabling participants to recognise their own abilities and capacity for change.	T1: Median: 2 SD: 1.00 T2: Median: 1 SD: 0.48
	5. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: an expectation for participants to reflect on the work they are undertaking outside of the programme and setting additional activities for them to complete.	T1: Median: 2 SD: 1.56 T2: Median: 2 SD: 0.58
	6. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: a focus on sexual respect.	T1: Median: 2 SD: 1.50 T1: Median: 1 SD: 0.65
	9. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: responding to trauma in a contained supportive way.	T1: Median: 2 SD: 2.36 T2: Median: 2 SD: 1.41
	12. Within a DVPP, a key driver which helps to reduce men's abusive behaviour is: helping men to develop enhanced empathy for the impact of their behaviour.	T1: Median: 2 SD: 1.24 T1: Median: 1 SD: 0.50
	13. Within a DVPP which helps to reduce men's abusive behaviour is: full disclosure of the nature and extent of their abusive behaviour.	T1: Median: 3 SD: 2.33 T2: Median: 3 SD: 1.56
	15. Within a DAPVP which helps which helps to reduce men's abusive behaviour is: a focus on the use of controlling and coercive behaviour.	T1: Median: 2 SD: 1.62 T2: Median: 1 SD: 0.63
	27. High quality practice supervision is key to bringing about change in DVPPs.	T1: Median: 1 SD: 1.42 T2: Median: 1 SD: 0.48
	30. The DVPP should include one-to-one sessions for all men with one of the facilitators.	T1: Median: 3 SD: 1.30 T2: Median: 2 SD: 0.57
	33. One-to-one support is an unnecessary addition and the group format of the DVPP alone should be sufficient for most men.	T1: Median: 7 SD: 1.33 T2: Median: 8 SD: 0.77
	34. DVPP 'top ups' (i.e. groups held monthly following the intervention) are unnecessary for most participants.	T1: Median: 6 SD: 2.35 T2: Median: 8 SD: 1.21
	44. Men with drug or alcohol problems would be included in the intervention if their use of drugs/alcohol does not impact significantly on their ability to benefit from the intervention.	T1: Median: 2 SD: 1.66 T2: Median: 1 SD: 0.51
	48. An appropriate 'control arm' or comparison for men who do not get the group intervention should be a monthly telephone call for no more than half an hour by someone trained in male offenders and domestic violence but who isn't one of the group facilitators	T1: Median: 5 SD: 2.21 T2: Median: 4 SD: 1.54
	49. Timely and persistent partner contact is key to creating change in DVPPs.	T1: Median: 2 SD: 1.38 T2: Median: 1 SD: 0.63

	50. All partners should have information and staff time to talk through the intervention and what it means for them.	T1: Median: 1 SD: 1.13 T2: Median: 1 SD: 0.28
	54. Support for partners and ex-partners should mirror the principles underlying the intervention for men and this is key in reducing men's abusive behaviour.	T1: Median: 2 SD: 2.10 T2: Median: 2 SD: 0.48
	56. As self-referral is a strong indication of being motivated to change, research recruitment should be encouraged through the use of media advertisements	T1: Median: 3 SD: 1.98 T2: Median: 3 SD: 0.86

[i] T1 refers to the first Timepoint – the first round of consensus statements. T2 refers to the second Timepoint.
[ii] The Median is the midpoint in the range of responses
[iii] The SD is the Standard Deviation. The lower the SD, the more closely the responses are clustered together. A higher SD shows more disagreement.
[iv] This was a particularly tricky statement, which more experts disagreed with at the 2nd timepoint than at the 1st timepoint.

Acknowledgements

The REPROVIDE team would like to especially thank Neil Blacklock, then Development Director at Respect, who provided advice in shaping the consensus statements. We would also like to thank Eszter Szilassy and LynnMarie Sardinha who stepped in to act as group facilitators at the group consensus meeting in July 2016. Finally, we would like to thank our panel of professionals, practitioners, and academic experts from across the domestic abuse field for giving up a day of their time to contribute to this process.

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