An Evaluation of the Culturally Integrated Family Approach to Domestic Abuse

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Acknowledgments

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Glossary

Abbreviation	Full term
APFA	Adult to Parent Familial Abuse
CIFA	Culturally Integrated Family Approach
DA	Domestic Abuse
DAPP	Domestic Abuse Perpetrator Panel
DASA	Domestic Abuse Safety Advisor
FADA	Female Awareness Domestic Abuse
IDVA	Independent Domestic Violence Advisor
IPV	Intimate Partner Violence
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, plus other gender and sexual minorities
MARAC	Multi-Agency Risk Assessment Conference
MOPAC	Mayor's Office for Policing and Crime
SU	Service User
VAWG	Violence Against Women and Girls
VS	Victim Survivor

A Note on Language, Abbreviations and Referencing

In this report, we avoid the language of 'perpetrator' in our analysis, choosing to use 'people who have caused harm' or 'person who has caused harm' and, where appropriate, 'service user' (SU). We acknowledge that the language of 'perpetrator' is seen as appropriate and important by many stakeholders and victim-survivors, given the harm caused and the need for accountability.

We use language here focused on the harm the person has caused. This is to indicate potential for transformation and change, and to recognise that the label of 'perpetrator' can be loaded and applied in problematic ways, particularly in relation to marginalised communities. We have chosen to adopt less stigmatising and shaming language, while continuing to foreground that they have caused harm. This choice aligns with the trauma-informed approach that underpins this evaluation which advocates for the use of language that acknowledges the complex factors that underlie violence and abuse.

The use of this terminology does not, in any way, negate or condone the harmful behaviour of the service users who have been referred to the programme due to their unacceptable and abusive behaviour against others. The use of 'service user' accurately reflects their status at the time of the evaluation. As discussed in the report, the use of such language can make it difficult for SUs to see beyond the limitations imposed by such labelling.

Section 4.3.7.1 reflects on the impact of this language specific to the CIFA programme. Please see Annex 2 for a table adapted from one prepared for the Drive Programme Evaluation 2023, which sets out the reasoning we have adopted here in more detail.

However, the word 'perpetrator' necessarily features throughout the report as it is a dominant framework within the DA system. We keep the language where it is used in intervention titles and systems, e.g., 'Domestic Abuse Perpetrator Panel' (DAPP), in academic literature, and where it has been used in interviews for this evaluation.

Assessments of risk in responses to domestic abuse are critical to ensuring that all decisions about suitability, engagement, and safeguarding are grounded in a robust understanding of risk posed to VSs, and help to determine which intervention is the safest and most appropriate for people who have caused harm, VSs, and where relevant, the wider family. From a critical criminological point of view, 'risk' can have different connotations, which we are aware of in writing this report. 'Risk' in criminal justice is a language and framework of understanding that seeks to understand the likelihood and seriousness of future actions by making predictions based on past behaviour and circumstances. There are significant critiques of this approach, including concerns that it is not responsive to present and future change, that it is heavily reliant on 'grouping' people on the basis of shared characteristics, histories and circumstances, and that it is inherently reactive. Working within this framework, the focus becomes managing risk – and groups who are perceived as 'risky' - rather than working to bring about long-term and sustainable positive change or transformation.

While we use this language in the report, we are aware of the limitations and risks of 'risk.' We feel that the work RISE Mutual CIC is doing with the CIFA programme is an important and significant challenge to this logic.

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Executive Summary

This evaluation of the Culturally Integrated Family Approach to Domestic Abuse (CIFA) was commissioned by the London Borough of Barnet, working in partnership with RISE Mutual CIC as designer and provider of CIFA, and funded by the Mayor's Office for Policing and Crime (MOPAC) and the Home Office. It was conducted by a consortium of researchers from Hearth Consultancy Ltd, Bridge Research Ltd and the University of Kent. The evaluation covered the programme's two-year operational period from 2023 to 2025 and took place in the six months between February and July 2025.

This evaluation explored the effectiveness, reach, and sustainability of CIFA, a holistic, culturally responsive, and systems-focused domestic abuse intervention operating across ten London boroughs: Barnet, Brent, Enfield, Haringey, Harrow Newham, Tower Hamlets and the tri-borough of Westminster, Hammersmith and Fulham and the Royal Borough of Kensington and Chelsea. Designed to support both people who have caused harm and victim–survivors (VS), CIFA places equal value on trauma-informed recovery and accountable behaviour change. The programme serves communities often overlooked or underserved by traditional interventions, including those from minoritised and racialised backgrounds, and its model seeks not only to reduce harm but to catalyse broader systems change.

CIFA's model includes direct work with individuals, integrated VS support, borough-level partnerships, and workforce training. This combination allows CIFA to offer a unique response to domestic abuse, one that is intersectional, community-rooted, and focused on long-term transformation rather than short-term outcomes. In three boroughs – Brent, Haringey and Newham - the integrated VS support is provided internally by RISE Domestic Abuse Safety Advisors (DASAs). In the other seven boroughs, this support is provided through commissioned partners: Cranstoun in Harrow; Solace in Barnet, Enfield and Tower Hamlets; and Advance in the tri-borough of Westminster, Hammersmith and Fulham and the Royal Borough of Kensington and Chelse.

Aims of the evaluation

The overall purpose of the evaluation was to:

- assess the extent to which service user engagement in CIFA programme contributes to the cessation of domestic abuse;
- assess how effective the CIFA programme is at combatting domestic abuse compared to non-culturally specific provision; and
- assess the extent to which the CIFA programme offers value for money.

Evaluation methodology and design

This evaluation is grounded in a realist framework, drawing upon Pawson and Tilley's (1997) assertion that an effective evaluation should identify what works, for whom, and under which specific

conditions. It also drew on the RE-AIM model to assist with the planning, design and analysis of the CIFA Programme and the ecological model which conceptualises domestic abuse as the result of intersecting individual, relational, situational, structural, and socio-cultural factors.

The research team employed a mixed-method approach that included qualitative and quantitative research processes and incorporated a range of academic and policy resources as well as data supplied by RISE Mutual and partner agencies.

The data contained in this evaluative report was generated from fieldwork employing three main strands:

- co-production of the evaluation plan with the CIFA team;
- qualitative research comprising: a) literature review of academic and policy-related research on domestic abuse, b) semi-structured qualitative interviews with CIFA practitioners and other sector stakeholders, with service users on the CIFA programme, with victim survivors and community stakeholders and analysis of case study material; and
- quantitative analysis of data held by RISE and partner agencies (e.g., referrals, service user engagement, behavioural and attitudinal change, reoffending rates) along with an economic cost-value analysis.

Key findings

The evaluation finds strong evidence of CIFA's positive impact across multiple dimensions of the RE-AIM framework, including personal behaviour change, effective victim-survivor support, professional learning, and systems- and community-level ripple effects.

<u>Reach</u>

- CIFA is reaching many of the communities it was designed to serve, particularly racialised and minoritised groups. Outcome Star data and participant feedback indicate particularly strong engagement among people from racialised minorities and religious backgrounds, as well as those requiring interpretation support, groups often stigmatised or underserved in other DA interventions.
- That said, reach is uneven across boroughs. Referral numbers have risen overall, particularly for victim–survivors, but this growth is not equally distributed. While Brent and Barnet showed strong engagement of ethnic minority groups, there are other boroughs where referral numbers remain low, especially for FADA (females who have caused harm) and APFA (adolescent-to-parent abuse) streams.
- The major racialised minority groups represented among the service users on CIFA are Other Asian/Asian British: Other Asian (15.9%), Other: European (19.8%), Other ethnic group: Arab (9.3%) and Asian/Asian British: Bangladeshi (8.8%). On the victim-survivor side, Other Asian (18%) and Other European 17% are the biggest group in the RISE VS data and Other Asian/Asian British: Other Asian (26.7%) in Hammersmith & Fulham, Kensington & Chelsea and Westminster. This highlights the importance of RISE's new outreach strategy plan and work to improve referral pathways.

- CIFA practitioners have made significant efforts in outreach and awareness-raising of the programme, building relationships, offering information and training, and working in a collaborative, coordinated way. This must be repeated, consistent and direct in order to overcome structural barriers.
- CIFA is leading a cultural shift in the system towards meaningfully addressing DA by pursuing behaviour change work with people who have caused harm. This requires resources and system buy-in, including the upskilling of referrers and other stakeholders.

Effectiveness

- Outcome Star data shows significant improvements among service users across six domains: taking responsibility, thinking and attitudes, safe action and reaction, communication, parenting, and wellbeing. Those requiring interpretation support show particularly strong progress, reinforcing the importance of culturally and linguistically inclusive practice.
- Qualitative data reveals meaningful changes in mindset, emotional regulation, and relationship dynamics among service users, including improved parenting. The experiences and wellbeing of children are reported as improved.
- Service users reported increased self-awareness and a deeper understanding of what constitutes domestic abuse, how their behaviour has impacted others, including children, and the harm they had caused.
- Victim–survivors described feeling safer, more informed, and more confident in their decision-making. Service users and victim-survivors both reported improved communication and reductions in conflict, often described as small but sustained steps.
- CIFA's delivery model offers education on legal and social norms around domestic abuse in ways that are culturally sensitive and trauma-informed, allowing participants to reflect on how their values and histories shape their behaviours. These shifts in understanding - about what abuse is, what consent means, and how families can change - are crucial for long-term prevention.
- There is a difference in effectiveness between the boroughs where CIFA is implemented that needs further investigation.

Adoption

- Service user referrals across the assessed years (2023-2025) aligned with CIFA's forecasted targets. Referrals vary between boroughs, something RISE and the CIFA team has worked hard to remedy through events and awareness raising. The number of victim–survivor referrals has grown, and CIFA staff have proactively worked to raise awareness, particularly around FADA and APFA.
- Completion rates were high overall, though the evaluation finds variations by ethnicity and religion in both completion and suitability. Some ethnic and religious groups are disproportionately likely to be deemed unsuitable or to not complete the programme. For service users, when looking in-depth, we see that those categorised as Other: Asian and Other: European have the highest completion rates which is to be expected as they also represent

the larger racialised groups on the programme. Other: Asian also represent a much larger proportion of those found 'not suitable' for CIFA than other groups.

- LGBTQ+ communities remain notably underrepresented in referrals and programme uptake. Future work must explore how to make CIFA more accessible and visible to these groups, including through inclusive messaging and community outreach.
- While referral pathways were described by many practitioners as clear and straightforward, many misconceptions were also articulated in interviews, as described in section 4.1.6.1. There is more work to be done to enhance referrer knowledge and clarify referral criteria and pathways.
- Risk assessments are routinely undertaken by CIFA practitioners and are essential for ensuring that CIFA is safe and effective for all parties involved, guiding tailored intervention plans and safeguarding processes. However, in some cases, they may identify levels of risk, particularly to victim–survivors or children, that mean participation in CIFA is not appropriate at that time. This protects the safety of victim-survivors, children, and staff, but can also mean that some individuals who might benefit from a programme like CIFA are not able to participate until risks are reduced or additional safeguarding measures are in place.
- Coordination with other stakeholders at assessment stage - and excellent feedback and recommendations - means that CIFA is valuable even before the person is accepted on the programme, or if they do not start.
- Further training and communication with referrers on CIFA's denial criteria is essential, as is a critical examination of how referrers use external motivation to encourage SU participation in CIFA.

<u>Implementation</u>

- The programme uses a range of tools (e.g., the CBT triangle, Power and Control Wheel, arousal thermometer) and adapts session formats for different needs, including simplified language and repetition for those with cognitive challenges. Identity-sensitive matching (e.g., LGBTQ+ or faith-based considerations) is part of the service offer, although attuned to appropriateness, and the programme design and effectiveness does not rely on it.
- CIFA stands out for its ability to adapt delivery to the needs of groups often marginalised or poorly served by statutory services. These include neurodivergent service users, individuals with mental health challenges, and those facing cultural, linguistic, or immigration-related barriers.
- Feedback from both service users, referrers and DA and VAWG leads described CIFA as "brilliant," "priceless," and "fantastic," particularly in terms of its cultural fluency and flexibility.
- Programme integrity is founded on robust quality assurance and an emphasis on safeguarding the victim-survivor and consent-based practice. However, there are some issues with referral processes and consent-seeking that need to be addressed.

Maintenance & Sustainability

- While many stakeholders voiced strong support for CIFA, sustainability remains a challenge. Buy-in from low-referring boroughs and broader institutional partners, such as the NHS, remains uneven.
- Referral pathways are not always clear, and CIFA's reliance on match funding has created inconsistencies in how the programme is delivered across boroughs.
- Despite this, CIFA is generating sustained learning through cross-borough partnership meetings and sector-wide training. These forums were described as energising, collaborative, and unique in their ability to share practical knowledge across boroughs.
- Stakeholders emphasised the need for more stable, long-term funding to preserve CIFA's integrity and expand its reach.

Cultural integration

- 'Culture' is effectively used by CIFA as a framework to explore beliefs, relationships and behaviours related to domestic abuse with both service users and victim-survivors.
- CIFA's culturally integrated approach is defined by curiosity, reflection, openness to complexity, intersectionality and understanding of context.
- The diversity of CIFA's staff body is a resource: staff bring cultural knowledge and insight to their work, and share it within the team.
- The programme approach, design and effectiveness, however, does not depend on the practitioner's specific cultural knowledge.
- CIFA's intersectional and tailored programme design ensures that service users feel heard and have space to explore their behaviour in the context of experiences of marginalisation.
- Engagement with the CIFA programme enables service users to critically examine their views on relationships, gender roles, parenting, and what constitutes abusive behaviour, particularly in the context of British legal frameworks.
- Victim-survivors are supported through CIFA to understand their experiences of abuse through an intersectional lens and in the context of British legal frameworks.
- Victim-survivors generally felt culturally respected and safe, with interpreters and culturally informed staff increasing trust and engagement.
- CIFA's adaptability to language and faith needs (e.g., respecting prayer, cultural communication styles) was cited as a major strength.
- Victim-survivors appreciated that staff understood, or tried to understand, how cultural beliefs and extended family dynamics shaped abuse.
- CIFA's culturally integrated approach is a model for behaviour change programmes more broadly.
- Referrers could benefit from more insight into how CIFA works with culture through regular and culturally specific feedback.
- Evidence from outcome star shows CIFA having a positive impact on people from ethnic minorities, religious background and with need for interpreters - communities that rather than being supported often are stigmatised in many other interventions.

Strategic Alignment with VAWG Priorities

- CIFA contributes directly to the goals of the Violence Against Women and Girls (VAWG) strategy. By focusing on those who have caused harm, primarily men, while maintaining victim–survivor safety and support, the programme helps shift the burden of accountability away from victim-survivors. Its intersectional approach embeds cultural safety, challenges harmful gender norms, and supports system-wide reframing of how abuse is addressed.
- Victim-survivors acknowledged the role of CIFA in improving feelings of safety.
- The voice of children is articulated through practitioner interviews, who highlight how CIFA's work resonates with the voices and needs of both victim–survivors and children. Social workers, IDVAs, DASAs and others described cases where children reported feeling safer and more emotionally secure, and where victim–survivors expressed increased confidence, knowledge of their rights, and trust in services. Embedding these perspectives into programme delivery reinforces VAWG priorities by ensuring that safety, empowerment, and the disruption of intergenerational cycles of abuse remain central outcomes.

Ripple effects: Community Impact

- Beyond individual outcomes, CIFA's ripple effects are visible in homes, communities, and systems. Service users reported behavioural changes that improved family dynamics and parenting practices. The positive impact of the programme on children came through as a strong theme in interviews.
- Victim-survivors reported that they and their children felt safer and more comfortable seeing and/or visiting the family member who had caused harm thanks to an improved emotional environment resulting from behavioural changes made by SUs.
- Victim-survivors also reported talking to, and sharing insights about DA with friends, and community members, helping to raise awareness of DA within communities, and highlighting the support that is available.
- Many, particularly men from minoritised communities, referred others to the programme, highlighting a multiplier effect. Cultural norms around gender, parenting, and help-seeking were being actively challenged. In some communities, participants began speaking more openly about coercive control, parental abuse, and other taboo topics.
- Practitioners noted increased trust from communities that had historically viewed statutory services with scepticism. Faith leaders, women's groups, and community-based organisations engaged more closely with local authorities through the CIFA programme, further extending its reach and influence.
- By creating space for conversations previously silenced, CIFA is contributing to long-term shifts in how domestic abuse is understood, disclosed, and addressed.

Communication, Positioning & Funding

- While CIFA is primarily associated with Children's Services, there is a need to improve communication and outreach so that the programme is understood as open to individuals without children. Advertising and enhancing the clarity referral routes through broader

partnerships (including housing, NHS, and community organisations) could improve inclusivity.

- Self-referral is planned for LGBTQ+ communities through Respectful Partnerships – an informed, exceptional measure to respond to the needs of that particular community.
- CIFA has considered accepting self-referrals for the APFA programme. However, following careful consideration, the CIFA team agreed that self-referrals could not be accepted due to the potential risk and pressure this may place on the parent victim–survivor. Referrals are instead prioritised via trusted statutory pathways (e.g., Adult Social Care, Police Authorities, MARAC), with planned community outreach to raise awareness of APFA through safe channels.
- Stakeholders called for closer alignment and collaboration between IDVAs, DASAs, referrers and CIFA practitioners, particularly where services are delivered separately. Strengthening these parallel processes is critical for ensuring consistent and safe support for all parties involved. Promoting CIFA's dual focus on those who have caused harm and those who have experienced abuse is key to challenging siloed approaches within the domestic abuse landscape.
- To scale and sustain the impact of CIFA, stakeholders stressed the need to move beyond the current patchwork funding model. CIFA's long-term success will depend on more consistent, cross-borough investment that is not vulnerable to local political will or annual funding cycles.

1. Introduction

This document presents the evaluation of the Culturally Integrated Family Approach to Domestic Abuse (CIFA), led by London Borough of Barnet, designed and delivered by RISE Mutual CIC, partnering with local IDVA services across ten London Boroughs. The evaluation was funded by the Mayor's Office for Policing and Crime (MOPAC) and the Home Office. Conducted between February and July 2025, the evaluation covered the programme's two-year operational period from 2023 to 2025.

The report was authored by a team of researchers (see Appendix 1) specialising in evaluation and policy-relevant research. This team, comprised of Drs Rachel Seoighe (PI), Trude Sundberg (Co-I), Tara Young (Co-I) and Gemma Bridge (Co-I), and Miss Lucy Watson (Co-I) the team has extensive experience in conducting evaluative research with vulnerable and minoritised groups. The evaluation seeks to provide a comprehensive assessment of the CIFA programme, including its impact on service users (SUs), victim-survivors (VSs), the wider community, and its overall value for money.

1.1 Context

Domestic abuse (DA) significantly impacts the lives of millions in the UK, with enduring consequences for those affected. According to national estimates for the year ending March 2025, 3.8 million people aged 16 and over (7.8%) reported experiencing some form of abuse as defined by the DA Act 2021 (Office for National Statistics, 2025). The profound consequences of DA cannot be overstated. Research consistently highlights its strong association with self-harm, suicidality (McManus 2022) and homicide (ONS 2024; Women's Aid 2025; Rossiter et al, 2020).

DA, as a social phenomenon, transcends societal boundaries and is present across all human societies, regardless of gender, age, nationality, ethnicity, religion, sexuality, or socio-economic status. While DA is often a 'hidden crime', there are some 'social facts' that are consistent with its perpetration and victimisation. Since the 1970s, DA has been recognised as a form of patriarchal violence against women (Butterby and Donovan 2023). At a national level, research indicates that women and girls are disproportionately affected by DA across each of the crime types compared to men and boys (Office for National Statistics, 2025) particularly in heterosexual couples. The majority of people who have committed DA (45%) are male, and have perpetrated multiple offences against multiple female victims (Hadjimatheou et al, 2022), most notably partners or ex-partners (Office for National Statistics, 2024).

This does not mean DA does not impact other populations. There are recorded cases of DA committed by women against male partners (Barton-Crosby and Hudson, 2021; Williams et al 2008), adult children against their parents (Graham-Kevan et al 2021), by parents against children (Skafida et al 2023) and within the LGBTQ+ community (Bermea, Slakoff, & Goldberg, 2021).

While there appears to be little statistical difference in the latest profile of victims by ethnicity (ONS 2024), the majority of recorded people who have caused harm are white UK nationals (Hadjimatheou et al, 2022) who are most likely to have abused a victim of the same ethnic group as themselves (Westmarland and Hester 2007). However, reliable data on the ethnic profile of those who have caused harm through domestic violence remains limited. Official statistics indicate a higher level of

abuse experienced by individuals classed as 'Mixed' (7.1%) than 'White' (5.0%), Black (3.4%) and Asian (3.0%) (ONS 2024). These figures need to be read with caution not least because research has shown women from minoritised ethnic groups are particularly susceptible to DA because of the intersection of socio-cultural factors linked to patriarchal norms, economic dependences, immigration status and structural racism (Scottish Government 2024:7). Such factors have been shown to contribute to the under-reporting and mis-recording of abuse and violence in minoritised communities (Femi-Ajao et al 2020).

The economic and social cost of DA in England is estimated at approximately £71 billion with £427 million required to provide an adequate service to the public (Women's Aid, 2024). There have been significant efforts by previous and current UK governments to combat DA which have included legislative changes in the definition of DA and the criminalisation of coercive and controlling behaviour (Serious Crime Act, 2015). These actions have been matched with a significant fiscal investment to fund programmes that safeguard and support victim-survivors, prevent perpetration and promote behavioural change among those who cause harm to others (Home Office 2022). Specifically, £7 million has been set aside for behaviour change programmes, with additional support of £75 million set out to fund 'perpetrator' interventions over three years (HM Government 2023:7). The pervasive nature of DA, the significant harm inflicted on those affected, and the substantial economic costs of prevention underscore the need for a deeper understanding of the socio-cultural contexts in which it occurs, particularly through engagement with individuals who are most likely to cause harm.

1.2 The CIFA Programme

The CIFA programme, delivered by RISE Mutual CIC, is an example of a 'perpetrator' prevention initiative aimed at supporting individuals who engage in abusive behaviour. While it shares the broader goal of other DA prevention services—to change attitudes and behaviours—CIFA is distinct in several key aspects. These are:

- CIFA is a one-to-one intervention service for people who have caused harm from racialised and marginalised communities who pose a medium to high risk. This includes individuals who are born and/or resettled in the UK.
- The programme foregrounds culture, that is the shared socio-cultural norms, religious belief systems and values that govern individual behaviour, as a distinctive factor in the perpetration and prevention of DA.
- CIFA practitioners work with service users to identify the underlying socio-cultural factors contributing to their abusive behaviour (e.g., traditional gender roles, child rearing practices) to guide them toward more constructive, tolerant and non-harmful ways of resolving familial and/or relational conflict.
- CIFA adopts an intersectional and cross-cultural approach, addressing DA through the lenses of gender, sexuality, race, ethnicity, class, religion, immigration status, and geography, thereby promoting cultural competency.
- The programme operates a 'whole family' approach to DA, recognising that DA is not only engaged in by the archetypal male 'perpetrators' but also others (e.g., family members (including parents, siblings, in-laws) or wider community members) who may facilitate or be complicit in the abuse.

- It operates on an ecological framework (see section 3.2) and adopts a systems-thinking approach to DA that centralises the role of the family.
- The use of interpreters is an integral component of the programme, ensuring accessibility and inclusivity for diverse participants.

The overall aim of the CIFA programme is to:

- Reduce re-offending and promote the safety of current and future partners and children; and
- Work collaboratively with 'by and for' agencies to manage and reduce risk.

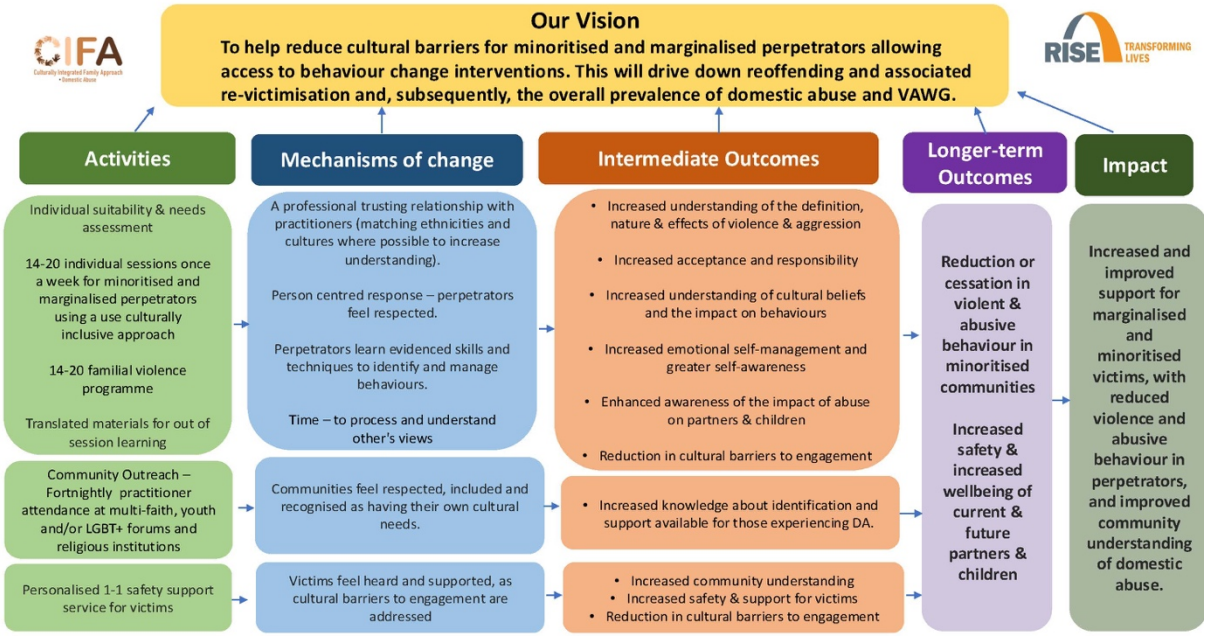
CIFA serves as an umbrella term encompassing a range of initiatives offered to individuals who are committed to addressing and changing their abusive behaviour. These individuals are referred to RISE Mutual CIC by Children's Services or other statutory and community-based agencies or organisations. The programmes within CIFA are:

- CIFA Perpetrator Programme - A one-to-one programme for male service users who pose a medium or high risk to others. The programme includes 16-20 sessions.
- Female Awareness of DA programme (FADA) - A one-to-one, trauma-informed female DA service lasting 9-17 sessions.
- Adult to Parent Familial Abuse programme (APFA) – A one-to-one intervention with adults who have been abusive towards a parent. It comprises 6 sessions with parents and 10 sessions with the service user who has caused harm.
- Respectful partnerships (RP) – This programme is aimed at medium to high-risk service users from the LGBTQ+ community. It offers 16-20 sessions.

Each programme can be adapted to work with neurodiverse individuals. The programme is integrated with VS support, which is provided by RISE DASAs in three boroughs - Haringey, Brent and Newham - and by partnering with IDVA services Advance, Cranstoun and Solace in the other seven boroughs, as set out above. These services are available across the 10 boroughs in which RISE Mutual is operational. In addition to the above programmes, CIFA offers five "pre-intervention" sessions that are designed for Ss who are either unable or unwilling to acknowledge the abusive nature of their behaviour or demonstrate significant resistance to change.

CIFA operates to a specific theory of change (see Figure 1) that reflects its unique approach to tackling DA.

Figure 1. CIFA's theory of change



1.3 Evaluating CIFA

It is against this backdrop and significant policy interest that this evaluation of the CIFA programme was designed and conducted. An evaluation of the CIFA pilot programme was carried out in 2023 (Goodman et al 2023), which focused on the 3 boroughs initially served by the programme. Our focus was to conduct a process and outcome evaluation of the CIFA programme, operating across 10 boroughs in London, each aiming to work with people who have engaged in domestic abusive behaviour and offering simultaneous support to VSs impacted by that abuse. The evaluation was conducted over the period of six months from February to July 2025 and was based on a combination of qualitative and quantitative research methods. The evaluation aims to answer the following questions:

1. To what extent does service user engagement with CIFA contribute to the cessation of DA?
2. How effective is CIFA in combating DA compared to non-culturally specific provision?
3. To what extent does the CIFA programme offer good value for money?

To answer these questions, and using a mixed-methods approach, the evaluation sought to:

- Explore and evaluate referral pathways to the CIFA programme;
- Explore the expectations and experiences of service users and victim-survivors involved in the CIFA programme;
- Assess the experiences of practitioners who deliver the CIFA programme;
- Gauge the short, medium and long-term impact of CIFA on service users and victim-survivors; and
- Assess CIFA's value for money.

Report structure

A fuller explanation of the methodology for this evaluation is provided in section 3, following the literature review. The findings are subsequently presented (sections 4.1 - 4.5). The 'ripple effects' of the CIFA programme are described in section 5 and the value for money analysis is set out in section 6. The report concludes with a consideration of the evaluation's impact on DA policy and practice (section 7). A comprehensive annex and reference list is provided.

2. Literature Review

This literature review establishes the research foundation for the CIFA evaluation, drawing on the academic and policy literature to examine the nature and scope of DA in the UK. It focuses on the intersection of culture as a significant factor in the commission of DA with particular emphasis on gender, sexuality, ethnicity, neurodiversity, and familial relationships. Grounded in an analysis of public perceptions of DA, the review describes current policy and approaches to DA, particularly within minoritised groups. It offers an analysis of institutional barriers to accessing support, drawing on insights and recommendations from the academic literature. The review concludes with a discussion of the gaps in knowledge and the appeal of the CIFA approach.

2.1 What is DA?

DA, as defined in the Domestic Abuse Act (Legislation.gov, 2021), relates to the conduct of a person ('A') towards a person ('B') who are both aged 16 years and older and personally connected at the time of the abusive event.[1] Such behaviour is considered to be abusive if it consists of any of the following: a) physical or sexual abuse, b) violent or threatening behaviour, c) controlling or coercive behaviour; d) economic abuse; e) psychological, emotional or other abuse. The Act states that it does not matter whether the behaviour consists of a single incident or a course of conduct. This legal definition includes groups (such as 16 and 17-year-olds) and behaviour unrepresented in previous definitions.

DA includes, but is not limited to, intimate partner violence (IPV), which is defined as "physical violence, sexual violence, stalking, psychological aggression, or control of reproductive or sexual health by a current or former intimate partner" (CDC, 2021). While the bulk of research, policy and public discourse on DA centres on IPV, often in heterosexual relationships and particularly male-perpetrated violence against women and girls, this focus represents one dimension of a broader and more complex phenomenon. DA also includes harmful behaviour occurring within the family between siblings, children and parents and/or extended family members (e.g., in-laws, step and grandparents). The multifaceted nature of DA requires a more inclusive understanding that accounts for diverse relational and contextual dynamics.

2.2 The prevalence of DA in the UK

DA is known to have a fundamental and long-lasting effect on the lives of millions of people in the UK. National estimates on the level of DA in the year ending March 2025 show that 3.8 million people (7.8%) aged 16 and above reported some form of abuse as outlined in the DA Act 2021 (Office for National Statistics, 2025). Research consistently shows that women and girls are significantly over-

[1] Domestic Abuse Act 2021 - Personally connected means: intimate partners, ex-partners, family members or individuals who share parental responsibility for a child. Statutory definition of domestic abuse factsheet - GOV.UK. Domestic Abuse Act 2021.

represented in the statistics (1.6 million, 72.5%) in comparison to boys and men (712,000) and that the majority of those causing harm through DA are male.

The serious impact of DA can never be overstated. While deaths – both homicide and suicide - are discussed here as one devastating measure of impact, the impact of DA is much broader, including physical, emotional and psychological harm. The femicide statistics, first published in 2009, show little decline in the impact of men's fatal violence against women. The Femicide census states that since 2010, nearly 2000 women have been killed by a man in England and Wales, equating to about 1 woman every 2.7 days (Femicide Census 2024). Of the one hundred and eight (108) cases of domestic homicide recorded in the year ending March 2024 (ONS 2024), the majority (77%) were committed against women and in most instances, the person causing harm was recorded as a partner or ex-partner (ONS 2024). A recent report on femicide states that nearly two-thirds (61%) of the first 2000 women and girls (aged 14 and above) killed since 2009 were killed by a current or former partner, with one in 10 (9%) killed by a son, and 6% by another family member (Femicide Census 2025: 24).[2] The overwhelming majority (71%) of women were killed in their own homes (Femicide Census 2025).[3] Intimate Partner Violence is a significant global health issue, affecting approximately 17% of men and 27% of women worldwide (Sardinha et al., 2022).

There is a strong correlation between the experience of DA and self-harm, including suicidality. Research analysing cross-sectional survey data of people who experienced DA, including physical violence and sexual, economic, and emotional abuse from a current or former partner, found that of the people who had attempted suicide, nearly half (49.7%) had experienced intimate partner violence (McManus et al 2022). Such numbers illustrate the significant and detrimental impact DA has on partners and ex-partners.

2.3 DA within minoritised communities

While the latest figures on domestic violence show little statistically significant differences between ethnic groups in the year ending March 2024, other sources show such differences. Data on levels of DA by ethnicity shows that rates of reported DA are disproportionately higher in racially minoritised communities than those found in the White community. Figures produced by the ONS for the year 2023/24 (ONS 2024b) illustrate the highest rates amongst VSs classified as being from a mixed-ethnic background (7%), particularly the group identified as 'African Caribbean and White', followed by 3.5% as 'Black' and 2.0% as 'Asian', compared to 6% classified as 'White'.

However, these figures are likely to be an underrepresentation of levels of abuse experienced by minoritised VSs and need to be read with caution not least because research has shown women from

[2] This report defines femicide as: 'the misogynistic killing of women by men' and 'the killing of women because they are women'. The former emphasises the role of misogyny, the latter places femicide within 'the context of the overall oppression of women in a patriarchal society' (2025:17).

[3] These are solved cases. The figure does not represent all women killed by men since 2009. The figure doesn't include unsolved cases, hidden homicides, road traffic accidents or deaths of women and girls because of 'gross negligence'. Data gathered through FOI, media searches and other publicly available material including court reports, judges' summaries. Where mothers are killed by their sons' mental health issues is a significant feature. In three out of five cases (58.2%) the use of violence far exceeded the level required to bring about the death indicating gratuitous violence.

minoritised ethnic groups are particularly susceptible to DA because of the intersection of socio-cultural factors linked to patriarchal norms, economic dependences, immigration status and structural racism (Scottish Government 2024:7). Such factors have been shown to contribute to the under-reporting and mis-recording of abuse and violence in minoritised communities (Femi-Ajao et al 2020). In London, the ethnic representation of DA VSs differs from the national profile. Statistics provided by MOPAC (Dawson et al, 2022) report victim characteristics to 56% of victims 'White', 22% 'Black' and 19% Asian, illustrating a disproportionate level of DA among victims classified as 'Black'.[4] Three-quarters of reported cases of DA (73%) were repeat offences committed by current or ex-partners (Dawson et al, 2022).

2.4 DA within the LGBTQ+ community

On a national level, the main focus of domestic abuse services and support is heterosexual couples, where abuse is enacted largely by cisgender, heterosexual men against their female partner or ex-partner. This stance stems from the historical focus on domestic abuse from the 1970s, when domestic abuse was recognised as a form of patriarchal violence against women (Butterby and Donovan 2023). Statistics still show that this demographic is disproportionately most likely to be VSs of domestic abuse. It is crucial to note that recorded statistics are often poor when it comes to recording sex, gender and sexual orientation, thus underreporting is likely. The suspicion of underreporting is supported by research that shows that domestic abuse extends beyond the demographic included in recorded statistics to affect a wider range of people with different sexual orientations and, as such, there is a need for a wider holistic understanding of domestic abuse experienced by people in the LGBTQ+ community.

Within this community, the exposure to DA differs, with bisexual women having the highest experience of IPV (69.3%), followed by lesbian women (56.3%) and gay men (47.7%) (Chen et al., 2023). Compared to cisgender individuals, transgender individuals are 1.7 times more likely to experience IPV (Peitzmeier et al., 2020). Some studies report that the experience of IPV among lesbian, gay, and bisexual college students is as high as 50%, and 9 times greater among transgender students compared with their cisgender peers (Whitfield et al., 2018). When episodes of severe violence were considered, prevalence was similar or higher for LGBTQ+ adults (bisexual women: 49.3%; lesbian women: 29.4%; homosexual men: 16.4%) compared to heterosexual adults (heterosexual women: 23.6%; heterosexual men: 13.9%) (Breiding, Chen, & Walters, 2013). It is unknown how gender identity and sexual orientation influence cyber IPV (Muñoz-Fernández, & Sánchez-Jiménez, 2024).

The dynamics of violence within lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority (LGBTQ+) relationships are influenced by power imbalances, identity-specific factors, and societal stigma (Rossiter et al., 2020; Tran et al., 2022). Research has suggested that internalised

[4] According to the ONS (2021) census data, London is the most ethnically diverse area of England and Wales with an Asian population of 20.7%, Black, 13.0%, Mixed, 5.7%, White British, 36.8%, White other, 17%, and 'other' 6.3%. It's important to note that the ethnic population of London is not geographically spread either with some boroughs, like Newham, being the most ethnically diverse in London with 69.2% of the borough being non-white.

homophobia is more consistently and strongly associated with aggression than victimisation (Badenes-Ribera et al., 2019).

2.5 Adult Child to Parent DA

DA by definition (in the DA Act 2021) includes abuse between people who share a familial relationship (Benbow et al. 2023; Home Office, 2022a). Yet a lack of research and definitional issues concerning wider family abuse means that understandings of, and social responses to, adult child to parent abuse are routinely subsumed within other types of DA.

Abuse of parents by their adult children straddles several fields of study: DA (as a form of violence and abuse between family members); child-to-parent abuse (based on the parent-child relationship, largely focused on adolescents), and elder abuse (based on the age of the parent). Yet, within and across these fields, "it occupies spaces of near invisibility" (Nguyen Phan 2021: 8). Few research studies have quantified the amount of (adult) child to parent DA and those in existence offer enormously different estimates of the problem because of divergent tools and approaches in conceptualising and recording practices (Holt 2016; Nguyen Phan 2021). The generic and broad terminology of 'family members' in data collection poses another challenge. In the Crime Survey for England and Wales, for example, no further breakdown in family relationships beyond 'family abuse' is available (Nguyen Phan 2021; Office for National Statistics, 2020). Therefore, there is no nationally available data on the prevalence of abuse of parents by adult children. Data issues also mean that we know little about race and ethnicity in relation to domestic homicides (and by extension, adult family abuse) (Bracewell et al 2021).

Nevertheless, a 24-hour snapshot study of calls to a DA helpline in Bristol found that 15% of calls related to familial abuse (and 3% familial and intimate partner abuse (Westmarland et al 2005). Of these cases, children were those causing harm in 52% of cases, while parents, siblings, in-laws, grandchildren and adoptive parents were also named (Westmarland et al 2005). A recent 26-month study of recorded DA cases in Lancashire Constabulary found that over 10% involved abuse by a child aged 16 or over towards a parent (Graham-Kevan et al 2021). This figure is likely an underestimate due to parents' reluctance to contact the police, and how this abuse is interpreted (Graham-Kevan et al 2021). Mothers are overwhelmingly the primary targets of adult child to parent abuse (Nguyen Phan 2021), and sons are most likely to cause this harm (Clarke et al 2012; SafeLives 2016).

2.6 Parent-to-child DA

While there is evidence to show the harm children do to parents, children are much more likely to be abused by parents and carers than to abuse them. Few studies quantify the level of DA committed against children and young people even though, as set out in the DA Act 2021, children are VSs in their own right. It is estimated that around 3 million children under the age of 17 live in a household where an adult has experienced DA. This equates to an estimated 1 in 5 children (Skafida et al 2023). The majority of children living with DA (78%) will be directly harmed, in addition to the harm caused by

witnessing the abusive event (SafeLives 2023) which may account for the 19% increase in children contacting the NSPCC to report incidents of DA in their home (NSPCC 2024).[5]

Few studies look at child homicides in a domestic setting. One such publication, released by Women's Aid (2025), reports on nineteen cases where children were fatally harmed by a parent who carried out DA. Focusing on the experiences of the child, the report shows the extent of trauma children experience within the familial home. Of the 19 cases, 17 children were killed by their biological father, or the biological father of their siblings, and some perished alongside their mother. As a result of these homicidal episodes, twenty-four remaining children had lost a sibling, and six had lost a sibling and a parent (Women's Aid, 2025).

2.7 Neurodiversity and DA

Neurodiversity is a term used to describe neurological differences in the human brain (Kircher-Morris, 2022). The concept of neurodiversity views neurological differences as natural variations in human brain function rather than deficits (Kircher-Morris, 2022) and speaks to the potential challenges that individuals might face in navigating relationships (Kauffman et al., 2020). Neurodivergent individuals, particularly those with autism spectrum disorder (ASD or autism), often struggle with forming and maintaining romantic relationships (Smusz, Allely and Bidgood, 2024) while communication difficulties, emotional connection issues, and intimacy concerns are common in neurodiverse partnerships (Sickels, 2021). These relationship challenges can lead to social isolation and mental health issues (Fox et al., 2015) and to behaviour that increases an individual's likelihood of being involved in DA.

In an investigation of IPV among people with ADHD, Wymbs et al (2016) found that adults with ADHD-related symptoms reported higher rates of IPV than their 'neurotypical' counterparts. Women in neurodiverse relationships report higher rates of psychological and physical abuse, lower perceived physical health, more somatic symptoms, higher levels of depression, and lower subjective well-being compared to women in neurotypical relationships (Arad et al., 2022). However, Hwang et al., (2019) found that autistic VSs of DA were more commonly male (58%), likely reflecting the 3:1 - 4:1 male-to-female gender bias in the prevalence of autism in the population. Individuals with autism spectrum disorder or attention-deficit/hyperactivity disorder may experience increased risk of victimisation, particularly among females (Young and Cocallis, 2023). This research demonstrates that particular considerations are present in understanding and addressing DA where neurodiversity is present.

2.8 Profile of those who have caused harm through DA

According to reported and recorded statistics on DA in England and Wales, men are the group overwhelmingly most likely to carry out DA. There is limited data available on the ethnic profile of those causing harm through DA but Hadjimatheou et al' s (2022) quantitative analysis of police data indicates that they are more likely to be male, white nationals. However, as indicated above, this

[5] Between April and September 2024, NSPCC received 3,879 contacts relating to the issue, a 19% rise compared to the previous year.

finding needs to be viewed with caution as there is under-reporting and mis-recording of abuse and violence in minoritised communities (Femi-Ajao et al 2020). Nevertheless, we know from research that those causing harm are most likely to be abusing a VS of the same ethnic group as themselves (Westmarland and Hester 2007).

Research exploring the factors that precipitate abusive and violent behaviour in males within a domestic setting has identified annoyance, anger, power/control, e.g., assertion of dominance, control of physical and verbal behaviours and emotional responses, punishment for unwanted behaviour as being among the most common (Elmquist et al 2014). While reports of IPV and DA incidents disproportionately involve men causing harm, this does not mean that women do not commit such offences. Data from one of the few reports on IPV focusing specifically on women who have caused harm, shows little gender differentiation in the motivational factors that influence IPV (Barton-Crosby and Hudson, 2021). The authors, drawing on the findings from their non-systematic review of the available literature found that, like their male counterparts, women who commit IPV do so because of a desire for power and control over 'their' VS. These actions are influenced by socio-psychological factors such as developmental issues, alcohol use, relationship conflict, jealousy and acute childhood experiences (Barton Crosby and Hudson, 2021:42).

While motivations appear to be similar, some differences are worth mentioning not least because these need to be taken into consideration when tackling DA. For example, men more likely to be repeat offenders (Hester 2002; 2018) and more likely to make threats, harass and use physical violence against their target (Hester 2018) that is lethal. While research found women to be as violent and domestically abusive as men (Stauss 1999), their aggression is more likely to be psychological and emotional (Barton Crosby and Hudson, 2021), to be isolated to one incident (Hester 2018), more likely to use a weapon, and women are more likely to be arrested for more serious offences than their male counterparts (Hester 2009:10). The greater use of weapons amongst women is correlated to their exposure to multiple DA events as VSs and the fear/control experienced. Women who committed DA in this research also had greater mental health needs. Women are more likely to use self-defensive and retaliatory violence - violence used to protect themselves and others from an abusive partner (Dasgupta 2002; Elmquist et al. 2014)

The dynamics of violence within lesbian, gay, bisexual, transgender, queer, and other sexual and gender minority (LGBTQ+) relationships are influenced by power imbalances, identity-specific factors, and societal stigma (Rossiter et al., 2020; Tran et al., 2022). Those who do not appear stereotypically masculine may be considered incapable of IPV. Buttell and Cannon (2015) state that IPV within the LGBTQ+ community is not about gender, but about dynamics of power and control, therefore, it is pointless to take into account gender-related stereotypes about those causing harm.

2.9 Tackling DA: existing 'perpetrator' services

The previous and current governments expressed a commitment to tackling DA. The Tackling DA Plan initiated in 2022 pledged over £230 million to deliver provisions to overcome DA (Home Office 2022) and ensure a robust, coordinated service. Part of the commitment included new measures to protect people against DA. DA Protection Notices and DA Protection Orders bring together available orders for VSs found in other protective orders such as (soon to be obsolete) Domestic Violence Protection

Orders, Non-Molestation Orders and Restraining Orders, to place further restrictions on people who have committed DA (Home Office 2024).

Some investment is being made in DA intervention schemes focused on those who cause harm: £7 million has been set aside for behaviour change programmes, with additional support of £75 million set out to fund 'perpetrator' interventions over three years (HM Government 2023: 7). There is also the 'Domestic Abuse Perpetrator Intervention Fund' that has a budget of over 36 million pounds (HM Government 2023:10) and as part of the Labour government's Plan for Change a further £53 million investment (over the four years between 2025-2029) will be ringfenced for tackling DA perpetrated by those who pose the highest risk (Home Office 2025).

Money is being made available to protect women and girls from DA but more research is needed to demonstrate the effectiveness of these services in stopping violence. The available research shows that the majority of DA prevention services are those where the objective is to change the attitudes and behaviours of abusive men. Men's Behaviour Change programmes aim to enhance women and children's safety by focusing on accountability and responsibility with the person who has caused harm (O'Connor et al., 2020) enhancing women and children's safety and monitoring men's use of coercive control, abuse and violence, as well as the risk they pose to partners/ex-partner and their children (Day, Vlais, Chung & Green, 2019; Kelly & Westmarland, 2015).

Conversely, there is a lack of provision for women who have caused harm through IPV or DA, which some have identified as being the result of DA being conceptualised as a male-to-female offence (Barton-Crosby and Hudson 2021). Where services are available, they tend, as Barton-Crosby and Hudson (2021) note, to be generalist criminal justice services designed to tackle offending behaviour rather than services that acknowledge the specialist needs of women who have committed DA.

2.10 How effective are existing DA services?

There is ongoing disagreement in research internationally about the effectiveness of domestic violence 'perpetrator' programmes, and a widespread scepticism about their effectiveness. Part of this stems from an overly narrow definition of 'success,' often understood as an absence of subsequent police callouts or incidents of physical violence. There are other methodological issues, such as the definition of DA, lack of random control trials, high attrition rates (Senker et al, 2021) and the limited focus on ending physical violence (Westmarland and Kelly 2013; Gondolf, 2004) that have caused scepticism about the efficacy of such programmes.

With few high-quality evaluations (HMPPS, 2019) it is difficult to say with certainty 'what works' to prevent DA. However, along with the findings of this evaluation, there is other strong emerging evidence to show that approaches aligned with CIFA's approach is effective. For example, there is evidence to suggest that projects that employ Duluth model around power and control, Cognitive Behavioural Therapy (CBT) techniques, Johnson's domestic violence typology, Dutton's Nested Ecological Model and or Anderson and Bushman's General Aggression Model (Senker et al 2021:37) can have positive outcomes (Hughes, 2017). Also showing promise are strength-based approaches - which focus on the whole person, creating a context of safety and skill-building (Bowen et al., 2018; Simmons & Lehmann, 2009) – which can reduce male violence against women in marginalised ethnic groups (Waller 2016; Turhan 2020) and projects that take into account men's specific needs –

psychological and social - including experiences of systematic racism in social, political, economic and health settings (Waller 2016; Turhan 2020). Motivational interviewing - a strengths-based approach (used by CIFA) that creates an empathic environment, aiming to reduce client resistance and address ambivalence to elicit behaviour change - also appears to be effective for marginalised ethnic groups who often experience difficulties in building rapport and a trusting relationship with professionals in interventions (Turhan, 2020; Gondolf & Williams, 2001).

There is also evidence to suggest that successful reduction of DA and violent episodes is correlated with programme completion. Research conducted by ADVA and Penna Associates (2009) on the efficacy of the REPAIR programme found that men who are motivated to engage with the programme are more likely to complete it. Moreover, there were reports of fewer recorded incidents of DA the longer men are on the project, reflecting a real change in men's awareness of the impact of their behaviour on others, resulting in positive life changes for the men and improved stability and security for the family (ADVA and Penna Associates 2009:8). Similarly, Kelly and Westmarland's (2015) evaluation of the Project Mirabel, an extensive multi-site study of DA 'perpetrator' programmes across the UK reported positive outcomes finding that for many women the abusive behaviour (e.g., including sexual and physical violence) had ceased, children were less likely to witness domestic violence episodes, to be scared of the person causing harm or worry about the safety of their mother, and men's awareness of what constitutes DA and violence increase substantially to include and recognise other forms of abusive behaviour such as coercive control (Kelly and Westmarland 2015).

Multi-agency approaches to tackling DA that include a focus on the risk posed by the person who has caused harm, accountability and responsibility are also aligned with successful outcomes, as are those programmes where the facilitators are subject experts and adopt an inclusive and non-judgemental interactive style practice, have some understanding of group dynamics and are unafraid to challenge individuals constructively (Hughes, 2017). Lastly, as Hughes (2017) notes, programmes that are more impactful tend to consider how wider socio-cultural norms and values influence the attitudes and behaviours of those who have caused harm, and recognise that people who harm others do not act independently.

2.11 What is the significance of culture in DA?

The concept of 'culture' is a contested and porous one, with no single definition. As Bauman (1973: 1) argues, the "unyielding ambiguity of the concept of culture is notorious." The use of this concept in DA interventions – and more widely in social work, criminal justice and other areas – has been critiqued, calling for reflection on how 'culture' has come to stand in for race, ethnicity, religion or 'Otherness' (Park 2005; Masocha 2017). Where people are 'othered,' they are framed as outside the dominant culture and denigrated or discriminated against as a result.

2.11.1 Culture & Masculinity

Patriarchy, a system that perpetuates and endorses men's dominance and control over all aspects of social life, including over women, children and other men considered weaker, is substantiated in academic and policy research as being a contributing factor to IPV and DA. Living in a patriarchal

culture is to learn what is expected of men and women to learn how to behave and what actions are punished and rewarded as a consequence (Johnson 2014). A study conducted by Sileo et al (2022) found that men experience stress when they feel unable to meet the culturally prescribed gendered ideal of what a 'real man' is. This 'discrepancy stress' is correlated to anger, low self-esteem and perceived powerlessness that underpins the perpetration of DA (Sileo et al 2023:6).

Turhan (2020) describes how male cultural beliefs are integrated into interventions using the Duluth model, which is the model underpinning CIFA's work. This work aims to raise critical consciousness of gender norms that shape men's perceived right to control and dominate their female partners, describing the cultural beliefs of male abusive behaviour as perceived as acceptable in their male-dominated environment (Turhan 2020; Gondolf, 2007; Langlands et al 2009). Utilising the 'Power and Control Wheel,' practitioners challenge men's denial or minimisation of their violent behaviour (Turhan 2020; Gondolf, 2007). Race and ethnicity are considered in this model by concentrating on cultural and ethical dynamics related to violent behaviour (Turhan 2020: 3). However, the Duluth model's impact might be limited by inadequate strategies to address men's issues related to racial and cultural backgrounds, such as experiences of racism and discrimination, or immigration related obstacles (Turhan 2020).

2.11.2 Ethnicity

While these factors are correlated to men's DA and violence, research suggests that DA is not just affected by gender norms but also by other cultural influences. It is important, at this point, to recognise and challenge myths about DA within minority communities that suggest it is a consequence of racial determinants (i.e., that men of colour are predisposed to aggression) or cultural characteristics (i.e., that a culture of violence and misogyny is pervasive in communities of colour) (Sokoloff 2004). Notwithstanding this caveat, there is a need to gain knowledge of wider community norms, values and beliefs when considering the prevalence, type and impact of DA; not least because these can be useful for service providers working in the community (Wellock 2007).

Gill's research (2009) highlighted how people from minoritised communities are disproportionately impacted by DA. Some systemic inequalities can be drawn on to account for elevated rates of violence and abuse perpetrated and experienced by Black and minority ethnic groups. Sokoloff (2004) draws attention to the part played by extreme levels of poverty within communities of colour, which create the conditions for DV to occur and it is widely accepted that violence and poverty are strongly associated (Short 1997). People from minoritised ethnic groups (especially those from Pakistani and Bangladeshi ethnic groups) were most likely to live in low-income households (Gov.co.uk 2025). In addition, people from minoritised groups are likely to experience institutional racism (Bowling & Phillips, 2002) and racism more broadly. These factors can undermine an individual's sense of self, contribute to 'discrepancy stress' and act as a precursor to abusive and violent episodes. Researchers have argued that those who experience discrimination and racism need to receive culturally-sensitive treatments to reduce the negative outcomes of these experiences (Almeida & Dolan-Delvecchio, 1999 and Almeida & Hudak, 2002, cited in Turhan 2020).

In addition to structural factors there are other factors attributed to culture that can precipitate abusive behaviour and victimisation. Drawing on the perspectives of practitioners who provide specialist DA services for minoritised women, Gill and Sundari (2022) identified several unique factors

such as 'honour-based' violence; violence that is enacted against women who are thought to have brought shame and dishonour to the family usually via inappropriate sexual behaviour (Idriss 2017). But Idriss (2017) notes that while this is a form of DA, therein lie some distinct characteristics with DA encompassing a wider range of behaviours including but not limited to forced marriage and patriarchal control over women's acts as exercised by both men and women. Women who enter the UK as 'marriage migrants' via a spousal visa after marrying a British national or resident - experience a different form of risk than British-born VSs (Gill and Anitha 2022). Among these is the risk of deportation should the marriage fail. Therefore, a significant power imbalance exists between the abuser, who has residency and citizenship, and the VS who is dependent upon them for the right to remain.

Additional difficulties for these spouses include not being familiar with the socio-economic context, norms and cultural values, meaning that they can experience social isolation. Anitha et al (2018) show how those who have caused harm through DA can weaponise social isolation to further control their partners. Broader social factors such as poverty, deskilling, racism, immigration and welfare politics can facilitate/sustain DA (Gill and Anitha 2022:254).

For VSs in minority communities, family abuse can take a particular shape: in-laws can be abusers, specifically mothers-in-law. Ragavan and Iyengar's (2020) research in India reveals cultural attitudes about abuse by mothers-in-law, which might be reproduced in diaspora settings. Drawing on interviews with men and women in Northern India who were asked about perceptions of the prevalence, nature and community support for mother-in-law abuse. Findings illustrated a mix of opinions about prevalence with mainly women respondents stating that mother-in-law abuse was commonplace (Ragavan and Iyengar 2020: 3316). Both male and female respondents rendered it acceptable for the mother-in-law to yell at, scold and to stop her daughter-in-law from visiting her natal family, in other words to be psychologically abusive towards her, under certain conditions; these were if the daughter-in-law failed to obey her mother-in-law, if she did not clean or cook well enough or was otherwise thought to be disrespectful or lazy. In such interdependent family settings, where the wife is subordinate to the mother-in-law and her husband, wives have little recourse to deal with the violence themselves and rely on their husbands to intervene on their behalf (Ragavan and Iyengar 2020).

However, the research found husbands wouldn't always support their wife in domestic matters involving his mother which compounded the DA experience for them. In instances where the husband is supportive of his mother's actions - or ideologically committed to DA, the study showed that women have few options to behave in ways that do not bring shame upon her, the family or compound the abusive situation further.

2.12 Wider cultural perceptions of DA

Living in a patriarchal society is to exist in a social system that extends beyond the confines of any one individual family. Public perceptions and attitudes towards DA encourage or prohibit the enactment of abuse. A recent study conducted by Women's Aid (2022) surveyed over 2000 adults aged 16+ in the UK on attitudes to DA. Questions explored perceptions of what behaviour constituted DA, how common it is, levels of tolerance towards DA, whether it should be reported to the police, and whether DA is an important political issue. The findings show that public attitudes towards DA are influenced

by gendered, oftentimes sexist views of women and their role in society. UK adults believe DA to be relatively common and increasing. Explicit in the findings is a tacit acceptance of DA in society and this is underpinned by sexist views derived from entrenched views on gender roles (Women's Aid 2022:30), which play a part in maintaining attitudes that tolerate DA.

Victim-blaming attitudes were found to be present among respondents and forms of coercive behaviour towards women were downplayed or deprioritised in favour of the well-being of men. Respondents expected women to behave a certain way, particularly in regards to sexuality and fidelity, and perceived as complicit in DA committed against her if departing from that behaviour (Women's Aid 2022: 30). Those with misogynistic views were less likely to be aware of the nature of DA, less likely to acknowledge the harm caused, and more tolerant of it. Moreover, they tended to individualise DA rather than see it as a societal issue, placing the responsibility to deal with DA on VSs. Men were consistently less likely to see DA as wrong and by extension less likely to see the harm caused than women (Women's Aid 2022: 30). The findings show a notable downplaying of certain harms enacted against women such as sexual abuse and coercive control with a tendency to excuse these and other forms of behaviour. Media presentations greatly influenced public perceptions. The study found that DA was considered to be an important political topic by 14% of the sample, mostly among young women aged 16-24 years old, but the volume of DA in the news rendered it not newsworthy and thus more tolerable (Women's Aid 2022: 31). Without a shift in attitude, tackling DA will be challenging for services attempting to interrupt abusive episodes and keep VSs safe.

2.13 Conclusion

As this literature review illustrates, DA is a significant social problem that affects many people across all social strata. A comprehensive understanding of the socio-cultural factors that contribute to its occurrence is essential for safeguarding current VSs and preventing the emergence of new cases. While DA is ubiquitous in society, existing research shows that it is disproportionately carried out by men against women in heteronormative relationships and within certain communities (e.g., among the poor, marginalised and ethnic minority groups). Limited research exists on domestic violence perpetrated by children against parents, abuse committed by women, or DA within the LGBTQ+ community and among neurodiverse individuals. Our understanding of 'what works' to combat DA is also somewhat sketchy. Evaluations of DA 'perpetrator' programmes show promise in changing the behaviours and attitudes that give rise to abuse and, as a result, reducing the risk to VSs; present and future. However, the outcomes are modest and appear to be dependent upon what variables are measured and on what population. Further, the significance of culture in the commission of DA warrants further examination.

3. Methodology

The evaluation of the CIFA programme, commissioned by the London Borough of Barnet, was conducted over six months between February and July 2025. It included the CIFA programme delivered in ten boroughs across London during the two years between 2023-2025.

The overarching goal of this evaluation is to deliver an evaluation that assists the short and long-term decision-making about CIFA and supports the development of the programme and the sustainability of the programme. The evaluation focused on three key aspects. These were:

- whether SU engagement with CIFA contributes to the cessation of DA;
- how effective CIFA is in combating DA compared to non-culturally specific; provision; and
- the extent to which the CIFA programme provides value for money.

The holistic approach guiding this evaluation has enabled us to draw on the evidence produced through a variety of methods, including quantitative data analysis and qualitative interviews, to provide a nuanced understanding of the implementation and impact of CIFA. The research methodology and methods employed in the evaluation are outlined in the following sections.

3.1 Evaluation approach

This evaluation was informed by a realist approach and draws upon Pawson and Tilley's (1997) assertion that an effective evaluation must identify 'what works', for whom, and under what conditions. As an approach, it is ideal for evaluating a multi-site intervention such as CIFA. It recognises that interventions involve an intricate and mutable set of components, the impact of which is contingent on the *context* in which they are applied (e.g., location), the *mechanisms* (or factors) through which the programme drives change (e.g., programme content and resources, referral process, participant engagement and attitude and wider cultural processes) and the resulting *outcomes* produced by those mechanisms.

The CIFA programme is specifically designed to provide a targeted, multi-faceted DA service for racially minoritised and marginalised communities through a coordinated family and community approach. Within the programme, there is a strong emphasis on identifying the role culture plays in the commission and cessation of DA; therefore, our realist evaluation took an intersectional approach and sought to understand how socio-cultural factors such as ethnicity, sexuality, gender, and class shape lived realities. Additionally, given the seriousness of DA as a social issue, we were attentive to the challenges of engaging marginalised groups and sought to design a research study that was trauma-informed, transparent, person-centred (i.e., recognised individual agency and choice) and culturally sensitive.

In this evaluation, we draw on the RE-AIM model to assist with the planning, design and analysis of the CIFA Programme. RE-AIM has been applied as an evaluative tool across several policy settings. In particular, RE-AIM has been applied consistently to evaluate community services and within the area of public health (Holtrop et al, 2021) and has proven to be an effective and pragmatic model for assessing the implementation and impact of health-related, 'real world' interventions (Kwan et al

2019) like CIFA that are hoping to affect change at an individual and systemic level. Five key dimensions are essential to the RE-AIM framework to provide a robust, evidence-based evaluation. These are as outlined by Glasgow et al (1999:1323):

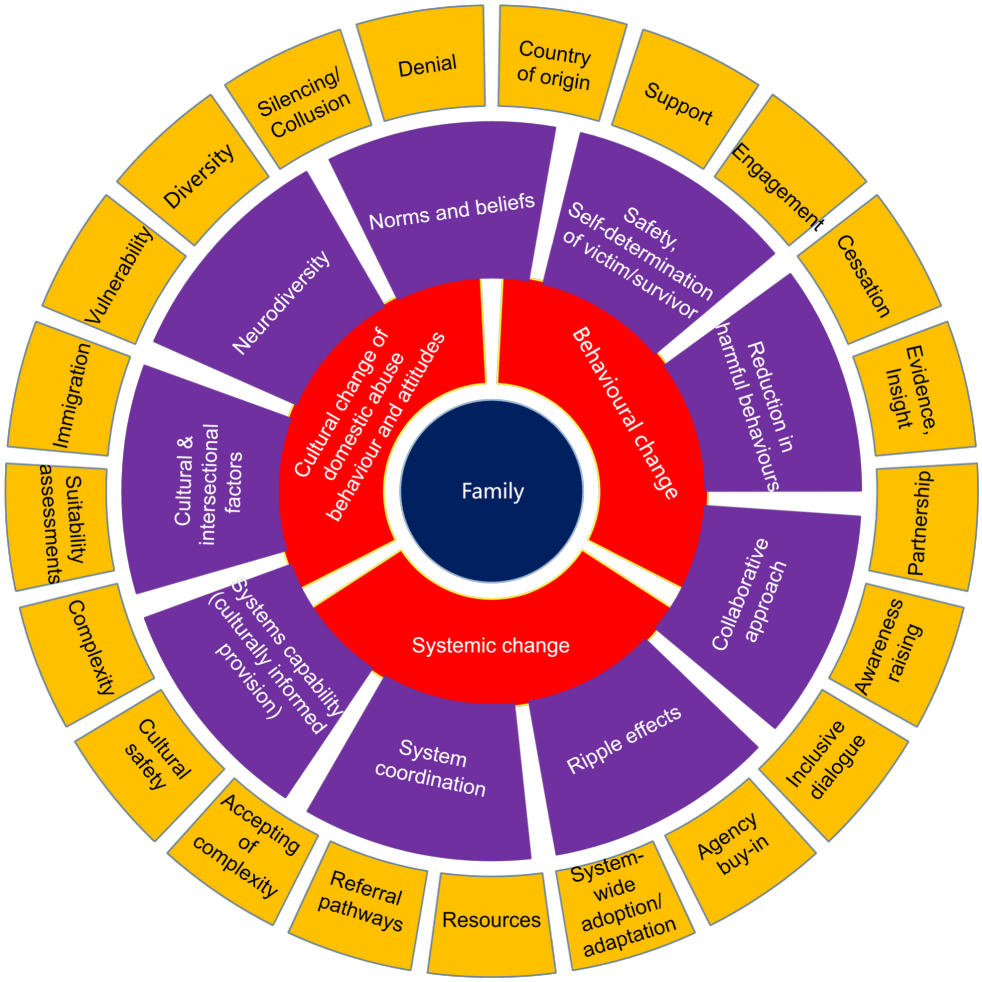
- **Reach** – the number, percentage, risk characteristics and representativeness of people who participate in the intervention.
- **Efficacy** – the impact of the intervention on the participants, including positive/negative outcomes (success rate) affecting quality of life and economic outcomes.
- **Adoption** – the number, proportion and representativeness of the settings (such as work-sites, health departments or communities) that adopt a given policy or programme.
- **Implementation** – The extent to which the programme is delivered as intended (i.e., fidelity). This also includes an appreciation of consistency, timeliness and cost of the intervention.
- **Maintenance** – The extent to which participants demonstrate consistent behavioural change and the programme becomes a relatively stable, institutionalised part of organisational and community practice.

Each dimension can be analysed at an individual and institutional level. RISE Mutual is keen to understand the role of culture thus, we added an extra dimension to the existing RE-AIM (C) framework to capture this important aspect of the CIFA programme within the evaluation.

3.2 An ecological model

Domestic abuse is complex, with multiple, intersecting causes. Heise (1998) sets out an ecological model, situating DA as the result of intersecting individual, relational, situational, structural, and socio-cultural factors. At the individual level, factors such as behavioural and psychological traits, a history of maltreatment, substance or alcohol abuse, and systemic inequality and discrimination are commonly associated with DA. At the relational level, relationship dynamics shaped by coercive control, power imbalances, and harmful behaviours among family members, peers, intimate partners, and the broader community are also significant contributors. Additionally, socio-cultural norms and values play a critical role in shaping public attitudes and tolerance toward DA, which can influence the prevalence and perpetuation of abusive acts (Shorey et al 2023). People who have caused harm are shaped by these factors – recognising this does not equate to excuse or justification, or a failure to call for personal accountability. This evaluation is informed by an ecological model devised by RISE Mutual, London Borough of Barnet and Dr Olumide Adisa (see Figure 2). It is a realist evaluation that incorporates the RE-AIM framework and the ecological model.

Figure 2. The ecological model of CIFA



Note on figure: This is an ecological model of CIFA devised by RISE Mutual, London Borough of Barnet and Dr Olumide Adisa.

3.3 Research Methods

The evaluation utilised a mixed-methods approach to examine engagement with the CIFA programme and its impact on people who have caused harm, VSs, and the wider community. Adopting a multi-method research design as we have done here integrates both quantitative and qualitative methods, allowing for a more comprehensive understanding of the process and impact of the CIFA programme. It also enhances the validity of the data collected by capturing diverse perspectives and insights (Bryman, 2012). The data contained in this evaluative report was generated from fieldwork employing three main strands:

1. Co-production of the evaluation plan with the CIFA team;
2. Qualitative research comprising: a) literature review of academic and policy-related research on DA, b) semi-structured qualitative interviews with CIFA practitioners and other sector stakeholders, with service users (SUs) enrolled in the CIFA programme, with victim-survivors

(VSs) and community stakeholders; analysis of case study material and pre- and post-programme reports; and

3. Quantitative analysis of data held by CIFA and partner agencies (e.g., referrals, engagement, behavioural and attitudinal change, reoffending rates) along with an economic cost-value analysis.

3.3.1 Co-production

In the first stage of the evaluation, we engaged in a process of co-production with CIFA practitioners and stakeholders, including IDVA services and VAWG and DA leads, in order to understand aspirations for the evaluation, to inform the evaluation measures of success, to understand what data would be made available, and to seek support and guidance on engaging interviewees in qualitative research. This process included an initial series of conversations with seventeen people in various roles: RISE staff, IDVAs, VAWG leads and other borough representatives who engage with CIFA. These co-production conversations informed the research design.

At this early stage, we also formed an advisory group made up of SUs and VSs who had been supported through CIFA. This group was recruited to assist with the research design process, specifically the development of the qualitative research tools. Four SUs and three VSs were recruited and engaged one-on-one with members of the evaluation team. Their task was to scrutinise the draft interview schedules and participant information sheet to determine if these research materials were clear and informative and whether any of the questions were unduly triggering. Members of the advisory group were also asked for their thoughts related to SU recruitment, including language and mode of communication, and the offer of specific incentives. The feedback of the advisory group was integrated into the materials and evaluation plan.

The primary objective of this exercise was to ensure that the qualitative research tools utilised in the evaluation were sufficiently robust to capture the attitudes, behaviour, and experiences of participants in the CIFA programme. It aimed to ensure that the research team was working in partnership with others in the production of policy relevant and impactful research that is of benefit to stakeholders.

The research team, specialising in user-focused, co-produced evaluation methods, worked closely with the CIFA team – both council and service provider staff - throughout the evaluation process, discussing feedback and adjustments. Co-production conversations with CIFA staff and London Borough of Barnet continued over the six-month period of the evaluation, where questions were raised, issues were clarified and explored, emerging themes were discussed, and guidance and support were sought on methodological and data collection issues. Most of these meetings were held online but the evaluation team also attended an extended team meeting in March 2025, where we had the opportunity to meet in person and discuss the evaluation progress. While the research process was shaped by conversations, guidance and feedback with stakeholders including RISE, which shaped research priorities and offered essential context, research integrity and independence was maintained throughout the process, including rigorous and objective analysis and interpretation of data.

3.3.2 Qualitative research

The evaluation of several qualitative research tools which are outlined in this section.

a. Literature review

The literature review served as a foundational component of the qualitative design for the evaluation. This piece provides a framework for the findings of the evaluation insofar as it considered the academic and policy-relevant publications relevant to DA. It is important to note that we did not conduct a systematic literature review. Unlike a systematic review, which would require a comprehensive synthesis of all existing research on DA and 'perpetrator' service provision, this review offered a broader overview of the topic. Its purpose was to trace the evolution of thought on DA and the provision of services for people who have caused harm through DA.

Digital resources, including Academic Search Complete, were utilised to identify national and international academic and policy-relevant literature, with a particular focus on material related to the experiences of minoritised communities served by CIFA. This process culminated in a review incorporating 121 published works (see literature review) and informed the theoretical and conceptual foundations of the evaluation.

b. Semi-structured interviews

A purposive and snowball sampling strategy was employed to identify participants for the evaluation. Access to research participants was facilitated by staff at RISE Mutual involved in the delivery of the CIFA programme. Through this approach, the research team conducted 52 semi-structured interviews with CIFA practitioners, IDVAs and DASAs, VAWG and DA leads, SUs (individuals who have caused harm), VSs, representatives from community organisations across the boroughs where CIFA operates, and one interpreter (see **Table 1**). RISE staff were instrumental in securing and facilitating interviews with service users and victim survivors.

The interviews were guided by an interpretivist epistemology, which emphasises understanding respondents' perspectives and how they interpret their experiences and reality. Practitioner interviews explored topics such as their knowledge of the CIFA programme, the referral process, views on its culturally integrated approach to DA, its contribution to and integration within DA service provision, and its impact on SUs and VSs.

These topics were also addressed with SUs and VSs, excluding questions related to service provision. Additionally, they were asked to reflect on their expectations of the CIFA programme compared to their actual experiences, how CIFA supports individuals and families, and to provide recommendations for improving the service to better serve others in the future (see Appendix 3).

Table 1. Interviewees

Role	London Borough	Count
Community organisations	Harrow, Tower Hamlets, Newham	3
IDVA	3 interviewed (+ 3 consulted in co-production)	3
Interpreter	Newham	1
RISE Practitioner	Pan London	9
Service users	Brent, Barnet, Enfield, Hammersmith and Fulham, Haringey, Harrow, Royal Borough of Kensington and Chelsea, Newham	18
Social worker / social work manager	Barnet, Enfield, Hammersmith and Fulham, Newham, Tower Hamlets, Westminster	12
VAWG Lead/DA Commissioner or Strategic Lead	3 interviewed (+ 2 consulted in co-production). Boroughs not mentioned to retain anonymity	3
Victim-survivors	Barnet, Brent, Enfield, Harrow	7
	TOTAL	56

The interviews were primarily conducted online via platforms such as Microsoft Teams or Zoom, lasting between 30 minutes and 1½ hours, although a few were conducted face-to-face at the request of participants. The interviews were recorded, transcribed, and subjected to thematic analysis. Thematic analysis is a structured and transparent method (Bryman, 2012) that involves systematically organizing, sorting, and coding qualitative data to identify key patterns and themes (Ritchie and Lewis, 2003). This approach ensures the consistent application of the analysis, thereby enhancing the validity of the findings.

c. Thematic Analysis of CIFA/FADA Case studies and Participant Reports

Case studies (n = 3) and structured pre/post participant reports (n = 11) were provided by practitioners across the CIFA and FADA delivery strands. These sources were analysed and summarised to provide insight into the lived experience of programme participants, and offered practitioner-informed evidence on programme delivery, outcomes, and contextual factors influencing effectiveness.

Three case studies were provided, aiming to reflect a range of participant experiences, including participants of CIFA (*Mr X*, *Mr I*) and a female participant of the FADA programme (*Ms AE*). These case studies were thematically analysed using the REAIM-C framework, focusing on the domains of Effectiveness, Adoption, Implementation, Maintenance/Sustainability, Cultural Integration/Consideration, and Ripple Effects/Community Impact.

Eleven pre- and post-programme reports were reviewed and thematically coded across the same REAIM-C domains. These reports, written by CIFA practitioners, captured narrative accounts of participants' engagement with the programme, progress towards behavioural change, challenges faced, and shifts in awareness, parenting, communication, and risk. Learnings about what supported or constrained change were drawn out.

d. Observation of Partnership and other meetings

The evaluation team also attended monthly CIFA Partnership VAWG leads and IDVA services meetings over the course of the evaluation, where these stakeholders come together to reflect on key data and insights related to the programme, and any issues arising with delivery or coordination. These spaces of connection and coordination offered essential insight into how the various stakeholders in CIFA work together and how issues are addressed. The evaluation team also attended RISE's 10 year anniversary event, which included presentations, SU testimony, staff feedback on the programme and staff culture and opportunities for informal conversations with stakeholders.

In presenting qualitative data, the following referencing abbreviations have been used. Where the reference is to Mr X or Ms Y, this denotes a case study or a CIFA assessment or report. Interviews are denoted by service user (SU), victim-survivor (VS), CIFA practitioner (CP), referrer (R) and DA lead (DAL), which includes VAWG leads and DA commissioners and coordinators, all with a randomly allocated number, e.g., VS1, SU2, etc. This coding is also used when referencing comments by practitioners in meetings. RISE staff are coded as CIFA practitioners in this context. IDVAs are also coded as CIFA practitioners for the purpose of this report as they deliver CIFA VS support, and to protect anonymity as a small interviewee group. The one interpreter interviewed is coded as I1.

3.3.3 Quantitative Research

a. Quantitative data analysis

The evaluation team was granted access to a wealth of quantitative data generated by RISE Mutual and partner agencies. The quantitative data included in the study comprises data from the 10 boroughs and includes data on SUs and VSs.

The quantitative data analysis is used to answer questions across the REAIM-C framework, with a particular focus on answering questions in Reach, Effectiveness and Adoption as quantitative data is well suited to assess questions such as: whether the programme reaches its target audience (Reach), how effective it is in meeting its goals (Effectiveness) and who is referred and who completes the programme (Adoption).

The data used for the quantitative analysis includes data from five different sources. Firstly, we used data from tracking reports and narrative reports provided to MOPAC for the full period of the evaluation, 1st April 2023 to 31st March 2025. This data was used to assess Reach and Adoption in the REAIM-C framework and includes data on SUs and VSs from the 10 boroughs. Second, we analysed data on VSs and their journeys through CIFA using data from RISE that included 217 VSs from 7 boroughs, representative of the VSs in these boroughs. The data provided by RISE covered the time period of 1st of April 2023 to 13th of February 2025. This data did not include data on the tri-borough -

Kensington & Chelsea, Hammersmith & Fulham and Westminster. This data was provided separately by Advance and included 30 VSs covering the full period of the evaluation. By analysing both data sets, we were able to analyse data on VSs from the full 10 boroughs covered by CIFA. Though the RISE data analysed does not cover the full period evaluated, we see the data that has been analysed as representative of the populations and journeys of VSs through CIFA programmes.

It is important to note that gathering data on VSs was challenging at several levels, often related to safeguarding and adhering to good practice with consent-based contact. Importantly, there are many different stakeholders holding data on VSs, and data sharing is often difficult due to ethical and other concerns. We therefore treat the data as representative where there are high numbers of responses, but cannot generalise with the same strength as we can for the SU data. We also analysed data on VSs from Barnet family support domestic abuse service, Barnet family support safer relationship programme and Brent family support domestic abuse service, 189 in total, to compare their journeys and characteristics with those on CIFA.

Third, we used data about SUs provided by RISE for the period of 1st of April 2023 to 13th of February 2025. This data included 555 SUs. This data does not include data from the last month, March 2025, covered by the evaluation. However, the population for that month was similar to those represented by the 555, and the numbers found in the analysis would not change statistically if they were included. The choice was therefore made to go ahead with analysis, after ensuring that the SU analysis would be robust and representative. The data also included a sample of 230 SUs from Brent and Barnet family support domestic abuse services to allow for a comparison with service users on other programmes. This was seen as particularly important to assess Reach and Effectiveness.

Fourth, we analysed outcome star assessments carried out for the full period of the evaluation to assess effectiveness of the programme. This included data on assessments from assessment 1, 2 and 3. The number of assessments varied greatly, with 118 assessments carried out for assessment 1, 53 for assessment 2 and 13 for assessment 3. Due to the low number of assessments on assessment 3, we have focused the analysis on the two first assessments to create as robust analysis as possible. However, due to the low numbers, analysis tended to be non-significant when including assessment 2. When analysing this data, we merged the outcome star dataset with datasets on people who cause harm who have participated in CIFA so that we can assess whether there are variations in behavioural change by background characteristics.

Fifth, the data used in the quantitative analysis also includes data used to carry out value for money analysis. This data included re-referral data from Westminster, Kensington and Chelsea, and Hammersmith and Fulham to determine effectiveness, and spending data from reports to MOPAC to estimate costs.

When analysing the data, we used a set of quantitative data analysis software packages including R, JASP and SPSS - depending on the data analysis required. These are all state-of-the-art software packages, producing high quality outputs. The quantitative data analysis made use of a range of methods ranging from descriptive data analysis and bivariate analysis to using a Markov model. The latter was used to calculate the value for money and will be described in detail in section 6. The aim of the quantitative analysis was to ensure robust findings, and we will comment on findings' statistical significance throughout. For some of the analysis, there were small samples - for example, the data

on the three boroughs with a total sample of 30 - which means statistical significance is very difficult to establish.

The analysis was adapted to the type of data we were provided with, and chosen to achieve the strongest and most robust findings possible. A crucial part of the quantitative analysis was to analyse CIFA through our REAIM- C model. This means that we analysed each of the categories and their relations to background characteristics that were measured in the datasets., These included: ethnic minority, religion, whether an interpreter was needed, sexual orientation and other characteristics. It is important to note that there was some variation as to whether these characteristics were recorded across boroughs, in particular for VSs. Applying a holistic, cultural lens allowed us to understand the impact, effect and support provided by CIFA across minoritised groups. In the report, we discuss findings by these characteristics when they are included in the dataset, and when they are statistically significant. Overall, the aim of the quantitative data analysis is to provide an overview of trends and patterns, a strength of this method. However, we recognise that there are some challenges with the data on VSs in particular as noted above.

b. Economic Cost Analysis

Economic analysis - or 'value for money' analysis - was conducted to estimate the cost-effectiveness of CIFA compared with no formal intervention. MARAC and DRIVE were also included in the analysis to provide contextual information on costs and outcomes, recognising that these interventions target different populations and risk profiles and are not directly comparable to CIFA. The purpose of the analysis was to assess whether CIFA represents good value for money in supporting individuals affected by domestic abuse.

A state transition Markov model was developed to estimate the costs and health outcomes over an individual's lifetime. In this model, individuals could occupy one of two health states:

- Domestic abuse (DA) - the individual is experiencing abuse
- No DA - the individual is no longer experiencing abuse

The model adopted a societal perspective, recognising that DA has far-reaching consequences not only for the health system but also for the criminal justice system, lost productivity, and wider society.

All costs are reported in 2024 prices, and costs and health benefits are discounted at 3.5% per year, in line with UK economic evaluation guidelines (NICE, 2025). The economic analysis was carried out in the analysis software R.

Inputs

Transition probabilities were applied to estimate the probability of an individual transitioning from the DA to the No DA state, based on re-referral rates for CIFA, MARAC, and Drive, respectively (Safe Lives, 2025; Hester et al., 2025).

The cost of a single DA incident was taken from national estimates, which account for healthcare, criminal justice, lost income, and other societal costs (Oliver et al., 2019).

The cost of CIFA was taken from internal budgetary reports, while the cost of MARAC and Drive were estimated from published literature (Home Office, 2011; DA Bill Committee, 2020).

To reflect the impact of DA on individual's wellbeing, utility values were used. These range from 0 (equivalent to death) to 1 (perfect health). Utility values were sourced from national estimates of the impact of DA on wellbeing (Oliver et al., 2019).

Assumptions

Modelling assumptions were required to reflect the natural history of DA and the characteristics of the interventions being evaluated. The following assumptions were applied to the model:

- Individuals can transition from the DA state to the No DA state only. Transitions were not possible from the No DA to the DA state.
- Individuals can remain in the DA state for a maximum of six years.
- No costs were assigned to individuals in the No DA state.
- As MARAC and Drive are targeted at high-risk individuals, the model assumed 1 DA incident per year in the DA state, while 0.5 DA incidents were assumed for individuals in the CIFA group, as CIFA targets a lower risk group of individuals. This assumption was based on a lack of published literature regarding the incidence of DA incidents per year for varying risk categories of 'perpetrator', thus this conservative assumption may minimise the impact of DA on VSs.

Uncertainty

In order to account for uncertainty in model inputs, driven by a scarcity of available data, a probabilistic approach was employed. Instead of assuming a single fixed value for each model parameter, this involves drawing samples from parametric distributions representing the potential variability of these parameters. A 20% variation was assumed for all parameters in the model, with 1,000 model simulations. This approach allows for the exploration of a range of possible outcomes, incorporating the inherent uncertainty into the model's predictions.

Outcomes

Using a probabilistic approach results in a probability of cost-effectiveness of CIFA compared to No Intervention at varying willingness to pay thresholds, as well as the cost-effectiveness of each of the 1,000 model simulations to determine the impact of uncertainty on the probability of cost-effectiveness.

Cost-effectiveness was estimated using the incremental cost-effectiveness ratio (ICER), calculated as the difference in costs divided by the difference in effectiveness between interventions. Effectiveness is estimated using quality-adjusted life years (QALYs), where 1 QALY represents 1 year in full health.

The economic analysis also resulted in Return on Investment (ROI) values for each of the interventions, indicating the relative cost savings achieved per pound spent compared to no intervention. A positive ROI suggests that the intervention not only improves outcomes but also reduces overall costs, making

it a financially advantageous option. Among the interventions, those with higher ROIs offer better value for money by delivering greater savings relative to their implementation cost.

3.4 Limitations and considerations impacting the evaluation

Several factors should be considered when interpreting the findings of this evaluation.

First, there were challenges in accessing complete and consistent data across boroughs and programme strands. In some cases, the information available was not sufficient to allow robust comparison of referral, uptake, and completion rates by borough or demographic group. Variations in how data was recorded across delivery partners, as well as differences in the availability of demographic information, limited the ability to fully disaggregate findings. This can be attributed in many cases to a reluctance among SUs and VSs in particular to provide data. This is further complicated by the high number of stakeholders involved on the VS side, resulting in higher numbers of missing values for VS. However, this is an area for improvement for RISE and the stakeholders they work with.

Second, the short timeframe for conducting the research and analysis (six months overall) placed constraints on the depth of exploration possible. While the evaluation sought to capture both quantitative and qualitative evidence, time limitations restricted opportunities for extended follow-up, longitudinal tracking, and deeper cross-strand comparisons.

Third, engaging with a diverse group of practitioners managing competing priorities and heavy caseloads proved challenging. While the evaluation benefited greatly from their input, the need to balance service delivery demands meant that we were unable to speak to several practitioners, whilst others were necessarily brief, potentially limiting the breadth of perspectives captured. Insights captured in co-production conversations have been included in the report, especially where follow-up interviews were not possible.

Fourth, the evaluation required navigating the expectations and existing systems of a large number of stakeholders, including multiple boroughs, delivery partners, and statutory and voluntary sector agencies, and funders. This complexity sometimes created delays in accessing information and required careful negotiation to align on evaluation priorities, processes, and timelines.

Fifth, despite the importance that the CIFA programme places on children's safety and wellbeing, children's voices in this evaluation are indirect. However, multiple data sources including VS accounts, various practitioner observations, and outcome star changes were collected and analysed, and they converge on a picture of positive shifts for children's wellbeing.

Sixth, the qualitative research captured the perspectives of SUs and VSs who have engaged with CIFA. The voices of those who have not engaged could not be heard through this research project.

Finally, while every effort was made to gather VS and SU perspectives, these voices may not be fully representative of all participants in the programme, particularly in strands where recruitment for interviews was more challenging, and where data access was limited. Essentially, the excellent safeguarding practice followed by RISE impacted on our ability to reach VS who were no longer being supported through CIFA. Being in contact with VS without current understanding of their context could

cause or elevate risk to that person. Combined with quite low numbers currently being supported through CIFA and persistent patterns of low VS engagement across such research, our qualitative sample of VSs is quite low. Yet, it captures important insights from a range of experiences and cultures across four boroughs.

These considerations underline the importance of early agreement on evaluation design, clear data-sharing arrangements, consistent data recording across partner organisations, and sufficient research time to support more comprehensive and comparable analysis in future evaluations.

3.5 Ethical considerations

The sensitive nature of this project highlighted the need for an ethically robust piece of research. To this end, care was taken to ensure that all respondents were fully briefed about the project before participation. Respondents were asked to read and sign a consent form. It was also made clear to participants that they were under no obligation to take part in the research and if, having decided at a later stage in the research process, they wanted to withdraw, they could do so without repercussions.

It was agreed that each respondent would receive a gift, in the form of a £25 voucher, in recognition of their participation. There are valid arguments for and against the use of incentives in research with vulnerable groups. Mostly, these cohere around the fear that the offer of incentives contaminates the data by introducing some form of bias (see Bloor et al, 2001). This evaluation did make use of incentives, gauging that the offer of vouchers would help to overcome issues with recruitment and not overly influence or coerce participants. We were led by RISE and our SU and VS advisory board in making this decision.

Ethical approval for the evaluation was obtained through the University of Kent, and a data sharing agreement was created between the University of Kent, RISE and the 10 boroughs.

4. Findings

4.1 Reach

Ecological model: Systemic change

System coordination; Collaborative approach; Systems capability (culturally informed provision); Complexity; Cultural safety; Accepting of complexity; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; partnership

Key findings

- The evaluation shows that CIFA reaches its target audiences when it comes to racialised communities. However, this varies by borough and there are ethnic and religious groups that could be better represented overall, and within particular boroughs.
- Newham and Enfield are top referring boroughs, whilst Tower Hamlets, Kensington & Chelsea, Hammersmith & Fulham and Westminster have the lowest numbers of referrals.
- When doing a spotlight on Brent and Barnet domestic abuse interventions compared to CIFA, we see that all interventions in these two boroughs engage good levels of ethnic minorities. However, we also identify specific groups among which CIFA does better than other interventions. This is likely a testimony to their outreach work.
- Referrals are strong overall, with victim-survivor numbers increasing over the last year compared to previous years. However, these increases are not equally distributed across the boroughs and there are areas for improvement when it comes to increasing the number of referrals.
- Most referrals are for the main programme of CIFA, with CIFA neurodivergent, FADA and APFA referrals increasing over the years. However, they remain much lower than the other programmes, which reflects patterns in domestic abuse and the need for a socio-cultural shift in reporting and acknowledging wider familial harms.
- The extent to which CIFA is widely recognised as an available service for the LGBTQ+ community is uncertain. RISE has carried out significant research and partnership work and investment in this area, which – with further attention to messaging – promises impact.
- CIFA practitioners have made significant efforts in outreach and awareness-raising of the programme in the boroughs - building relationships, offering information and training, and working in a collaborative, coordinated way. However, referrers still have an uneven and often incorrect understanding of referral criteria and pathways.
- Referral pathways, therefore, are established but need further embedding. Outreach and information-sharing must be repeated, consistent and direct to potential referrers.
- The use of the language of 'perpetrator' can be an impediment/obstacle to reaching potential service users and securing referrals. While CIFA practitioners – and RISE as an organisation - seek to avoid this language, the manuals, website and wider sector frameworks currently further embed it.

- CIFA is leading a cultural shift in the system towards meaningfully addressing domestic abuse by pursuing behaviour change work with people who have caused harm. This requires resources and system buy-in, including the upskilling of referrers and other stakeholders.
- Many victim-survivors discovered the programme via trusted professionals (e.g., social workers, GPs) and some expressed concern that others in similar situations may be unaware of the programme, highlighting the need for wider visibility and promotion.
- Some victim-survivors independently researched CIFA and advocated for referral, showing initiative and unmet need for accessible, culturally resonant services.

4.1.1 Overall participation in CIFA

This section explores the overall number of SUs and VSs served by CIFA in the last two years. By looking at CIFA's general referral patterns, as reported in their quarterly reports to MOPAC, we can see that the referrals are healthy compared to the forecasted numbers across the quarters, with some seasonal variations that are to be expected.

For VSs, the forecasted number supported is 50 per quarter, however, the total numbers fell short of this in 2023-24 (see **Table 2**2). However there has been an increase in VSs supported in the last year, much thanks to the work of staff at RISE and collaboration with IDVAs and VAWG leads addressing issues regarding referral pathways, as we will discuss further in the effectiveness (4.2), adoption (4.3) and implementation (4.4) sections of this report. Also attributable to the work of these organisations is the improvement in waiting time and length of waiting lists for VSs, which is hugely important to achieve the goals of the programme.

Table 2. VS CIFA pathways

Delivery component	*Actual number of victims supported and actively in receipt of a service during quarter	Number of new victims engaging with (in contact with) the service during the quarter	Average length of support for victims (days)	Number of victims on the waiting list for support	What is the average waiting period (days)?	Number of referrals declined	Number of victims onwardly referred to other VAWG related services	Number of victims engaged in support who reported to police during or after the support/intervention.
23-24	231	109	37.25	34	11	73	31	4
24-25	311	165	23.975	5	1.85	64	28	6
Total	542	274	30.7375	39	23.025	137	59	10

Note: *The number of victims supported during the quarter in the table above may include individuals who were also receiving services in the previous quarter.

For SUs, forecasted numbers by quarter are: referral - 75, assessed - 60, starting – 44, and completions - 30. The variations seem to be similar across the two years assessed. However, the number of assessments, starters and completions are under the forecasted number every quarter. The numbers of people deemed 'not suitable' are also quite high. An in-depth analysis of completions and suitability by demographic backgrounds, including ethnic background, can be found in section 4.2.1, analysing patterns that need to be considered to improve CIFA's reach to relevant populations. Analysis of the referral pathways by borough can be found section 4.2 on effectiveness.

Table 3. SUs CIFA pathways

		Referrals received	**Assessments**	**Suitable**	**SU starts**	**Session attendance**	**Completion**
23-24	Q1	34	8	2	5	6	0
	Q2	80	55	46	31	99	0
	Q3	94	51	41	49	346	6
	Q4	79	54	44	39	434	25
24-25	Q1	81	36	29	26	384	22
	Q2	64	35	25	23	322	24
	Q3	94	26	15	24	247	17
	Q4	83	50	31	26	196	8
Total		609	315	231	220	2033	102

Below, we see that there are variations in referrals across the boroughs, with Newham and Enfield having the highest referral numbers, whilst Tower Hamlets, Hammersmith & Fulham, Kensington & Chelsea and Westminster have lower numbers. For the APFA and FADA programmes, there are lower numbers both for VSs and SUs, representing areas for CIFA to improve (see Table 4). This work is already happening, and we are seeing increases in numbers. The fact that numbers vary by borough underlines the need for further work to enhance adoption of the CIFA programme in lower referring boroughs. There is also lower uptake of VSs (see Table 5), with similar patterns of higher referring boroughs. This is discussed further in the effectiveness section. The VS data measures new engagers rather than referrals and gives us a good indication of levels of VSs supported by boroughs and programme.

Table 4. SUs referrals by programme & borough

Borough	CIFA main programme	CIFA APFA	FADA
Barnet	62	2	10
Brent	64	2	3
Enfield	89	1	8
Harrow	69	0	3
Haringey	67	2	5
Newham	99	2	7
Tower Hamlets	27	1	2
Hammersmith & Fulham	32	1	1
RBKC	18	0	2
City of Westminster	24	1	5

Data from tracking reports sent to MOPAC.

Table 5. VS new engagement by borough and programme

Borough - VS	VS main programme	APFA VS	FADA VS
Barnet	22	1	0
Brent	35	1	0
Enfield	38	1	0
Harrow	42	0	0
Haringey	48	3	3
Newham	75	0	2
Tower Hamlets	5	0	0
Hammersmith & Fulham	8	1	0
RBKC	8	1	0
City of Westminster	7	0	1

Note: This is based on data form the tracking reports sent go MOPAC. The Q1 Y1 victim data from the MOPAC Annex 1. narrative report is absent from Table 5 due to changes in reporting forms over the

years included in this evaluation and this information was not included in the original report. Over time, the MOPAC Annex 1 Narrative Progress Report has been refined to more effectively present key findings.

4.1.2 Who is the intended audience?

The main audience for the programme, as outlined in the RISE Mutual CIFA Delivery Manual (version 5.0), is heterosexual male 'perpetrators' of DA from racialised and marginalised communities who present a medium to high risk to their partners or ex-partners (RISE Mutual 2025:18) or other family members. Notably, CIFA represents a consolidation of four distinct initiatives, including CIFA itself, FADA, APFA, and Respectful Partnerships. Among these, one initiative provides services specifically to females who have caused harm, while another caters to those in the LGBTQ+ community.

When asked to describe who CIFA is designed to serve, referrers said minority communities, those from ethnic backgrounds (R12) and *"marginalised men who were not being accommodated before"* (R8) in terms of culture and language, and *"communities not served by current provision"* (DAL3). Referrers were aware that it is a programme for *"perpetrators who want to change"* and who are willing to commit to the programme (R3, R7).

CIFA is seen by referrers in Children's Services as a unique way of engaging fathers and men, where the onus in this system is often placed primarily on mothers, and fathers often won't engage (CP10, R1). CIFA is perceived as a useful programme for couples who want to stay together and for those with children who are *"determined to keep their families"* (CP5, R2). One social worker noted that DA is at play in most families who become known to Children's Services (R7). As discussed in section 4.3.1 and 4.3.3, social workers in Children's Services are glad to have a DA programme to refer to. The question, for social worker R2, is: *"who is in the home and who is not?"* A referral to CIFA is considered appropriate and likely if the person who has caused harm is still in the home and keen to keep their family together. There can be cultural dimensions to this desire not to separate (CP5). One referrer said that he will refer to CIFA when a *"less generic, more culturally attuned programme"* is required (R1). This speaks to a recognition amongst referrers of CIFA's importance as a programme that benefits the whole family, including children.

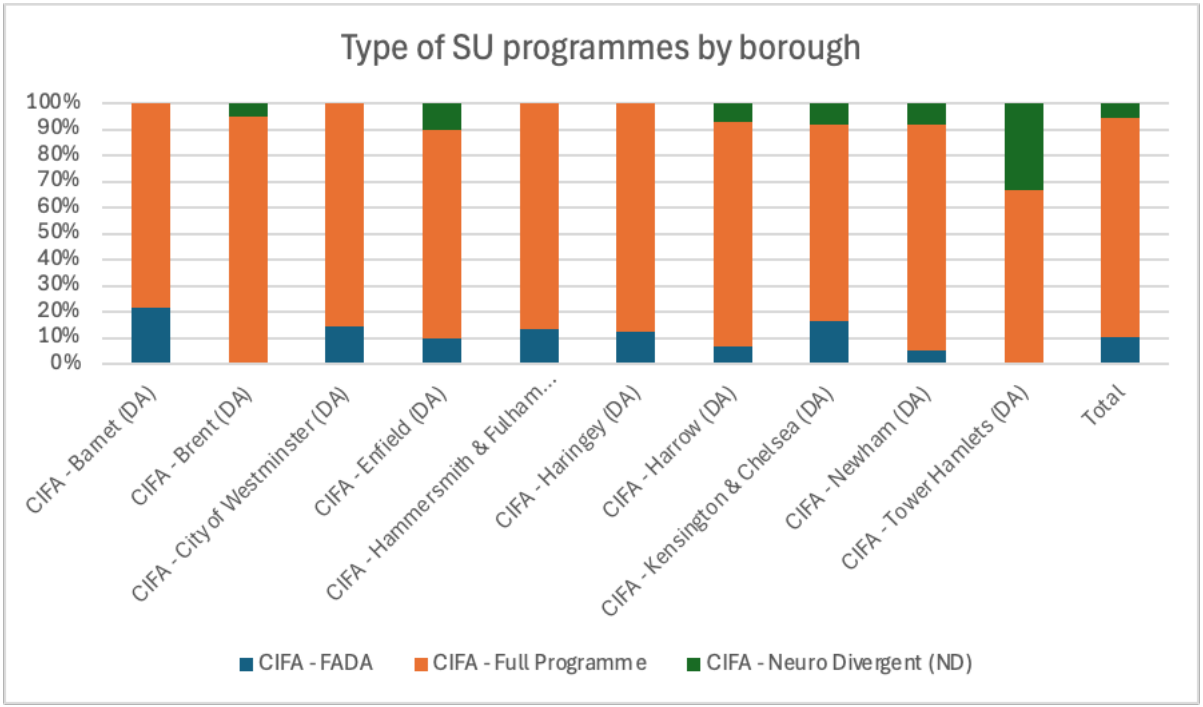
Several referrers mentioned APFA and FADA. APFA is a programme focused on familial abuse: parents who are being abused - financial, physical, verbal and emotional abuse - by an adult child or other relative (CP12, CP13, CP3). Social workers were aware of FADA's approach, which recognises that women on this programme may also have been VSs (R9). As described below, referral to FADA is assessed through a trauma-informed lens and the woman is supported in a fluid and holistic way. She may be referred to a victim's service in addition to engaging with the programme or at completion, after exploring the circumstances more deeply on the programme (CP13). Some referrers also mentioned a mental health pathway, where GPs and therapists might refer a client to CIFA (R2, R12, CP11) and nascent partnerships with forensic mental health units (CP3, CP13).

4.1.3 Is CIFA reaching the intended audience in practice?

CIFA's intervention addresses key needs in minoritised communities, however, as one practitioner stated, CIFA *"barely scratches the surface"* in terms of addressing those needs (CP4). RISE needs more resources in order to generate higher referrals and work with more SUs and VSs. While CIFA has increased numbers of VSs substantially, there is still room for improvement, and the same is true for APFA and FADA referral numbers. As set out in the literature review, DA is disproportionately carried out by men. There is no expectation of comparable or equal numbers of referrals for women. RISE reject a significant number of referrals for FADA on the basis that the woman has acted in self-defence or has used violent resistance as a reaction to abuse she has experienced. According to internal RISE research - data analysis of 67 cases of women assessed as suitable for FADA between April 2020 and Jan 2025 - 42 out of those 67 cases (62.6%) disclosed having experienced some form of trauma. In these cases, recommendations are offered to referrers for alternative support. When it comes to referrals through Respectful Partnerships, these are non-existent, highlighting a crucial area for enhanced and targeted work, which is being invested in by RISE, as described in section 4.1.5.

Most SUs are on what is categorised as the main CIFA programme in the RISE data, but there have been growing numbers on the FADA and CIFA Neurodivergent programmes. Overall, there have been 12 SUs on APFA across boroughs. Numbers on each of the SU programmes vary by borough (see Figure **Figure 3**. Of those on the full programme, Barnet and Kensington & Chelsea have proportionally more of their overall SUs on FADA than other boroughs than other programmes. Using RISE's data on SUs, we observe lower numbers on FADA compared to the main SU intervention – which reflects statistics in terms of who carries out DA but can be enhanced to reach women who do commit DA. We see that there is a good uptake of the CIFA neurodivergent programme, with a higher proportion of those on this programme compared to the main programme and FADA in Tower Hamlets and Enfield than other boroughs. For Tower Hamlets this might be explained by the fact that they have lower numbers of SUs in general, thus having just a couple of SUs on this programme would change the proportion significantly.

Figure 3. Referral type by borough



As seen in the engagement numbers for VSs, there has been a strong effort to improve referral numbers across boroughs but there still is some way to go in increasing numbers, in particular in boroughs in west London. This will be discussed further in the section on effectiveness (4.2), where we analyse referral pathways. When looking at the boroughs, it is clear that Haringey and Newham have more male VSs. However, these are still low numbers compared to women who are the dominant population among VSs. Of those declining support, 95% were women and 5% men. Similar numbers complete the programme, which is reflective of their proportion (96% vs 4%). Numbers for Hammersmith & Fulham, Kensington & Chelsea and Westminster (provided by Advance) show similar distributions as the RISE dataset. Religion is included in the dataset provided for Westminster, Hammersmith & Fulham and Kensington & Chelsea. However, there are high levels of missing values here. An in-depth analysis of the impact of religion on completion, engagement and suitability will follow in section 4.2.1, to indicate and analyse another dimension of culture that might influence the effectiveness and adoption of CIFA. When investigating the reach to racialised groups in the RISE VS data, Other Asian is the biggest group (18%), followed by Other European (17%) and Bangladeshi (11.1%). The same group is the largest group in Westminster, Hammersmith & Fulham and Kensington & Chelsea. The data shows that whilst CIFA does reach racialised communities, there are communities whose proportion is quite small such as Other Black (2.8%) and South American (2.8%). In the dataset for the tri-borough, we also see good reach and inclusion of target audiences. When we look at sex, 96% of VS are female, and in the data on Hammersmith & Fulham, Kensington & Chelsea and Westminster on VSs, all VSs are female. Religious affiliation is another measure of reach, and Muslims are the largest group - 25% among the VS in the RISE data. In the Hammersmith & Fulham, Kensington & Chelsea and Westminster, Muslims are also the largest group at 33.3%, followed by Christians at 30%. These numbers are presented with a caveat as the VS data has high levels of unknown on this dimension. This is particularly true in the data on VSs relating to other individual characteristics such

as mental and physical health, learning needs etc. While we recognise the challenges, the data on VS must be more carefully and rigorously collected to comment confidently on variations, reach and effectiveness among people with these different characteristics. We are therefore not able to comment on the prevalence of physical health issues among VSs, and overall, we need better and more reliable data recording. Marital status is another area that would be important to analyse. However, 53.2% is 'unknown' for VSs in the RISE data.

Table 6. SUs by programme and ethnicity

	CIFA - FADA	CIFA - Full Programme	CIFA – Neuro Divergent	Total
Asian/Asian British: Bangladeshi	0.0 %	9.5 %	15.4 %	8.8 %
Asian/Asian British: Chinese	4.2 %	1.1 %	7.7 %	1.8 %
Asian/Asian British: Indian	0.0 %	4.7 %	7.7 %	4.4 %
Asian/Asian British: Other Asian	16.7 %	15.3 %	23.1 %	15.9 %
Asian/Asian British: Pakistani	0.0 %	5.8 %	0.0 %	4.9 %
Black British: Other Black	0.0 %	5.8 %	7.7 %	5.3 %
Black/Black British: African	0.0 %	10 %	0.0 %	8.4 %
Black/Black British: Caribbean	12.5 %	7.9 %	0.0 %	7.9 %
Mixed/multiple ethnic group: Other Mixed	0.0 %	1.1 %	7.7%	1.3 %
Mixed/multiple ethnic group: White and Asian	0.0 %	0.0 %	0.0 %	0.0 %
Mixed/multiple ethnic group: White and Black African	0.0 %	0.5 %	0.0%	0.4 %
Mixed/multiple ethnic group: White and Black Caribbean	4.2 %	0.5%	0.0 %	0.9 %
Other ethnic group: Any other ethnic group	0.0 %	1.6 %	7.7 %	1.8 %
Other ethnic group: Arab	4.2 %	10 %	7.7 %	9.3 %
Other: European	33.3 %	19.5 %	0.0 %	19.8 %
Other: South American	8.3 %	3.2 %	0.0 %	3.5 %
White: English/Welsh/Scottish/Northern Irish/British	12.5 %	2.6 %	15.4 %	4.4 %
White: Irish	0.0 %	0.0 %	0.0 %	0.0 %
White: Other White	4.2 %	1.1 %	0.0 %	1.3 %
% within column	100.0 %	100.0 %	100.0 %	100.0 %

The main racialised minority groups represented among the SUs in CIFA are: Other Asian/Asian British: Other Asian (15.9%), Other: European (19.8%), Other ethnic group: Arab (9.3%) and Asian/Asian British: Bangladeshi (8.8%). This shows that CIFA is having success reaching their target audiences, however, there are racialised communities that are not as well represented which is an area for improvement. In the above table, we also see that these groups are also the groups with higher participation on FADA and CIFA neurodivergent programme. The numbers on the APFA programme are low, 12 in total, and these are spread across the same racialised communities as the other CIFA programmes.

To understand whether CIFA is reaching its target audiences, we did a comparison of SUs on RISE programmes in Brent and Barnet comparing CIFA to RISE's other programmes. This analysis showed that it is not clear that there are more racialised SUs on CIFA programmes than Brent and Barnet's other RISE programmes. This might be due to the demographic composition of the communities in Brent and Barnet. However, Other Asian, European, Bangladeshi and Arab are particularly well represented on CIFA, whilst other groups are larger on other programmes, thus the programmes seem to be serving different communities. This highlights a need to improve outreach, as it seems to be more effective among some groups than others. Looking at the distribution of sex assigned at birth, most SUs are male (92%) on the main programme. On APFA, 3 of those referred were female and 9 male, whilst all of those on the CIFA neurodivergent programme for SUs were male.

We see religion as another measurement for whether CIFA is reaching culturally minoritised groups. Looking at the distribution of religious affiliation, we see that Muslims represent 40.4% of SUs. Christians are the second largest group, representing 15% of SUs. This group is followed by Hindus, at 6.3% of SUs. This shows that CIFA is successful in reaching a range of religious groups, however, there is potential to achieve higher referrals from other groups. Which religious groups are represented also varies by borough, showing a variation in who CIFA reaches, which we will discuss further in section 4.3 on adoption.

When looking at reach, we take a wide approach to minoritised communities and the following will look at other important, intersecting characteristics to consider when it comes to DA interventions. Looking at the prevalence of people with learning disabilities as SUs, we see that 61.8% have no learning disabilities. However, there are a lot of missing values and disabilities recorded as historical cases (24%) in the dataset. This percentage is high and does not give us the needed information about the current population. When it comes to mental health issues, 55% of SUs have no mental health issues, and 24% are recorded as historical cases, again making it hard to ascertain lived experiences of mental health among SUs. There are small numbers of depression and anxiety reported, both below 5%. We also need better data on physical health issues as 60% are reported as none and 25.6% as historic cases, making it hard to draw conclusions. 36.2% of SUs are married/civil partnered. CIFA has over the years aimed to reach LGBTQ+ communities, however, the numbers of referrals from these communities remain low, and the numbers include very high numbers of missing values. There is a need to not only improve the referrals from these communities, but also the recording of data. This is a challenging structural issue, with a range of reasons for poor data availability, as set out in the literature review.

To expand its reach among its intended audience, there is more systemic change for CIFA to pursue. In a system dominated by a focus on reacting to harm by safeguarding the VS, social workers' priority tends to be the VS and it may not occur to them to consider a programme for the person who has caused harm (DAL1). CIFA is unique in its approach to DA, aiming to achieve systemic change through a holistic community lens. CIFA sees the need for change not only in those who have caused harm and support for VSs but also in their communities. This is evidenced in the way they work with their clients, as well as their wide set of referral pathways and outreach networks and strategy. Especially unique are the APFA and Respectful Partnership programmes, which are both groundbreaking and in their infancy as interventions and areas of concern within wider systems. Recorded statistics on both types of abuse are low because of data collection issues and social norms such as silencing and shame. Both will take time to embed, and for RISE and others to *"break down barriers"* in social norms and systems

that are obstacles to help-seeking (CP13). The 'ripple effects' of CIFA's work are crucial and potentially extraordinary, given proper resources and space to develop.

4.1.4 How do people hear about CIFA?

CIFA practitioners have been proactive with relationship-building, networking and training in the boroughs, ensuring that they are present in the boroughs, actively encouraging referrals and working closely with referrers, partners and other stakeholders. CIFA practitioners have attended social work team meetings to explain the CIFA programme, criteria and referral process. This effort was noted and appreciated by stakeholders (DAL2, CP3, R8, CP7, DAL3). One CIFA practitioner tends to be allocated cases from a particular borough, meaning that they are present in the borough for meetings, though this is not a rigid or fixed arrangement (CP7, R8).

The CIFA programme is also promoted in the borough's social work teams through manager emails and information sent around among colleagues. Boroughs tend to circulate information about available DA programmes to social workers in different ways, for example by sending out regular emails with reminders of programmes or developing quick reference sheets or internal libraries for social workers to refer to (DAL2, DAL3). Flyers are produced by RISE for distribution to referrers, and these flyers are translated into various languages to maximise reach to different communities. RISE DASA materials have also been translated into multiple languages and distributed by staff to enhance engagement levels, explaining what DASAs do and the potential benefits of engagement.

RISE has delivered multi-agency training events to reach a range of professionals across a range of support areas such as drug and alcohol services, adult safeguarding teams and housing. RISE has also delivered training events for NHS services including 'lunch and learn' sessions for GPs. However, RISE is aware that more outreach and communication work needs to be done to promote CIFA and to ensure that referrers are aware of the programme, referral criteria and process. The new RISE strategy is discussed in section 4.1.5. According to a RISE outreach monitoring document covering 2024 - 2025, outreach activities have taken place in informal spaces such as restaurants and barber shops, and issue-specific fora such as stalls at VAWG events. RISE has delivered workshops and presentations at conferences and training with social work teams, and had a range of conversations with LGBTQ+ groups, faith groups and women's groups. Through this outreach, RISE is keen to shift the culture in social services, to ensure that work with the person who has caused harm is considered as an option in every case (CP4).

Referrers and CIFA practitioners alike would like CIFA practitioners to be more present in the boroughs, to provide more (responsive, borough-specific) training and to remind social workers about the programmes more regularly (R4, CP4, R5, R3). This, of course, requires significant resources and RISE appears to be investing meaningfully in this work within financial restraints. CIFA are responsive to requests for support from the boroughs, and proactive with outreach. In one Partnership meeting we attended (12 March), a borough VAWG lead requested a refresher on the CIFA programme to support referrals, which was immediately offered with a reminder that RISE are available to support the promotion of CIFA. One CIFA practitioner noted that the team is becoming more experienced and, with responsive training and direct, in-person conversations, could help resolve issues and problems that exist (CP6).

One simple planned intervention is to circulate a brief cover sheet directly to social workers, with clear bullet points of the CIFA offer (CP3, CP13). CIFA has also developed an outreach strategy and is investing in this work by hiring people in specific engagement roles, including one focused on Respectful Partnerships (CP6, CP15, CP13, CP3). RISE is expanding, hiring more staff and working across more boroughs: RISE will provide CIFA in three new boroughs from this year. The organisation is attentive to the need to reach new communities and to build relationships with community organisations, especially in the newer boroughs, where there has been less time to establish relationships and referral pathways (CP11, CP15, CP6). Recognising the importance of this engagement work, and how time-consuming it is, specific, specialised roles are being created.

Outreach related to the Respectful Partnerships programme is also being prioritised. Despite bespoke training delivered across boroughs on the programme, which raised awareness of the LGBTQ+-centred programme and equipped potential referrers with valuable knowledge and language, RISE did not see an uptake in referrals (CP3, CP10). In 2023, RISE commissioned a scoping exercise by Sustainable Communities CIC and worked with the organisation to reach LGBTQ+ groups and deliver training. Since April 2025, Rainbow Communities CIO have been commissioned to continue outreach activities. As referrals do not seem to be coming through social services, CIFA are planning to hire an outreach person to work specifically on the Respectful Partnerships programme, engaging with community groups and attentive to the specific issues and needs of this community (CP3, DAL1). As stated in a Partnership Meeting (3 April 2025), potential participants on Respectful Partnerships will be able to self-refer under the new CIFA contract, which is exceptional for the programme, in order to increase reach with the LGBT+ population.

From the VS perspective, CIFA's reach should be expanded through the DA system and in community spaces so that more people can benefit from support:

> *"I just wish I knew for the programs and support like this before. It would have been so helpful. Otherwise, the referral process was very good and I am very grateful that this was done for me" (VS5).*

> *"I wish more women knew about programs like this. Information about programs like this should be available in councils and many other places for women to see" (VS5).*

One recurring suggestion in interviews with SUs was to broaden the programme's visibility through increased advertising. Many SUs, particularly those referred by social workers, noted that this was their first opportunity to engage with such a service and noted that the referral may not have occurred if they had been aware of a service for men that could have helped to stop the incident for which they were referred. SU14 noted that CIFA could extend their reach by notices in GP surgeries and advocated for the introduction of a peer mentoring service within CIFA because

> "*Sometimes people just don't want to talk to your relatives or friends. They want themselves to talk to somebody like this, done this program." (SU14)*

4.1.5 Reflections on RISE's new outreach strategy

RISE has developed a new community outreach strategy to support its aim to create safer communities, reduce harm and promote healing. Working in and with communities is a central part

of this work. The importance of and emphasis on communities is a central tenet in the work done by CIFA, and this new strategy plan is designed to help meet these aims. The dedication to this work is not only shown in the strategy plan, but also in staffing, with RISE hiring a member of staff to lead on this work. Overall, the outreach strategy plan is extremely well thought through and thorough, showing the careful, holistic and inclusive approach seen throughout RISE's work. The strategy is set out in a clear, stepwise way, highlighting communities identified as particularly important to engage based on RISE's research-led understanding of needs. The plan is inclusive and flexible, and shows a clear acknowledgement of the need to be adaptable to engage diverse minoritised communities. As evidenced by this evaluation, this is crucial to ensure inclusion of marginalised communities overall, which CIFA does very well, but particularly those who are currently not as well represented among current SUs and VSs on CIFA. The plan's step by step strategy includes careful thinking around how to build trust and sustainable ties with communities as well as addressing obstacles including translations of materials for those who need them. It also gives some examples of practice and processes to ensure activities and engagement is recorded, which is very helpful to ensure sustainable engagement across teams.

Whilst the plan is excellent overall, there is an area that could be enhanced. We will use the LGBTQ+ community as an example to illustrate this. The LGBTQ+ community is one of the communities that CIFA has identified for improved engagement. The strategy plan is excellent in setting out the process to engage communities. However, it is less focused on how to adapt the messaging and language used so that communities not only understand but also see the value of it for their communities. We know from interviews that adapting language, examples and context is an emphasis in other parts of CIFA's work. However, it is also crucial in outreach. In LGBTQ+ communities, for example, conversations about families can be different than in other communities due to LGBTQ+ families not being recognised for a long time, which has led to different systems of kinship being emphasised (see literature on Queer Kinship, eg. Bradway, 2022). Added to this are challenges around lack of awareness and acknowledgement of harm in same-sex relationships and for trans people within and outside of LGBTQ+ communities. This means that the communication and language used to talk about CIFA needs to be adapted to the challenges faced by the community to ensure they feel and see the connection to their lives. We have used this community as an example here, but the need to adapt communication applies across different marginalised communities. Thus, an additional part of the strategy plan could be dedicated to the importance of communication, underlining how to show the relevance and importance of CIFA to different communities.

4.1.6 Barriers to reach

The primary concerns emerging from the evaluation in relation to reach are: a lack of referrer knowledge of CIFA (and the need for greater CIFA embeddedness and resources to accomplish that); the use of the language of 'perpetrator'; and the need for a cultural shift in pursuing behaviour change work, including upskilling referrers.

4.1.6.1 Lack of referrer knowledge

In interviews with referrers across boroughs, there were misconceptions about the CIFA referral process and variable knowledge of referral criteria. As described in section 4.3.1, any organisation can refer to CIFA. However, some referrers believed that they can only refer through Children's Services, for example, or that a person could only be re-referred to CIFA after a gap of six months (R12). As one CIFA practitioner reflected, a culture has developed – to some extent - where *only* Children's Services refer to CIFA (CP13). In Tower Hamlets, in contrast, CIFA is largely used for non-parents because their internal programme Positive Change is the primary referral route for parents. There is a risk that other potential referrers know about CIFA but are under the impression that they cannot refer to the programme. At the same time, CIFA practitioners reported that non-suitable referrals are common (CP7, CP13, CP3, CP11). For example, the NHS has referred people to CIFA for couple's therapy (CP3). One social worker said that she had only recently learned about the different risk thresholds for referrals to CIFA and DRIVE (R3). One IDVA expressed a desire to see a programme focused on women who had caused harm, having not heard of FADA (CP5). Other referrers had *"just heard about it two weeks ago"* (R10, R11). One referrer was delighted when he recently *"found out something like CIFA was out there…thought 'yes!'"* (R1). These insights demonstrate a lack of referrer knowledge of CIFA and its referral criteria.

A lack of referrer knowledge may also contribute to limited information about the specifics of CIFA being offered to potential SUs. SU4 stated that he was given little information about CIFA beyond knowing that "*it was going to be about something to do with dealing with relationships, with DA or domestic violence*" linked to his case. Thus, he struggled to fully comprehend the potential benefits. This lack of clarity led some SUs, such as SU12, to anticipate the CIFA programme as "*one hour just giving me education"* (SU12) and to think that "*I'm gonna be like a lectured […] and be blamed a lot of the time"* (SU10), neither of which was appealing to these SUs.

Some instructions are getting "*lost in translation"* in communications between RISE, managers and frontline referrers (CP13). One important reason for this is staff turnover in social services (DAL1, R3, CP3). Information about programmes needs to be cascaded to referrers regularly, as institutional memory is precarious. The loss of key members of staff was mentioned in particular boroughs as a reason for the lack of knowledge: some DA advocates who previously supported social workers to make referral decisions are no longer in those roles (DAL1). A CIFA practitioner anecdotally noted that when one VAWG practitioner left her role, referrals from that borough dropped significantly (CP6). Another reason is the newness of the CIFA programmes: it takes time to *"warm up a referral route"* (DAL3) and for programmes to become embedded in the system and present in referrers' minds. As one DA commissioner noted, this takes resources. She was enthusiastic and committed to embedding and promoting CIFA, including pioneering outreach, but her capacity is limited. She would like to receive CIFA funding to support a dedicated member of staff (DAL1).

4.1.6.2 The language of 'perpetrator'

Another important barrier in CIFA's ability to engage its target audience is the language of 'perpetrator' used within social services. While internally and on their programmes RISE uses the terminology of 'SUs,' the language of 'perpetrator' is established in the wider system and they *"need to work within that"* (CP15). At the RISE 10-year anniversary event, many terms were used, including

'perpetrator,' 'SU' and 'people who have caused harm.' In co-production meetings, it was stated that neither social workers nor RISE use the term in reference to the CIFA programme. Yet, as CIFA practitioners confirmed, this slippage between terms is an issue across the sector and it presents an issue with reach and engagement. Importantly, there is a disconnect between this position among practitioners and the CIFA training materials and website. The manuals – and RISE's website - use the word 'perpetrator' repeatedly, bringing the framework that CIFA purports to resist into the room with SUs and making it unavoidable for practitioners. A move towards a comprehensive language shift within the organisation would achieve greater alignment with its principles.

In co-production meetings, RISE reported having a lot of discussion around the use of terminology. They have seen that it alienates and isolates the person: SUs feel judged and shamed. When they come to CIFA, there is a need to undo the impact of that language in order to be able to work effectively, including to overcome resistance and denial. This can have an impact on the relationship between practitioner and SU, which is navigated by the skill and experience of the practitioners (CP13). However, in the wider system, amongst VAWG leads for example, there is an insistence on using the language of 'perpetrators' and linking it to accountability. It can be perceived by VS services that RISE are 'on the side' of the person who has caused harm, and the organisation needs to maintain the trust of these organisations and individuals too. CIFA, as one practitioner said, *"is doing a very different piece of work to the work of the VAWG sector,"* (CP13) though the goal is the same: enhancing the safety of VSs and achieving accountability for abuse.

Many referrers stated that this language prevents people from engaging in such programmes, including CIFA. Both men and women are resistant to the label and did not feel that it reflected who they are or what had happened (R4, R5, R8, R12). One social worker recalled a conversation with a potential SU:

> *"[He said] 'I did the violence just once. This is the very first time. I broke something at home in my anger. So it's an anger issue, not domestic violence.' So he was very argumentative to me, and because of that… he didn't want to pursue further with CIFA. And CIFA had to close the case as well. So after that, this father has not been engaging, and also he's been blaming mom on what happened; [he perceived that] because of her he had to undergo these things. [He said] 'They are calling me a perpetrator, though I'm coming from a good family', things like that. Yeah, they don't just accept it"* (R12).

The refusal of the label of 'perpetrator' can be linked to denial and minimisation, and the person's inability to acknowledge or address their behaviour (R4), which is discussed in detail in section 4.3.7.1. But viewing the issue through a cultural and trauma-informed lens, it is also more subtle. Men in particular may feel that their experiences and perspectives are automatically not heard or believed; they expect to be blamed and may not engage as a result (R8, CP13). This may especially be the situation where the person has experienced discrimination in previous interactions with the system (DAL1, CP13, DAL2). Two referrers reflected on examples of mutually abusive relationships, where neither party would accept the label of 'perpetrator' (R9, R12). A CIFA practitioner noted that parents who are suffering abuse at the hands of an adult child can also be reactive and respond with violence (CP12). CIFA is a voluntary programme and the language of 'perpetrator' can discourage engagement. As one social worker said: *"when you say to women, 'you are a perpetrator', they've not accepted. If there's some other term, I think it would be better"* (R12). While RISE makes efforts not use this language, those efforts are incomplete and others in the system continue to, which has an impact on

referrals, denial and motivation. By using language that does not automatically block participation in meaningful behaviour change programmes, the possibility of accountability and personal and relational transformation emerges.

4.1.6.3 A cultural shift in pursuing behaviour change work

Several DA/VAWG leads suggested that a piece of work needs to be done with social workers to help them feel comfortable referring people to CIFA (DAL2, DAL4). In a system built around safeguarding VSs, the people - often men - causing harm, tend to be neglected and excluded from the support of social services. CIFA - and RISE as an organisation - is doing essential work to ensure that there is a referral route for people who have caused harm. This is a route to accountability, non-repetition, meaningful support and prevention.

This essential and seismic shift within the system will require resource and upskilling. While CIFA practitioners are skilled and experienced in work with people who have caused harm, there must be training and support offered to social workers and other referrers, to build comfort and confidence in having these conversations with people who have caused harm and in making referrals. This training has begun to take place – RISE staff have delivered training to social workers and other referring agencies focused on engaging SUs and how to frame initial conversations to motivate SUs to take part. Further investment in this work would help to raise referral numbers and to significantly shift the culture within social services and beyond to immediately consider work with the person who has caused harm (CP4). This is an aim of CIFA: to ignite a wider culture of addressing DA by meaningfully addressing the behaviour of the person who has caused harm.

4.2 Effectiveness

Ecological model: Behavioural change

Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Collaborative approach; Support; Engagement; Cessation; Evidence / insight

Key findings

- Victim-survivors reported improved emotional safety, co-parenting dynamics, and respectful communication from those who had previously harmed them.
- Several participants recognised positive shifts in service user parenting involvement and reduction in conflict, particularly in cases where people who have caused harm had completed more sessions.
- The programme empowered victim survivors to understand abuse dynamics, set boundaries, and prioritise their and their children's safety (e.g., securing protective orders).
- Victim-survivors were offered valuable emotional and practical support that increased their agency and safety.

- When analysing the outcome star data - which assesses the change in behaviour and attitudes among service users along the six dimensions of taking responsibility, thinking & attitudes, safe action & reaction, communication, being a good father and wellbeing - it is clear that those going through CIFA in general improve significantly in the course of the intervention.
- The outcome star data also shows that improvements vary depending on ethnicity and whether or not a service user needs an interpreter, with the latter group improving greatly. This is testimony to the impact of CIFA on some of the groups they aim to serve.
- There are variations between boroughs, which shows us that service users in the different boroughs start the programme with different levels of behaviour and attitude challenges. This underlines the need to further strengthen the programme to ensure it addresses the range of needs amongst the SUs.
- Completion rates are good. Findings show variations by ethnicity and religion both for completion rates and suitability for the programme. This means that some ethnic minorities do better than others on the programme. The same is true for religion.
- There are patterns when it comes to who is found to be not suitable for CIFA at different stages of assessment.
- Some minoritised groups are not represented on CIFA programmes, notably LGBTQ+ communities.
- The relationship between service users and CIFA practitioners is central to the effectiveness of the intervention, with trust, personal characteristics and professional skills mentioned by service users.
- Through the programme, service users develop greater self-awareness and emotional regulation, are supported to learn the roots of their harmful behaviour and effective tools for change. Emotional reflection and self-awareness leads to behaviour change and personal transformation.
- Change is evidenced in big and small ways that are all important: the cessation of abusive behaviour, the ability to de-escalate conflict, more presence and empathy with partners and children, and helping around the house.
- Service users developed greater insight into their abusive behaviour - in terms of harm and legality - and its impacts, with “lightbulb moments” facilitating personal transformation and change.

4.2.1 Completion, suitability and engagement rate

The first measure of effectiveness assessed is the engagement of both SUs and VSs, and their completion of the programme. This analysis offers an initial insight into effectiveness, which is followed in later sections by analysis of CIFA’s programme behaviour change measures, qualitative research, and analysis of CIFA case studies and pre- and post-programme reports. As discussed in the literature review, completions are crucial and can be seen as a measure of reduction in DA.

Table 7 and Table 8 outline the patterns of referrals, completion, non-suitability and decline of support of SUs and VSs that have been referred to CIFA. The text will also compare this to non-CIFA programmes (here represented by DA programmes in Barnet and Brent). The tables show that there

are higher completion rates on the family support domestic abuse programmes included in the data. There are many reasons for non-completion of CIFA, which are set out in detail in section 4.2.1.3.

4.2.1.1 Victim-survivors

Table 7 outlines completion rates by borough for VSs in the 7 boroughs covered by the RISE data. This shows us, not surprisingly, that higher referring boroughs have higher rates of completion. Completion rates could be improved as they vary from as low as 2.9% in Enfield to 17.8% in Brent, the highest performing CIFA borough measured by completion.

Overall, VS completion rates are lower on the CIFA programme than one the two non-CIFA programmes, and completion rates vary for CIFA programmes, with Brent, Newham and Haringey having the highest rates. This shows room for improvement when it comes to VS completion. In Hammersmith & Fulham, Westminster and Kensington & Chelsea, only one VS has completed, which is related to the low referral numbers from these boroughs. However, these boroughs have higher acceptance rates for VSs onto CIFA than many other boroughs, with 43.3% in Hammersmith & Fulham, and 27% in Westminster (Kensington & Chelsea is lower at 3%). Thus, it is clear that CIFA is effective in accepting people from a range of racialised community groups onto their programme in these three boroughs.

Looking at the RISE completion data by ethnicity for VSs, there is a larger spread between completion rate among the different ethnicities represented compared to the SUs. This means that there is less difference in completion rates when it comes ethnic minority. As is the case for SUs, Other Asian (11.5%) and Other European (18.2%) are among the two largest categories. They are joined by Pakistani also at 11.8% of those completed. Kensington & Chelsea, Hammersmith & Fulham and Westminster also reach a range of ethnic minorities. This shows that efforts are being made to ensure completion across ethnic minorities. To assess CIFA's effectiveness in reaching target audiences, we compared data on VSs on CIFA with VSs on other borough programmes. To do so, we looked at the correlation between belonging to different racialised groups on a programme and the CIFA and non-CIFA Programmes (measured as DA & SPE). We find that the correlation between the different programmes and ethnicity is statistically significant and has a Cramer's V of 0.42, which is a strong effect. This indicates that different racialised groups are distributed differently across the three different programmes (CIFA, DA, SPE) and that there is a strong relationship between racialised groups and particular programmes. This is evidenced by the fact that whilst the DA programme for VSs has representation of some racialised minorities, the CIFA programme overall has larger percentages of racialised communities across a wider range of the ethnic groups measured in the data. For Hammersmith & Fulham, Kensington & Chelsea and Westminster, Arab and North African communities represent 18.1% of those accepted, whilst Other Asian represent 32%. Together, these two represent the two largest racialised groups accepted in these boroughs. Overall, this shows the success of CIFA in reaching its goals.

When looking at reach within different religious groups, we again find a statistically significant effect, where Muslims (20% of those completed) have higher completion rates. However, the VS data does have high levels of 'missing' data which means the accuracy of these numbers is lower. When comparing the effectiveness of CIFA compared to DA and SPE for VSs, CIFA has a positive effect for people with a diverse range of religions. Compared to the other programmes, Muslims (25%) are a

particularly large VS population. However, the data requires improvement. More VSs on CIFA need an interpreter (54%) than those on DA (30%) and SPE (0%). This is statistically significant and has a strong positive effect (Cramer's V 0.2.64), which is strong proof that CIFA is effective in reaching its desired populations. When looking at the Advance data from Hammersmith & Fulham, Kensington & Chelsea and Westminster for VSs, their data includes a smaller range of religions than the RISE data, but overall CIFA is also effective at reaching different religious groups in these three boroughs.

Table 7. VS engagement patterns across boroughs

Borough - VS	VS across programmes	Completion	Not consent	Minoritised groups
Barnet	23	• Completion rates vary between boroughs, and higher referrers have higher completion rates. • Completion rates are lowered due to VS being withdrawn as well as no consent.	• Percentages that decline support are quite high (31.7% across boroughs) • Higher referrers have higher rates of decline, which is to be expected	• Of those completed, the largest racialised groups are Other European 18.4% and Other Asian 16.3% which are also the two biggest groups declining support at 21.7%. This is related to these being the larger groups.
Brent	36			
Enfield	39			
Harrow	42			
Haringey	54			
Newham	77			
Tower Hamlets	5			
Hammersmith & Fulham	9			
RBKC	9			
City of Westminster	8			

Data on referrals from tracking report combines the main VS programme, FADA, and APFA. Completion and not consent calculations are based on status reason data from the RISE VS dataset.

The Q1 Y1 victim data from the MOPAC Annex 1. narrative report is absent from Table 5, 'RISE VSs by borough and programme,' as it was not included in the original report. Over time, the MOPAC Annex 1 Narrative Progress Report has been refined to more effectively present key findings.

4.2.1.2 Service users

When we look at completion rates of those SUs that are deemed suitable in the initial assessment the majority are either attending, have completed or the case is to be closed. 29.7% have completed,

17.3% are attending, 13.3% are to be closed, 38.4% are cancelled (across cancelled categories such as withdrawn). This shows a good record of completion for those deemed suitable. SU completion rates vary by borough, as seen in the table outlining completion rates for SUs from the data provided by RISE and in the tables set out in section 4.1. The higher referring boroughs - Barnet, Newham and Harrow - also have the higher completion rates. However, the correlation between referrals and completion is not automatic as a high referring borough such as Haringey has a much lower completion rate than other high referring boroughs.

Of those completing, the majority are from the main CIFA programme for SUs. APFA and FADA programme numbers remain low not only in referrals but also completions, as would be expected. APFA was described by one CIFA practitioner as the *"next big stone to be lifted"* (CP13). As described in the literature review, social and research work in this area may bring improved referrals in the near future. Of those on APFA, 12 SUs in total, 3 were found suitable, and all 3 completed. For those on the CIFA Neurodivergent programme, 13 in total, 8 have completed, 2 were disengaged, 1 is enrolled but has low engagement and 2 are enrolled. There are 24 cases on the FADA programme in the SU data. 13 have completed the course and 1 is attending. Overall, these are excellent results for these programmes, showing strong engagement with the different programmes. For these programmes we will not analyse by ethnicity, as the small samples mean that we cannot generalise about trends. However, they do have a good spread across the diverse racialised groups reached by the CIFA programmes.

The next step in the quantitative analysis focused on looking at the completion rates of the racialised communities on the CIFA programme, an important part of assessing whether CIFA is effective in achieving its goals. For SUs, when looking in-depth, we see that those categorised as Other: Asian and Other: European have the highest completion rates which is to be expected as they also represent the larger racialised groups on the programme. Other: Asian also represent a much larger proportion of those found 'not suitable' for CIFA than other groups. This is likely correlated to them being the highest proportion assessed, followed by Other: European. However, it is important to note that the group categorised as Other ethnic group: Arab have a much higher proportion of being found 'not suitable' compared to their share of the population than other groups.

In addition to whether or not a SU has been deemed suitable in the initial assessment, the data on SUs provides information about three different categories of being not suitable for CIFA, pre- and post-assessment and those found not suitable for being in denial. This provides insights into the different stages and reasons for SUs being found not suitable. At pre-assessment stage, a referral may be rejected by the Service Manager or Team Leader for the following reasons: there is no robust evidence of the SU being abusive; there are ongoing criminal justice proceedings; the SU has made an application for a Child Access Order at a private Family Court; the case has already been closed by the referring party; or during the initial phone call the SU has indicated they are not willing to attend. Post-assessment reasons for finding a SU unsuitable include: total or very high levels of denial; no internal motivation; unwilling to undertake a programme or to commit to a regular day/time; or disclosure of a new arrest/ongoing criminal court proceeding/application to the Family Court.

Post-assessment rates see higher 'not suitable' assessment for Other Asian (24%), Arab (14%) and Black/Black British: African (12%). The two latter categories are quite high percentages compared to their proportion of the total sample and shows a need to assess the reasons for these groups having higher 'not suitable' rates in post-assessment. Pre-assessment sees a high proportion of the English

and Welsh group (27%) being deemed not suitable, followed by Other European (18%), White and Asian (9%) and Irish (9%). For the category of being found 'not suitable' due to being in denial, Other Asian (21%) is the largest group, followed by the group categorised as Arab (16%) and Black/Black British: African (10.7%). The two latter are again quite high given that their proportion of the total number of SUs is lower than other groups. Overall, there are patterns by racialised minorities in terms of who is found 'not suitable.' This needs exploration to improve the effectiveness and reach of CIFA.

The data includes information on whether those on the programme require an interpreter, which we see as another measurement of whether CIFA is effective in reaching and working with those from minoritised backgrounds. When analysing SUs need for an interpreter and its correlation to 'reason for closure,' we find that it is almost statistically significant (just over 5%) and has a Cramer's V of 0.266. This indicates that requiring an interpreter or not has an effect on the reasons for closing SU cases. 48.6% of SUs found 'not suitable' due to being in denial post-assessment need an interpreter, which seems like an area for improvement for CIFA. When measuring completion, we look at those who have completed 90% of sessions. Of those in this category, 71.7% do not require an interpreter. In the total sample, 65.4% percent do not require an interpreter. Thus, the completion rates of those not needing an interpreter is slightly higher than their share of the full sample. Interestingly, more SUs on the male CIFA programme need interpreters - 35.5% versus 27% of those on FADA.

Continuing the analysis of the effectiveness of CIFA when working with minoritised communities, we look at the effect of religion on status reason. In the data, status reason includes information about completion, suitability, cancellation, whether the case is on hold and whether SUs are attending. For SUs, this is statistically significant and has a Cramer's V of 0.183, showing that religion matters and influences status reason. 13% of those completed are Hindu, which is fairly high as they are 6% of the total sample. In comparison, 41% of those completed are Muslim, which is similar to their proportion of the sample. It is important to note that 'unknown' is 22.3%, which is high. Yet, with the available data, there are clearly some patterns showing that religion matters. When turning to 'not suitable,' we similarly find that SUs who are Muslim represent a high percentage of those found 'not suitable' in post-assessment (53%). The second largest group found 'not suitable' in the post-assessment are Christians at 21%. These are also the larger religious groups represented among the SUs, but their levels of being assessed as 'not suitable' are still important to note.

Table 8. SU referral pathways across boroughs

Borough	**Referrals (incl. all programmes)**	Completed	Not suitable (combined pre & post assessment)	Minoritised groups
Barnet	74	20.9%	16.1%	• Other: Asian and Other: European (both 20/9%) have highest completion rates which is to be expected as they also represent the larger racialised groups on the programme. • Other ethnic group: Arab (14.5%) have a higher proportion of found 'not suitable' compared to their share of the population. • Other: Asian (24.2%) also represent a larger proportion of those found 'not suitable' for CIFA than other groups.
Brent	69	13.4%	21%	
Enfield	98	7.5%	33.7%	
Harrow	72	23.9%	34.3%	
Haringey	74	9%	17.2%	
Newham	108	17.9%	33.3%	
Tower Hamlets	30	0%	19.8%	
Hammersmith & Fulham	34	3%	10.7%	
RBKC	20	3%	10.7%	
City of Westminster	30	1.5%	3.2%	

Note: Data on referrals from tracking report combines FADA, APFA, CIFA neurodivergent and main programme Completion and not suitable calculations are based on status reason data from the RISE SU dataset.

4.2.1.3 The qualitative, underlying reasons for non-completion

Reasons for non-completion are varied. CIFA practitioners stated that most non-completions are related to denial and risk escalation (CP3, CP6). False compliance becomes obvious (CP7) or it becomes clear that the SU is not engaging meaningfully with the programme or reflecting on their beliefs in a way that would bring about behaviour change. Non-completion might also occur because of a change in circumstances or feedback from DASAs or IDVAs that make continuing to work with the SU too risky for the VS. The person may instead be referred to DRIVE, RISE's high-risk programme. While this *"looks bad for numbers"* (CP3), CIFA are primarily concerned with safeguarding the VS and the integrity of the programme. As various practitioners reflected, not all SUs are ready to engage with the work and to embrace change (R8; CP10). A CIFA practitioner estimated that about 10% of non-completing SUs do not complete because of poor mental health (CP3). The person might also leave the country or the area (R5, CP3, CP13). Cases are also often closed by Children's Services, as discussed in Section 4.5.4, which often necessitates the end of CIFA's work with the SU for VS safeguarding reasons. CIFA

practitioners do everything they can to close cases properly, even if the end is abrupt by signposting to other services, resources or support, and finalising or revisiting essential concepts or tools (CP8, CP3).

People can also lose motivation halfway through (CP3). CIFA practitioners have techniques to maintain engagement and motivation, including establishing and revisiting aims with the SU, ensuring an end date is clearly set, and attending the SU's multi-agency meetings and Children's Services meetings and feeding back positively about the SU's participation (CP3, CP6).

4.2.2 SU engagement with the CIFA Programme: benefits and impact

SUs were asked about their experience of the CIFA programme to explore its effectiveness, understood as the programme's ability to generate meaningful change in the SU attitudes about DA and bring about behavioural change and a cessation of DA. Three themes emerged from SU interviews in terms of the effectiveness of CIFA: 1) space to explore attitudes and behaviours, 2) the CIFA practitioner and SU relationship, and 3) the programme content. Each will be discussed in detail below.

CIFA is a behavioural change programme wherein the practitioner facilitates discussions with SUs' accounts of the domestic event(s). Admission to CIFA requires SUs to take responsibility for their abusive actions. Another component of the programme is providing space for SUs to critically examine their attitudes and behaviours related to DA, thereby encouraging SUs to reflect on how the incident(s) have impacted familial relationships and the well-being and safety of the children. For many SUs, the availability of a safe space to explore their behaviours and attitudes, without judgment, was essential to their full engagement with CIFA. SU1 articulated the importance of having this space to reflect.

> *"Yeah, this is most important when you speak. You don't expect the other person to judge you. You know, this is how you open yourself […]. You open yourself to other people to teach you what is right, what is wrong, what you have done wrong, and what you can change"* (SU1).

The testimonies suggest that the CIFA programme offers a rare opportunity for SUs to openly discuss the abusive incident(s), enabling critical reflection and fostering behavioural change. As SU1 noted

> "*It allowed me to share and allowed someone else to comb through the information I'm giving them and then maybe pinpoint certain things that I've overlooked, which was kind of useful. Like I said, it made me look at things a lot deeper*."

Moreover, the space provided by CIFA allowed SUs to start to challenge deeply ingrained assumptions about masculinity, patriarchal gender norms and the intersection with broader social issues such as race and class. For example, SU2, a young Black man, found it particularly useful to discuss his understanding of masculinity and socialised to be "*tough, being strong, having all the brothers and as a young boy, you know, being taught to, you know, be strong. I feel like that stigma as a man to be strong"* (SU2).

SU2 found it useful to be able to talk about his experiences outside of the Black community, where external help of the type offered by RISE is often stigmatised and treated with suspicion. Similar sentiments were echoed by other SUs, such as SU14, who identifies as Jamaican, noting that the safe

environment provided by CIFA is a vital resource for people unable to share intimate details about family dynamics within their local community due to the stigma and shame.

In summary, the testimonies emphasised the value of providing a non-judgmental learning environment that encouraged SUs to share intimate details of their experiences. This approach effectively addressed cultural barriers to engagement, particularly within communities where traditional norms and the stigmatisation of therapy present significant challenges. The CIFA programme, therefore, serves as an essential platform for SUs to critically examine and challenge deeply ingrained beliefs, facilitating personal growth and fostering behavioural change.

4.2.3 SU behaviour change

The CIFA programme aims to reduce the number of DA VSs. Whilst the evaluation did not directly inquire about specific incidents, SUs and practitioners provided examples of how the programme had prompted attitudinal and behavioural shifts in understanding the impact of DA that had, in turn, reduced further incidences. These changes included: a) self-enlightenment and b) improved family relationships.

4.2.3.1 Increased self-awareness and emotional regulation

One of the core mechanisms through which CIFA supports behaviour change is by helping SUs develop greater self-awareness and emotional regulation. Many SUs arrive at the programme with limited understanding of their own emotional triggers, communication styles, or internal states. Through structured sessions and trauma-informed practice, SUs are supported to explore the roots of their behaviour and develop practical tools to manage it.

SUs are introduced to new concepts such as passive aggression and different communication styles, often for the first time. The programme draws heavily on CBT techniques and body-based awareness to reconnect participants to their emotional experiences. This includes learning to identify and respond to physiological cues of anger, practicing time-outs, and using positive self-talk in moments of rising tension. Reflecting on the programme's effective techniques, CP10 said that:

> *"on a deeper level, the ones that I think take it to the next level is the body maps and the recognising emotions in the body. I think those are helpful to actually kind of reconnect the people to what they're actually experiencing and being able to …communicate what they are experiencing and how they're feeling."*

The cumulative effect of these experiences is not just emotional insight, but the development of tools for change. As one CIFA practitioner put it:

> *"it's an intervention which is very, very needed, you know, to break that cycle of violence. It's, it's kind of a prevention… Change, it comes from within…there is a lot of reflection involved, and that is very important, and that works as a prevention"* (CP8).

Mr A reported using CIFA's emotional management strategies to prevent escalation and described recognising the physical signs of anger before acting. Mr I reflected on how positive self-talk helped him stay calm during conflict with his wife. Similarly, Mr S named healthy communication as a personal

development focus, adopting assertive strategies and working to stop bottling up emotions. Mr I developed increased insight into the impact of his behaviour, describing a *"pressure cooker effect"* from years of unresolved conflict and emotional suppression. He began to see how cultural expectations and family dynamics had shaped his responses and reported feeling better equipped to reflect and self-regulate. Ms AE demonstrated this shift clearly, using assertive communication, reflection, and self-regulation to prevent escalation. Her strategy of not *"meeting conflict at the same level"* and relying on prayer and focus on her daughter showed both emotional control and intention to break harmful cycles. While some SUs, like Mr X (who is neurodivergent), made more gradual progress, there was evidence of partial insight and emerging self-awareness around his emotional patterns, particularly in relation to co-parenting and managing volatility.

Practitioner reports from the APFA strand highlighted how building self-awareness in family members, particularly mothers, was important to improving awareness and emotional management:

> *"this is about self awareness for the parent, you know, this is about giving them the power back to acknowledge what's happening. You're not going to get the answers from that young person" (*CP12).

Most SUs reported profound personal transformations and referred to aspects of the programme that had fundamentally impacted their outlook on DA, perception of self, relations within the family, and parenting style. For example, on completion of CIFA, SU1 noted that he had

> *"I actually took some good gems out of this thing, and I did learn a little bit. And it did make me also like not just reevaluate my own behaviour….and you know, it weren't so much just going over the difficult parts and rehash and shit and then thinking about how I could, how I could have handled it differently*." (SU1)

Practitioners – including referrers and an interpreter - described a range of positive changes in SUs participating in the programme. Many highlighted that SUs became more reflective, developed greater insight into the root causes of their behaviours and learned tools to address their behaviour (R5, R2, I1, CP10). As I1, an interpreter, explained,

> *"At the end, I believe it will be like a more complex, total makeover of the SU. What I like is they go really deeper to make the people think. Many times I had like an 'aha moment.'"*

Social worker R12 described the transformation of one father during the CIFA programme:

> *"the father itself was able to tell that so many things which they did not think was important, how it was being, you know, delivered to them was very good, and they could understand that it's really important, like the role of a father, how to manage their anger, how triggers like these things, particularly, they would say the developmental milestones of a children, how it's impacted due to domestic violence."*

The programme also offered SUs the space, and a framework, to explore the impact of trauma, learned behaviour, and emotional suppression on their actions. One practitioner (CP3) noted that men begin to understand how experiences of trauma, abuse, and learned gender roles shape how they treat women in their lives. This trauma-informed approach was particularly evident in the FADA strand of the programme, which several CIFA practitioners described as supportive, self-esteem-building and empowering, even when the learning was challenging. One practitioner (CP3) described how FADA

boosts self-esteem, helps SUs understand why they used violence, and can help them see they deserve more than abusive relationships.

One strategy that seemed to have a significant impact on a number of SUs was the 'time-out' strategy; being able to walk away, distance from potentially conflictual situations. This technique was recalled by multiple SUs as being a way to defuse quarrels or disputes, leading to increased security and well-being in the family. Employing this learning and other techniques, SU5 revealed how he was doing better and communicating in a positive way with his wife and children.

> *"Now, I'm taking better care of myself than I was. I'd sort of started trying to do that when everything happened. I realised why I need to turn my life around. But yeah, it's helped me maintain them behaviours [those learnt through CIFA] and make them habitual."*

Similarly, SU12 described a shift in mindset, noting how he was "mentally different" now and was being less stubborn. Ultimately, via the CIFA programme he learned *"that in the house or in a home, love and communication is an important thing"* that impacted his attitude and approach with his family. The effectiveness of these tools and approaches echoes findings in the literature about 'what works' in such intervention programmes.

4.2.3.2 Improved relationships with family

A key focus of the CIFA programme was to improve relationships with partners and children to protect them from further victimisation. Through structured exercises within the CIFA programme, SUs were able to critically examine their views on parenting and partnering. The programme supported SUs to work on their relationships by improving communication skills, offering support to their partners, and developing greater empathy. These SUs found CIFA exercises particularly good for exploring their own cultural views on how partners and children should be treated. This reflective process enabled SUs to adopt more effective strategies for engaging with their families. SU12, for instance, highlighted the value of learning "*how to work with the family and do things with the family*," which contributed to noticeable improvements in their domestic situation. The programme also increased SUs' awareness of the impact of DA on children. For some, this led to a re-evaluation of cultural norms that condoned punitive practices such as spanking or shouting. In an interview, SU7 reflected on the benefits of this shift in consciousness.

> "[The CIFA sessions] *has helped because…it helps you to think outside the box and how to talk to someone, how to deal with your family,...especially the children, how to help them. To think along in their line as well rather than being strict, rude or anything like that. So, it's very helpful"* (SU7).

The programme's emphasis on behavioural change had a direct impact on parenting styles and, by extension, on children's wellbeing and experience. SU12 noted a transition from an authoritarian or absentee parenting approach to a more engaged and supportive one. Similarly, SU8, who previously struggled with frustration when their children did not listen, reported significant improvements post-CIFA. He said, "*I'm much more knowledgeable now of what it is like for them"* and that he now doesn't *"withdraw from the family."* There were significant improvements reported in parenting, with SUs becoming more attentive to their children and spending more time with them and their partners, described by one CIFA practitioner as breaking intergenerational cycles of trauma and harmful

behaviours (CP10). Referrers and other stakeholders noted that fathers became more actively involved in their children's lives, such as picking them up from school, and demonstrating a stronger sense of responsibility for their children's needs and the impact of harmful behaviour (CP10, R8, R7, R12, I1). As reported by social workers:

> *"The dad is picking them up from school. They will go to the park. So it kind of brings the family together. I would say it gives the perpetrator an insight to the impact of their behaviour on the children, which is a very good positive for us"* (R7).

> *"…she could see the full change in the husband, the way he's dealing with children, he's taking responsibilities of the children's needs, everything. So she could say that very confidently"* (R12).

This shift towards greater emotional and physical presence was noted by other SUs. Mr A, for example, noted better mutual understanding with his wife post-programme. SU5 noted feeling more in control of his emotions which facilitated better connections with his children and partner:

> "*I'm communicating a lot better with my wife […] I feel a lot more ready to listen to my wife and my children's needs, whereas before, although I'd listened sometimes - in my head - I'd dismiss them. So, I'm a lot more ready to hear and talk.*"

Overall, the programme has delivered significant benefits for families, including fewer arguments in front of children and, in some cases, even leading directly to the de-escalation of Child Protection cases (R12). Case studies noted that safeguarding concerns reduced as a result of CIFA for some SUs. Mr H progressed from supervised to unsupervised contact with his children, a shift that reflected both improved trust from professionals and reduced risk. Mr M also experienced a downgrade in child protection status, moving from Child Protection to Child in Need, following improved engagement and reductions in harmful behaviour. Mr S shared that his partner Ms F (who was also supported through CIFA) and their baby had returned home, and he was actively supporting her emotionally and practically.

By encouraging SUs to reflect on their parenting practices and improve emotional regulation, the CIFA programme facilitates meaningful changes in family relationships. SUs reported becoming more engaged, communicative, and attuned to the needs of their children and partners. These transformations not only enhanced immediate family dynamics but also demonstrates potential for long-term benefits.

Many participants are on complex journeys, shaped by trauma, cultural values, external pressures, and systemic inequalities. Within this context, CIFA facilitates small but meaningful steps, many of which represent major breakthroughs for individuals, with shifts in mindset and behaviour for those involved. For some, even naming emotions or acknowledging harm was a transformational step. As one IDVA put it, *"for some clients, you can hope for so much, and for others, even that little step forward, sometimes even that small step means so much"* (CP9). Referrers and practitioners noted, for example, that some SUs began to understand how their body language and non-verbal cues affect others, especially in family contexts. These shifts, though subtle, were often seen by co-parents, children, and schools, who reported improved emotional climates and calmer communication in the home (R5, R8, R12). VSs also recognised these changes. One reported that her partner now helped

more around the house, a shift she associated with changes in cultural beliefs about gender roles and domestic responsibility (R2).

While many SUs reported positive outcomes, some, like SU13, were more reserved in their assessments. They acknowledged changes in perception, thought patterns, and acceptance of responsibility but suggested that the learning might not be long-lasting or sufficient to overcome structural barriers, such as visa conditions and housing issues, that could hinder long-lasting progress. CIFA practitioners take an intersectional, structurally informed approach, recognising that change is not always uniform; outcomes will look different depending on each individual and their circumstances.

4.2.3.3 The importance of willingness

While the programme was widely recommended by SUs, they also emphasised the importance of personal readiness and commitment. SU17 spoke to the concern around false compliance and denial (discussed in Section 4.3.7), cautioning that the programme's effectiveness depends on the individual's willingness to acknowledge their mistakes and actively engage in the process: *"Without that it's a waste, it's a waste of time basically for everyone, if the person is…there just for the sake of being there and attending"* (SU17). SU2 summarises this point:

> "*I'd say, ultimately, you get what you put in. If you're not honest, if you can't bear to be the villain, you won't get anything out of it. But if you're honest and understand that you're not being judged, I found it very internally validating [….] I felt like you can only get help for things you talk about, you can only get advice on the things you talk about. So, if you're not willing to be open with yourself, but like maybe you might not be ready for RISE. You know, you have to come into it with an open heart, open mind. Know that things happen. Everybody has a past and if you're trying to better yourself. So come live your truth and let it set you free*" (SU2).

CIFA practitioners emphasised that SUs described feeling listened to and supported by CIFA to understand the roots of their abusive behaviours. As a result of this understanding, SUs find the willingness to change (R8).

4.2.3.4 Behaviour changes in SUs sustained over time

The positive effects of the CIFA programme appeared to be long-lasting for many SUs, with participants demonstrating increased self-awareness, emotional regulation, and more respectful approaches to conflict, though the extent to which these changes were embedded varied by individual context, support needs, and programme duration. In many cases, as one CIFA practitioner noted, the true extent of change might only be evident when the SU faces a situation where they need to apply the skills and techniques they have learned (CP10).

Several SUs described continuing to apply the tools and insights they had developed after completing CIFA. Mr T reported that incidents at home were no longer escalating and that he was using positive self-talk to help de-escalate tensions. Mr A was able to identify emotional cues and reported successfully using a time-out strategy in a time of conflict. Similarly, Mr S reflected that the use of positive self-talk helped him stay calm in stressful moments. Mr D also showed sustained

improvements, reporting increased self-awareness and emotional reflection, especially during moments of pressure. In an interview, SU18, who completed the programme two years ago, reported that there had been "*no more quarrels with my wife"* since finishing the sessions. This sustained impact underscores the potential of the programme to foster enduring changes in family dynamics and interpersonal relationships.

While many participants appear to have made significant and sustained progress, there is a clear demand, for both SUs and VSs, for extended or follow-on support to ensure that new behaviours are embedded. Mr I expressed a commitment to continuing the work initiated in CIFA. He emphasised the importance of respectful responses, emotional regulation, and boundary setting, while also recognising his ongoing vulnerability due to unresolved relational and cultural tensions. He shared that he still had more to address within his relationship and within himself, saying he was continuing to look for ways to work through differences and inner conflict. Mr X, whose CIFA programme was adapted for neurodiversity, showed some motivation for respectful co-parenting, but continued to experience volatility and inconsistency in applying what he had learned. This suggests that for some participants, especially those with cognitive or emotional processing needs, longer-term support may be required to embed new behaviours. Similarly, Ms AE showed clear evidence of behaviour change, reporting that she now uses assertive communication, reflection, and prayer to manage difficult moments. She actively avoids meeting conflict at the same level and has built self-awareness around her emotional triggers. However, her ongoing mental health and co-parenting challenges highlight the importance of continued support and follow-up to ensure changes are maintained.

VS perspectives echoed these concerns. Several expressed anxiety about what would happen once programme support ended, fearing that change might not be sustainable without continued intervention. VS7, for example, who is a parent supported through APFA, reflected on her need for more in-depth, longer-term support:

> *"Maybe these six, the original six sessions, maybe they are not enough, and probably we need something more than this… but otherwise, as I mentioned before, it is and it was very, very helpful for me."*

VS5 articulated a strong appreciation for the support she had received and a desire for it to continue:

> *"My husband is about to complete the program, so I am going to lose this support soon. Now I understand how valuable it was. The space given for conversation was very precious as I did not have this before and I am so grateful that I have been open to something like this."*
>
> *"I have been with the program since the beginning, and I will complete it. I wish I could continue receiving this support for much longer."*

Some VSs expressed uncertainty or concern about whether the behaviour change observed during the programme would be maintained in the long term. For example, VS5 described the limitations of judging behavioural change when her husband was frequently absent:

> *"My husband is OK. The thing about him is, he is always at work. I rarely see him, so I am not able to say much."*

There was recognition amongst CIFA practitioners and referrers alike that for some participants, particularly those with high levels of trauma or structural barriers, a time-bound programme may not

be sufficient. Practitioners questioned whether a more holistic, embedded, long-term approach might be more effective for some (CP10), and suggested that others may benefit from additional therapeutic support, especially when carrying intergenerational trauma or navigating highly complex family dynamics (CP10, R8). Some reported that SUs expressed an interest in ongoing therapeutic support (R8).

CIFA practitioners also acknowledged the **s**tructural and systemic factors that can limit or complicate change. Many SUs remain embedded in family, cultural, or community contexts where abuse is minimised or normalised.

> *"…they're engaging, but the rest of the world they are connected with are same, right? …yeah, they're like extended families. They are, you know, in touch with their families back in their country, they have that value system"* (CP8).

There is also recognition that individual interventions may not always reach the wider family networks or dynamics that shape behaviour.

> *"often we work in isolation with the victim-survivor and maybe perpetrator, and that generally cannot, in a longer term, cannot work out well unless family just simply separates and everybody goes their own way and never get in touch again…*
>
> *how does that affect communities who are not well enough informed about everything, but they are just there, kind of floating around like satellites"* (CP9).

Research by CIFA on how to work with family members would benefit the programme and wider system (CP9). On a related point, practitioners such as CP10 noted the importance of continued innovation, research and multiple routes to engagement with SUs.

4.2.4 Improved understanding of DA and its impacts: Service users and victim-survivors

One of the clearest indicators of effectiveness within the CIFA programme is the shift in participants' understanding of what constitutes DA and how their behaviour has impacted others. This learning was evident across both SUs and VSs, with increased awareness of the legal and emotional consequences of abuse, the gendered and cultural roots of controlling behaviour, and the importance of personal accountability. The programme's strength lies not only in providing this education, but in doing so in a trauma-informed, culturally sensitive way that facilitates deep personal reflection and behavioural change.

Practitioners including DA leads and IDVAs consistently observed that the programme helped participants develop a broader understanding of abuse, including emotional and psychological harm, and of the spectrum of abusive behaviours. CIFA practitioners noted that SUs begin to see that without consent, behaviour constitutes abuse, and as that learning and reflection develops throughout the programme, they can start to admit other things, even where they were initially resistant (CP3). Accountability is slowly developed through the process, with conceptual understanding that leads to broader applicability and behaviour change. The programme becomes *"more and more useful"* (CP3). SUs often began the programme with a limited or narrow view of abuse, typically equating it

solely with physical violence, but many came to recognise the broader dynamics of power and control. Mr T, for example, initially minimised his actions but later developed a more nuanced understanding of how his emotionally abusive and controlling behaviours had harmed his partner. Similarly, Mr AB was able to acknowledge the coercive elements of his behaviour and reflect on how substance use had shaped his actions and relationship patterns.

For many, this learning marked a critical turning point. R1, a social worker, reported that the language used by SUs began to shift, with participants expressing greater acceptance and responsibility for their actions as the programme progressed. A DA lead explained how the programme facilitated important cultural and gendered realisations:

> *"He's talking about his experiences, and he's like, 'look, in my country, this is normal. This is how my mother lived. It's how my sisters lived. Coming to England, I did not know this was not normal. So for me, I had to understand, yes, it's the different countries, different rules and regulations. But also I had to look at, well, this is not right. What happened to my mother and my sisters and my relatives actually wasn't right"* (DAL1).

These moments of insight and reflection, described by this DA lead as "light bulb moments" (DAL1), helped participants begin to challenge inherited gender norms and cultural beliefs that had previously gone unexamined. For many SUs, especially those from migrant or multicultural backgrounds, CIFA provides critical education on how behaviours considered 'normal' in other contexts could be considered harmful or illegal in the UK (CP11, CP5, DAL1, DAL3).

VS also described how support they received helped them understand and name abuse in their own lives. The programme prompted reflection on past and current relationships, allowing many to question patterns they had previously normalised. Several CIFA practitioners noted that VSs experienced the programme as an *"eye-opener"* (CP1) enabling them to identify behaviours that were unacceptable, regardless of whether they had previously been excused or justified by cultural or religious norms (CP1, CP9).

Education and empowerment were central to the VS experience. VSs gained a better understanding of legal rights, systems of protection, and the psychological underpinnings of abuse (CP9, CP12, DAL1). As a result, they became more independent, and stronger. In the context of APFA, work with non-partner family members, particularly mothers, also demonstrated impact in terms of improved understandings of DA and its impact. For example, one CIFA practitioner (CP3) worked with the mother of a son experiencing psychosis. She noted that the VS did not have anyone to talk to and did not know anything about psychosis and, as a result, she blamed herself. Through the support offered by CP12, another APFA parent was able to avoid being reactive when her son was being aggressive, learnt that her own behaviour is within her control, and understood avenues of action:

> *"she's had an opportunity to consider, to talk to somebody where she would never have that opportunity before …She knows her legal right. She knows what she can do."*

However, CP12 noted that the particularities of the parent relationship makes it difficult to put that learning in action, particularly self-safeguarding: *"in reality, she's not going to change that, because there's a real strong essence that 'I can't get rid of my son, he can still come home."*

4.2.5 Quantitative measures of behavioural change

Outcome star's change star is a tool that assesses change in behaviour of those causing harm. The assessment measures six behavioural areas: taking responsibility; thinking and attitudes, safe actions and reactions, communication, being a good father, and your wellbeing. The CIFA programme assesses the behavioural change quantitatively in those causing harm at three points in their journey through CIFA, at the beginning, middle and end of the programme. For the evaluation, we analyse the overall change in behaviour between change star assessment 1 and 2, but also variations between SUs behavioural change depending on which borough they are in, their ethnicity and a range of other individual characteristics. This helps us assess the effectiveness of CIFA when it comes to behavioural change through a systematic approach that considers racialised and other minority backgrounds.

A first point to note is that there are very few SUs who have been assessed on all three assessments (see **Table 9**). This means that we will focus our assessment of behavioural change on results from change star 1 and 2. There are too few responses in change star 3 to carry out a meaningful quantitative analysis. Given that RISE uses a range of other tools to assess behavioural change, we can see why the third assessment is not given importance. However, it is important to ensure that those going through the programme are assessed consistently as this can create a systematic understanding of behavioural change in SUs, and also allow us to assess the effectiveness of CIFA in changing behaviours among those from racialised minorities and other minority background.

Table 9. Number of assessments overall

Star Type	**Count of SU Id Number**
Change Star 1	118
Change Star 2	53
Change Star 3	13
Grand Total	**184**

The number of change star assessments carried out also varies by borough (see **Table 10**), which is linked to the number of SUs on the programme in each borough but it also indicates that there is room for improvement in terms of ensuring that all boroughs carry out change star assessments consistently.

Table 10. Number of outcome star assessments by boroughs

Count of Service	**Star Type** (% by column)			
Service	**Change Star 1**	**Change Star 2**	**Change Star 3**	**Grand Total**
CIFA: Barnet	17.8%	24.5%	23.1%	20.1%
CIFA: Brent	7.6%	9.4%	15.4%	8.7%
CIFA: Enfield	10.2%	11.3%	7.7%	10.3%
CIFA: Hammersmith and Fulham	3.4%	0.00%	0.00%	2.2%
CIFA: Haringey	16.1%	13.2%	23.1%	15.8%
CIFA: Harrow	18.6%	30.2%	15.4%	21.7%
CIFA: Kensington and Chelsea	3.4%	0.00%	0.00%	2.2%
CIFA: Newham	15.3%	9.4%	15.4%	13.6%
CIFA: Tower Hamlets	4.2%	0.0%	0.0%	2.7%
CIFA: Westminster	3.4%	1.9%	0.0%	2.7%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

In the assessment, SUs are given a rating between 5 and 1 in each of the six areas of behavioural change assessed (see Figure Figure **4**).

Figure 4. Rating for each behavioural change area

Looking at the overall improvement in change star outcomes across between change star 1, 2 and 3 we see a general improvement in behaviour across the six areas of behaviour measured (see

Table **11** to Table 16). Tables 11 to 16 use a heatmap to show the overall improvement from one assessment to the next in the outcome change star assessment. The improvement is identified in the table through indicating that the majority (indicated by green colours) moves from being rated as

stuck in the first assessments (the lowest rating) towards being respectful (the highest rating) in the second and third assessments. This is testimony to overall improvement due to CIFA. This is shown by more people achieving 3, 4 and 5 rankings in the second and third assessments. However, the improvement varies a bit by outcome areas, for example communication has a high improvement rate, and being a good father is an area where SUs come in with a higher rating at the start of the programme. Overall, the general conclusion that improvement and moving towards being respectful in each area is the direction of those on the CIFA programme.

Table 11. Outcome area 1: Taking responsibility

Outcome area 1	**Change Star 1**	**Change Star 2**	**Change Star 3**	**Grand Total**
Stuck	14%	0%	0%	9%
Engaging	42%	9%	0%	29%
Acknowledging	42%	26%	15%	36%
Learning new ways	3%	49%	31%	18%
Being respectful	0%	11%	54%	7%
Practitioner: Acknowledging	0%	4%	0%	1%
Grand Total	100%	100%	100%	100%

Table 12. Outcome area 2: Thinking and attitudes

Outcome area 2	**Change Star 1**	**Change Star 2**	**Change Star 3**	**Grand Total**
Stuck	22%	2%	0%	15%
Engaging	41%	11%	8%	30%
Acknowledging	35%	28%	8%	31%
Learning new ways	2%	53%	62%	21%
Being respectful	0%	4%	15%	2%
Practitioner: Acknowledging	1%	0%	0%	1%
Practitioner: Learning new ways	0%	2%	8%	1%
Grand Total	100%	100%	100%	100%

Table 13. Outcome area 3: Safe actions and reactions

Outcome area 3	Change Star 1	Change Star 2	Change Star 3	Grand Total
Stuck	13%	0%	0%	8%
Engaging	43%	9%	8%	31%
Acknowledging	42%	32%	15%	37%
Learning new ways	3%	53%	38%	20%
Being respectful	0%	4%	23%	3%
Practitioner: Acknowledging	0%	2%	0%	1%
Practitioner: Learning new ways	0%	0%	15%	1%
Grand Total	100%	100%	100%	100%

Table 14. Outcome area 4: Communication

Outcome area 4	Change Star 1	Change Star 2	Change Star 3	Grand Total
Stuck	14%	0%	0%	9%
Engaging	43%	9%	0%	30%
Acknowledging	37%	36%	23%	36%
Learning new ways	5%	43%	38%	18%
Being respectful	0%	8%	31%	4%
Practitioner: Acknowledging	1%	2%	8%	2%
Practitioner: Learning new ways	0%	2%	0%	1%
Grand Total	100%	100%	100%	100%

Table 15. Outcome area 5: Being a good father

Outcome area 5	Change Star 1	Change Star 2	Change Star 3	Grand Total
Stuck	10%	4%	8%	8%
Engaging	43%	4%	0%	29%
Acknowledging	36%	32%	8%	33%
Learning new ways	8%	53%	38%	23%
Being respectful	2%	8%	46%	7%
Practitioner: Learning new ways	1%	0%	0%	1%
Grand Total	100%	100%	100%	100%

Table 16. Outcome area 6: Your wellbeing

Outcome area 6	Change Star 1	Change Star 2	Change Star 3	Grand Total
Stuck	19%	2%	0%	13%
Engaging	45%	13%	8%	33%
Acknowledging	27%	23%	8%	24%
Learning new ways	8%	51%	31%	22%
Being respectful	1%	11%	54%	8%
Practitioner: Learning new ways	1%	0%	0%	1%
Grand Total	100%	100%	100%	100%

4.2.5.1 Outcome star assessments by borough and area of assessment

Whilst the overall behavioural change was positive, we assess improvement by borough and also want to understand whether SUs in the different boroughs vary in terms of need for support when coming into and going through the programme. The following looks at the variations in ratings by borough and their change between the first and second assessment. There are fewer second assessments, and measurements are missing in some boroughs. However, overall, there is a good indication of the positive impact of the CIFA programme.

Taking responsibility – outcome area 1

It is clear from the first assessment of taking responsibility (see Figure 5) that there are higher levels of SUs being stuck in some boroughs: Kensington & Chelsea, Brent and Westminster. This is crucial to note to help tailor support for these SUs in the future.

In the second assessment (see **Figure 6**igure 6), fewer SUs are rated as stuck, and more as learning new ways. However, again, there are some boroughs that are working with SUs requiring more support than others. Overall, the general effectiveness of CIFA remains, showing an improvement in behaviour in this area.

Figure 5. Outcome star: Taking responsibility - first assessment

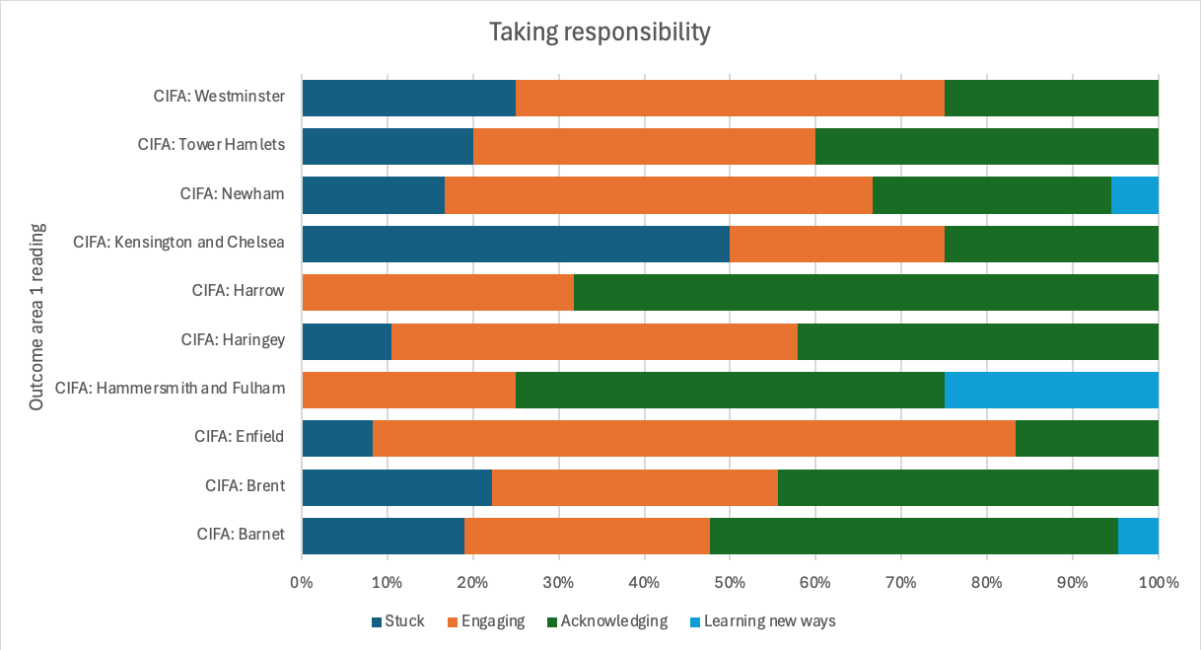
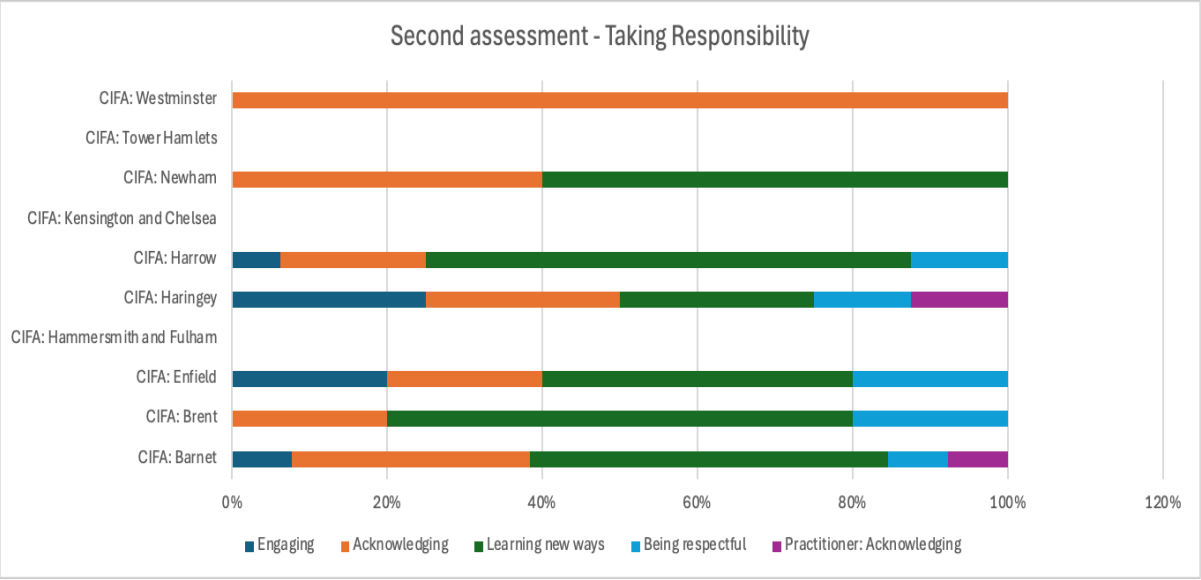


Figure 6. Outcome star: Taking responsibility - second assessment



Thinking and attitudes – outcome area 2

When looking at change in thinking and attitudes, behavioural challenges vary by area of assessment as well as borough, with larger shares being categorised as engaging in the assessment carried out in the outcome area of thinking and attitudes than in the outcome area of taking responsibility. Again, we see an improvement across boroughs from the first to the second assessment, with variations between boroughs both when it comes to proportions rating as stuck, engaging, acknowledging and learning new ways in each of the assessments and when comparing the progress from assessment 1 to 2. In this area, Tower Hamlet and Westminster have higher proportions of SUs rated as stuck in their first assessments.

Looking at the second assessment on thinking and attitude, there is a clear improvement in behaviour in the second assessment compared to the first, with much fewer rated as stuck and higher proportions rated as acknowledging and learning new ways. However, we see variations between boroughs with some boroughs moving from more SUs being rated as stuck to engaging whilst others have a larger proportion of SUs moving from engaging to acknowledging compared to the first assessment.

Figure 7. Outcome star - thinking and attitudes: first assessment

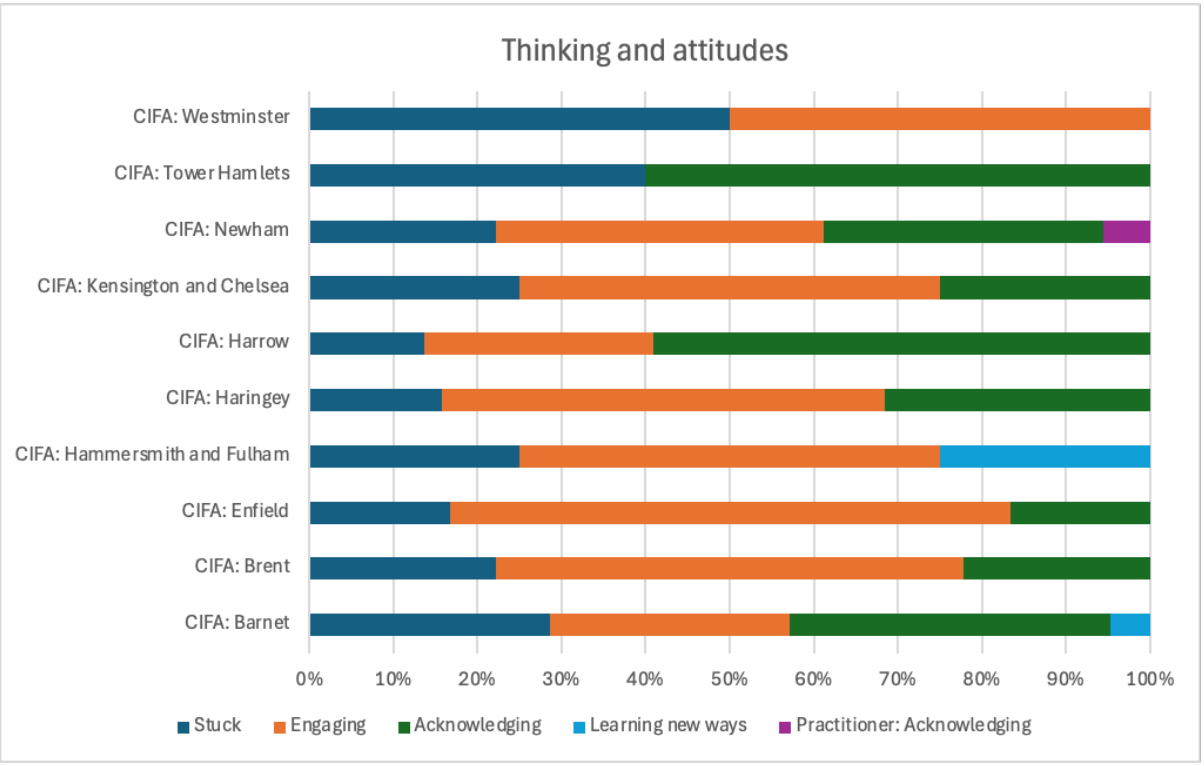
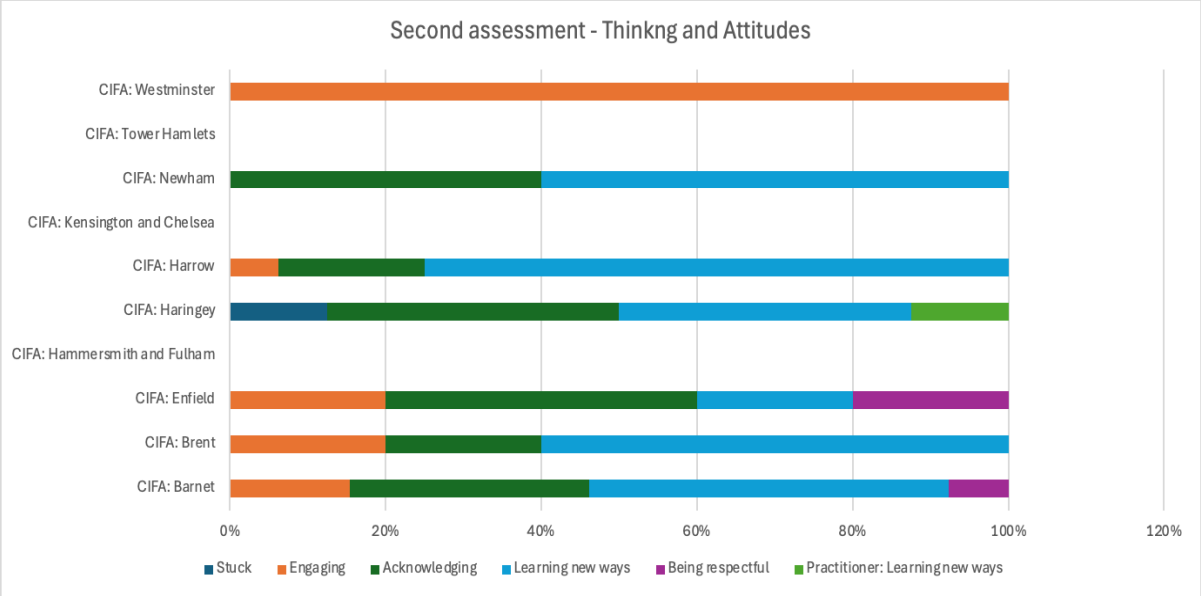


Figure 8. Outcome star - thinking and attitudes: second assessment



Safe actions and reactions

Overall, there are less SUs rated as stuck in the first assessment here than in the two previous areas at the start of the programme, with 4 out of 10 boroughs reporting no SU as stuck. There is variation in the proportion of SUs ranked at the different levels in the different boroughs and compared to the overall distribution of ratings seen in the grand total.

Figure 9. Outcome star: Safe actions and reactions - first assessment

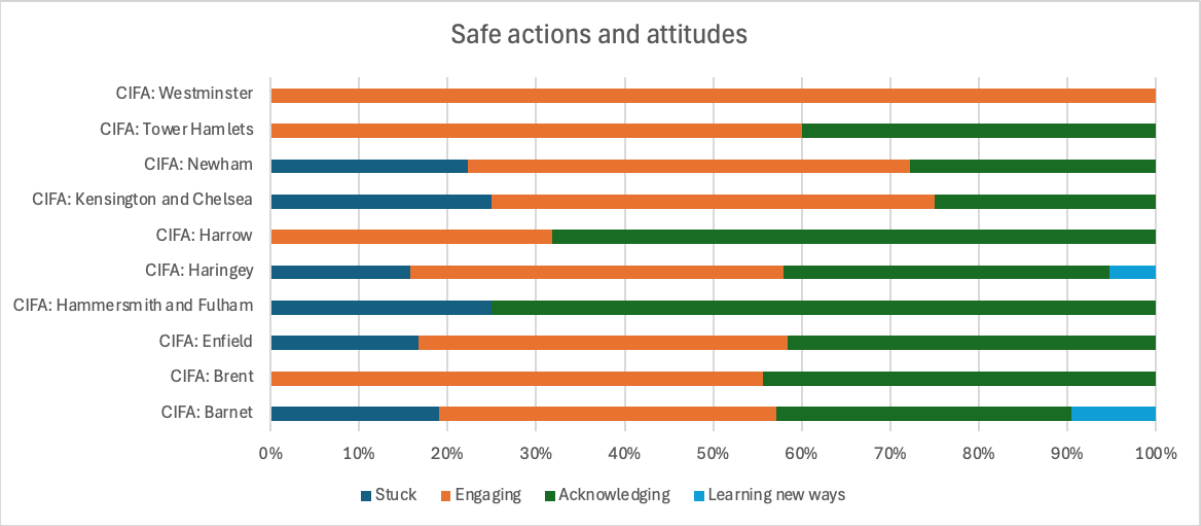
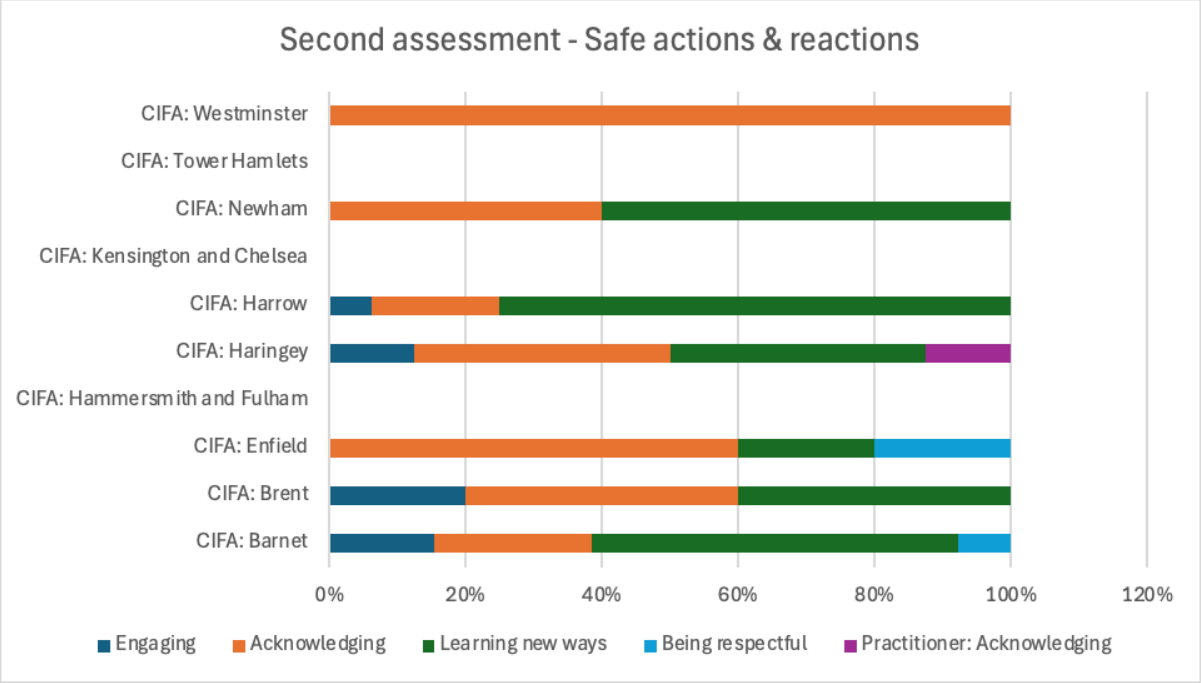


Figure 10. Outcome star: Safe actions and reactions - second assessment



Communication

Overall, communication also varies by borough. The proportion of SUs being stuck, engaging and acknowledging vary by borough and compared to the other outcome areas, more SUs are ranked as learning new ways at the start of the programme. We still see a good level of positive change from change star 1 to 2 across boroughs.

Figure 111. Outcome star: Communication - first assessment

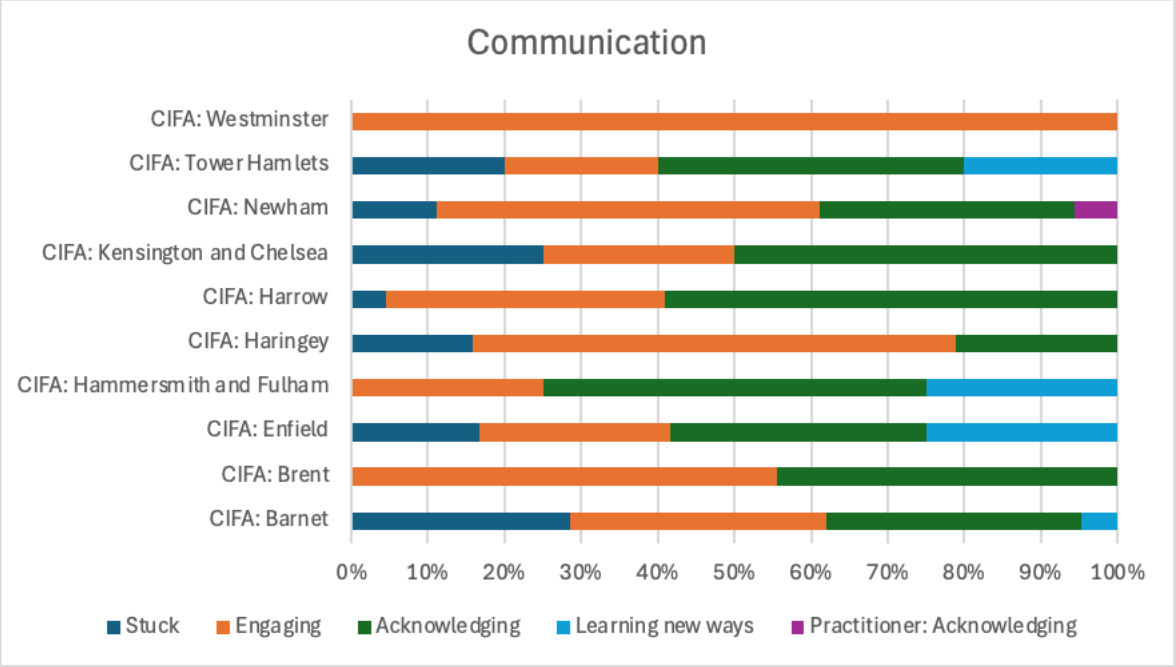
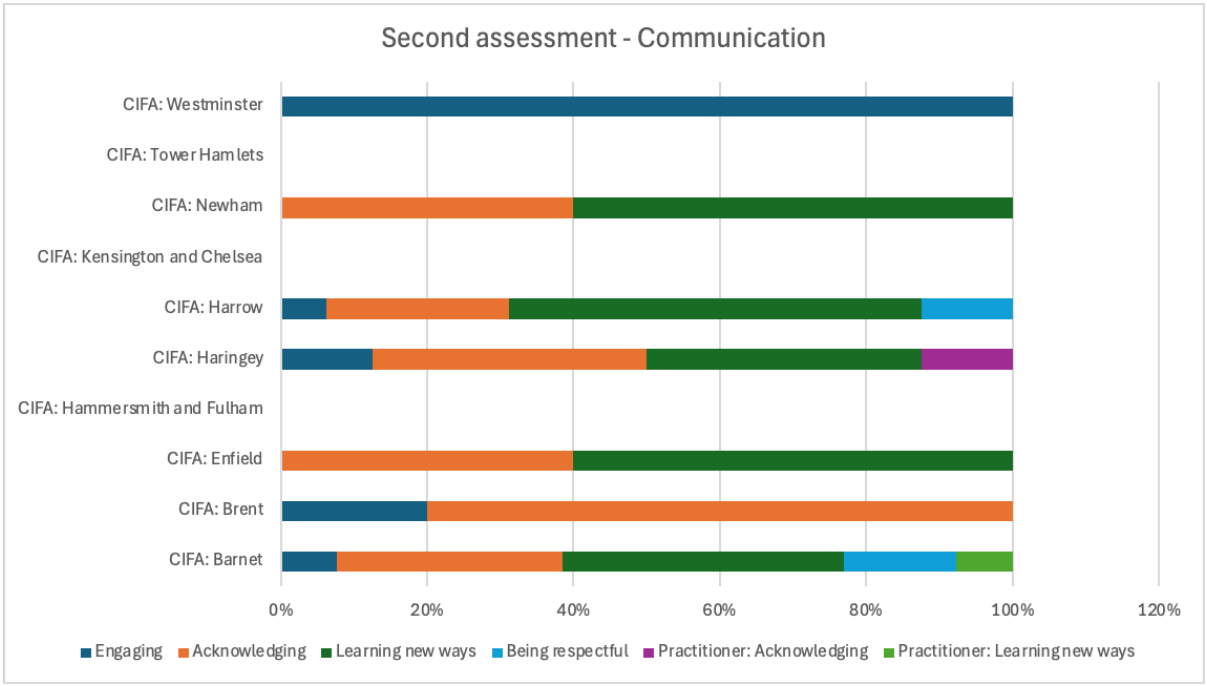


Figure 12. Outcome star: Communication - second assessment



Being a good father

In the first assessment, the biggest group of SUs assessed were categorised as engaging in all boroughs apart from Harrow where the largest category in the first assessment was categorised as

acknowledging. We also see higher rates of acknowledging overall, indicating that this is a shared value across those completing the assessment. This is also an area where we see higher scores in the second assessment.

Figure 13. Outcome star: Being a good father - first assessment

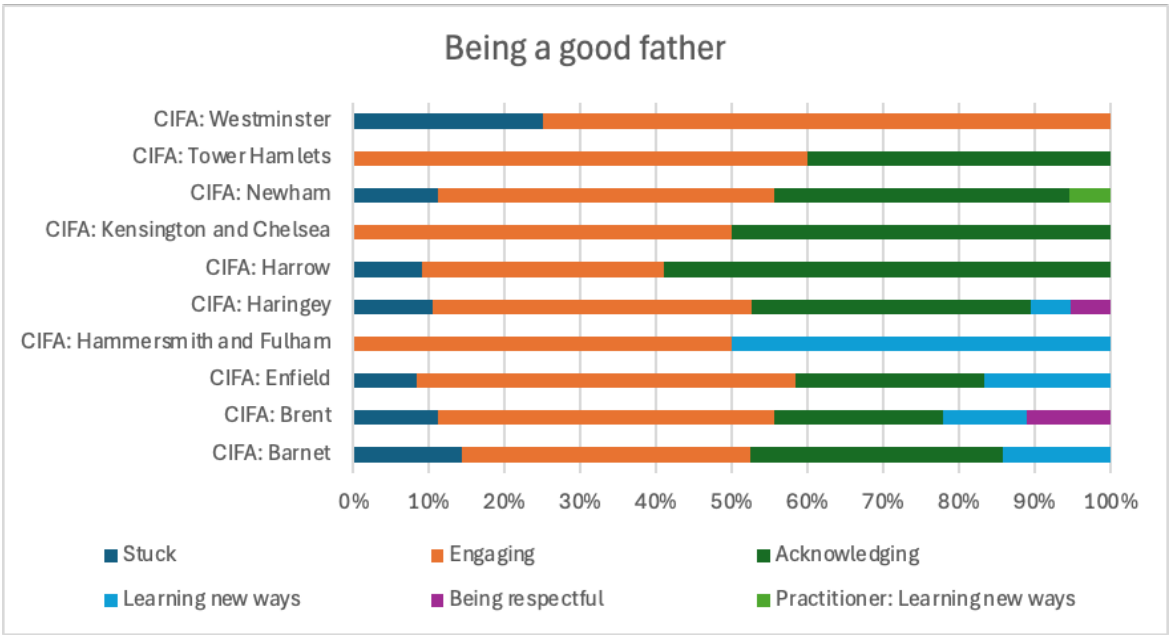
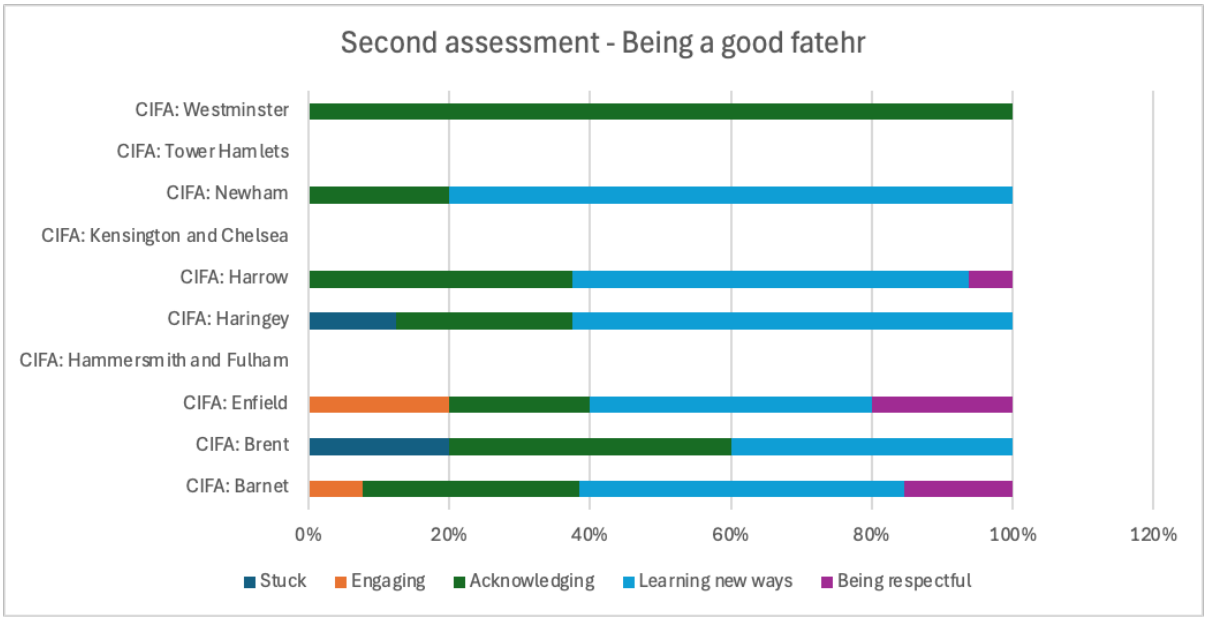


Figure 14. Outcome star: Being a good father - second assessment



Your wellbeing

When looking at your wellbeing, more SUs are stuck than in the previous outcome areas, however many SUs are engaging. There is again a difference between boroughs, suggesting a need to have in mind the variations in behaviours CIFA practitioners need to address in the different boroughs. Again, we see improvement from the first to the second assessment with many boroughs having the majority of SUs rated as learning new ways in the second assessment.

Figure 15. Outcome star: Your wellbeing - first assessment

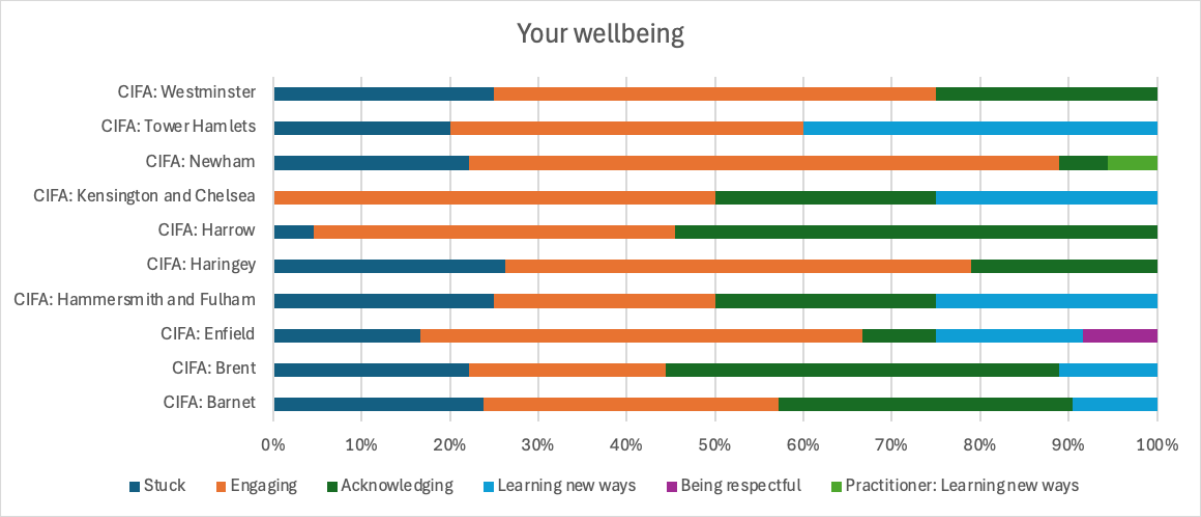
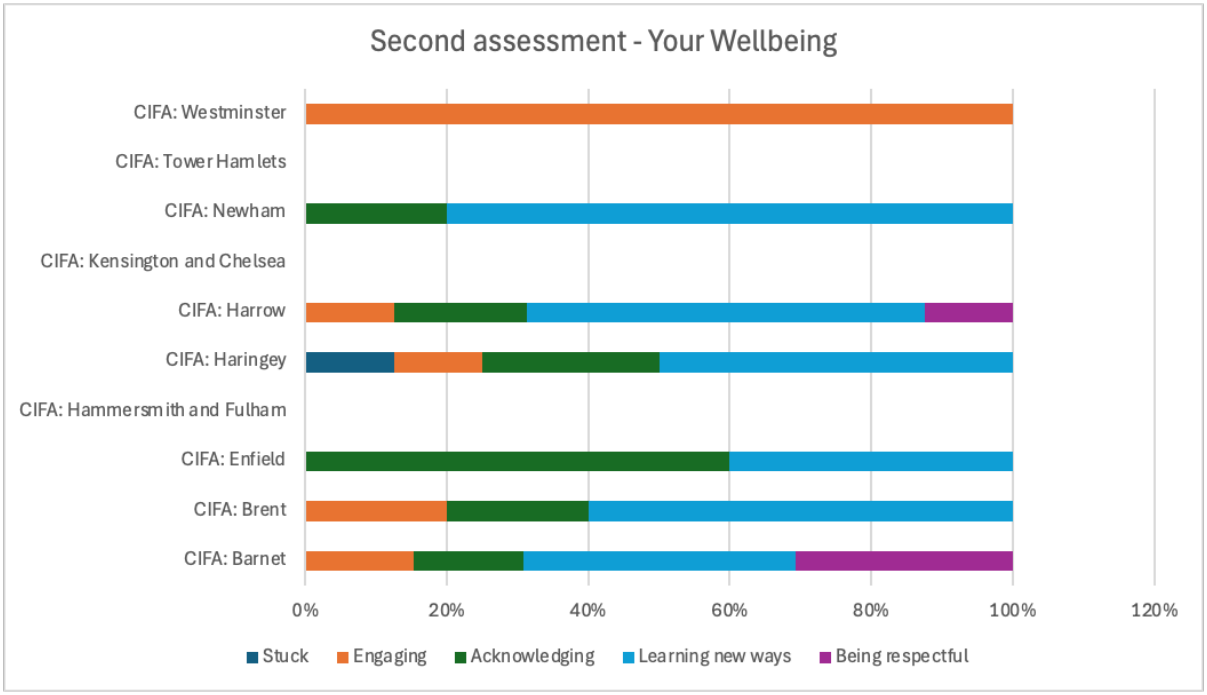


Figure 16. Outcome star: Your wellbeing - second assessment



4.2.5.2 Impact of CIFA: Assessments & racialised minorities

When assessing the effectiveness of CIFA, it is crucial to understand whether behavioural changes are achieved amongst racialised and minoritised groups. The following therefore discusses the variations in behavioural change among different minoritised groups. When assessing the change star data we carried out analysis of the full range of demographic characteristics available in the dataset but have only commented on them when they are found to have statistically significant effects, as this shows that effects are not by chance. It is crucial to understand the change in behaviour of the different racialised groups to ensure that CIFA is effective across the minoritised groups they aim to target. When doing this analysis, it became clear that the combination of low numbers of second assessment and many missing values when it comes to categorises such as learnings needs, mental health concerns and sexual orientation makes it difficult to assess change for these groups, and both an increase in number of assessments and better data recording is needed to be able to assess change by these characteristics.

Overall, this in-depth analysis shows that CIFA is effective in creating a positive change among SUs from diverse racialised minorities. The following analysis highlights which groups are represented within each of the categories in the assessment. The results show that different racialised groups do differently, thereby identifying racialised groups that may need further support to improve the effectiveness of CIFA for these groups in each of the areas.

Taking responsibility – outcome area 1

When it comes to the behavioural change of racialised minorities, we saw a general improvement in behaviour across groups in change star rating 2. In terms of the distribution of different racialised groups, Asian/Asian British: other Asian had the highest proportion of those scored as engaging here with 26%, and for those rated as stuck, the distribution was European 26.6%, Arab 13%, Asian/Asian British: other Asian 13.3% and Indian 13.3%. Overall, in the first assessment the majority of the assessments rated service users as stuck or engaging.

From the first to the second assessment, there was a general move towards star rating stuck and engaging, with 46.9% assessed as engaging – the biggest category compared to 42.8% in the first assessment. Furthermore, more are rated as learning new ways and being respectful – 12.2% versus 4 % in the second assessment - and no SUs are rated as stuck. In the second assessment, the distribution of different groups across the three biggest behavioural groups are acknowledging at 23% each for those categorised as Other Asian, Arab and European. When we look at learning new ways, 26% were categorised as Other Asian and 21.7% European. Lastly, for the category being respectful, 33% were categorised as Caribbean. Of those categorised as being respectful, Indian made up 16.7%, Other Asian, 16.7% Arab and 16.7% South American. When it comes to those needing an interpreter, we see a great - and statistically significant - improvement. The analysis shows that those who need an interpreter represent higher percentages of those rated as stuck in the first assessment, but this is no longer the case in the second assessment which is strong evidence of the effect of CIFA for this group. In the second assessment, a majority (66.7%) of those scoring 5 in being respectful need an interpreter compared to those who do not need an interpreter.

Thinking & attitudes – outcome area 2

When looking at thinking and attitudes in the first assessment, fewer achieve an assessment of acknowledging than in the first outcome areas. When looking at the proportion rated within each racialised group, we see that of those rated as stuck Asian/Asian British: other Asian represent 19.2% and European 19.2%, followed by Arab 15.3% and Asian / Asian British: Pakistani 11.5 %. Of those rated as engaging, Asian/Asian British: other Asian represent 14.6% and Black/Black British: Caribbean 12.2%, whilst for those assessed as acknowledging, the distribution is Asian/Asian British: other Asian 22.8 % and Black / Black British: African 11.4%. In the second assessment most are ranked as acknowledging at 51%, 28% as learning new ways and 12.2% as engaging, which is a great improvement in behavioural change. There is also a change in which ethnic minorities represent the largest proportion of acknowledging, as Europeans (28.6%) now represent most of those categorised as such, followed by Other Asian at 21.4%. These are also the two largest groups categorised as learning new ways, Other Asian (28%) and European (20%), followed by Indian (16%).

Safe actions & reactions – outcome area 3

When it comes to safe actions and reactions, there is - as on the other dimensions - a general move up one category in improvement from the first to the second assessment.

In the first assessment, those rated as stuck are divided as follows: Asian / Asian British: Pakistani 21.4%, Arab 21.4% and European 21.4%. Of those rated as engaging, Europeans represent 16.6% and Asian/Asian British: other Asian 16.7%. For those assessed as acknowledging, Asian/Asian British: other Asian represent 21.7%, European 19.6% and Black / Black British: African 10.9%. In the second assessment, the distribution has changed and different groups dominate different categories in the assessment. Of those ranked as acknowledging, 35.3% are Other Asian followed by 17.6% European and 11.8% Arab and 11.8% other Black. Of those seen as learning new ways, 16.7% are Indian, 20.8% Other Asian and 25% European.

Communication – outcome area 4

In communication, there was - as in the other areas - a positive move from the first to the second assessment, showing improvement in behaviour across all racialised groups. In the first assessment we see that Arab (28.6%) represents the largest group rated as stuck, followed by European (21.4%) and Bangladeshi and other Asian both represent (14%) of those categorised as stuck in the first assessment. When looking at the category of engaging, European constitutes 26.1% and Other Asian 15.2%. The third largest group of assessments were acknowledging, where Other Asian represented 23.7%, Indian 10.5% and African 10.5%. In the second assessment, most SUs were rated as acknowledging or higher. Of those assessed as acknowledging, Other Asian represented 36.8%, European 15.8%, Pakistani 15.8% and Other black 10.5%. Learning new ways was constituted by Europeans (25%), Other Asian (20%) and African and Caribbean at 15% of those found to be learning new ways.

Being a good father – outcome area 5

Between assessment one and two, there is a positive movement in behaviour overall and the largest move is from engaging to acknowledging and learning new ways. In the first assessment, 36.3% of those assessed as stuck were Other Asian, and 27.3% Arab. Of those seen as engaging, European constituted 20.5%, and Arab 11.4%, which was the same proportion as Other Asian. The third largest group was acknowledging where Other Asian represented 20%, the same proportion as European. In the second assessment, most moved one category up. Of those rated as acknowledging, 17.6% were Other Asian, 23.5% European and 11.8% Pakistani, showing a change in the composition of those ranked as acknowledging compared to the other outcome area. The second large group of results in this round of the assessment was learning new ways, where 33.3% were Other Asian, 16.7% Indian and 29.2% European.

Your wellbeing – outcome area 6

The last area of the Change star behavioural assessment is your wellbeing, where we saw 18.1% of those assessed being rated as stuck in the first assessment which changed to 2% in the second assessment - evidence of the positive effect of CIFA's intervention. Between the two assessments, there was a particularly good movement from those ranked as stuck and engaging towards acknowledging and learning new ways.

When it comes to ethnic minorities in the first assessment, of those rated as stuck 21% were Other Asian 21%, 15.8% Bangladeshi and 15.8% European. Of those rated as engaging, these two groups were again the biggest with Other Asian at 16.7% and European 25%. When it came to the third largest categorisation, acknowledging, Other Asian constituted 21.4%, European 14.3%, Indian 14.3% and African and Caribbean 10.7% each. In the second round, we saw a positive change as in the other outcome areas. Of those ranked as acknowledging, 25% were European and 25% Other Asian whilst 16.7% were categorised as Other Black. Of those rated as learning new ways, 29.2% other Asian and 16.7% European and for those assessed as being respectful, 40% were European, 20% South American, 20% other white and 20% Indian.

In this outcome area, needing an interpreter was statistically significant in the first assessment and at 6.6% level for the second assessment (Cramer's V 0.4 in both first and second assessment) which shows that this area saw a great improvement for this group. For the second assessment, the majority of those scoring 5 need an interpreter and they also represent 20% of those in category 4 which is impressive as this group represented the majority of those assessed as stuck, 57.9%, in the first assessment.

4.2.6 Victim-survivor support, safety and self-determination

VS consistently reported that the support provided through CIFA contributed to their sense of safety, empowerment, and emotional validation. Many described feeling heard, respected, and supported in ways that helped restore their confidence and sense of control. Initial concerns or fears about engaging with services were often replaced by trust and reassurance once relationships with key workers, especially DA Support Advisors (DASAs), were established. As VS4 reflected:

> *"I was a bit worried at the beginning, but when I started working with DASA I realised that there is nothing to worry about and that people are here to help me. I feel safe, heard, understood and not judged."*

Some VS described the support as transformational, helping them not only to process past abuse but also to regain self-worth and agency. VS2 spoke about her journey from surviving to recovery:

> *"My DA support advisor helped me work through a wide range of problems… I felt much more able to cope thanks to my DA support advisor… CIFA helped me to realise the abuse wasn't my fault. This was the biggest issue I had."*

For others, simple but consistent communication offered significant emotional benefit. As VS5 shared:

> *"I think that phone conversations are very helpful. I was given an opportunity to talk to someone and even that small thing can sometimes mean so much."*

> *"I was glad that there was a space where I could talk about my experiences… I did not have space like that before… I just wanted to do it as doing something to help myself was better than doing nothing"* (VS5).

Support extended beyond emotional reassurance to include practical help, demonstrating an understanding of the holistic needs of VSs:

> *"DASA listened to my concerns and offered advice… I was referred to another organisation… they gave me an Air-Fryer and some other things which I needed at the time, so there was a practical benefit to it"* (VS5).

This integrated model of care, combining emotional, informational, and material support, helped VSs feel less isolated and more prepared to advocate for their own safety and wellbeing. VS2 described this sense of community connection as central to her recovery:

> *"The programme, the collaboration with people, is very, very good… Everything is all right. The support is great, and… it's also good to know if anything was going to happen… that I've got a community, I've got support behind me."*

VSs reported an improved sense of safety and empowerment resulting from the establishment of physical or emotional boundaries, often supported by legal measures and informed by CIFA's education and guidance. VS1, for example, spoke of how the programme had equipped her to prioritise her own and her children's safety:

> *"Thanks to CIFA, I can clearly see now how abusive my ex-partner was and our perpetrator cannot come within 100 metres of us. I have got an order in place to keep him away. And because of CIFA, I have set boundaries and put mine and the children's safety first… I feel in a better place to cope with what has happened"* (VS1).

4.2.7 CIFA as an inspiring and essential intervention

CIFA was widely praised by stakeholders across boroughs as an inspiring and essential intervention. In a co-production conversation, one DAL described it as *"fabulous"* and *"priceless,"* noting that it *"makes communities feel seen,"* particularly through its focus on immigration, dependency, and cultural

nuance (DAL5). Others called it "*wonderful and inspiring*" (CP9), *"fantastic"* (R7, R9), and *"brilliant"* (I1). The FADA strand in particular was described by one CIFA practitioner as *"the most effective programme we have"* (CP3), with participants reportedly more focused, willing, and reflective than in other interventions. These reflections highlight not just impact, but also the perceived uniqueness and urgency of the CIFA model.

This quote from a social work manager (R11), captures the value of CIFA beautifully:

> *"All of us, as in, social workers, were doing that piece of work, and we just didn't have the time to do it at the level, right? Say, RISE can do. It's just, I think the work is amazing, and I've seen the outcome of, I mean, it's been specifically men of young men as well, who have engaged with the program. And the longer they've been able to engage, the more meaningful the work has been and for meaningful change. So I think their work is excellent. They're very amenable. They will really try with parents, and I think they're great. I think it'd be a massive loss if it was to go, a massive loss, because their work is deep. It's a deep piece of work."*

4.3 Adoption

Ecological model: Systemic change

Cultural and intersectional factors; Collaborative approach; Ripple effects; System coordination; Systems capability (culturally informed provision); Suitability assessments; Complexity; Cultural safety; Accepting of complexity; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; Partnership

Key findings

- Referrals over the years assessed are in line with those forecasted, thus meeting the goals of the intervention. When assessing this, we note that the referral numbers of victim-survivors have increased over the last year.
- Referrals vary between boroughs, something RISE and the CIFA team has worked hard to remedy through events and awareness raising. This is particularly true for victim-survivors, APFA and FADA.
- Some minoritised groups are not represented, notably LGBTQ+ communities.
- There is a need to further support low referring boroughs, as well as a focus on referrals from racialised communities that are not well represented among service users and victim survivors so far.
- The established referral process is based on excellent, consent-based practice that prioritises victim-survivor safety.
- However, there is a need for the referral pathways to be clarified – repeatedly and directly to referrers - so that all referrers who can refer do so, and for social workers to fully understand the referral criteria and process.

- Coordination with wider system stakeholders at assessment stage, and excellent feedback and recommendations, mean that CIFA is valuable even before the person is accepted on the programme, or if they do not start.
- Victim-survivors generally described CIFA support as welcome and timely, often saying they wished they had known about the programme earlier.
- Victim survivors saw the programme as relevant and helpful to their lives, even when initial hesitation was present.
- Victim-survivors reported that the engagement of their partner/the service user varied, but many were motivated by a desire for understanding, healing, and support for their children.
- Barriers to adoption include the programme length and commitment required by the service user, which CIFA responds to with flexibility.
- There is a need to enhance referrer's understanding of the programme's denial criteria and why it is important.
- CIFA works productively with service users and referrers to maximise the number of people accessing the programme, by conceptualising denial in complex ways and exploring capacity to change pre-programme.
- External motivations often shape initial service user participation on the CIFA programme, eg. demonstrating engagement to improve their chances of seeing their children. CIFA should work with referrers to explore the distinction between motivation and coercion.

4.3.1 Referral pathways: who refers, and how?

The process of referral to CIFA is the same across all 10 boroughs, with some variation in Tower Hamlets and Newham. It will also be the same in the new CIFA boroughs – Lambeth, Islington and Waltham Forest (which were not included in this evaluation). RISE accepts referrals to CIFA from any organisation or part of the local authority. This might include the NHS, GPs, police, probation, voluntary organisations, the Housing team, Adult Social Care and Children's Services for example. The primary referrer to CIFA across boroughs is Children's Services and a concern – which will be discussed in detail in Section 4.5.4 – is that a culture has developed in some boroughs where only Children's Services will refer to CIFA (CP13). In fact, any referrers can liaise directly with RISE and fill in a form to make the initial referral.

Tower Hamlets and Newham, however, have slightly different referral pathways. In Tower Hamlets, referrals from Children's Services must go through the borough's long-established internal 'perpetrator' programme, Positive Change. This is the main programme used for people with children impacted by DA. It offers group and individual work with parents who have caused harm, VSs and their children. All referrals from Children's Services first go to Positive Change, who assess the cases. Some will be referred to CIFA if considered suitable. The standard referral process is in place for all referrers outside Children's Services.

The system in Newham has recently changed. Previously, all referrals were brought to the DA Perpetrator Panel (DAPP), which is led by Children's Services. This process was established while the borough assessed the need for the programme. DAPP met fortnightly and considered both CIFA and DRIVE referrals. Now, referrals to CIFA are made through the DAPP lead via a designated inbox. The DAPP lead consults with CIFA and refers if appropriate. She brings the case to DAPP if unsure whether

it should be referred to CIFA or DRIVE. Referrals to CIFA can come from any referrer, not just Children's Services.

In every borough, multi-agency risk conference (MARAC) meetings are held monthly – or bi-weekly where there is a large volume of cases - and high-risk cases are discussed. All DRIVE referrals must be made through MARAC or DAPP. RISE will send a practitioner to every MARAC and if a person is not referred by MARAC to DRIVE and seems to fit the CIFA criteria, the RISE practitioner will suggest referral to CIFA (CP13). MARAC might recommend this but will not make the referral. The lead organisation can make the referral directly to RISE, following the standard process.

The referral process was described by referring social workers as clear and easy (R5, R8, R12:

> "*The template, what they are using, is really good, very clear, like not confusing the questions and also, not only the referral, they use their interpreters, if required…they don't depend on us to help them out with that"* (R12).

CIFA has no waiting list and the work with the SU can begin quickly, responding to immediate need, though referrals can take some time regardless because of practitioner workload and delays in particular teams or inter-agency work (R2, R7, R12). This delay *"can be an excuse for someone not to engage: 'I had to wait, nobody called...'"* (R7).

In some boroughs, there is, or was, a support infrastructure for social workers to make referral decisions. For a short period in Harrow, for example, a DA advocate in Children's Services worked with social workers. The advocate explained what the CIFA programme was, guided them through the referral pathway and would hold a "mini triage" to support social workers to make their decisions. After seeking this advice, social workers would make the referral directly to CIFA. However, Harrow no longer has a DA advocate in Children's Services. In Enfield, there is a 'perpetrator lead' in the DA Social Work team, who can offer guidance to social workers. Newham has DA leads and Safe & Together leads who can advise social workers on referral criteria and pathways. Social workers in Barnet, Westminster and in Hammersmith and Fulham can also consult with the borough's Safe & Together leads to help them decide on a referral route. This child-centred programme works – at the time of writing - across ten London boroughs. It frames DA as harmful parenting and aims to support Children's Services to make good decisions for children impacted by domestic abuse through training, assessment and planning underpinned by the model's principles.

In terms of the APFA programme, a CIFA practitioner reflected that it can be very difficult to engage the adult child who has caused harm within the family (CP12). Often mental health issues and substance use are factors contributing to the familial abuse. VSs are supported by CIFA, with an assessment of risk and safety planning. Like all current CIFA programmes, self-referral is not possible.

Referral numbers and issues arising are discussed monthly in the Partnership meetings. These meetings are attended by VAWG leads, IDVA services and CIFA staff. Patterns of referrals, assessments and completions are discussed in this forum, questions and concerns can be raised, and best practice shared. They are productive and generative meetings, which give rise to connection and coordination beyond the space, as discussed in Section 4.5.5. This forum is also a space of subtle resistance to quantitative measures of programme integration and success. Referral numbers for each borough are reviewed and commented upon, with encouragement offered and strategies discussed. Some stakeholders use the space to note the difference in the size and diversity of boroughs, which can

explain the lower numbers of referrals, alongside the embeddedness of CIFA in boroughs where it has been longer established.

Whilst in general referral pathways are clear, in interviews with community organisations, concerns were raised about referral pathways between community organisations and RISE/ CIFA. For example, one interviewee stated that within the LGBTQ+ community, most community groups are 'by and for', with referrals typically taking place between each other. However, they suggested that if a referral pathway to CIFA were established - as is planned with the investment in Respectful Partnerships outreach - it could serve as a valuable connection and widen the ripple-effect impact of the CIFA services.

4.3.2 Referrals: the SU perspective

Most SUs were referred to CIFA programmes (CIFA, FADA, APFA and Respectful Partnerships) via social services, mainly Children's Services, within the borough. This referral pattern is not surprising since it aligns with the core objective of the CIFA programme, which is to deliver a culturally informed and integrated family service to people in the borough experiencing DA as people who have caused harm and/or VSs. In the main, SUs were signposted to the CIFA project by social workers because they were in relationships with current or ex-partners marked by DA where children were present. These referrals were based on the belief that the SU, should they choose to engage with CIFA, could improve the familial environment for all, especially the child(ren). The type of assistance social workers thought CIFA could provide to SU10, for example, was linked to anger management, with the expectation that it would address both individual and relational challenges. However, participation is not mandatory and SUs could choose whether they wanted to participate in the programme. In addition, a SU could not participate in the programme if no support provision was in place for the VS throughout the 16-20 weeks they were attending CIFA. Individuals who were unable to acknowledge the harm caused by their behaviour or denied it outright were not eligible to take part.

The structured, evidence-based risk assessment process employed by CIFA ensures that all decisions about suitability, engagement, and safeguarding are grounded in a robust understanding of risk. For people who have caused harm, CIFA uses the Spousal Assault Risk Assessment (SARA), a structured professional judgement tool that evaluates both static and dynamic risk factors for intimate partner violence. For VSs, CIFA employs the Domestic Abuse, Stalking and Honour-Based Violence Risk Identification Checklist (DASH/RIC) to assess immediate and ongoing safety risks. These tools are administered at the point of referral and revisited as needed throughout engagement with the programme. Risk assessments help CIFA practitioners identify protective factors, inform tailored support plans, and determine whether CIFA is the safest and most appropriate intervention for both the individual and the wider family. Where risk is deemed too high for safe engagement, CIFA works with partner agencies to ensure appropriate alternative interventions are in place.

All SUs interviewed met the admission criteria and were subsequently enrolled on the CIFA programme following referral. The majority, like SU16, found the process 'straightforward', relatively easy and free from significant obstacles. However, a few reported procedural barriers that caused delays in the referral process. For instance, SU3 experienced a waiting period of several months before being able to start the programme. Similarly, SU16 waited a long time when CIFA were trying to find a replacement practitioner. He reported that the process was frustrating, describing it as "disruptive"

and “challenging”, noting that it had the potential to undermine his engagement with CIFA altogether.

> *“I was assigned to a worker, [and] while I was doing it [the programme] they sometimes cancelled because of some other training they had to do. It's a bit disruptive. Then they actually left RISE. Then I was left for like, a month or two without no one contacting me, sending a message, or an email. I didn’t get nothing back from RISE until my son's social worker contacted them - and they didn't contact me directly – then I continued with a new person.”*

For this SU, the transition period and re-referral led him to resist further engagement with CIFA and he did not want to “*go back*.” His social worker persuaded him of the benefits of the programme and he gave it another try.

Additional personal reservations, which could be interpreted as ‘barriers’ to the referral, included initial reluctance to engage because they could not see the benefits of doing so. For example, SU1 stated, *“I didn't think I would gain anything from it, truthfully, and I thought it was just going to end up being a waste of time and a tick box exercise*.” This sentiment reflects, at least in the beginning, mere compliance rather than genuine engagement.

SU13 was initially deeply concerned about whether any disclosure to CIFA practitioners would be detrimentally used against them:

> *“I had it in the back of my mind, if this is gonna be used against me somehow, the information I share with them. Mainly about like me sharing some stuff and I didn't want it to affect my child. I'm feeling lots of guilt because my son is witnessing some stuff that children shouldn't. I guess, I didn't want like social workers to know that.”*

Another concern for SUs was the perceived time commitment. CIFA is a long programme: 16-20 weeks, plus a potential pre-intervention programme of 5 weeks. This can feel like a big commitment for SUs, who can be reluctant to engage as a result (R9). SU5, for instance, voiced concerns about he was going to “*juggle work, the legal proceedings, my own therapy and the DA program.*” Whilst he could see the merits of accepting the referral for himself and his family, SU5 was “*just a bit unsure”* as it was *“untrodden territory.”*

The stigma of being associated with a DA programme was cited as a barrier to accepting the referral. For instance, SU4 expressed discomfort about the referral and “*didn’t like the thought of being involved in any of it*.” This is linked with the use of the word ‘perpetrator,’ discussed in Section 4.1.6.2. Similarly, SU2 perceived the referral as an error of judgment by the social worker. While SU2 accepted responsibility and was not in denial of his actions, he viewed his situation as much more complex than the social worker(s) had understood. He explained how the referral to CIFA followed unfounded allegations made by “*the mother of my child”* and that he was instructed to participate. He said,

> “*At first, I thought at first, I felt like it was a judgment of my character. It felt like a stain on my character. Because, from my perspective, I believe that I didn't need a service like this, especially after, like, a lot of things that were said about me wasn't exactly true. So, I felt like me being part of this was like, like, an admission of guilt or something, you know. So, it was very difficult for me*.”

The perceived 'stain on his character' fuelled animosity in SU2, initially hindering his full engagement with CIFA. He described being belligerent and obstructive as he did not see the need for the referral. However, like many SUs, SU2 overcame his reservations and engaged with the programme. For some, this decision was instrumental (e.g., serving as a means to maintain contact with family or facilitate the return of their children to the family home) while others came to recognise personal development benefits of participating. As SU7 noted, the referral was ultimately beneficial because it:

> '[…] *help[ed] families to learn, to create a bond with each other and then spend more time with each other; 'to manage and do things' better within the family unit'. [... this programme was really helpful to help people or families who are struggling to cope with members of the family, like how to speak with them and how to deal with the situation*.'

This is what attracted SU7 and others to participate in CIFA. They expected that doing so would improve relationships with their partners and children.

4.3.3 Rise assessment & suitability

When the case comes to CIFA, they assess the person's suitability for the programme. This will involve reading relevant paperwork in relation to the SU (SU) and the VS (VS) and consulting with the referrer. Before any contact is made with the SU, CIFA practitioners ensure that consent has been sought from the VS. This is an essential example of CIFA's consent-based, integrated VS support in practice. The DASAs or IDVAs (depending on provision in the borough) will reach out to the VS, explain what CIFA does, what the programme is, and the support available to them while CIFA works with the SU. Seeking consent in this way is central to CIFA's victim-centred, integrated approach, which is in line with the Respect standards. They will not work with someone who has caused harm if it could potentially increase the risk to a VS.

If the VS consents to RISE working with the SU, RISE can proceed. If the VS does not offer consent, refuses support or is not contactable, RISE will assess – with support from the IDVAs and social worker (or other referrers) – the risk of going ahead. A central question is *"who has eyes on the VS?"* (CP13) RISE will do a risk assessment and consider the circumstances, exploring whether the work can go ahead without elevating the risk to the VS. For example, if the SU and VS are no longer together and not in contact, RISE could begin to work with the SU. If the VS does not consent to RISE support but is actively in contact with social workers – referring from Children's Services for example – CIFA might be sufficiently connected to the VS' experience throughout the programme and able to work with the SU. The referrer will state on the form that they have spoken to the VS, that they know the referral is being made and that the VS is happy for RISE to call and offer support. As a CIFA practitioner explained: *"If no, why is she saying no? any other way to get her voice in?"* (CP4). The holistic, wrap-around communication approach between CIFA, IDVAs/DASAs and social workers and other referrers is discussed in section 4.3.4 and 4.4.5.2.

With the potential impact on the VS considered, RISE will continue the assessment with a conversation, or several conversations, with the SU. The SU's suitability for the CIFA programme at this stage usually hinges on their willingness to acknowledge responsibility for the harm they have caused and desire to change their behaviour. While quantitative data captures and analyses progress from the beginning of the programme, CIFA practitioners were keen to emphasise the value and

importance of the period before the person begins the programme (CP3, CP13). From referral to assessment, there is a period of relationship- and trust-building, where referrers and CIFA practitioners support the SU to be ready to engage with CIFA (CP13). Social workers will work with SUs to encourage them to agree to a referral to CIFA (R9, R5).

CIFA will accept a SU on the programme if they demonstrate some willingness to admit that they have caused harm. At this point, RISE might decide to recommend their five-week pre-intervention programme of introductory sessions, aiming to prepare SUs for the CIFA programme. The focus in these sessions is working with the person to explore their readiness to engage meaningfully within the programme and whether their denials and minimisations might shift. These sessions are culturally informed: issues of identity, migration and resettlement, and awareness of categories of, and laws related to, DA in different countries are explored. If the person demonstrates openness in these discussions, they can be accepted on the programme (CP7).

CIFA practitioners might decide to *"tentatively assess"* a SU as suitable for CIFA, erring on the side of generosity to give the person the opportunity to benefit from the programme (CP3). RISE are alive to the possibility of *"false compliance"* at assessment stage (CP13) and the line between encouragement and coercion is complicated where there is social services involvement and a lot at stake for potential SUs. Section 4.3.7 discusses the varying external factors and influences that can motivate SUs to pursue the programme. Practitioners were keen to emphasise that an initial refusal *"is not a closed door"* (CP3). They might encourage the referrer to work with the SU on their denial – discussed in detail in Section 4.3.7.1 - and to re-refer if they feel there is a shift towards acknowledgment or accountability (CP3, CP13). Again, after the assessment stage, the impact on the VS is considered. If the person is not accepted on the programme, RISE will communicate this in a way that will not elevate risk for the VS. (CP13).

CIFA practitioners emphasised the value of CIFA even at assessment level. Positive work is carried out with the SU before the programme, which is valuable even if the person is not accepted onto the programme. This includes coordinated work on risk management plans with social workers and other referrers and with CIFA's high-risk programme DRIVE. Social workers reported that the CIFA team provides exceptional feedback, even before the SU began the full programme. CIFA produced *"an excellent report, and recommendations, even if they can't work with him,"* meaning that social workers were *"not left with nowhere to go"* (R3). While the focus is often on the quantitative – how many people are assessed and how many people start the programme – the people who do not start are just as important (CP3).

The pre-programme period can be lengthy, as CIFA practitioners navigate assessments, communication with IDVAs or DASAs, work with social workers and other referrers and arrange sessions with the SU. SUs are given every opportunity to engage, even where there appears to be a lack of motivation:

> *"...when there's a lack of motivation, and then there's consistent absences, and that kind of shows, you know, when you're trying to contact them to or send messages to remind them to, you know, their session's on this date, this time, and they don't attend…you make numerous calls, you contact the social worker or probation officer, you know, and you're not getting anything back. And sometimes doing that can take two to three weeks or even a month, sometimes just the to-ing and fro-ing, because you have to give them that opportunity"* (CP11).

It can be difficult to contact SUs because of work, language issues, or a mistake in the contact details provided to CIFA (CP11). CIFA practitioners will persist and be flexible (CP11), informed by an intersectional understanding of people's experiences: as a programme supporting marginalised people, there is an understanding that SUs can struggle to find time for sessions with work commitments (R4, R12; CP11), that SUs may be resentful of services because of experiences of discrimination and unwelcome interventions in their home lives, and that there may be cultural elements too, linked to embarrassment or concern about reputation and the family name (CP11).

4.3.4 Victim-survivor referral

VSs access support through CIFA via a range of referral routes, with many first introduced to the programme by trusted professionals already involved in their care. Social workers play a central role, frequently acting as the main point of referral.

> *"My social worker referred my husband and me to this program. The referral process was good. Everything went well"* (VS4).

Other routes into the programme include referrals from GPs, DA support advisors, and in some cases, direct outreach following police involvement. Several survivors reported being connected to the programme in moments of acute crisis, highlighting the importance of a responsive, trauma-informed referral system.

> *"I've been referred to [CIFA] because I was in a situation that I locked myself off in the spare room because of his abusiveness… I called the police, and it started from there"* (VS7).

> *"I was referred to this program through my GP. I did not know that programmes like this existed. I received a call from RISE and since then I have been in touch with a DASA"* (VS5).

> *"My ex-partner was included in CIFA as a perpetrator. I, as a victim of his violence, was offered to participate in the programme. I received an email offering to contact me from my DA support advisor"* (VS1).

In some cases, survivors found their way to the programme themselves, then advocated for their own referral through professionals they trusted:

> *"I have done my own research, and I found this programme, and I asked my social worker…to refer me onto this programme"* (VS2).

While the referral process was described by many as smooth and supportive, some expressed concern that the programme is not yet widely known or accessible to all who may benefit from it. One survivor reflected:

> *"One is really sort of troubling me… maybe other women are sat at home and they are not aware of this organisation… and there are people out there who would help them. That is really sort of heartbreaking for me to know they haven't got access"* (VS2).

This insight underscores the importance of expanding awareness and visibility of the CIFA VS support offer, particularly among underrepresented groups and isolated individuals.

Most VSs who are contacted by IDVAs or DASAs engage and are happy to have the support (CP1). These practitioners reflected that the involvement of social workers and Children's Services also motivates them to engage (CP1, CP2).

CIFA practitioners offered a range of explanations for VS reluctance to engage with the support offered through CIFA. The direct VS voice is missing from these explanations as those who engaged with the evaluation also engaged with the programme. Disengagement can be related to external context, overwhelm, disinterest or distrust of services: VSs *"get a lot of calls"* and sometimes disengage as a result (CP1).

Many have busy lives and simply do not have capacity to engage. Some see the CIFA programme as focused on the person who has caused harm and refuse to engage themselves, stating *"he's the one on the programme"* (CP1). Another issue, which is important from an intersectional and cultural analysis, is that some VSs do not trust professionals, and therefore will not engage with the support offered (CP1, CP13). One social worker reflected that the partner who reports violence to services can feel guilty about doing so, which can generate reluctance to engage (R5). IDVAs and DASAs noted that referrals from social workers can be poor quality, which limits their ability to connect with the VS and encourage participation in the programme. Referrals sometimes come with basic information and no context, often not even the name of the SU, *"just saying 'call this client'"* (CP1, CP5).

While experienced as frustrating for IDVAs, in a partnership meeting (12 March 2015), the reasons for the lack of detail were discussed. At the initial point of contact, VS consent may not yet have been confirmed. RISE staff explained that it is not appropriate to send the whole referral at that point due to GDPR. RISE had previously agreed with IDVAs that they can contact the referrer directly if they need more details to make the initial call to the VS.

4.3.5 What are the patterns in adoption across boroughs?

The overall levels of referrals for SUs are close to the forecast as seen in Table 8 in section 4.2, varying by being slightly under or over the forecasted numbers, depending on the time of the year. These are season variations that are to be expected. VS referrals have greatly improved over the last year, whilst the number of referrals of APFA and FADA SUs and VSs still remain low. Furthermore, there is potential for improvement when it comes to reaching and including racialised minorities and LGBTQ+ minorities onto the programme.

The number of referrals, completions and suitable candidates from different racialised and religious groups also vary by different groups, as seen in section 4.2. The quantitative data thus shows that whilst CIFA does well in serving communities that are often not well supported, they still have a potential to improve their numbers, and the support given to groups from different backgrounds. LGBTQ+ individuals are underrepresented as set out in 4.1 and whilst efforts are being made through outreach and awareness campaigns the numbers are still very low and often not recorded, making it difficult to assess whether or not there are positive outcomes of the mobilisation efforts being made. The number of referrals by these different groups also vary by borough. This highlights the different challenges when it comes to increasing referral numbers in different boroughs. It also helps us identify and improve outreach and referral work in the future by identifying which groups are currently not as well represented among referrals, the same is shown in section 4.2 when it comes to rates of

completion and being found not suitable highlighting a need to adapt processes of suitability and the programme to ensure all racialised groups are well supported.

When looking at the numbers of referrals of SUs by boroughs, it is clear that there are quite large differences in numbers of referrals between the different boroughs. This is true for all three SU programmes offered by CIFA. See tables for data from the RISE dataset and section 4.1 for numbers as reported to MOPAC, and section 4.2 for an in-depth analysis. Barnet, Brent, Haringey, Harrow, Enfield and Newham all have higher numbers of referrals. See section 4.1 and 4.2 for referrals by borough and SU programme. These boroughs have the highest referrals for SUs across the three SU programmes and for VS. Other boroughs have potential to increase their numbers considerably. It is worth noting that when looking at the numbers for the three boroughs served by Advance for VSs - Hammersmith & Fulham, Kensington & Chelsea and Westminster - there are low referral numbers. However, they seem to have higher numbers of referrals accepted than other boroughs.

Considerable work has been put into improving referral numbers and mobilising for CIFA, including mobilisation meetings with VAWG and IDVAs across the ten boroughs and awareness events among other initiatives as reported in the narrative reports sent to MOPAC and discussed in section 4.1. Despite these efforts, the ongoing differences between boroughs prevail, and we see this as an opportunity for the team to consider new approaches to improve referrals.

When it comes to attendance, seen here as a measurement of engagement, CIFA is longer than other programmes, as it is focused on long-term sustainable behaviour change, which some SUs have noted as a disincentive in the qualitative findings. The quantitative data from RISE shows lower rates of being categorised as attending among SUs on the CIFA programme than that of Brent (15.8%) and Barnet's (15.8%) DA programmes with CIFA programmes having range of 1.8% to 15.8% as attending. The higher number is represented by Newham and does not represent the level of attending of other boroughs when it comes to CIFA. Percentages of attending on FADA (15.3%), main programme (19%) and on CIFA neurodivergent (4%) show an area for improvement on the last programme. Overall, there is good engagement both with VSs and SUs when they are on the programme, but there is still a potential to improve numbers of referrals to the programme, in particular through improving the number of referrals through a wider range of referral pathways than is currently occurring.

4.3.6 Stakeholder buy-in and system coordination

In interviews, referrers, DA leads and CIFA practitioners reflected on why the CIFA programme is needed. Before CIFA, there was a previous lack of support or intervention for those who have caused harm (DAL1, CP5, CP10, R1). This meant that social workers could not support SUs in the same way. With CIFA, social workers now have somewhere to refer people who have caused harm, particularly men and fathers (CP10, R1). For one DA commissioner, it was *"unfathomable"* that such a programme and referral route did not previously exist. Without doing this work with those who had caused harm, social services receive a lot of repeat DA referrals (DAL1). In Child Protection, the mother usually becomes the focal point of attention from social services and the father is almost entirely absent from the process (R1, CP13).

CIFA brings specialism and capacity to the system: other stakeholders are excited for CIFA to do work they cannot do, to help them manage the risk of those who have caused harm (CP7). An essential part

of the CIFA offer is cultural competence: referrers and DA leads were aware that communities were not being served through existing provision (DAL3, R1). The work, however, as one VAWG lead asserted, needs to be properly resourced, or nothing changes (DAL4).

4.3.7 Barriers to adoption: denial, external motivation and false compliance

4.3.7.1 Denial

A central criterion when assessing someone as suitable for the CIFA programme is some element of acceptance, of accountability, of recognition that they have caused harm. This is also in line with the Respect standards for safe delivery of programmes with people who have caused harm. This is required for CIFA to be able to work productively with the person. There are many reasons why a person might not want to admit to or acknowledge harm caused or abusive behaviour: as described earlier from the SU perspective, they may be concerned about a police investigation; they may anticipate that admission will have a negative impact on access to their children; or they may be conscious of raising their risk level in the system (R9, R5). The person who has caused harm can find it challenging to accept that their behaviour is defined as abusive: *"when it's been put direct to them, they struggle"* (R7). Denial may also be present in some SUs due to defensiveness, or persistent challenges in understanding the extent of, or potential for harm due to behaviours. For example, according to a case study, Mr X, who is neurodiverse, adopted the programme learnings in a partial way. Whilst he accepted some programme ideas, defensiveness persisted.

CIFA practitioners have a complex and intersectional understanding of denial which underpins programme flexibility and a commitment to working with SUs where possible. One CIFA practitioner stated that the language of denial can be misleading. It may be more helpful to see people as *"stuck, reluctant, ambivalent"* (CP13). The person *"just doesn't see it"* (CP13). Non-engagement or denial perceived as 'cultural' can also be about the person's perception of the state and a well-founded fear of state intervention, both in the UK and their home country (CP13, DAL1). Cultural beliefs can shape this denial and these beliefs are explored with the person in assessment conversations and introductory/preparatory sessions.

CIFA want people to be prepared for the programme - ready to reflect on and explore their behaviour – and they make significant efforts to get SUs to a place of readiness, including working to shift denial. The CIFA assessment, as described above, may lead to a recommendation that the person does some pre-intervention, introductory sessions, to explore their readiness to engage with CIFA. For CIFA practitioners, an assessment of non-suitability on the basis of denial is *"not a fully shut door*" (CP3).

> *"...we couldn't work with someone…if they deny all abuse, so every type of abuse, they say their relationship is perfect, they say they don't need any help. That person requires motivational work from their social workers. So we wouldn't just reject them. I would write the assessment, I would write recommendations, and in some cases, I send social workers resources on how to reduce denial and say, you know, do this work and then come back to us. So it's not, it's not a fully shut door. It's just a saying, you know, it's not right now"* (CP3)

They may ask the referrer to work with the person to address the denial and to come back if there is shift towards accountability. Articulations of SU accountability are *"often partial"* (R5) and that can be sufficient (CP3). In this assessment process, a primary concern is the experience of, and risk to, the VS.

Accepting a person onto CIFA where they are not willing to accept the harm they have caused and explore their behaviour could increase risk to the VS (CP4, CP13). The practitioner will exercise professional discretion in accepting SUs onto CIFA, and onto the pre-intervention programme too (CP6).

There is some frustration among referrers and other stakeholders around CIFA's denial criteria. One IDVA wondered whether CIFA could be more flexible, to try to work with SUs despite their denial (CP1). CIFA practitioners recognised that referrers might be hesitant to refer again if they have experience of people not being accepted (CP7). This frustration comes in part from the lack of alternative programmes open to people who have caused harm. In many boroughs, RISE offers the only 'perpetrator' programme(s). If the person is not considered high-risk and cannot be referred to DRIVE, and CIFA will not accept the person because of denial, there is no available referral route (CP1). If they are not assessed as suitable for CIFA:

> *"I think that sometimes social workers get very frustrated in terms of we are not accepting the perpetrator because he's not accepting, or acknowledging his abusive behaviour and I feel that suddenly all this man [sic] are not being supported, or at least there hasn't been an opportunity for them to enter the course, the training and see if maybe they can learn something if they can"* (CP1).

Essentially, social workers may not necessarily know the extent of the DA or analyse the suitability of a SU by discussing their perspective on the DA. They may *"just want someone to work with them"* (the person who has caused harm) (CP7). The person referred to CIFA, as seen in SU accounts, might not be given much information about CIFA; the programme might simply be pitched by the social worker as part of a child plan (CP6).

CIFA practitioners, however, insist that they are flexible and err on the side of generosity with assessments, tentatively assessing them as suitable. The practitioner may later need to close the case because the person is not cooperating or the risk level changes:

> *"it's a shame that that looks bad for our stats, but I think it's really important that we maintain our integrity, that we're giving people the opportunity, and then there's the odd case where risk events happen later that are so concerning or severe that we can't continue"* (CP3).

CIFA practitioners will sometimes contact the referring social worker to learn more about the context before starting the referral process, to identify issues, discuss suitability and avoid non-suitable referrals (CP7). In a Partnership Meeting (3 April 2025), denial was discussed in detail, including the possibility of referring an SU to the pre-intervention sessions where there is denial. It was noted by a VAWG lead that social workers have not understood that route and that she would begin to promote it. RISE clarified that the person still needs to be assessed, that as part of the usual referral pathway. It is clear that some work remains to be done in this area. Detailed and regular communication with referrers and stakeholders working alongside CIFA focused on the denial criteria, its necessity and the CIFA assessment process should be improved and prioritised.

4.3.7.2 External motivations: Children's Services

SUs are often encouraged by social workers in Children's Services to do the CIFA programme. For some social workers, it is a way of helping the SU to demonstrate they are working with Children's Services and seeking help, which may facilitate the SU's ability to see their children and to help their court case (R9, DAL1). This view of the programme is quite instrumental, which echoes findings that referrers often simply want a referral pathway for people who have caused harm (primarily men and fathers). Social workers can refer parents where they want to show the family court that they have given the family every opportunity to engage and address their issues (R4). Another social worker said, however, that while other programmes connected to Children's Services are viewed and experienced in this way - as a means to an end for SUs to get their children back - *"CIFA feels more meaningful,"* that SUs embrace it to learn and change (R1).

A concern raised across interviews is the risk of false or disguised compliance. This can be generated by referrers offering external motivations to SUs. As one social worker said, some people simply want social services to stop *"breathing down their neck"* (R8) and can feel forced or obliged to begin the CIFA programme to demonstrate their willingness to engage and change. CIFA practitioners noted that social workers can put pressure on SUs to do the programme, sometimes offering external motivations that can be understood as coercive. For example,

> *"I've had so I've had the experience of social workers saying, 'if you agree to this referral, we'll let you move back home,' and then we do the referral, and then we look at the assessment, and we say 'they're not suitable because they were doing it under false pretences or external motivations that was nothing to do with them admitting DA,' but they'll do whatever they want, because they're so compliant with authorities. So I think some of the instructions getting lost in translation"* (CP7).

These external motivations are used to override reluctance to do the programme, which is often linked to denial of abuse. Where a person denies all abuse, as discussed earlier, they are not considered a suitable referral for CIFA. Coercing a person who denies all harm to engage with CIFA *"won't work"* (CP7). If these external motivations are revealed in the CIFA assessment, alongside denial, CIFA practitioners will go back to social workers:

> *"...if they're completely denying it, and you know, they've said yes to this because they're going to get something out of it, like child contact, moving back home, having something lifted, you've just given them an external reason to say yes to something that they're not suitable for"* (CP3).

There is a distinction between encouraging or motivating a person to engage with the programme and these coercive tactics. Where a SU is willing to recognise the harm they have caused, they might *"want to engage on a deeper level,"* have a positive experience and find CIFA helpful despite initially feeling resistant (CP10, R2, R1, R8) Further training and engagement with referrers should be undertaken to clarify and assist in referrer decision making.

4.4 Implementation

Ecological model: Cultural change of domestic abuse behaviour and attitudes; Behavioural change

Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Neurodiversity; Cultural and intersectional factors; Collaborative approach; Denial; Silencing / collusion; Country of origin; Support; Engagement; Diversity; Vulnerability; Immigration; Suitability assessments; Complexity; Cultural safety; Accepting of complexity

Key findings

- The quantitative evidence's findings show that CIFA is successful in adapting its programme to the needs of people from backgrounds that are often stigmatised and experience institutional racism. These are among other those with interpretation needs and people of different ethnic and religious backgrounds.
- CIFA's strengths are in its use of a cultural framework to explore abuse, its adaptive, person-centred approach, its integrated VS support and holistic, collaborative approach to multi-agency working.
- CIFA bring deep insight on SUs' progress, which benefits social workers and, in turn, the CIFA participants' experience of the programme and outcomes.
- CIFA practitioners bring exceptional skillsets, including reflective capacity, dedication and cultural competence, which facilitates effective intervention.
- Accessibility and flexibility are central principles in the implementation of CIFA. Practitioners make active efforts to adapt the programme's content, structure, and delivery to accommodate the wide-ranging needs, preferences, and circumstances of participants.
- Participants report a consistently positive experience, underpinned by compassionate, flexible and culturally sensitive support.
- Victim-survivors valued key IDVA and DASA traits such as kindness, non-judgement, cultural sensitivity, and patience.
- CIFA provides feedback to social workers following their work with SUs, and this is detailed and helps social workers understand how to keep children safe.
- Support delivered via phone or in person was described as flexible and emotionally validating, with interpreters helping overcome language barriers.
- Some concerns emerged around fears of confidentiality, clarity of role separation (between support for victim-survivors vs. person causing harm), and how to navigate post-programme relationships.
- CIFA's internal quality assurance structure is robust, including mentoring and supervision, feedback reviews, and regular and relevant training.
- Programme integrity is founded on an emphasis on safeguarding the VS and consent-based practice. However, there are some issues with referral processes and consent-seeking that need to be addressed.
- Some organisations are reluctant to refer into CIFA due to concerns about practitioners' understanding of nuanced cultural and religious beliefs and behaviours

4.4.1 Core components of the CIFA programme

Though each of the programmes offered under the CIFA umbrella - CIFA, FADA, APFA and Respectful Partnerships - are distinct in content, they share an approach and set of principles that can be considered the core components of the programme. These are: 1) the use of culture as a framework for reflection on abuse; 2) an adaptive, person-centred approach; 3) integrated VS support; and 4) a holistic, collaborative approach to multi-agency working and contribution to the overall DA system.

As described in detail in Section 4.6, CIFA uses culture as a useful lens to have conversations about values and behaviours with programme participants (R9, CP5, I1). The programme is culturally responsive and inclusive, and encourages reflection on the role of culture in abuse without explaining abusive behaviour in a reductive way or suggesting that abuse is synonymous with particular cultures.

The programme is implemented in one-to-one sessions which are individualised and adapted to the person's needs. There is an intentional focus on relationship-building and connection, and sustained attention to participant engagement style, as discussed in detail in Section 4.4.2 and 4.4.3. The SU programme is designed to incrementally explore concepts and prompt reflection with culturally adapted examples, with activities to help the SU engage (CP11, I1). The programme is slow and deliberate, meeting individual SUs where they are in their journey. For example, as one CIFA practitioner reported, SUs can find the concepts of coercive control, humiliation and emotional abuse hard to relate to until later in the programme. Building on knowledge and reflection throughout the programme, these concepts begin to make sense. Prompts are used to help them to reflect on their own behaviour in light of those concepts (CP11).

Another core component of the programme is its integrated VS support, which is consent-based and places VS safety at the centre of the programme. The programme is founded on rigorous and careful risk assessments and consent-based practice (CP6, CP4, R12, CP13, CP5). CIFA's strong communication and collaborative multi-agency working ensures consistent follow-through, risk reviews and the provision of emotional and practical support to the VS. The concern for, and voice of, VSs is *"always present in the programme"* (CP4) even if they refuse the CIFA support. Risk reviews are regularly undertaken with the support of social workers, family therapists and other practitioners, and if there is no oversight of, or contact with, the VS, work with the SU cannot continue (CP4, DAL1, CP10).

The voice of the VS is crucial in understanding the impact of the programme on the SU - tracking progress in behaviour change and enabling assessments of risk. Social workers, IDVAs, DASAs and CIFA practitioners communicate regularly in a holistic, wrap-around approach, ensuring the VS is being supported, understands the CIFA process and is also being asked for their views and feelings about the SU's engagement. The VS can offer insights into the SU's behaviour at home, perspectives on the causes and triggers of the abusive behaviour, and potentially flag false compliance. Recognising that working only with the SU risks *"not getting the whole picture"* (CP8), this *"integrated, 360 approach"* (CP8) means that the DASAs and IDVAs act as a *"bridge"* between the VS and CIFA practitioner, keeping the VS voice at the centre (CP8). Insights from conversations with the VS can be carefully and indirectly fed into sessions to make progress with the SU (CP4, R3, DAL1, CP7, CP8). However, the VS is not used instrumentally or exposed to risk in order to make progress with the SU: VS safety and wellbeing is prioritised above all else, as described in Section 4.4.5.2.

Finally, CIFA takes a holistic, collaborative approach to multi-agency working and, as a result, makes a valuable contribution to the overall DA system. The support offered to SUs is holistic and

intersectional. CIFA practitioners, including IDVAs, are "not just doing exercises" with SUs and VSs but are *"with you, by your side,"* offering practical support and signposting to other interventions, eg. English language, immigration, mental health or benefits support (CP8, CP9).

CIFA's integration with the wider system is mutually beneficial. Practitioners working with VSs through APFA, for example, provide emotional support, safeguarding and safety planning. This includes assessment, documentation of history and concerns, and listening to what the parent wants from the support. The CIFA practitioner will work collaboratively with social workers to achieve shared understanding of the circumstances and to draw up an engagement strategy that sets out how to support the parent, for example by focusing on de-escalation techniques (CP12). Despite the common lack of engagement by the adult child who has caused harm, this work with APFA is valuable.

As one Children's Services social worker reported, the feedback she receives from CIFA about their work with SUs is detailed and helps her understand how to keep children safe in her work (R3). CIFA practitioners regularly attend Child in Need or core group meetings, providing feedback that shapes the work of social workers. CIFA practitioners work very closely with SUs *"working with the perpetrators in a way that no one else has"* and that insight is relied on by social workers, who are concerned with managing the risk of SUs (CP7). Those meetings also provide important insight for CIFA, which helps to shape sessions with SUs (CP7).

> *"I make it a point to try and attend every single one…it gives you so much insight into what's going on in the background, because we don't know how we know there's minimization, denial, blame and all that sort of stuff. And they might not always tell the truth, because they might want to be seen in a good light, but sometimes you have to use that information to inform the [...] topics that you're working with... I want to make sure I listen and I hear what they're saying, because I don't know if they're just giving me lip service or false compliance. And also, even if they feel like they're telling the truth, that might be just their vision or their view of the or their perspective"* (CP7).

4.4.2 Practitioners' skill sets and reflective practice

The effective implementation of the CIFA programme can be attributed to the work of practitioners who are skilled, responsive and reflective. Practitioners across both the SU and VS strands of CIFA are described by participants and other practitioners as committed, emotionally attuned, and deeply invested in building safe, trust-based relationships. Their ability to provide flexible, trauma-informed support is a critical factor in the programme's effectiveness. The practitioner skillset is a major strength of the programme, playing a central role in participants' willingness to engage and their ability to begin a process of sustained, supported change.

CIFA practitioners routinely demonstrate adaptability and emotional intelligence, adjusting the pace, language and content of sessions to meet the diverse needs of participants. This is particularly evident in their work with neurodivergent participants, such as Mr X, where practitioners coordinated with the IDVA and social worker and tailored the approach to ensure accessibility and psychological safety.

CIFA practitioners are described by other stakeholders in the system as proactive and collaborative, working closely with social workers to maintain oversight and share insights between sessions. Social

workers noted that CIFA practitioners are very engaged and present, and integrate knowledge from meetings to inform their next sessions. CIFA's work is meaningful, coordinated and proactive (R3, R11).

Many practitioners show a strong ability to listen for nuance, spotting the difference between false compliance and genuine engagement, and the subtleties of change. They are alert to the emotional dissonance that may emerge during behaviour change and hold space for participants to work through contradictions and the expectations of partners. One CIFA practitioner described the journey of a SU who is *"making really good progress in terms of engagement and participation in the sessions"* and his partner reports that he is no longer *"reacting abusively"* (CP7). However, his *"communication and shared responsibility"* in the home was still causing problems:

> *"…this particular VS is saying that he just doesn't talk. And when I speak to him about communication, it's like, 'I don't want to start anything.' So it's almost like a minimization situation, because you want peace and harmony. But ultimately, it's not. What he's starting to learn is it's not peace and harmony because it's underlying, suppressed stuff that's going on. Yeah, so he's trying to figure it out. He's working through all of those little tidbits, and he's really enjoying it, because it's not something that he's had that space to do"* (CP7).

VSs consistently praised the kindness, professionalism, and non-judgemental attitude of the CIFA practitioners they engaged with. VS3, for instance, described feeling seen and respected by those supporting her:

> *"Everyone call me. I really respect and good, nice talk with everyone. And I appreciate social worker… Nice lady."*
> *"I appreciate for everyone, because everyone tell me, don't worry, you're not alone… they support me"* (VS3).

VS4 similarly shared how validating and helpful she found her conversations with CIFA practitioners:

> *"I have been receiving this support for at least a couple of months… Staff is kind and caring, I feel understood, and my experiences are validated."*
> *"DASAs understand my needs. I like the service. The service supports us by guiding us on how we should live within our family, by explaining to us what a healthy relationship means."* (VS4).

Another VS further emphasised the importance of compassionate, understanding support:

> *"I wanted to express my deepest gratitude for the incredible support you have provided me during one of the most challenging times of my life. Your understanding, kindness, and gentle approach were exactly what I needed to find the strength to leave an abusive relationship I had been trapped in for 12 years."*

VS also appreciated the way the practitioners respected confidentiality and boundaries, particularly where both VS and SU were engaged in the programme. As VS1 explained:

> *"I was scared a little bit because I thought everything I will say will be repeated to my ex-partner, like it's the same programme. But she explained to me, like, this is two different things… He has separate person who will work with him."*

This clarity helped foster trust and allowed VSs to engage fully in their support without fear of repercussions.

Importantly, the practice is rooted in risk-awareness, particularly when working with people who have caused harm. CIFA practitioners are constantly attuned to the potential for unintended consequences at home, particularly if tensions are triggered during or after a session.

> *"…at the end of the day I'm thinking the work that we've done in today's session, what could that possibly impact on the victim if they were to go home, back to their partner? So if I'd said anything that allowed them to answer not because they're frustrated towards me, but frustrated about the relationship, I've still got to use those strategies to bring that frustration down and challenge it, because I have no idea what's going to happen at the end of the session when they go back to their life. So that is always on my mind"* (CP7).

However, there is some evidence of concerns that practitioners may lack the requisite cultural capital necessary to work effectively with some populations. For example, one interviewee from a Jewish women's group reported that they haven't referred to CIFA for several years due to a lack of information and transparency about the programme, and a perceived lack of cultural competency and knowledge about the Jewish community, particularly on the intersection between religion, gender and culture and DA (e.g., navigating issues related to a 'religious divorce').

4.4.3 Accessibility, flexibility and adaptations (e.g. language support)

CIFA is a manualised programme, which sets out the structure, aims, timings, examples and activities. However, practitioners are flexible with the delivery, acknowledging that while some people like working directly from material, using slides and examples, others respond better to a conversational approach (CP3, CP6). Each programme - CIFA, FADA, APFA and Respectful Partnerships - can be adapted for neurodiverse participants. This pathway is research-led, manualised and receives positive feedback (CP6, CP3). It is supported by in-house training designed and delivered for staff and managers on how to work with neurodiversity, and in forensic settings.

Accessibility and flexibility are central principles in the implementation of CIFA. Practitioners make active efforts to adapt the programme's content, structure, and delivery to accommodate the wide-ranging needs, preferences, and circumstances of participants. This responsiveness ensures that the intervention is not only theoretically inclusive, but practically accessible for those often marginalised or underserved by traditional DA services. This adaptability is not just a feature of the model; it is essential to its success, ensuring that participants are met where they are and supported in ways that are meaningful, respectful, and safe. Mr AB, for example, used the neurodiverse CIFA manual and sessions were supported by a Farsi interpreter. The practitioner noted the importance of future psychological work with this SU being supported by an interpreter.

Essentially, CIFA relies on interpreters to ensure that SUs and VSs can speak their own language. This is not always the case with social services, which is a barrier to working effectively with minoritised groups. Language was described as *"the main barrier"* by this VS when accessing other public services (VS4). Though working with interpreters can be difficult and comes with challenges in terms of the flow of conversation and ensuring shared understanding, being supported to communicate in this way was described as important by SUs and VSs:

> "*CIFA helped me with the language barrier by using interpreters. I feel respected and well supported…if I did not have an interpreter, for example, I would not be able to share my thoughts"* (VS4).

Interpreters are a resource made available by CIFA to referrers at the referral stage, which a social worker described as useful (R12). Many CIFA practitioners also speak other languages: they are often matched, if possible and appropriate (CP11, CP3, CP9). Sensitivities and concerns related to this matching are discussed in Section 4.6.2.

For SUs and VSs, flexibility begins with scheduling. Sessions may be delivered in person, online, or by phone depending on availability, risk, and individual context. Practitioners routinely offer flexibility with timing, frequency, and location, allowing participants to engage when it is safe and feasible (R9, CP3, CP13, CP6, CP11). Practitioners are attentive to the potential risks of remote engagement, considering whether meeting online might increase risk for the VS. They will only meet the SU if the VS is not nearby after the session, as it *"can evoke emotion"* (CP13). In line with the programme's intersectional approach, CIFA practitioners appreciate the complexity of SUs' lives. If a SU disengages or does not complete the programme, they will offer a gap in programme delivery if considered reasonable, and as long as the reasons are communicated and CIFA are kept informed (R9, CP3, CP11, CP13). Similarly, if the SU does not complete the programme and is re-referred, they could potentially pick up where they left off (CP3).

For VS, accessibility is also about responding to emotional readiness. Support is responsive and survivor-led, with staff checking in regularly to ensure the method and frequency of contact are appropriate. Practitioners are mindful of how trauma may shape engagement and are careful not to overwhelm or re-trigger participants.

> *"If they don't want to engage but you keep calling – it can be a trauma awakening experience"* (CP9).

This flexibility was valued by participants, as VS1 shared:

> *"It was whenever I wanted to call, how long I wanted to talk. This was wonderful… It wasn't like you have 10 minutes to talk… You were hurt. Yeah, it was wonderful."*

CIFA's flexibility also extends to communication styles and learning needs. Tools such as the CBT triangle, arousal thermometer, and power and control wheel were commonly used across cases, and participants often found them accessible and transformative. These are tools and approaches mentioned favourably in the academic literature. Mr T cited the CBT triangle as pivotal in helping him link thoughts, feelings, and behaviours, while Mr S used time-outs and positive self-talk to de-escalate conflict. As discussed in a CIFA team meeting (15 April 25), many SUs left formal education very early. The concepts might all be new and learning styles are varied. The neurodiversity manual is useful for those with low education and mental health needs. This focus on accessibility is transforming how the team works in general.

Informed by neurodiversity training, practitioners now use tools like a 'communication passport', asking participants how they prefer to receive information, and adapting accordingly. This might include avoiding metaphors, minimising text, using visuals, or adjusting the length and structure of sessions. This approach was particularly helpful in the case of Mr X, who is neurodiverse. He was led

through an adapted version of the programme that used simplified language, visual aids, shorter sessions, and repeated check-ins. He expressed appreciation for the clarity and support:

> *"You took time to explain the process of the course and was very clear in your explanation of the aim, the expectation, goals and the intended outcome of the sessions"* (Mr X, case study).

Other adaptations included matching participants to practitioners with shared lived experience, such as LGBTQ+ SUs being paired with LGBTQ+ staff in Respectful Partnerships. While staff are not required to disclose personal identities, the option is available where appropriate and consensual.

Flexibility around cultural and religious identity was also demonstrated in terms of programme content and focus. Mr I was offered a programme tailored to explore how cultural norms and religious beliefs shaped his use of control. Although he initially voiced discomfort with a female practitioner due to faith-based gender norms, he continued with the programme and ultimately benefited from the challenge of engaging with a woman. Similarly, Mr H was supported to explore how trauma, refugee experience, and cultural identity influenced his views on masculinity and gender roles. The programme was also adapted to Ms AE's individual needs, supporting implementation fidelity while addressing complex intersections of trauma, caregiving, and mental health complexities (schizoaffective disorder and the effects of medication). In a team meeting (15 April 2025), a CIFA practitioner offered the example of working with a deaf person, where longer, more complex words were more difficult. This required adaptation in every session.

It is clear that RISE takes accessibility and adaptability seriously as a core principle of implementation. As described by one practitioner in the same team meeting (15 April 2025):

> *"We are learning together. There is something special happening. We are always evolving, the manual is changing. We need flexibility in the work that they are doing. We can still do a lot more. We are learning from each other with using different exercises. We are keen to make the manual more flexible, to add more freedom and creativity."*

4.4.4 Participant experience of delivery (Victim-survivor and service user perspectives)

Participant reflections on the delivery of the CIFA programme reveal a consistently positive experience, underpinned by compassionate, flexible and culturally sensitive support. While engagement was often accompanied by initial anxiety or emotional difficulty, both SUs and VSs expressed appreciation for how the programme was delivered and how they were treated throughout. Their feedback reinforces the importance of skilled, culturally aware practitioners who prioritise safety, respect and choice in every interaction.

For many, beginning the programme was emotionally complex. VS4 described feeling hesitant and afraid to revisit painful memories or speak out about her experiences, particularly within the context of her faith and cultural identity:

> *"I was worried at the beginning. I did not want to share many things about my experience and the ways my husband treated me. I did not want to make things worse. You know, we are*

Muslims. Also, thinking about my experiences made me worried, I did not want to repeat things that happened to me, I did not want to live in my past. I wanted to move forward."

VS7, an APFA parent, described how her engagement was driven by a desire for clarity, guidance, and safety in complex and ongoing abuse situations:

"How I have to deal with it, how I will make him understand? Because whenever I say to him, he's going to be abusive, he's going to be in verbally, sickly sometimes… that is my point. You see, this is what probably I asked for, what I probably wait for—someone to tell me what to do for, or what I'm doing wrong, or I don't know."

Despite these fears and uncertainties, participants frequently reported building positive relationships with CIFA practitioners, including DASAs and IDVAs, emphasising how supported and understood they felt. Staff were described as kind, respectful, and skilled in building trust.

Participants are provided with clear information at the outset of the programme, including who to contact for questions or concerns. SUs are also offered opportunities to give verbal feedback and are provided with an anonymous online feedback link. This openness to feedback, coupled with responsive and adaptive delivery, appears to foster a sense of psychological safety and ownership among participants. It enables them to engage on their own terms, at their own pace, and with a clear understanding of boundaries and confidentiality, key ingredients in ensuring trust in trauma-informed work.

Multiple professionals interviewed across the evaluation echoed this view, describing CIFA practitioners as *"fantastic," "amenable," accommodating,* and committed: *"they really try to engage and support SUs"* (R9, R2, R3, DAL1, I1, R10, R11).

4.4.4.1 SU perceptions of the relationship with CIFA practitioners

The relationship between SUs and CIFA practitioners was central to the effectiveness of the intervention. SUs emphasised the importance of trust, highlighting some of the personal characteristics and professional skills that CIFA practitioners possessed that facilitated their engagement. Among these were the ability to listen, remain calm, to build rapport, to be non-judgmental and offer practical support. These qualities were identified as essential for encouraging participation, particularly among initially apprehensive SUs, to promote critical reflection and facilitate personal growth, ultimately contributing to the cessation of DA thus preventing further harm and future VSs. As SU9 explained,

"*You need a type of rapport with the practitioner. If you don't have that, it's so hard to give to the client. It's so hard for the client to give or try. They won't want to. They'll close up, get defensive, or they just won't put the effort in.*"

Many SUs found such relationships over the course of their involvement in the programme and referred to skills learnt that promoted attitudinal and behavioural change. Among the most helpful practical skills were those related to managing emotions, how to interact with partners and children, those linked to the '*circle of life'*, positive thinking skills, child-centered parenting skills and building healthy relationships. Such resources were so handy for one SU (SU7) who even after he left the programme, is pasting worksheets to the walls as an aid memoire.

4.4.4.2 Challenges in the practitioner-SU relationship

Not all relationships between SUs and practitioners were reported as helpful or free from complications. In some cases, matches with one CIFA practitioner broke down only to start with another (as in the case of SU3). In some cases, initial resistance to CIFA or false/disguised compliance rather than genuine interest posed challenges to engagement, as in the case of SU4 who admitted that his engagement with CIFA was driven by having to comply.

> "*Didn't really wanna have to do it, but I just wanted to comply to make sure because it is involving my children in the first place. That's why I've complied, that it's not something I really would have wanted to do, would have wanted to take part in or even be labelled like I wouldn't want it to be labelled in, like with what RISE deals with. I wouldn't have wanted to put myself in that bracket, in all honesty."*

This issue is further discussed in Section 4.3.7.2. However, SU4 came to recognise the value of the programme once he had been matched with a CIFA practitioner with whom he could relate. Speaking candidly, SU5 noted how the good relationship he'd built with the practitioner helped him enormously to *"face the realities of the harm he'd caused to his family"* even though "*it was at times difficult, and it felt hard to engage with the programme*." SU5 said the combination of personal therapy, along with the support of the CIFA practitioner, had led to his completion of the programme resulting in a significant change in his outlook on relationships.

4.4.4.3 Impact of CIFA practitioner support

Despite the challenges, many SUs expressed profound gratitude for the support provided by CIFA practitioners, who they reported helped them to transform themselves and their relationships in a fundamental way. These testimonies by SU2, SU9 and SU4 typified the profound impact of positive practitioner guidance and support. Talking about the practitioner they worked with over 16-20 weeks:

> "[when going to meetings] *Not a lot of people even cared what I had to say. I felt like this is an injustice. [But] having that person to talk to, you know, has really, really helped me. So, you know, I really, really, really appreciate her, you know, like forever, for the rest of my life, I'll appreciate her, because, like, she really helped me. So, yeah, I have a deep gratitude to her. I'll be honest'"* (SU2).

> "*He teach (sic) me everything. […] I'm very grateful. When somebody is learning something by heart and if somebody teaching by heart is more interesting*" (SU9).

SU4 highlighted the practitioner's consistency, attentiveness, and ability to build rapport, which facilitated open communication:

> "*What I do like and appreciate is that she's been very consistent. She's been very available. She's quite understanding. She allows me to talk, 'cause I can talk a lot of times and so she hears me out. And then, like, has good things and good responses. I feel that she's very attentive, like to a lot of the things I've mentioned. She's kind of like either remembered or made a note of things that are quite significant. So, I think that's that was very important because it helps. And obviously like, because she's built a bit of a rapport with me, which isn't always easy, but like by doing that...it's made me able to talk a bit more*."

The support provided by CIFA practitioners was characterised by SU6 and others as genuinely respectful and attentive. This approach helped SUs remain engaged, manage their emotions, and develop communicative strategies that fostered positive relationships with family members and partners. For many, the relationship with the practitioner was transformative, enabling significant personal growth and behavioural change.

4.4.5 Programme integrity

4.4.5.1 Quality assurance and training

CIFA's internal quality assurance structure is robust. CIFA practitioners benefit from mentoring, session observation, video monitoring and feedback and support with monthly risk reviews by advanced CIFA practitioners (CP6, CP4, CP10). Practitioners feel that they receive good support within RISE and many mentioned the quality of support and guidance received not only in formal supervision, but in informal sharing among the CIFA team (CP10, CP3, CP4, CP6). Practitioners are supported to carry out 4-6 week risk reviews for each SU with a CIFA advanced practitioner and Victim Support Worker. In these sessions, they collectively review progress, consider and respond to any feedback or concerns raised from social workers, or from the VS, communicated through the IDVA or DASA. The voice and experience of the VS is considered central to this review: the integrity of the programme is dependent on ensuring that it does not elevate the risk to the VS. In the review, the practitioners will think about next steps and make any necessary adaptations (CP6, CP6, CP3).

There is a meaningful commitment to developing and providing bespoke and useful training within CIFA. RISE as an organisation invests in continuous development and capacity-building of CIFA practitioners. Staff receive training on cultural diversity, working with complexity, and multi-agency collaboration. For example, one practitioner with particular expertise was asked to develop in-house neurodiversity training for staff and managers, as well as working on the adaptation of the CIFA programme for SUs. She reported that she was given sufficient time and space to complete this work, that it was clear to her that responding to the needs of neurodiverse staff and SUs was a priority for the organisation.

The practitioner team also undertakes cultural diversity training that encourages openness and shared reflection. This not only equips staff to meet the needs of diverse communities but also models the reflective practice they promote with SUs. Practitioners also receive training responsive to the demands of the programme. For example, one practitioner described receiving training on how to respond when social workers have closed Children's Services cases before SUs have completed the CIFA programme (CP3). This training included guidance on being proactive with social workers and escalation to managers, to address this problem (which is discussed in detail in Section 4.5.4 and 4.4.5.2).

Learning is also co-created across RISE programmes: DA Pillar internal training takes place once a quarter, where CIFA practitioners come together with DRIVE practitioners. The teams co-develop the space and share insights, good practice and challenges across projects (CP4). RISE also provide training for sessional workers who support with reports and assessments (CP4).

4.4.5.2 Safeguarding the Victim-survivor

CIFA practitioners interviewed for the evaluation demonstrated enormous care and good practice in implementing the programme. Working with a consent-based model and in an integrated, coordinated way, VS safeguarding is at the heart of implementation, in line with the Respect Standards. As discussed elsewhere (section 4.4.5.2), if there is a new incident which suggests the escalation of risk for the VS, CIFA's work with the SU is ended. Safeguarding the VS is the primary concern (CP4, CP11, CP13). This element of programme integrity – good, careful safeguarding practice - is also seen where CIFA practitioners will stop working with a SU where oversight of the VS is lost: for example where the VS has refused support through CIFA and is no longer in contact with a social work team when they close a Children's Services case (CP6, CP4, CP8, CP13). Though this can be frustrating for CIFA practitioners working with SUs, if this link to the VS is lost it is no longer safe to continue.

In interviews and in CIFA partnership meetings (which bring together CIFA practitioners, IDVAs, DASAs and borough DA and VAWG leads), concerns were raised about the consistency of consent-based practice and appropriate documentation. Some referrers have not always attained consent from the VS when referring the SU to CIFA. This failure to communicate with the VS has not always been communicated to the CIFA team. Some IDVAs noted that the process could be improved, that it is essential to double-check that the VS has been contacted. This oversight can cause delays with referrals and generates more work for IDVAs and DASAs, who will not progress the referral without exploring the VS circumstances:

> *"I'll send an email to the social worker and say, 'Please, we've received this referral form but can you also please complete a referral for the VS, because we are unable to contact her without knowing what exactly is going on in their life.' So, but that is double work. It should be a requirement, really"* (CP5).

In partnership meetings, CIFA practitioners have clearly and repeatedly explained the process of seeking consent to partners. In a 12 March 2025 meeting, RISE staff reasserted that IDVAs and social workers must cross-check with RISE that they have VS details and consent, stating that if *"a local pathway is not established, CIFA will pick it up"* (CP16). An amended referral form was created in 2024, to ensure double-checking of consent. The RISE staff member advised escalating these cases to the VAWG leads and managers: there is a need to ensure effective training and upskilling on consent and communications. At the moment, there is some confusion and occasional oversight, where information about the process may not reach referrers like social workers.

4.4.5.3 Working with integrity: organisational values in practice

CIFA practitioners reflected on how organisational values were brought to life in their daily practice. As described above, safeguarding was mentioned as key to programme integrity: never to compromise the safety of the partners and children of SUs. Practitioners reported that they were *"not willing to lose integrity for stats"* (CP3, CP7). They were aware of the programme's completion and engagement rates, but insisted:

> *"I wouldn't compromise my integrity in that way, because I think these people are human beings. You know, we don't know the knock-on effect it can have on partners and children if*

we're doing things for the sake of numbers, because it's just not safe. So that might be there, but I think we have to be conscientious to make sure we don't fall into that trap. It's got to be done for the right reasons" (CP7).

Referrers echoed that CIFA practitioners work with integrity: they would not *"rubber-stamp"* a SU's progress on the programme. In feedback to social workers, CIFA practitioners were clear where the SU would not take accountability for *"certain things"* (R5).

Organisational support and culture ensures that CIFA practitioners feel able to work with integrity in this way. As CP3 said:

"I think integrity is what I'd want to emphasise, that we're not willing to lose our integrity to improve our stats, and all to the detriment of the well-being of the staff. So I've never been overworked, been encouraged to skip steps or do something lacklustre to cut corners, none of that. My well-being has been prioritised, the integrity of the programme, the well-being of the SUs…I've worked in the NHS and probation, and I've never worked somewhere where that's been the case, that the values are maintained, and the fact that it's non-hierarchical, it says it is, and it and it actually is.''

4.5 Maintenance / Sustainability

Ecological model: Systemic change

Collaborative approach; Ripple effects; System coordination; Systems capability (culturally informed provision); Suitability assessments; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; Partnership

Key findings

- Stakeholders highlighted CIFA's transparent, collaborative way of working that adds enormous value to the domestic abuse system, particularly in working with historically neglected groups.
- Stakeholders want to see an increase in CIFA funding and for that funding to feel equitable across boroughs - the match-funding arrangement (including boroughs using existing IDVAs as part of CIFA provision) has led to a sense among some interviewees of unequal investment in service users and victim survivors.
- The CIFA programme is perceived by some as more effective in DASA boroughs, with interviewees citing issues with communication and consent practices with IDVA services.
- Integration with Children's Services creates a vulnerability in CIFA programme delivery - social workers prioritise the needs of children and the demands of their caseload. When they close cases, this often means that CIFA's work with SU must end.
- RISE is proactively addressing this issue with training, communication and escalation to managers.

- CIFA staff feel well-supported and valued at work but it is an intensive programme to deliver. There is a culture of care, professional respect and integrity at RISE.
- Partners benefit from collaborative and coordinated work that is contributing to the effectiveness of the system, and systems change.
- The quantitative evidence provides a series of areas of improvement of data recording and ongoing analysis of trends to help support and improve the CIFA programme.

4.5.1 Current funding and local buy-in

In interviews, stakeholders highlighted a range of sustainability challenges affecting CIFA's long-term viability. Funding emerged as a concern. Many stakeholders emphasised the need for resources and long-term investment (DAL4, CP14, R4, CP7). One borough DA lead suggested that programme funding should be increased to enable the recruitment of a dedicated staff member to manage follow-up, reporting, stakeholder engagement, and outreach activities. CIFA's operation requires boroughs to provide match funding, which some stakeholders flagged as placing an additional burden on local services. Several stakeholders described working within a very tight budget, and offering in-kind contributions, such as using unused spaces and internal services, such as IDVAs to be able to deliver CIFA. While creative, this approach was not seen as sustainable.

Stakeholders also raised concerns about the equity of funding distribution (CP14, CP5). In some boroughs, match funding from local services absorbed the delivery costs of the integrated VS support offered through CIFA. Some stakeholders suggested that a more balanced and equitable funding model would demonstrate equal investment in support for both VSs and SUs across boroughs (CP14). The use of IDVA services as match funding provision was also questioned for other reasons. Stakeholders in some boroughs suggested that the delivery would be more effective if RISE provided the entire integrated service, perceiving that communication and coordination were significantly better in boroughs where this was the case (DAL1, CP1). Boroughs tasked with delivering VS support through their own IDVAs reported a concern about their increased workloads, more clients, and additional reporting demands because of their work on CIFA. Although there was recognition of the programme's value and a commitment to delivery, the perception of inequity prompts some dissatisfaction (DAL1, CP3, CP1, CP2).

The importance of individual stakeholders and referrers was emphasised. For example, one CIFA practitioner noted that the departure of a single diligent DA lead in one borough reduced referrals drastically, showing the programme's reliance on key staff (CP6). To enhance the sustainability of CIFA, broader system buy-in must be improved.

In terms of broader sustainability risks, there were also concerns about pressure from funders to deliver against KPIs in order to justify CIFA's continuation, including referral and completion numbers, which might force RISE and other stakeholders into a more rigid, bureaucratic way of working (CP10, CP7). These measures - as described throughout this report - only partially capture the value of CIFA. Practitioners stressed the need to preserve flexibility in order to respond effectively to emerging needs, work with integrity and deliver meaningful outcomes. Finally, stakeholders in Partnership meetings discussed the pressure of CIFA reporting deadlines and how these timelines place strain on

services. There are plans to explore whether future contracts might allow for more flexible timelines to reduce pressure on partnership delivery.

4.5.2 Integration into wider VAWG or DA strategy/systems

The CIFA programme is built on a holistic, partnership-based approach that integrates support for both VSs and SUs, embedded through social and DA services across the ten boroughs. Stakeholders highlighted the transparent and collaborative way of working in this joined-up model, involving mental health nurses, social workers, and other professionals (R3, CP1). The CIFA team was praised by stakeholders for efforts to maintain contact and communicate effectively (R4, DAL1, DAL3). Nonetheless, there was a call for stronger multi-agency commitment and greater buy-in from partner organisations (CP4, DAL3).

The programme was also valued for providing concrete recommendations and feedback to social workers, even in cases where SUs were not accepted into the programme after assessment or pre-intervention. This added value was appreciated by referrers, who could still act on these recommendations to support clients (R3, CP3). Importantly, CIFA does not place additional demands on social workers beyond their existing caseloads, making integration more manageable for frontline professionals. However, as mentioned above, it was acknowledged that the programme can add to workload pressures for IDVAs in boroughs where they are the CIFA partners. Further, and perhaps relatedly, stakeholders noted that monthly coordination meetings between CIFA and IDVAs did not always take place, which risked weakening the VS voice within the system. Maintaining the centrality of the VS voice was seen as essential (CP2). Coordination challenges between CIFA practitioners and IDVAs were highlighted. They are required to liaise closely, but there were some reported difficulties, which slowed processes such as confirming VS contact and consent, compared to more efficient working with in-house DASAs (CP11, CP3, DAL1, CP2).

Several stakeholders emphasised that work focused on people who have caused harm - primarily men - has historically been overlooked, making this programme a necessary addition to the system. In many boroughs, there is no comparable programme available, underlining its strategic importance (DAL2, R4, R1, R7), especially in light of VAWG strategy that requires accountability for DA. Stakeholders recognised that people who caused harm were neglected by systems in the past, being excluded, penalised or spoken at rather than listened to, with no effort to understand their behaviour and the circumstances and experiences that shape it (CP4). Most men, one CIFA practitioner emphasised, are failed by the system and have had poor experiences of the system, and have often experienced abuse and trauma themselves (CP4). CIFA takes seriously those experiences and supports SUs to address their behaviour through a responsive, supportive and collaborative approach:

> *"I think it's an opportunity, especially for social workers who are working with families, who are working with both the victim, survivor and the perpetrator to find an avenue where the perpetrator can also get a chance to be heard, a chance to, you know, to create awareness, to be supported"* (CP5).

CIFA's importance to the overall system was emphasised by stakeholders who noted that without this programme, smaller population groups - including APFA families and particular ethnic groups - would experience a significant deterioration in service provision, raising equalities issues (CP12, DAL3). In

many boroughs, there are no alternative services available to meet this need, including the needs of those served by APFA and Respectful Partnerships.

4.5.3 Comparison with other DA services

VSs and CIFA practitioners drew clear distinctions between the CIFA programme and other DA support services, particularly in relation to quality, safety, and meaningful impact. These comparisons emphasised CIFA's strengths in practitioner skill, trauma-informed delivery, and ethical handling of risk and disclosure. These experiences underscore the importance of a carefully sequenced, survivor-centred approach, like the one embedded in CIFA. By prioritising safety, reflection, and accountability, not just contact or family preservation, CIFA avoids the common pitfalls seen in other services and strengthens its position as a sustainable, trusted intervention for families affected by DA.

One CIFA practitioner in particular expressed concern about the proliferation of unaccredited or private behaviour change programmes for people who have caused harm (CP4). These alternatives are often short in duration, lack robust risk management protocols, and can pose serious dangers when relied upon by statutory agencies or courts.

> *"You'll get a lot of more financially able perpetrators who will pay to complete those interventions and throw those certificates around afterwards, As though this is my stamp of approval – 'I'm not abusive' - with self referrals"* (CP4).

In contrast, CIFA is built around a structured, reflective process that integrates risk management, cross-agency collaboration, and consent-based and culturally competent practice. The programme does not rely solely on content delivery but prioritises deep engagement, practitioner supervision, and ongoing assessment of safety and change.

From the perspective of VSs, other services, particularly statutory services like social care, were sometimes experienced as inconsistent, superficial, or poorly coordinated. VS2, for example, described a fragmented experience with social services, where turnover and lack of continuity left her feeling unsupported:

> *"In 2021 that's the first time when social services were involved with our family. And unfortunately, that was a lot of social workers who came in and went from our case, which was, you know, very sad. And I also felt very neglected by the work of social services."*

She also contrasted CIFA's trauma-informed and relational approach with other interventions that appeared focused on quick fixes or reunification without proper safeguards:

> *"They were more orientated about support for the kids… just to fix a few problems, like abuse, and put the family together—as far as they can—to connect father and kids"* (VS2).

In some cases, external pressures to reunite families led to deeply negative experiences. This VS recalled feeling pushed into family contact prematurely, without adequate attention to risk or readiness:

> *"A social worker pushed me in March to do this family conference and for father to see kids as soon as possible. So it was like a very horrible experience"* (VS2).

4.5.4 Borough service pathways: challenges

While most CIFA referrals come through Children's Services, integration with the system presents some challenges for the delivery of the programme. A key issue identified by CIFA practitioners is working with social workers to ensure that Children's Services cases are kept open for the duration of the CIFA programme, which enables work with the parent who has caused harm, usually the father. CIFA practitioners (CP6, CP4, CP3) noted that social workers often close cases before the CIFA programme is complete, which often means that practitioners must stop delivering the intervention. Where VSs are not being directly supported through CIFA's DASAs (in Haringey, Brent and Newham) or IDVAs (Solace in Enfield and Barnet, Advance in the tri-borough - RBKC, Westminster and Hammersmith & Fulham, and Cranstoun in Harrow), the closure of the case means that CIFA DASAs and IDVAs lose the ability to monitor risk or maintain oversight of the VS.

Reasons for case closures were explored in interviews, and levels of completions have been discussed quantitatively in section 4.2.1. Here we discuss the underlying reasons identified in the interviews for closures. One fundamental issue is that social workers in Children's Services must prioritise the needs of the child, which does not always align with prioritising the CIFA programme. Case closure often relates to a reduction in risk in the family. Keeping a case open solely to allow a father to complete the CIFA programme is often viewed as unjustifiable given limited resources (R9). The long programme duration adds to this challenge, as it requires cases to remain open for extended periods (R9). Social workers face substantial pressures to manage high caseloads and reduce backlogs, which compels them to close cases as quickly as possible, especially to prioritise those at imminent risk (R9, CP10, CP4, R4). While some social workers may keep cases open on request to allow CIFA programme completion (CP3), others may not. Further, as Child in Need plans are voluntary, social workers cannot keep a case open unless parents agree, unless the risk is re-assessed as high and it is escalated to a Child Protection case (R4, R5, R7). As one social worker put it: *"If the family wants it closed, it closes"* (R4). Another issue is a lack of knowledge of the potential impact of the closure of the case among social workers: some will refer a SU to CIFA and immediately close the Children's Services case, unaware that the referral might be immediately redundant as a result (CP4).

CIFA has responded to this structural concern by raising the issue with team leaders and VAWG leads directly in team meetings and in CIFA Partnership Meetings to improve practice and support greater alignment between services (CP3, CP4, CP6, CP7, CP13). CIFA practitioners have received training on the issue and RISE is aware and working to address it (CP13, CP3). Nevertheless, it remains a widespread concern, with one stakeholder describing early closure as "*detrimental for everyone"* (CP4). This situation can feel particularly difficult for CIFA practitioners where SUs are motivated to continue the programme, but unable to proceed due to case closure. CIFA must manage disappointment and uncertainty among both SUs and VSs, who are often hopeful and relieved that their partner was receiving support (CP4).

Practical barriers also affect integration with the wider system. Working with social workers can be slow due to staff absences and lack of clear out-of-office communication (CP3). Moreover, the extent to which social workers invite CIFA practitioners to meetings and multi-agency processes such as MARAC varies significantly — a more consistent approach is needed, with the organisation invited to participate in all relevant forums (CP3).

4.5.5 Practitioner capacity and organisational support

It is clear that CIFA practitioners benefit from a strong and supportive internal organisational culture. Staff reported feeling valued, well-supported, and well-supervised. Unlike many settings, the organisation was not perceived as overly driven by urgency or performance pressure. Instead, there was a consistent culture of care, professional respect and integrity (CP6, CP3, CP10, CP11). This positive working culture was further characterised by flexibility, regular mentoring and trust. Staff described having the autonomy to shape their work and the space to develop professionally in the directions that interested them most (CP6). Overall, RISE is seen as a place where staff are nurtured and supported.

Despite these strengths, some challenges were noted around staff capacity. The CIFA programme is demanding, often involving complex cases and one-to-one delivery without the support of a co-facilitator. One stakeholder suggested that high staff turnover within the organisation may be linked to the difficulty of this delivery model (CP6). Similarly, IDVA practitioners were described as frequently managing too many cases, which can make it difficult to offer the in-depth, one-to-one approach that the programme aspires to deliver. Reducing caseloads and creating more space for reflective practice would support better outcomes (CP9).

Partnership Meetings - attended by VAWG leads, IDVA services and CIFA staff - were widely praised as a valuable forum for sharing best practice among CIFA practitioners and stakeholders across the ten boroughs. Interviewees noted that these sessions foster a sense of professional community, allow practitioners to learn from one another, and offer opportunities to hear how others are navigating challenges in their own boroughs (DAL2, CP1, CP2, DAL1). This cross-borough learning was seen as helpful in terms of practical insight and building a collaborative network (DAL2). The meetings give rise to connection and coordination beyond the space. For example, we observed how conversations in these fora led to one VAWG lead shadowing a more established CIFA borough team in order to learn from their referral process. Two other DA practitioners connected and arranged to discuss experiences and aspirations of setting up DA hubs in their respective boroughs.

4.5.6 Improving data and tracking practices & processes

The quantitative assessment of data provided by RISE and analysis of tracking reports submitted to MOPAC highlights a range of potential areas for improvement to support sustainability and growth of CIFA going forward. The quantitative evidence's findings highlight CIFA's success in reaching its target audience and adapting its programme to the needs of people from diverse backgrounds and with diverse needs. These are populations who are often stigmatised and experience institutional racism. This was evidenced by positive improvements in behaviour through the outcome star data as well as levels of completion among people from racialised and religious backgrounds and with interpretation needs - groups that are often not well supported on other programmes.

However, from quantitative analysis, it is clear that challenges remain in identifying people with different characteristics from target groups, to monitor their behavioural changes, identify support needs and to tailor efforts by boroughs and minoritised groups. The latter is possible by carrying out the kind of analysis done in section 4.2 - analysing and identifying how groups do when it comes to completion and suitability for the programme. This type of effort is also crucial when it comes to

ensuring support is provided to those from LGBTQ+ groups. Carrying out analysis of the outcome star data using existing data showed that there might be patterns where LGBTQ+ SUs do better on some behavioural measurements and not in others. However, these results are not statistically valid due to the low rates of recording. The same is true when it comes to those with mental health issues, learning needs and other characteristics. When analysing levels of completion and those assessed as 'suitable' for CIFA, it was also clear that the levels vary by borough and racialised minority, highlighting a need for ongoing tracking and adaptations of the mobilisation effort as well as practice to support SUs and VSs. Responding to this could be a way to improve support for these groups and create a stronger and more sustainable programme overall.

Areas of improvement include referral pathways and improving the reach of target audiences from racialised and religious communities that are not currently as well represented among CIFA SUs and VSs (see sections 4.1, 4.2 & 4.3). Currently, data does not regularly show analysis of referrals, completions and rates of those deemed as not suitable by characteristics such as ethnicity, religion and LGBTQ+ overall. This means that it is difficult to identify areas of improvement by borough and by these different characteristics. Given that the data is recorded, this would be an area that would allow for a holistic approach to improvement of referrals, completion rates and overall support for people going through the programme and their communities. Improved data recording is needed to identify areas of improvement, as well as tracking impact in community and outreach work.

4.6 Cultural Integration & Consideration

Cultural change of domestic abuse behaviour and attitudes

Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Neurodiversity; Cultural and intersectional factors; Systems capability (culturally informed provision); Country of origin; Denial; Silencing/collusion; Diversity; Vulnerability; Immigration; Suitability assessments; Complexity; Cultural safety

Key findings

- 'Culture' is effectively used by CIFA as a framework to explore beliefs, relationships and behaviours related to DA with both service users and victim survivors.
- CIFA's culturally integrated approach is defined by curiosity, reflection, openness to complexity, intersectionality and understanding of context.
- The diversity of CIFA's staff body is a resource: staff bring cultural knowledge and insight to their work, and share it within the team.
- The programme approach, design and effectiveness, however, does not depend on the CIFA practitioner's specific cultural knowledge.
- Engagement with the CIFA programme enables service users to critically examine their views on relationships, gender roles, parenting, and what constitutes abusive behaviour, particularly in the context of British legal frameworks.

- Victim survivors are also supported through CIFA to understand their experiences of abuse through an intersectional lens and in the context of British legal frameworks.
- Victim survivors generally felt culturally respected and safe, with interpreters and culturally informed staff increasing trust and engagement.
- CIFA's adaptability to language and faith needs (e.g., respecting prayer, cultural communication styles) was cited as a major strength.
- VSs appreciated that staff understood, or tried to understand, how cultural beliefs and extended family dynamics shaped abuse.
- CIFA's culturally integrated approach is a model for behaviour change programmes more broadly.
- Referrers could benefit from more insight into how CIFA works with culture through regular and culturally specific feedback.
- Evidence from outcome star data shows CIFA having a positive impact on people from ethnic minorities, religious background and with need for interpreters - communities that rather than being supported often are stigmatised in many other interventions.

4.6.1 CIFA's culturally integrated approach

The CIFA programme is a culturally integrated service designed to provide tailored support for racialised and minoritised communities through a focused, coordinated family and community approach. It employs a culturally informed, bespoke, intersectional framework to address the unique challenges faced by these communities. This section evaluates CIFA's approach and impact on cultural change of DA behaviour and attitudes. This includes analysis of: 1) CIFA's culturally-integrated approach, which meaningfully considers and works with cultural and intersectional factors; 2) the key features of that culturally-informed provision in practice, including staff cultural knowledge and competence; 3) self-reported and observed changes in SU norms and beliefs and a related reduction in harmful behaviours; and 4) changes in the norms and beliefs of VSs which enhance their safety and self-determination. The section ends with findings related to the articulated value of cultural approach, which could be integrated across system to great effect to enhance systems capability related to culturally informed provision.

CIFA's culturally integrated approach is defined by curiosity, reflection, openness to complexity, intersectionality and understanding of context. The value of the approach is its rich appreciation of intersecting oppressions, pressures, experiences and socially constructed beliefs that shape DA. The programme is alive to the complexity of experience, acknowledging, as one CIFA practitioner explained, that most 'perpetrator' programmes *"are designed here or in the US by white people for white people, for natives. So they don't talk about culture, they don't talk about where people are from"* (CP4).

This approach *"doesn't take into account the cultural experiences, or the experience of marginalised communities,"* whereas CIFA aims to gather *"a much more comprehensive picture of their experience"* (DM4). CIFA works with culture as a framework - not in a reductive way that condemns and vilifies

particular 'cultures' as synonymous with, or productive of, abuse, but as a way of exploring individualised, intersecting experiences. The approach is, as described by one practitioner, *"'know your client' on steroids":* CIFA practitioners bring their knowledge related to culture, professional experience, and curiosity to each session (CP6). Importantly, CIFA works with marginalised and minoritised people whose needs and experiences are not otherwise accommodated in the system (R8). This approach contributes to its effectiveness and is a model for behaviour change programmes more broadly.

CIFA offers a culturally tailored programme, delivered, where appropriate, in the person's own language (often with the support of interpreters, as discussed in Section 4.4.3), with meaningful exploration of how beliefs related to identity, faith and the norms of their 'home' country have shaped their experiences of DA. This approach is unique and valuable in a system where people are often not accommodated, in terms of language and broader exploration of how cultural beliefs shape DA (R8).

CIFA understands that DA does not occur in a vacuum: a person's beliefs and behaviours are shaped by family and community norms, pressures and expectations, by experiences of trauma and migration, by the experience of living between two sets of legal and social norms, and experiences of marginalisation, poverty, precarious migration status and discrimination (CP8, CP11, CP9, CP3). CIFA offers SUs and VSs space to reflect on these experiences and their emotional and relational impact (CP8, CP9, CP4). People accessing CIFA have often experienced displacement, war and various kinds of trauma. They can explore these experiences through CIFA's trauma-informed programme, not in a therapeutic sense but to understand their impact on behaviour, and to consider tools to manage those impacts (CP11, CP7, CP9). CIFA offers support to SUs and VSs in understanding and adjusting to the British legal framework and system (CP9).

Referrers reflected on their experiences with families who have just moved to the UK, where disciplining children with shouting and hitting was considered 'normal' (R8, R4). CIFA offers education on acceptable and non-acceptable behaviour in the UK context and system, and helps people adjust and understand their behaviour (R8, CP5, CP9). One IDVA noted that this understanding of context, and the complexity of families' experiences, is important and not always forthcoming within the system:

> *"there are different barriers, barriers, which could be families, understanding of religion, their language barrier, their isolation of both of the partners because they came from a different country. So sometimes there is that lack of awareness and they* [social workers] *maybe expect people to kind of just simply engage, you know, when it's not always straightforward for everybody"* (CP9).

The CIFA programme for SUs is designed with the complexity of intersectional experience in mind. (VS support is discussed in Section 4.6.4). While some SUs can come onto the programme feeling resistant or sceptical, the programme's approach design reassures: practitioners explore culture in a way that is not *"tick-box"* and does not make assumptions (CP3). SUs feel listened to and understood (CP3, R4). The design of the programme is intentional, approaching people with curiosity and care (CP4, CP3, CP5, CP8). It is not simply delivery of content, it Is *"deep diving", "exploration work"* with SUs (CP6).

Practitioners were engaged with concerns around the risk of imposing dominant, white cultural values on minority populations. This echoes important concerns in the academic literature. They demonstrated curiosity and respect for culture, while asking the person to consider the harm and

impact of particular behaviours. One CIFA practitioner, for example, reflected on her work with a man whose religious views shaped a *"particular kind of dynamic with his wife"* (CP10). While this dynamic was uncomfortable for the practitioner, she acknowledged that it was a *"personal agreement that he has with his wife, and this is one that they're happy with"* (CP10). Her role was not to impose cultural values on the relationship and say *"this is all abusive"* - which would also undermine the agency of his wife - but to explore the harm and the impact, asking the man to consider, *"How does this impact your wife? How does this impact your children?"* The practitioner stated that good supervision and support at RISE helped her to navigate this particular case.

CIFA case studies provide some key examples of how the programme encouraged SUs to explore the complexity of culture and its impact on abusive behaviour in an intersectional way. Mr H, for example, explored the "clash" between traditional Afghan gender roles and Western expectations. Mr I initially justified his controlling behaviour using religious beliefs but over the course of the programme recognised the harms caused. Mr S engaged in pre-intervention sessions focused on resettlement and cultural identity before beginning the core CIFA programme, which supported a sense of belonging. Mr M reflected on cultural expectations around marriage and feeling forced into a relationship by his family. Mr D found discussions around values and family roles particularly impactful as these were not usually explored in his cultural setting. CIFA's cultural approach allows for an exploration of issues like these, guided by competent and reflective practitioners who create a safe, respectful but challenging environment.

Whilst the culturally informed approach is generally received well, and acknowledged by community groups, in interviews with community groups, some expressed scepticism regarding the knowledge and experience of CIFA practitioners about the nuances of different communities, and suggested that specific and targeted training provided by community groups could enhance knowledge and cultural competency, for example in relation to the Jewish community. As discussed in section 4.4.5, RISE demonstrates a commitment to training staff in cultural competency and a high standard of responsive training. Community groups also emphasised the importance of stronger links between community groups and CIFA to achieve increased impact within the wider community. Again, RISE have made – and are continuing to make - significant investments in this area. With ongoing outreach work and responsive conversations, we expect that these community group concerns will be addressed.

4.6.2 Key features of culturally informed provision in practice

From the point of referral to the completion of the programme, SUs are assured that CIFA will cater to their individual needs, from language to adaptations for neurodiversity, and attend to the cultural nuances of their case (R3, DAL1). This reduces SU resistance to taking part and the tailored and culturally informed provision offered by CIFA practitioners throughout the programme reassures SUs and keeps them engaged. The quantitative data further confirms that the programme reaches racially minoritised and diverse religious groups as well as groups that need an interpreter. See sections 4.1, 4.2 and 4.3 for more analysis of the inclusion of these groups and how CIFA supports and facilitates positive behavioural change across these groups. Section 4.2.5.2 on effectiveness also highlights racialised groups that often are found not suitable, underlining the racialised groups where CIFA's practice might expand and further cultural integration.

4.6.2.1 Concepts and examples

Recognising that *"people connect culturally to a concept differently*," CIFA practitioners take the time to *"reach a shared understanding"* (CP10). Practitioners slowly help SUs and VSs to understand how cultural influence shapes personal responses and behaviours (CP7, CP6). Developing the lens of culture slowly in sessions, practitioners open a space for SUs to understand differences between cultures. For example, they might explore norms around DA in public, by asking how the person would respond to seeing abusive behaviour on the street. How might they respond, and why? The examples in the CIFA manual are designed to be *"more culturally friendly,"* where core questions and concepts are brought to life in a way that speaks to minoritised experiences (CP11). The practitioner will introduce ideas and concepts early in the programme and come back to them at a later stage to explore the SU's beliefs (CP6, CP10). This approach is supported by practitioner flexibility and experience, as described in section 4.4.3. One CIFA practitioner noted that people can feel *"attacked"* when being interviewed by a white person using unclear concepts (CP11): *"They can ask, 'how does this apply to me?'"* Being culturally competent means having an awareness of what examples will work with the individual. CIFA practitioners think carefully about how to explain concepts, to use analogies, how to bring things to life.

4.6.2.2 Practitioner cultural identity

The ethnicity of CIFA practitioners was a significant factor in fostering trust and engagement in the project. Many CIFA practitioners share cultural backgrounds with SUs, though they are not automatically matched (CP10, CP6, CP3, CP9, R12). This staff diversity is a significant strength. Practitioners' lived experience and cultural understanding means that they can build connections with SUs and can introduce examples that are relatable. The SU might be more open to conversations on the basis of shared identity, even if non-specific: *"It can help to see another black person*" (CP10). Several SUs mentioned how working with a practitioner from a minoritised community made a huge difference in the way they participated in the programme. SU13 noted that working with a practitioner from a similar cultural background facilitated a stronger connection and *"allowed me to have a better connection with {practitioner name} and be a bit more involved […] I was actually involved and invested*." Similarly, SU2 highlighted the relatability of shared minority experience:

> "*I'm from a minority place. {Practitioner name} also comes from a minority background where, it's like, a lot of things are different, but a lot of things are similar. I was able to relate on that point, so I know she understands*."

The presence of practitioners who understood their cultural contexts helped SUs feel heard and respected. As SU10 explained, "*I don't feel [as] judged by the person I'm speaking with because he did understand my situation…and I felt heard*."

Referrers reflected that knowing about cultural nuances and truly understanding can be different (R4, R8). They felt that with CIFA practitioners, SUs can feel fully understood in terms of culture and religion. That can be useful for SUs, to work with someone who *"gets it,"* whether by training or lived experience (R4, R8): *"CIFA staff understand where social workers may not. Not fully."*

As one social worker explained:

> *"All of my clients are from the same country, and the practitioner also has roots from that same country. So she was able to understand the background of the family. So that's really impacted. [...] the family could relate to her and say, 'Yeah, you know about this, right? This is how it is.' So, yeah, that was actually good. But whereas, if it was to be a different person who does not know about the culture or ethnicity of that particular group, is it difficult for them to make them understand"* (R12).

Working with a practitioner with a shared background can be a positive challenge for SUs:

> *"People from a shared culture can be good role models for men on the programmes - where they come in, and will see somebody from the same background and assume to have their ideas about domestic violence validated. But that doesn't happen and that that can be challenging"* (CP3).

Some men have struggled to work with a woman from the same culture, finding it shameful and challenging. But, one RISE practitioner reflected, this dynamic can be productive and potentially transformative: SUs can change for the better with this challenge (CP11). The academic literature on successful intervention programmes suggests that positive challenges bring positive results.

Several CIFA practitioners emphasised that the practitioner does not need to share cultural background with the SU for the programme to be effective, and being outside the person's community and culture can actually serve the relationship well. CIFA is a well-designed programme that offers all practitioners the ability to explore attitudes and beliefs (CP3). Connection and rapport is a matter of personality as well as culture (CP11, CP3). Some practitioners found it useful to present themselves as a novice, outside the culture and wanting to understand (CP10, CP3). However, a practitioner outside of the culture may not know specific nuances that could be used to positively challenge the SU, for example prompting reflection on religious teachings from a place of knowledge (CP11). The diversity of the CIFA team, however, means that they can and do share information and insight, supporting one another to work in a culturally informed way (CP11). CIFA practitioners and interpreters can also sometimes be perceived as too close to the community:

> *"some people I've worked with have said that you preferred the fact that I didn't belong to their community, because it kind of allows them to not feel judged. So that was them, the Somalian community, and when I got an interpreter there, she recognised the person and asked her to go"* (CP12).

Shared backgrounds, or perceived closeness in culture, was also important to VSs, some of whom built strong relationships with their support workers:

> *"{Practitioner name} is very close to me as well…her background is very close to me as well. So I'm very, very confident and very happy with the people around me. And, you know, I would like to sort of share my life with them in the future, so not just this moment of time when I need them. I would like to carry on sharing my life with them…going into the future"* (VS2).

Where VSs did not share culture and language with practitioners, VSs felt that they were *"very culturally informed"* (VS5) and mentioned qualities of patience and kindness. IDVAs and DASAs showed respect, inclusion and a lack of judgment:

"I feel that the CIFA programme resonated with my experience and understood my needs. I feel that my culture was being considered. I have received a culturally sensitive service for CIFA and because I'm Polish, I speak mostly Polish, to my parents, to my brother, about the situation, and I needed to express myself in English. She was very patient, and she understood, yes, what I want to say, because the way she repeated in English, it was like she understood extremely well what I want to say. She was very patient" (VS1).

"I feel like I have a good support when it comes to my culture, I already mentioned it why. Respect, no judgement, kindness…" (VS4).

"I felt inclusion, respect, understanding… there was no judgement. Everything was done well" (VS5).

"I am Muslim, and I always felt respected and valued. CIFA provides interpreters for me, so that I can share my thoughts and be able to talk to someone" (VS4).

Culturally informed provision enhanced perceptions of safety and respect among SUs and VSs. As explored in the following sections, this approach enabled changes in beliefs and a reduction in harmful behaviours in SUs, and changes in VS beliefs that enhanced their agency and safety.

4.6.3 Self-reported and observed changes in service user norms and beliefs and a related reduction in harmful behaviours

4.6.3.1 Reflection on cultural beliefs and behaviour

The CIFA programme offers SUs a structured and supportive space to reflect on how culture has shaped their beliefs, attitudes, and behaviours, particularly in relation to DA and family dynamics. While many SUs found it difficult to define 'culture; precisely, they were able to identify and discuss how deeply cultural and religious norms had influenced their relationships, values, and patterns of behaviour.

When asked whether CIFA provided a culturally sensitive service, SUs reflected on how cultural influences shaped their experiences, particularly in relationships. For example, SU3 highlighted the interplay between culture and religious upbringing in his home country and Britain

"*I was born in Syria. I was raised for half my life in Syria. I have a different background. Where you were born doesn't matter; it's in how you are raised and with your mother. It's also a religious thing. It affects what you think and can help you with the right and the wrong; what you should and shouldn't do. In our religion, we know what is halal, and haram and what is mercy, and this is what many people don't know"* (SU3).

CIFA practitioners emphasised that culture provided a powerful entry point or 'useful lens' for meaningful conversations about values, beliefs, identity, and harm. This framing enabled SUs to explore topics they had often not discussed before, such as masculinity, obligation within family structures, emotional suppression, and shame.

One DA lead noted that for some participants, acknowledging the role of culture in shaping their thinking created "light bulb moments" as they realised how inherited norms and past experiences were not only outdated but actively harmful to themselves and others:

> *'Men can realise that the beliefs they brought with them, what mothers and sisters experienced etc, is not right'* (DAL1).

CIFA allows SUs to explore the relationship between cultural narratives and emotional triggers, and to begin to develop insight into the consequences of their behaviour on others (R9, R4, I1).

The impact of using culture as a lens was evident in the experience of Mr I, who found the exploration of masculinity, culture, and belief systems deeply impactful. He explained that he had not previously realised how much these forces shaped his day-to-day decision making and expectations. He acknowledged that while some cultural strategies and coping mechanisms had become ingrained over many years, he was beginning to see the need to do things differently. Similarly, Mr X initially struggled to connect emotionally to the programme content. However, CIFA practitioners worked thoughtfully with his experiences of cultural identity and racism, helping him to contextualise his emotions and recognise the need to take responsibility for his behaviour. While this process took time, Mr X eventually demonstrated insight into the fact that only he could control his behaviour, regardless of the attitudes and norms he had internalised.

VSs also recognised the impact of cultural norms on their partners' behaviours. VS3, for example, described how extended family expectations and loyalty dynamics influenced her husband's actions:

> *"My husband, it was one bad habit because he listened to everyone. You know, this one not good because the mother, he do what they say, the sister and the brother wife, he do what they say"* (VS3).

Another VS provided a powerful example of how cultural beliefs can be used to justify violence and dismiss accountability:

> *"Because he's British, born here, and his parents are from Mauritius, I should understand, like, in his mind, his cultural beliefs, it's like he can hit woman, hit a child, spit on the woman's face, swear all those things. Like he's allowed to do those violence things because his cultural beliefs that he was trying to manipulate the result like, that's why they decided, with his advisor that they should finish, because he couldn't accept allegations which they never happened"* (VS1).

CIFA practitioners working with VSs of adult child abuse on the APFA programme noted that cultural narratives around family loyalty, privacy, and shame could prevent disclosure of abuse. One practitioner described the internal conflict some women face:

> *"It's the idea… that your sons will look after you when you're older. It's a cultural element… I don't want to ruin my child's life, no matter how abusive they are to me. I don't want people to know my business"* (CP12).

In these contexts, understanding family dynamics and identifying culturally meaningful sources of support are essential for safe and effective risk planning.

Through integration of cultural narratives, family systems, and belief structures, CIFA enables participants to surface and challenge the deeper norms that contribute to harmful behaviours, and to begin the process of replacing them with safer and healthier ways of relating.

4.6.3.2 Knowledge of legal frameworks

Engagement with the CIFA programme enabled SUs to critically examine their views on relationships, gender roles, parenting, and what constitutes abusive behaviour, particularly in the context of British legal frameworks. This is also reflected in the outcome star assessment analysis discussed in section 4.2.5 on effectiveness, in the outcome areas on Being a good father, Safe actions & reactions and Taking responsibility, among others. SU1 reflected on the need to adapt cultural norms and values in the UK. He stated:

> *"My culture is back home. You know, here we are in a different country. We have to understand, we have to follow the laws here, certain things this sometimes, you know, which we get it wrong. You know, because we say, our culture doesn't allow the wife this to do this. You know, back home, you're in England, and you have to think carefully. You have to, you know, to think positively. You have to discuss things, you know, on the way can be done here."*

SUs gave specific examples of behaviours considered as culturally acceptable in their countries of origin but were defined as DA under UK law. SU7 explained:

> "*In some culture you give, or you keep, control of your finances. You don't share your or you don't give your partner the spending money or you limit yourself, or you limit her spending. You say, 'you can't spend on this, you can't buy this or that.' In some cultures, there are very strict financial control. […] Even if she's working, you tell her to put money into your account and you keep it to yourself. You only give her spending money; that's like financial control. So, in some cultures is very difficult for do these things [like this] which affects the family life*."

Through the programme, SUs like SU7 came to understand that such behaviours fall under the legal definition of DA in the UK, as outlined in the DA Act 2021, which recognises coercive, controlling and economic restrictions as abusive behaviour sanctionable by law. Being culturally cognisant of the law of DA as it is implemented in Britain was noted as particularly helpful, with SUs like SU1 and SU11 acknowledging their mistakes and expressing a deeper understanding of their relationships within the context of UK laws and cultural expectations. As stated by other SUs:

> "*It's good to have somebody who knows the rules and the culture from here, where I live now"* (SU18).

> *"This programme helps to deal with, a little bit on the cultural side of the life. They see and they know how some cultures work and how family life is in that cultural. So, I think that it's really helpful that they know how each religion or culture the way they live*" (SU7).

4.6.4 Changes in the norms and beliefs of victim survivors which enhance their safety and self-determination

DASAs and IDVAs spoke directly to the cultural approach mobilised through the CIFA programme, describing that it was important to recognise that VSs can experience abuse like slapping as *"normal"* and *"still have those cultural beliefs, and you come to a country like UK, where they're talking about DA and the physical and then you say, Oh, he's not abusive"*" (CP5). They may not perceive some behaviours as abusive, such as violence coded as discipline, financial coercion and control, the abuse of children or female genital mutilation (CP5, CP4). Again, CIFA practitioners demonstrated a reflective

and careful approach, engaging with VSs with care and curiosity (CP4) and recognising that *"having those conversations and feeling quite open and brave to actually ask those questions, as opposed to shying away from them"* opens space to gently unsettle normalised abuse (CP4).

Some IDVAs stated that they focus on the relational aspect of work with VSs:

> *"sometimes I explained that to women in terms of The UK stance in DA and how in different cultures it might be, viewed as something that is normal, the normalisation of the abuse. But in general, I would say that…[my] approach is in terms of providing emotional support"* (CP1).

That said, she understands the communities they work with and might refer the VS to specialised services in relation to specific cultural issues, for example Asian Women's Resource Centre and Icarus (CP1).

A DA lead emphasised that culturally informed support work with VSs can be a *"massive"* challenge to the norms and ways of life of a VS. She referred to *"astounding"* levels of financial abuse and control, noting that this behaviour is normalised for many people - women in particular (DAL1). Sufficient support must be provided alongside reflective work with VSs.

4.6.5 The value of cultural approach and its potential to enhance systems capability (culturally informed provision)

Practitioners - both CIFA staff and across the system - were keen to acknowledge that *"we all have culture"*: all people come with cultural ideas about DA, including dominant white British culture (CP3, CP9, R9). Many emphasised that the particular focus on culture when working with minoritised groups through CIFA was not to say that minority cultures are more likely to be abusive.

> DA is *"not synonymous with one particular group, or …one particular culture. […] we have to break down those boundaries, those barriers and those misconceptions. But also we have to inform. 'Look, it is illegal in this country. You will be prosecuted,' you know, so that they understand those rules"* (DAL1, CP3).

It is important that the programme's focus on culture among minority groups is not taken to suggest that the dominant culture does not produce DA. As one social worker explored: *"what culture is being considered? Though culture is a factor, the culture of drinking in the UK is also a domestic violence issue"* (R2). In the context of familial abuse, one CIFA practitioner argued for a culturally specific approach *"because there's a deeper oppression and intersectionality with cultures from minority and marginalised communities"* and this experience makes them more vulnerable to state intervention, for example immigration control (CP12). These concerns and insights are echoed in the academic literature. Experiences of structural precarity are often - but not always - gendered and can prevent VSs from seeking support for DA. For example, they can be in the UK on a spousal visa, and entirely dependent on their spouse, with no access to finance or benefits (R12, CP5). Practitioners reported that VSs are often reluctant to involve the police or social services in DA because of immigration-related precarity, including the threat of deportation, and a fear of losing the family breadwinner (CP5). One IDVA offered a powerful example of a male VS being abused and kept silent with threats of calling the Home Office and having him deported (CP5). These accounts echo concerns in the academic literature about underreporting and suppressed help-seeking in relation to DA.

While many SUs valued the cultural focus of the programme, some critiqued its emphasis, arguing that DA should not be reduced to cultural differences. Instead, they suggested that abuse is often contextual rather than cultural. For instance, SU1 noted that the complex interplay of factors creates the conditions for DA to occur. Categorically acknowledging his wrongdoing in responding aggressively to his partner, he said:

> *"Like domestic violence ain't never been okay, and violence in general ain't ever been okay. Of that, I've always known violence on any level is wrong, even when you're reacting to something bad. I know it's still wrong…"*

He argued that the conflictual situation he was in, and the lack of ability to control his behaviour at the time, had escalated because of the immediate situation he was in rather than any cultural factor.

> "*As Christians, we're always taught to turn the other cheek, right? But we just know, truthfully, in the real world, it's not always that practical, and it's not always that realistic*" (SU1).

Further, SU1 touched on the culture of masculinity when trying to articulate his understanding of DA more generally. Similarly, SU13 described growing up in a Pagan culture which was *"very patriarchal"* and "*some weird rules' such as obeying older people."* SU13 noted how '*difficult it was to let go of these ideas*' and cited these artifacts as part of the struggle she has with her in-laws and the *"deep involvement"* they had in her life. These points were echoed by another SU (SU17, via an interpreter) referring to their Roma cultural heritage.

> *"The other aspect of the culture where in his grandparents' generation, the world of men or father or the provider, the male figure was more kind of more authoritative. In terms of what the man the head of the family said, that's what happened. So, he was always the one making the decision, making the choices. […] the mum would always support the generations [of men] before. While now, it's not like that. Now mum, will support the wife if mum knows the wife is true and the son is not.*"

For SU17, much had changed within the Roma; he accepts that the cultural influences are still alive in interpersonal relationships.

SUs recognised the place of culture and drew some connections between culture and their attitudes and behaviours, while emphasising that culture is a multifaceted concept. They suggested that the value of CIFA is creating a safe, supportive environment where practitioners listened and provide guidance to SUs. SU14, who'd been referred to the FADA programme, encapsulated this perspective:

> "*I just thought, no matter what culture you're from, it was so good that I did speak about it [culture] because his dad was that very beating and shouting sort of person. I think that's what affects him, and saying that, because it affects me too. But I didn't see that [culture] coming to it. I just saw [just talking to] someone who understands, no matter where you're from.*"

The CIFA programme's culturally sensitive approach was widely appreciated by SUs, who valued the opportunity to explore the intersection of culture, DA, and personal behaviour. While some SUs critiqued the emphasis on cultural differences, they universally highlighted the importance of practitioner empathy, cultural awareness, and the ability to listen and guide. These elements were seen as central to the programme's effectiveness in fostering understanding and behavioural change.

CIFA practitioners and referrers echoed these perspectives, stating that the programme's approach - defined by curiosity, care, trauma-informed principles and an openness to complexity - means that it could be used with and open up to anyone, not 'by and for' particular groups (R9, CP3, CP9).

Importantly, several social workers reflected that they did not have much insight into how CIFA works with culture (R5, R12). There is much to be learned from the CIFA approach and a sustained and regular feedback strategy - to individual referrers and with training - would be a useful and potentially transformative contribution to the wider DA system.

The CIFA approach is a model of effective, intentional practice that could be adopted across the wider DA system to great effect. In fact, CIFA's approach to culture is already re-shaping practice in important ways, which is explored in the next section on ripple effects. As two CIFA practitioners explained in a team meeting, when working together on different RISE programmes, they find themselves posing questions embedded in the CIFA model (CP6, CP7).

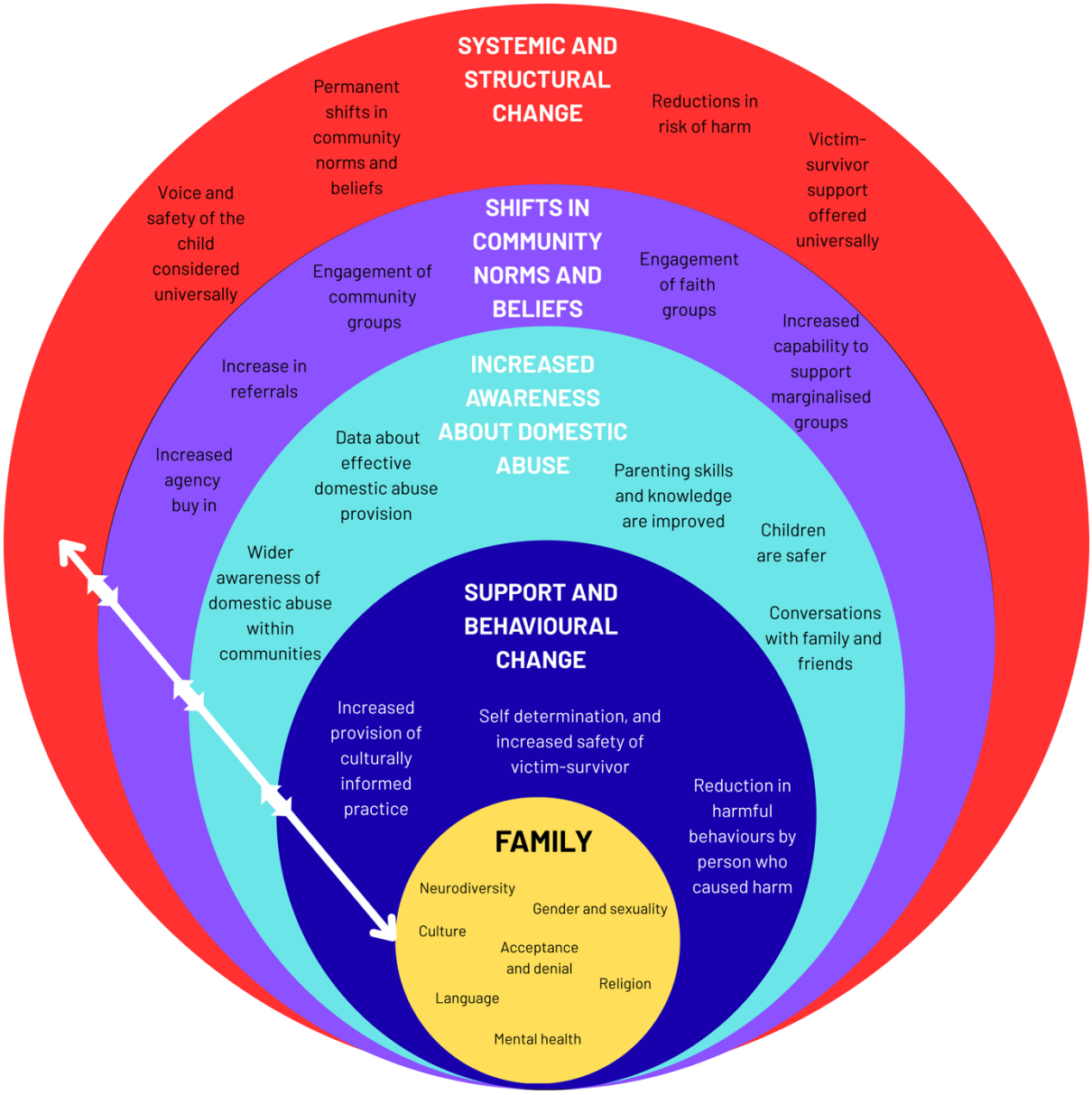
5. Ripple Effects / Community Impacts

Key findings

- Victim-survivor participants reported positive impacts on their (co)parenting, safety planning, confidence, and the emotional environment of the home.
- Victim-survivors felt more informed, supported, and empowered to seek help or advise others, suggesting a potential multiplier effect in their communities.
- Some victim-survivors suggested that CIFA increased their trust in social services and helped counter harmful cultural norms by validating their experiences.
- Some victim-survivors reported that both they and their children felt safer and more able to see and/or visit with the family member that had caused harm.
- Service users learn to challenge harmful gender/cultural norms in families, and in the wider community.
- CIFA practitioners are starting to look at people who have caused harm as potential advocates for change in their communities, with evidence that service users are speaking to family members and friends, and challenging cultural norms.
- CIFA is addressing a need for services directed at people who cause harm, shaping a culture of accountability and possibility of transformation within systems where this is often absent.
- Community groups and faith centres are engaging in conversations about DA, and raising awareness of safe relationships and CIFA's available support.

As evidenced by qualitative interviews conducted with CIFA stakeholders (SU, VS, and various practitioners) across the 10 boroughs included in the evaluation, and from case study and progress reports of SU, through culturally informed practice, integrated delivery, and a commitment to shifting the burden of accountability away from VSs, and instead placing this on people who cause harm, CIFA is helping to reshape not only families but also creating ripples of change in the systems and social norms that surround them (see Figure 17). These 'ripple effects' act at personal, relational, institutional, and cultural levels, and extend the programme's influence well beyond individual change. By exploring these ripples, we can assess and identify how DA support and prevention through behaviour change and discourse shifting can be sustained across networks and sectors, through everyday shifts in trust, discourse, and decision-making.

Figure 17. Summary of the 'ripples' of CIFA, acting at personal, relational, institutional, and cultural



5.1 Behaviour and mindset shifts among service users, victim-survivors and families

Changes in mindset and behaviour were reported by both SU and VS, with many describing deeper personal insight and a renewed sense of responsibility in relation to DA. Mr X (neurodivergent SU, case study) showed improved communication and began recognising the emotional impact of his behaviour, which in turn may improve his relationships with his family and wider network. Similarly, Mr I (case study) acknowledged relational triggers and longstanding beliefs shaped by cultural expectations, which could also impact his communications and relationships with his family and

beyond. Highlighting the impact of these shifts in mindset and behaviour, Ms AE (FADA SU, case study) reported that she had begun building healthier, non-violent relationships and support networks, modelling safer behaviours for others around her.

For many VS, changes in the SU behaviour were accompanied by their own shifts in outlook and confidence:

> *"Now everything is OK because I'm happy every time. Every day I meet to my husband outside in the park.*
>
> *'He used to have a lot of anger issues but he is a changed man. I've noticed a lot of change in him and in me too, I feel much less on edge. It has been a positive impact on him speaking with {practitioner name} every week. You have been amazing, I can't thank you enough."*

Other VS described growing trust in professionals and renewed optimism. As VS2 said:

> *"We feel supported… We feel really, really nice. We feel we get new hope… We know who to approach… I feel safe with the people I work with."*

5.2 Addressing a gap in services for men

Many SUs described CIFA as one of the only services available to them, particularly as men from minoritised communities. SUs emphasised the lack of tailored interventions that understand their cultural contexts, legal knowledge gaps, or trauma histories, and how this impacts the support that they can access. SU7 stated the importance of helping men before they reach crisis point:

> *"So that they don't ruin their family relationships or get into deep trouble, abuse, or do anything worse than they did not want to do."*

SUs viewed CIFA as an incredibly valuable resource for men, who oftentimes come from minoritised communities with varying degrees of knowledge of the legal ramifications of DA and who had few opportunities to share their experiences.

A range of stakeholders also echoed the importance of working with people who have caused harm, not only as a form of prevention, but as a necessary shift in system accountability. *"Working with VS alone doesn't drive change,"* one social worker explained. *"We want men to take responsibility- we need them to be willing to change"* (R8).

Practitioners also expressed a need for services, like CIFA, that speak directly to the needs of the people that have caused harm, as existing support systems are, in their opinion, 'not very good'. CIFA's impact, then, is not only in providing services, but in shaping a culture of accountability and possibility within systems where this is often absent.

5.3 Referring others to CIFA

Many SUs described the programme as transformative and said they had actively encouraged others to seek help. SU2 shared:

"If I have an opportunity to refer somebody, I'll refer it without even question… this, in my experience, was the best thing that happened to me… made me realise myself and make me understand myself."

SU8 shared:

"His behaviour is very bad to his family, so I often tell him to get in touch with this programme because it's going to be really helpful."

SU7 reflected on the lack of awareness about support:

"People like me… keep things to themselves. This programme helps open them up. I'll definitely recommend it… so people know these things exist."

This willingness to promote CIFA indicates strong perceived value and suggests the potential for a community-led amplification of its principles and reach, particularly among men who may otherwise struggle to seek help.

5.4 Impact on parenting and enhancing children's safety and wellbeing

Parenting improvements emerged as one of the most consistent ripple effects across interviews, case studies and reports. This has a potentially enormous impact on children, their safety and wellbeing.

- Mr A acknowledged how his emotional dysregulation had harmed his children and now models pro-social parenting.
- Mr T and Mr M both linked their participation to greater emotional security and safety for their children.
- Mr H and Ms S described collaborative co-parenting strategies (e.g. around screen-time boundaries).

Moreover, children were a powerful motivator for change among many SUs, with fathers explicitly naming their desire to be better parents as a reason for sustained effort. This was also apparent with female SUs, for example, Ms AE's case study highlighted improved co-parenting, reduced reactive behaviours, and prioritisation of child-centred decision-making as being important to her ongoing behaviour change, and narrative shifts.

5.5 Culture, community, and de-normalising abuse

Another key ripple effect of CIFA is its role in opening space for culturally nuanced conversations that destigmatise help-seeking, challenge silence, and disrupt normalised violence. SUs such as Mr I and Mr H began to openly challenge gendered norms and traditional expectations that had previously shaped their behaviour. Practitioners also described how the programme helped VSs acknowledge abuse in contexts where silence was culturally expected. CP12 noted:

"It's the idea… your sons will look after you when you're older. I don't want to ruin my child's life, no matter how abusive they are to me… I don't want people to know my business."

These conversations are slowly interrupting cycles of shame and denial and helping communities reconsider what constitutes respectful relationships.

5.6 Effects on community discourse

Beyond the household, the programme contributes to subtle but important shifts in community norms and narratives. VSs described how peers and family members were now asking questions, listening, or seeking help themselves, sometimes for the first time. Moreover, SUs such as Mr H and Mr I began to question and challenge patriarchal and cultural norms around violence and gender roles. Ms AE's development of calm, boundary-based communication has implications beyond her household - rippling into relationships that she holds in the wider community, and possibly in the workplace. Their growing confidence in speaking up could create community-level ripple effects, especially in extended family contexts. There is also some evidence of increased respect for social services and practitioners, which may signal a shift in trust and openness within families and communities toward external support.

However, some interviewees from community groups highlighted that there are ongoing challenges in raising awareness of DA within some communities, and as such, driving behaviour change within these communities remains difficult. These community voices argued that there is a need for a more nuanced understanding of what DA is amongst communities, highlighting the importance of differentiating between 'domestic conflict' (e.g., 'common-garden' arguments and disputes that occur within families) and 'domestic abuse' (i.e., an insidious form of coercive and controlling behaviour that engenders fear and insecurity). This lack of understanding of what constitutes DA, particularly among those who cause harm, hinders progress in addressing DA and the potential 'ripple effects' required to engender real change. However, despite the limited funding and resource available to overcome this risk, RISE is undertaking outreach work with social workers, and undertaking a range of community engagement activities to improve awareness. Careful outreach strategies have been designed and funding secured for two outreach workers, with one focused on the LGBTQ+ community.

5.7 Borough-level and cross-borough collaboration

The CIFA model is distinct in its ability to foster meaningful connections across boroughs, an effect not often observed in other DA programmes. Stakeholders referenced the value of linked-in meetings and learning exchanges across local authorities, with one noting this *"doesn't happen with other programmes."* These regular spaces have created a sense of shared mission and professional community. One DA lead described how CIFA "lit a fire" in her and the borough to do more proactive outreach, with ripple effects seen in community group engagement and interagency collaboration (DAL1).

5.8 Sector-wide learning

Training on DA and CIFA's cultural approach and offer has taken place across the ten boroughs, raising awareness of issues and cultural competence and knowledge of DA amongst referrers. Respectful Partnership training was designed and delivered by CIFA in collaboration with United Communities. CIFA practitioners involved in the training reported that the training provided valuable knowledge, and helped potential referrers feel more comfortable and confident with DA terminology with LGBTQ+ communities. The training was considered important for borough level staff, regardless of the impact on referrals.

5.9 Systemic shifts in professional attitudes and partnerships

CIFA has influenced how social workers, safeguarding leads, and other frontline practitioners approach people who have caused harm. There is strong evidence that these stakeholders are more reflective, open to challenging biases (including their own), and adopting more nuanced, culturally competent approaches. Some professionals reported greater confidence in stepping back and allowing CIFA to take the lead on certain cases, particularly where safeguarding risks had reduced. Others described how the programme inspired renewed passion and purpose in their practice. The creation of new partnerships with community groups further shows how CIFA has catalysed interagency trust and knowledge-sharing.

5.10 Systemic shifts in line with VAWG strategy

At a strategic level, CIFA is contributing directly to the VAWG strategy by:

- Reducing reliance on VSs to "prove" harm;
- Placing accountability on those causing, or have caused, harm;
- Offering a holistic, cross-sectoral model of prevention and response; and
- Embedding culturally sensitive, community-informed support.

The programme's holistic, cross-borough approach challenges the traditional siloed model of support and embeds a more accountable, intersectional framework for tackling DA. By focusing on cultural safety, accountability for those that have caused harm, and community collaboration, CIFA is paving the way for a system-wide reframing of how DA is understood and addressed within London's local authority and voluntary sector ecosystems (and beyond).

6. Value for money

Economic analysis was conducted to estimate the costs and outcomes associated with CIFA, MARAC, DRIVE, and no formal intervention. The primary focus of the analysis was to compare CIFA directly with No Intervention, while recognising that MARAC and DRIVE target different populations and risk profiles, and are therefore not directly comparable to CIFA in terms of cost-effectiveness.

17 demonstrates that CIFA generates the lowest costs compared to MARAC, DRIVE, and No Intervention. Compared to No Intervention, CIFA generates substantially more quality-adjusted life years (QALYs). At a willingness-to-pay (WTP) threshold of £20,000 per QALY (1 year in full health), CIFA demonstrates the highest net monetary benefit across all interventions.

While direct cost-effectiveness comparisons with MARAC and DRIVE are not appropriate, their inclusion in the tables provides useful context. CIFA's total costs are notably lower than both MARAC and DRIVE, while QALY outcomes are of a similar magnitude.

Table 17 shows that CIFA is both more effective and less costly than No Intervention, meaning CIFA dominates No Intervention.

A comparison with MARAC and DRIVE is presented for reference. In the comparison with DRIVE, both the incremental cost and incremental QALYs are negative. In such cases, the ICER does not represent the cost per additional QALY gained, but instead reflects the cost saved per QALY lost when choosing the less effective but less expensive option. The difference in effectiveness is marginal while the cost difference is substantial - this results in a high ICER value. This indicates that the additional cost of DRIVE is not justified by the small QALY gain at commonly accepted willingness-to-pay thresholds. Table 18 shows the disaggregated costs in the DA health state per intervention. These results indicate that CIFA is cost-saving compared to No Intervention in terms of domestic abuse related societal and public sector costs. It not only reduces the number of domestic abuse incidents, but also leads to substantial savings across health, criminal justice, and productivity losses.

Return on investment analysis shows that for every £1 invested in CIFA, an estimated £39.16 is saved, compared to £4.84 for MARAC, and £72.91 for DRIVE.

Table 17. Intervention costs: Comparison across provision

Intervention	Total Costs (£)	Total QALYs	Net Monetary Benefit (£) (at £20,000/QALY)	ICER (CIFA vs)
CIFA	39,658.09	18.47	329,761	-
MARAC	101,526.86	18.45	267,536	Dominated
DRIVE	63,392.14	18.51	306,748	593,351.25
No intervention	242,995.27	17.60	109,026	Dominated

Table 18. Costs per component: Comparison across provision

Component	CIFA	MARAC	DRIVE	No intervention
Physical (£)	24,666.88	51,627.72	43,262.11	173,696.68
Output (£)	7,297.67	15,446.35	13,210.20	51,703.24
Health (£)	1,228.72	2,549.69	2,183.36	8,588.80
Victim Services (£)	373.38	786.54	663.45	2,627.41
Police (£)	651.90	1,373.40	1,166.56	4,643.33
Criminal (£)	171.27	360.28	308.35	1,199.85
Civil (£)	70.23	148.72	125.83	500.81
Other (£)	5.07	10.56	9.07	35.15
Total DA State Cost (£)	34,465.12	72,303.28	60,928.94	242,995.27

Figure 18 shows the cost-effectiveness of CIFA compared to MARAC, DRIVE, and No Intervention for each of the 1,000 simulations. This demonstrates the impact of uncertainty on the results. Compared to No Intervention, CIFA demonstrated greater effectiveness and lower costs.

Figure 18. Cost-effectiveness of CIFA compared to MARAC, DRIVE, and No Intervention for each of the 1,000 simulations

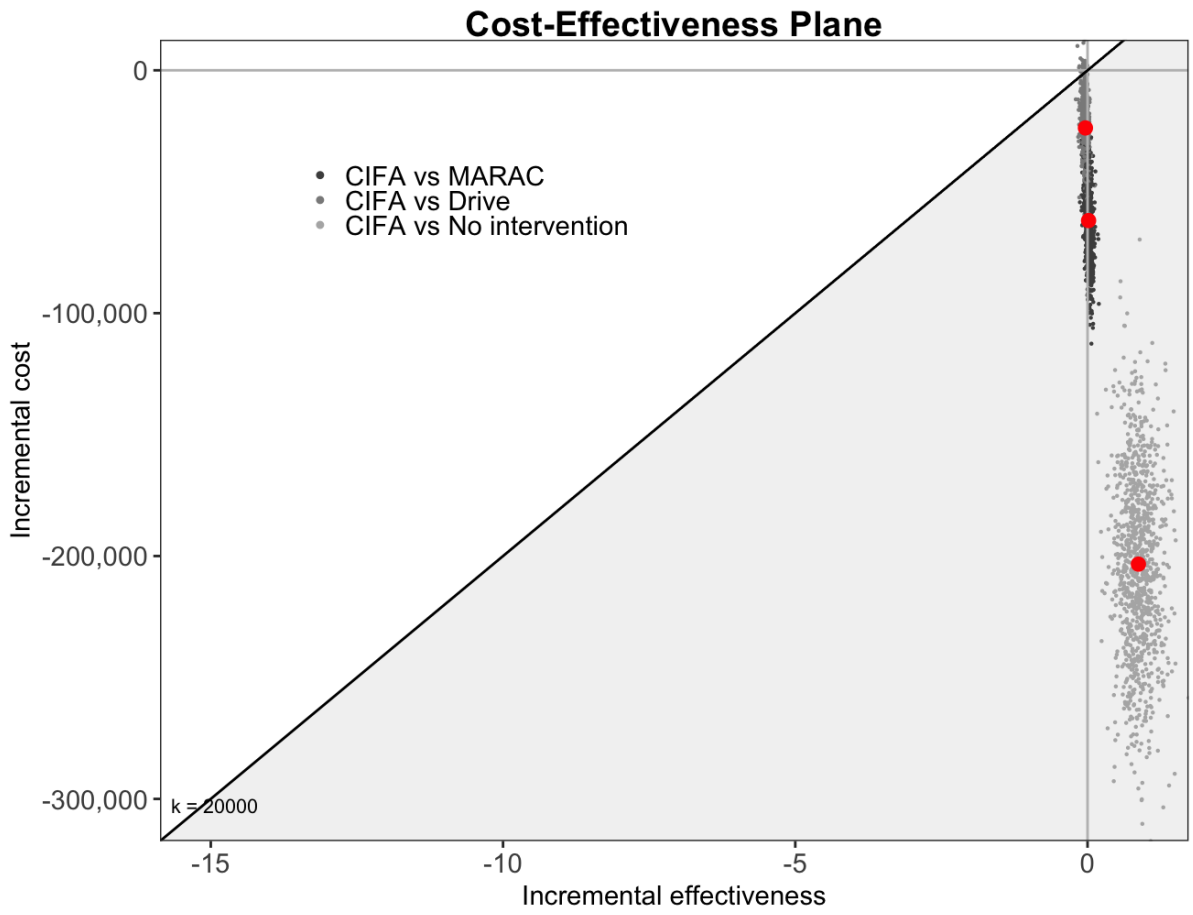
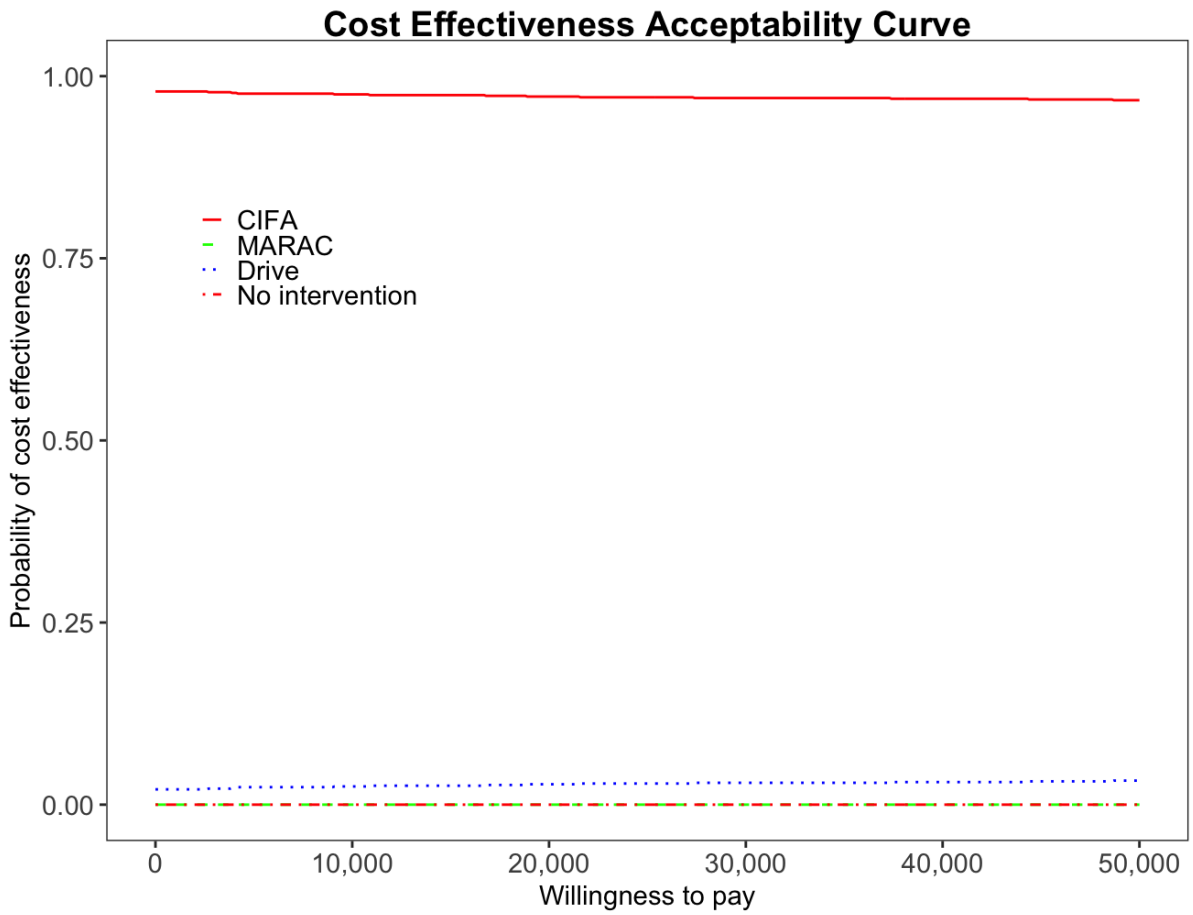


Figure 18 shows the probability cost-effectiveness of each of the interventions at varying willingness to pay values. This shows that CIFA is likely to be considered the most cost-effective at all given willingness to pay values.

Figure 19. Probability cost-effectiveness of each of the interventions at varying willingness to pay values



6.1 Limitations

While this evaluation offers valuable insights, some limitations should be considered:

The assumption that individuals cannot re-enter the DA state may underestimate the risk of recurring abuse. In reality, individuals may cycle between the DA and No DA states over their lifetime, which the current model does not reflect. This reflects the need for a long-term commitment to interventions such as CIFA.

The decision to limit time in the DA state to six years may also underestimate the long-term cost savings of CIFA compared to No Intervention. Under this assumption, even individuals in the No Intervention group are forced to transition to the No DA state after six years, which may not reflect real-world patterns.

The model is constrained by limited data, particularly regarding the number and type of domestic abuse incidents. Published data on the DRIVE intervention is especially scarce. Furthermore, data for MARAC and DRIVE do not distinguish between participants' ethnicity. It is hypothesised that such interventions may be less effective in culturally diverse populations, thus overstating effectiveness in

the economic model compared to CIFA. To address this uncertainty, probabilistic modelling was employed to reflect the variability in input parameters.

The model may not fully capture the long-term benefits of CIFA. For example, by targeting a lower-risk group, CIFA may help prevent escalation to higher-risk behaviour, thereby reducing future demand for intensive (and more expensive) interventions such as MARAC. While the functions of MARAC and CIFA are distinct, and the two work together, the cost analysis is useful.

6.2 Conclusion

This analysis suggests that the CIFA programme represents excellent value for money, with lower costs and greater effectiveness than No Intervention**.** Although it targets individuals assessed to be at lower risk, its comparatively low cost and similar effectiveness to higher-risk interventions result in substantial savings for public services and society more broadly.

7. Implications for Policy & Practice

This evaluation highlights CIFA as a promising, culturally responsive, and community-embedded intervention for addressing domestic abuse. The programme's dual focus on both people who have caused harm and victim–survivors (VS), alongside its emphasis on cultural sensitivity and trauma-informed practice, positions it as a distinctive and impactful model.

Participants and community members consistently described the delivery as skilled, flexible, and emotionally intelligent, enabling deep engagement even in complex family and cultural contexts. Notable areas of success include the programme's capacity for meaningful cultural adaptation, its person-centred and trauma-informed approach, and its strong multi-agency model that fosters collaboration across boroughs and sectors.

The ripple effects of CIFA extend beyond individual behaviour change to influence family wellbeing, professional practice, and broader community engagement. These findings offer valuable insights and direction for commissioners, funders, policymakers, and practitioners seeking to scale, sustain, or adapt effective domestic abuse interventions.

7.1 Key takeaways for commissioners and funders

- CIFA fills a critical gap in holistic, cross-borough responses to domestic abuse, particularly with its dual focus on people who have caused harm and victim–survivors, and its culturally-informed delivery model.
- Demand for this approach goes beyond CIFA's provision, particularly related to follow-up and long-term support. Both service users and victim-survivors often expressed a desire for continued engagement to build on CIFA's offer.
- Funding models need to allow for flexibility in delivery (e.g. session pacing, cultural adaptations, neurodiverse needs) and support the infrastructure required for safe, multi-agency collaboration. Measures of 'success' must also include pre-intervention work such as risk planning, feedback and collaboration with stakeholders.
- Investment in relational, trauma-informed practice, not just 'programmes,' is crucial. CIFA's success is closely tied to practitioner quality, reflective supervision, and cross-sector relationships.
- The language of 'perpetrator' should be critically examined and challenged within the system, as it is a direct impediment to effective work with service users.

7.2 Strategic recommendations for CIFA

7.2.1 Scaling and sustaining CIFA

- Secure long-term, cross-borough funding to maintain consistency, avoid fragmentation and process issues, and meet growing demand.

- Prioritise ongoing capacity-building, training and reflective supervision for staff and stakeholders, particularly as the model scales.
- Continue to build a regular presence in boroughs and in existing borough DA hubs, including online fora.
- Ensure flexibility in re-engagement, for example, allowing SUs to return to the programme if disengaged or after a significant life event.

7.2.2 Embedding learning across sectors

- Prioritise CIFA-informed practice across housing, youth services, schools, and health services through training and outreach.
- Continue to support inter-agency case reviews and cross-borough knowledge sharing to prevent siloed working.
- Improve communication with referrers: ensure that stakeholder across sectors understand their respective roles and how to collaborate. This includes more training focused on upskilling referrers in work with people who have caused harm.

7.2.3 Community engagement

- Continue investment in partnerships with grassroots and culturally specific organisations (e.g. mosques, synagogues, women's groups, LGBTQ+ groups and 'by and for' groups working with marginalised communities). The appointment of Outreach Officers is a strong first step towards enhancing community connections.
- Position service users and victim survivors as potential community change agents, particularly in challenging norms around masculinity, parenting, and abuse.
- Ensure community-based conversations around domestic abuse are ongoing, visible, and inclusive of young people.

7.2.4 Equity and access

- Ensure future delivery and expansion of CIFA includes strategies to reach underrepresented groups (e.g. LGBTQ+ people, disabled people, those without recourse to public funds).
- Continue to invest in accessible materials and interpreter services where needed, considering outreach to currently underserved communities, and continue to offer neurodivergent-informed adaptations as standard.
- Prioritise consistent collection of demographic variables (e.g. ethnicity, gender identity, sexuality, disability, language, religion) to enable disaggregation and equity-focused analysis across boroughs and strands.

7.3 Areas for future research and evaluation

Capturing the child's voice

- Explore safe, ethical, and age-appropriate ways to include children's voices directly, such as creative or proxy reporting methods, while ensuring their wellbeing and safety.

Explore reasons for non-engagement

- Further investigate reasons why some referred participants do not take up or complete the programme, including any borough- or demographic-specific patterns. This includes qualitative exploration of victim-survivor experiences.

Measuring long-term impact (e.g. data capture and recording)

- Develop a sustainable framework for longitudinal follow-up, including standardised metrics for behavioural change, family safety, and ripple effects.
- Improve data capture and recording, particularly demographic data, regarding reoffending rates, child protection outcomes, and victim-survivor wellbeing post-intervention.
- Consider holistic, qualitative indicators of success, such as changes in language, shifts in family dynamics, or new community partnerships.

Evaluating outreach

- Ensure that CIFA's outreach strategy and activities are carefully evaluated, to capture learnings and the impact of this work. Careful documentation and evaluation of work with LGBTQ+ groups and community partners will be essential and enormously useful for RISE and other organisations.

Evaluating victim-survivor work

- A focused evaluation of CIFA's work with victim-survivors from racialised communities and other under-served groups, including LGBTQ+ communities, would greatly benefit the programme and generate important insights for policy and practice.
- Building on the insights of this evaluation, the evaluation could further explore cultural, systemic and structural issues that impact engagement and the factors that impact trust in services.
- Such an evaluation could also further explore how CIFA can most effectively support VSs, analysing how local services and integrated victim services currently work together and the structures that would best support effective VS work.

References

Adisa, O., Allen, K., Manning, M., Ferreira, J. & Horvath, M. (2023) Drive Systems Change Evaluation: Final Report. Institute for Social Justice and Crime, University of Suffolk.

Adisa, O., & Allen, K. (2020) *Black, Asian and minority ethnic male victims of crime: Exploring experiences, perceptions and expectations of the criminal justice system.* Centre for Crime, Justice and Policing, University of Leicester. https://doi.org/10.29311/2020.08.

Adisa, O., & Redgwell, F. (2023) Rethinking responses to domestic abuse perpetration in racialised communities. *Journal of Gender-Based Violence, 7*(1), 36–54. https://doi.org/10.1332/239868021X16661080440821.

ADVA and Penna Associates (2009) The Community-based 'Repair' Programme Evaluation. pm adva 09 full.pdf

Anitha, S., Yalamarty, H., & Roy, A. (2018) Changing nature and emerging patterns of domestic violence in global contexts: Dowry abuse and the transnational abandonment of wives in India. In *Women's Studies International Forum* (Vol. 69, pp. 67-75). Pergamon.

Arad P, Shechtman Z , Attwood T (2022) Physical and Mental Well-Being of Women in Neurodiverse Relationships: A Comparative Study. *J Psychol Psychother*.12:420.

Badenes-Ribera, L., Sánchez-Meca, J., & Longobardi, C. (2019) The relationship between internalized homophobia and intimate partner violence in same-sex relationships: A meta-analysis. *Trauma, Violence & Abuse*, 20(3), 331–343. https://doi.org/10.1177/1524838017708781

Barton-Crosby, J., and Hudson, N. (2021) Female perpetrators of intimate partner Violence: Stakeholder engagement research, NatCen, 27.5.2012. Accessed 28.7.25 Female IPV perpetrators report

Bassel, L. and Emejulu, A. (2017) *Minority Women and Austerity: Survival and Resistance in France and Britain*. Bristol University Press

Bauman (1973) *Culture as Praxis*. Sage: London, UK.

Bermea, A.M., Slakoff, D.C., & Goldberg, A.E. (2021) Intimate Partner Violence in the LGBTQ+ Community: Experiences, Outcomes, and Implications for Primary Care. Primary care, 48 2, 329-337.

Bowen, E., Gilchrist, E., & Beech, A. (2018) *Change in readiness to change and treatment engagement among men in domestic violence perpetrator programmes: A motivational interviewing approach.* Aggression and Violent Behavior, 41, 25–35. https://doi.org/10.1016/j.avb.2018.05.002.

Bowling, B., & Phillips, C. (2002) *Racism, Crime and Justice.* Harlow: Pearson Education.

Bracewell, K., Jones, C., Haines-Delmont, A., Craig, E., Duxbury, J., & Chantler, K. (2021) Beyond intimate partner relationships: utilising domestic homicide reviews to prevent adult family domestic

homicide. *Journal of Gender-Based Violence*, 1–16. https://doi.org/10.1332/239868021X16316184865237.

Bradway, T (2022) *Queer Kinship.* Durham: Duke University Press.

Breiding, M. J., Chen, J., and Walters, M. L. (2013) The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Findings of Victimization by Sexual Orientation. Atlanta, GA: National center for injury prevention and control.

Bryman, A. (2012). Social Research Methods (4th Edition) Oxford: Oxford University Press

Buttell F. and Cannon C. (2015) Illusion of inconclusion: the failure of the gender paradigm to account for intimate partner violence in LGBT relationships. *Partner Abuse* 6 65–77. 10.1891/1946-6560.6.1.65

Donovan, C., Barnes, R., and Nixon, C. The Coral Project: Exploring Abusive Behaviours in Lesbian, Gay, Bisexual and/or Transgender Relationships. The Coral Project Newsletter.pdf

Centers for Disease Control and Prevention (CDC) (2021) Overview: CDC's national intimate partner and sexual violence survey. CDC. https://www.cdc.gov/violenceprevention/datasources/nisvs/overview.html [Accessed 08/02/25]

Chen, P., Jacobs, A., & Rovi, S. (2013) *Intimate partner violence: IPV in the LGBT community*. FP essentials, 412, 28-35.

Chen, J., Khatiwada, S., Chen, M. S., Smith, S. G., Leemis, R. W., Friar, N., Basile, K. C., & Kresnow, M. (2023) National Intimate Partner and Sexual Violence Survey (NISVS) 2016/2017: Report on victimization by sexual identity. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Clarke, A., Williams, J., & Wydall, S. (2012) *An evaluation of the "Access to Justice" project: A specialist legal advice service for older victims of domestic abuse in South Wales.* Cardiff: Welsh Government.

DA Bill Committee, 2020. Written evidence submitted by Drive (DAB34). [online] Available at: https://publications.parliament.uk/pa/cm5801/cmpublic/DomesticAbuse/memo/DAB34.pdf [Accessed 20 Jul. 2025].

Davis, L.S., & Crain, E.E. (2024) Intimate partner violence in the LGBTQ+ community: Implications for family court professionals. *Family Court Review*.

Day, Vlais, Chung & Green (2019) Evaluation readiness, program quality and outcomes in men's behaviour change programs. Australian National Research Institute for Women's Saftey. (Online) Available from: https://d2rn9gno7zhxqg.cloudfront.net/wp-content/uploads/2019/04/29225748/Day-et-al-Evaluation-readiness-MBCPs-Research-report-01.2019.pdf [Accessed 15/08/25]

Dawson, P., Charleton, B. and Conroy, L. (2022) A Research Deep Dive into DA in London, MOPAC (Online) Available at: https://www.london.gov.uk/sites/default/files/da_deepdive_final.pdf [Accessed 15/08/25]

Donovan, C., & Barnes, R. (2019) Domestic violence and abuse in LGBTQ+ relationships. In N. Lombard (Ed.), *The Routledge handbook of gender and violence* (pp. 235–246). Abingdon: Routledge.

Dustin, Moira (2016) Culture or masculinity? Understanding gender-based violence in the UK. *Journal of Poverty and Social Justice,* 24 (1). pp. 51-62

Elmquist J, Hamel J, Shorey RC, Labrecque L, Ninnemann A, Stuart GL (2014) Motivations for intimate partner violence in men and women arrested for domestic violence and court-referred to batterer intervention programs. *Partner Abuse* Oct 1;5(4):359-374. doi: 10.1891/1946-6560.5.4.359

Equality and Human Rights Commission (2012) The impact of changes in commissioning and funding on women-only services. Research Report 8. Available at: https://www.equalityhumanrights.com/sites/default/files/research-report-86-the-impact-of-changes-in-commissioning-and-funding-on-women-only-services.pdf

Everhart, A., & Hunnicutt, G. (2013) Intimate partner violence among self-identified queer victims. In *Gendered perspectives on conflict and violence* (pp. 67–88). Emerald Group Publishing Limited. https://doi.org/10.1108/s1529-2126(2013)000018a007

Femi-Ajao, O., Kendal, S., & Lovell, K. (2018) A qualitative systematic review of published work on disclosure and help-seeking for domestic violence and abuse among women from ethnic minority populations in the UK. *Ethnicity & Health*, 25(5), 732–746. https://doi.org/10.1080/13557858.2018.1447652

Femicide Census (2024) 2000 women: Every Dead Woman is One Too Many 2000-Women-full-report.pdf

Fox, C. L., Corr, M. L., Gadd, D., & Butler, I. (2015) Young teenagers' experiences of domestic abuse. *Journal of Youth Studies, 18*(4), 537–552. https://doi.org/10.1080/13676261.2014.992321

Gill, A.K., & Sundari, A. (2022) The nature of domestic violence experienced by Black and minoritised women and specialist service provision during the COVID-19 pandemic: practitioner perspectives in England and Wales, Journal of Gender-Based Violence (7)2, 252-270

Glasgow, R.E., Vogt, T.M., and Boles, S.M. (1999) Evaluating the Public Health Impact of Health Promotion Interventions: The RE-AIM Framework. American Journal of Public Health, Vol 89, No.9, 1322-1327.

Gondolf, E. W., & Williams, O. J. (2001) Culturally focused batterer counseling for African American men. *Trauma, Violence, & Abuse, 2*(4), 283–295. https://doi.org/10.1177/1524838001002004001.

Goodman, A., Saini, R. and Porteus, D. (2023) *Final Report on the Culturally Integrated Family Approach (CIFA) to Domestic Abuse Project in Barnet, Brent and Enfield delivered by RISE Mutual CIC*. 31 October.

Graham-Kevan, N., McManus, M. A., Ritchie, J., & Bates, E. A. (2021) Child and adolescent to parent violence: Findings from a 2-year study in Lancashire. *Journal of Family Violence, 36*(5), 589–601. https://doi.org/10.1007/s10896-020-00174-2.

Guru, S. (2006) Working with asian perpetrators of domestic violence - The British Experience, *Practice*, 18:3, 153-166, DOI: 10.1080/09503150600904037.

Gov.co.uk (2025) People in Low Income Households, July 9th, 2025 People in low income households - GOV.UK Ethnicity facts and figures

Hadjimatheou, K., Hohl, K., & Kelly, L. (2022) Improving police responses to domestic abuse: Developing a risk-led framework. *Policing and Society, 32*(9), 1099–1117. https://doi.org/10.1080/10439463.2021.1913595.

Heise, L. (1998) Violence against women: An integrated, ecological framework. *Violence Against Women* 4(3): p. 262-290

Hester, M., Ortega-Avila, A.G., Eisenstadt, N. and Walker, S., (2025) Evaluation of the Drive Intervention for High-Harm DA Perpetrators in England and Wales Using a Quasi-Experimental Approach. Social Sciences, 14(2), p.55. Available at: https://doi.org/10.3390/socsci14020055.

Hester, M. (2009) *Who does what to whom? Gender and domestic violence perpetrator*s. Bristol: University of Bristol.

Hester, M., Pearson, C., & Harwin, N. (2002) *Making an impact: Children and domestic violence – A reader.* London: Jessica Kingsley.

Holt, A. (2016) Adolescent-to-parent abuse as a form of "domestic violence": A conceptual review. *Trauma, Violence, & Abuse, 17*(5), 490–499. https://doi.org/10.1177/1524838015584372.

Holt, S., & Ahuja, A. (2024). *LGBTQ+ Intimate Partner Violence*. Routledge: New York. https://doi.org/10.4324/9780429031397

Holtrop, J. S., Estabrooks, P. A., Gaglio, B., Harden, S. M., Kessler, R. S., King, D. K., Kwan, B. M., Ory, M. G., Rabin, B. A., Shelton, R. C., & Glasgow, R. E. (2021) Understanding and applying the RE-AIM framework: Clarifications and resources. *Journal of clinical and translational science*, 5(1), e126.

Home Office. (2019) Violence against women and girls and male position factsheets. Available from https://homeofficemedia.blog.gov.uk/2019/03/07/violence-against-womenand-girls-and-male-positionfactsheets/

Home Office (2011) Domestic Violence Impact Assessment. [online] London: Home Office. Available at https://assets.publishing.service.gov.uk/media/5a7b1f4640f0b66eab99f23d/ia-dv.pdf

Home Office (2024) DA Protection Notices/Orders Factsheet, January 2024 https://www.gov.uk/government/publications/domestic-abuse-bill-2020-factsheets/domestic-abuse-protection-notices-orders-factsheet

Home Office (2025) Landmark package to pursue DA perpetrators, 16th July 2025 Landmark package to pursue DA perpetrators - GOV.UK

Hughes, W. (2017) Lessons from the Integrated DA Programme, for the implementation of Building Better Relationships. *Probation Journal*, *64*(2), 129-145. https://doi.org/10.1177/0264550517701199

Hwang, W.-C., Myers, H. F., & Takeuchi, D. T. (2019) Cultural predictors of intimate partner violence in Asian American communities. *Psychological Services, 16*(1), 127–135. https://doi.org/10.1037/ser0000292.

Idriss, M.M. (2017) Not domestic violence or cultural tradition: is honour-based violence distinct from domestic violence?, Journal of Social Welfare and Family Law, 39:1, 3-21, DOI: 10.1080/09649069.2016.1272755.

Imkaan (2022) *We exist: Racialised survivors of domestic abuse and the need for culturally specific responses.* London: Imkaan.

Ishkanian, A. (2014) Neoliberalism and violence: the big society and the changing politics of domestic violence in England. Critical Social Policy, 34(3), pp. 333–353

Johnson, M. P. (2014) *A typology of domestic violence: Intimate terrorism, violent resistance, and situational couple violence.* Boston: Northeastern University Press.

Legislation.gov.uk (2021) Domestic Abuse Act (Online) Available at: https://www.legislation.gov.uk/ukpga/2021/17/contents (Accessed 16/08/25)

Kauffman, K., Goodman, L. A., & Dutton, M. A. (2020) Service utilization and barriers among immigrant and refugee women experiencing IPV. *Journal of Interpersonal Violence, 35*(23–24), 5772–5796. https://doi.org/10.1177/0886260517720736.

Kelly, L., and Westmarland, N. (2015) Domestic Violence Perpetrator Programmes: A Step Towards Change.
https://respectphoneline.org.uk/wpcontent/uploads/2020/10/ProjectMirabalfinalreport.pdf

Kelly, L., Burton, S., & Regan, L. (1996) *Beyond victim or survivor: Sexual violence, identity and feminist theory and practice.* London: Taylor & Francis.

Kircher-Morris, E. (2022) *Counseling gifted clients: A guide for mental health professionals.* Routledge.

Kulkarni, S. (2019) Intersectional trauma-informed Intimate Partner Violence (IPV) services: Narrowing the gap between IPV service delivery and survivor needs. Journal of Family Violence, 34(1), 55–64. https://doi.org/10.1007/s10896-018-0001-5

Kwan, B. M., McGinnes, H. L., Ory, M. G., Estabrooks, P. A., Waxmonsky, J. A., & Glasgow, R. E. (2019) RE-AIM in the Real World: Use of the RE-AIM Framework for Program Planning and Evaluation in Clinical and Community Settings. Frontiers in public health, 7, 345.

Longobardi, C., & Badenes-Ribera, L. (2017) Intimate partner violence in same-sex relationships and the role of sexual minority stressors: A systematic review of the past 10 years. Journal of Child and Family Studies, 26(8), 2039–2049. https://doi.org/10.1007/s10826-017-0734-4

Masocha, S. (2017) A 'Turn to Language' as a Response to the Shifting Contours of Racist Discourse, *Practice,* 29:3, 159-177, DOI: 10.1080/09503153.2016.1250876

McCarry, M., Hester, M., & Donovan, C. (2008) Researching Same Sex Domestic Violence: Constructing a Survey Methodology. *Sociological Research Online*, 13, 174 - 187.

McGray, T.L., Hutton, B., Dodge, B., & Koss, M.P. (2024) Effects of social support interventions on LGBTQ+ survivor-victims of Intimate Partner Violence: a systematic review. *Sexual and Gender Diversity in Social Services*.

McManus, S., Walby, S., Barbosa, E.C. Appleby, L., Brugha, T., Beddington, P.E., Cook, E.A and Knipe, D. (2022) Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England - Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England

Messinger A. M. (2011) Invisible victims: same-sex IPV in the national violence against women survey. J. Interpers. Violence 26 2228–2243. 10.1177/0886260510383023

Muñoz-Fernández, N., & Sánchez-Jiménez, V. (2024) Intimate partner violence among LGB and heterosexual adults: Prevalence and associated minority stress factors. Sexual and Gender Diversity in Social Services, 1–21. https://doi.org/10.1080/29933021.2024.2426187

NICE (2025) NICE health technology evaluations: the manual. [online] Available at: https://www.nice.org.uk/process/pmg36/resources/nice-health-technology-evaluations-the-manual-pdf-72286779244741 [Accessed 20 Jul. 2025].

NSCPP (2024) We've seen a surge in concerns about children experiencing DA, News, 26.11.24 We've seen a surge in concerns about children experiencing DA | NSPCC

Nguyen Phan, T. T. (2021) *'It's ruined me being a mother': Mothers' experiences of abuse by their adult children.* (Doctoral thesis). University of Manchester.

O'Connor, C., Glover, L., & Jones, L. (2020) Domestic violence in Irish Traveller communities: Addressing barriers and developing culturally sensitive responses. *Violence Against Women, 26*(15–16), 1962–1983. https://doi.org/10.1177/1077801219892190.

Office for National Statistics (2024a) Homicide in England and Wales: Year Ending March 2024. Homicide in England and Wales - Office for National Statistics

Office for National Statistics (2024b) DA victim characteristics, England and Wales: year ending March 2024. DA victim characteristics, England and Wales - Office for National Statistics

Office for National Statistics (2025) Crime in England and Wales https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2025#domestic-abuse

Oliver, R., Alexander, B., Rose, S. and Wlasny, M., (2019) The economic and social costs of DA. [online] London: Home Office. Available at:

https://assets.publishing.service.gov.uk/media/5f637b8f8fa8f5106d15642a/horr107.pdf [Accessed 20 Jul. 2025].

Park, Y. (2005) "Culture as Deficit: A Critical Discourse Analysis of the Concept of Culture in Contemporary Social Work Discourse," *The Journal of Sociology & Social Welfare* Vol. 32: Iss. 3, Article 3.

Peitzmeier, S. M., Malik, M., Kattari, S. K., Marrow, E., Stephenson, R., Agénor, M., & Reisner, S. L. (2020) Intimate partner violence in transgender populations: Systematic review and meta-analysis of prevalence and correlates. American Journal of Public Health, 110(9), e1–e14. https://doi.org/10.2105/ajph.2020.305774

Ragavan, M., & Iyengar, K. (2020) Intimate partner violence in immigrant and refugee communities: Barriers, strategies, and promising practices. *Current Psychiatry Reports, 22*(5), 22. https://doi.org/10.1007/s11920-020-1144-7.

Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice*. London: Sage Publications.

Rossiter, K.R., Reif, K., & Fischer, O.J. (2020) Domestic homicides within LGBTQ2S+ communities: barriers in disclosing relationships and violence. In P. Jaffe, K. Scott, & A.-L. Straatman (Eds.), *Preventing domestic homicides: Lessons learned from tragedies* (pp. 63–85). Elsevier Academic Press.

SafeLives (2023) Ending Domestic Violence: Impact Report. Safe Lives Impact Report 2023.

SafeLives, (2025) Reviewing your Marac data. [online] Available at: https://safelives.org.uk/resources-for-professionals/marac-resources/reviewing-your-marac-data/ [Accessed 20 Jul. 2025].

Sanders-McDonagh, E., Neville, L and Sevasti-Melissa Nolas (2016) From Pillar to Post: Understanding the Victimisation of Women and Children who Experience Domestic Violence in an Age of Austerity. *Feminist Review*.

Sardinha, L., Maheu-Giroux, M., Stöckl, H., Meyer, S. R., & García-Moreno, C. (2022) Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. Lancet (London, England), 399(10327), 803–813. https://doi.org/10.1016/S0140-6736(21)02664-7

Santoniccolo, F., Trombetta, T., & Rollè, L. (2023) The help-seeking process in same-sex intimate partner violence: A systematic review. Sexuality Research and Social Policy, 20(1), 391–411. https://doi.org/10.1007/s13178-021-00629-z

Scheer, J.R., Martin-Storey, A., & Baams, L. (2020) Help-Seeking Barriers Among Sexual and Gender Minority Individuals Who Experience Intimate Partner Violence Victimization. In Russell, B (ed) *Intimate Partner Violence and the LGBT+ Community: Understanding Power Dynamics.* Springer.

Scottish Government (2024) Minoritised Ethnic Women's Experiences of DA and Barriers to Help-Seeking: A Summary of the Evidence minoritised-ethnic-womens-experiences-domestic-abuse-barriers-help-seeking-summary-evidence.pdf

Senker, S., Elvin, D., Hill, J., and Scott, M. (2021) The Perpetration of DA by those within Minoritised Communities: A Focus on minioritised ethnic communities and the Lesbian, Gay, Bisexual and/or Transgender+ Community, Home Office, 28th May, 2021.

Short, J.F. (1997) *Poverty, Ethnicity and Violent Crime*, Routledge: New York

Shorey, S., Chua, C.M.S., Chan, V., Chee, C.Y.I (2023) Women living with domestic violence: Ecological framework-guided qualitative systematic review, Aggression and Violent Behaviour, Vol 71, pg. 1-8.,101835, ISSN 1359-1789

Sickels, L. A. (2021) *Neurodiverse relationships: When partners' brains are wired differently*. In R. J. Crisp (Ed.), *The Routledge international handbook of social work and sexualities*. Routledge.

Sileo KM, Luttinen R, Muñoz S, Hill TD. (2022) Mechanisms Linking Masculine Discrepancy Stress and the Perpetration of Intimate Partner Violence Among Men in the United States. *American Journal of Men's Health* 16(4). doi:10.1177/15579883221119355

Simmons, C. A., & Lehmann, P. (2009) *Tools for resolving conflict: Introducing students to the literature on domestic violence.* Journal of Social Work Education, 45(2), 279–293. https://doi.org/10.5175/JSWE.2009.200700089.

Skafida, V, Devaney, J & Morrison, F (2023) Children living with DA: Social inequalities in mother and child experiences and repercussions for children's wellbeing. The University of Edinburgh. - Children-living-with-domestic-abuse.pdf.

Smith, C. M. (2014) Examining access barriers to emergency domestic violence shelter services for transgender identified survivors of intimate partner violence in New York State.

Smusz, R., Allely, C. S., & Bidgood, R. (2024) Exploring domestic violence intervention programmes for neurodivergent perpetrators. *Journal of Gender-Based Violence, 8*(1), 99–118.

Sokoloff, N. J., & Dupont, I. (2004) Domestic violence at the intersections of race, class, and gender. *Violence Against Women, 11*(1), 38–64. https://doi.org/10.1177/1077801204271476.

St Pierre M, Senn CY. (2010) External barriers to help-seeking encountered by Canadian gay and lesbian victims of intimate partner abuse: an application of the barriers model. Violence Vict. 25(4): 536-52. doi: 10.1891/0886-6708.25.4.536. PMID: 20712150.

Straus, M. A. (1999) The controversy over domestic violence by women: A methodological, theoretical, and sociology of science analysis. In X. B. Arriaga & S. Oskamp (Eds.), *Violence in intimate relationships* (pp. 17–44). Thousand Oaks, CA: Sage.

Tran, D., Sullivan, C.T., & Nicholas, L. (2022) Lateral Violence and Microaggressions in the LGBTQ+ Community: A Scoping Review. Journal of Homosexuality, 70, 1310 - 1324.

Turhan, Z. (2020) Improving approaches in psychotherapy and domestic violence interventions for perpetrators from marginalized ethnic groups. Aggression and Violent Behavior 50: 101337

Waller, B. (2016) Culturally sensitive domestic violence perpetrator interventions for ethnic minority men: A systematic review. *Aggression and Violent Behavior, 31,* 96–104. https://doi.org/10.1016/j.avb.2016.08.001.

Wellock, R. (2007) *Child protection and the law: The illusion of protection.* London: Routledge-Cavendish.

Westmarland, N., Hester, M., & Reid, P. (2005) *Children living with domestic violence: Learning from outcomes for children from refuge and outreach services.* Bristol: University of Bristol.

Westmarland, N., & Hester, M. (2007) Time for change: An evaluation of the Domestic Violence Perpetrator Programme in the North East of England. *Project Report.* University of Bristol.

Westmarland, N. and Kelly, L. (2013) Why Extending Measurements of 'Success' in Domestic Violence Perpetrator Programmes Matters for Social Work. British Journal of Social Work 43, 1092–1110.

Whitfield, D.L., Coulter, R.W., Langenderfer-Magruder, L., & Jacobson, D. (2018) Experiences of Intimate Partner Violence Among Lesbian, Gay, Bisexual, and Transgender College Students: The Intersection of Gender, Race, and Sexual Orientation. Journal of Interpersonal Violence, 36, NP6040 - NP6064.

Willis, R. (2018) Systemic silencing: Addressing the complexities of child sexual exploitation and abuse. *Journal of Gender-Based Violence, 2*(1), 7–23. https://doi.org/10.1332/239868018X15179205612238.

Winiker, A. K., White, S., Candelario, J., Takahashi, L. M., & Tobin, K. E. (2023). "Through the things that have happened to me, they've made me stronger": Individual and interpersonal sources of violence and resilience among a diverse sample of transgender women in Los Angeles. Journal of Interpersonal Violence, 38(5–6), 5019–5043. https://doi.org/10.1177/08862605221120896

Women's Aid (2025) Nineteen More Child Homicides Child-Homicides-2025-Web-Final.pdf

Women's Aid (2025) The impact of DA. [online] Available at: https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/the-impact-of-domestic-abuse/ [Accessed 20 Jul. 2025].

Wymbs, B. T., Dawson, A. E., Egan, T. E., & Sacchetti, G. M. (2016). Rates of Intimate Partner Violence Perpetration and Victimization Among Adults With ADHD. *Journal of Attention Disorders*, *23*(9), 949-958. https://doi.org/10.1177/1087054716653215

Young, A., & Cocallis, K. (2023) Perpetrator intervention programmes for CALD (Culturally and Linguistically Diverse) communities: Evidence and gaps. *Journal of Interpersonal Violence.* Advance online publication. https://doi.org/10.1177/08862605231111145.

Appendices

ANNEX 1. Researcher biographies

- Dr Rachel Seoighe

Rachel Seoighe is a criminologist, honorary Senior Lecturer at the University of Kent and co-director of Hearth Consultancy. She earned her PhD at King's College London and has held academic appointments at the University of Warwick, Middlesex University and the University of Kent. Her work is grounded in innovative, qualitative research methods with marginalised groups, including women in prison and minoritised and criminalised populations such as the Tamil community. Her work is collaborative, participatory and community-focused, often integrated with advocacy and creative dissemination such as documentaries and exhibitions. Rachel has over a decade of experience designing and leading research projects and evaluations and managing budgets. She has published widely in leading criminology and social science journals. Rachel also has significant experience in the third sector, as a trustee for Women at WISH, Every Casualty Worldwide and Beauty out of Ashes CIC.

- Dr Trude Sundberg

Trude Sundberg is the Co-Director of the University of Kent's Q-Step Centre and a Senior lecturer in Social Policy. Trude brings their longstanding international experience leading large, co-produced, mixed-methods research with marginalised populations. Trude is a passionate researcher and facilitator focused on transforming the injustices and inequalities that are shaping our societies today through working as part of affected communities. They are a trans nonbinary researcher who has worked internationally doing research on emotional and physical effects of discrimination, stereotyping, values, attitudes and inequalities, and specialise in inclusive quantitative methods. Trude is an academic at the University of Kent, where they also earned their PhD. They have a vast international cross-sector network including the European Anti-Poverty Network, UNESCO Regional Office for East Asia, UN Poverty group in Beijing, and research and education centres such as the Taksashila Institution in India, working closely on large international research and public engagement projects.

- Dr Gemma Bridge

Gemma Bridge is Director of Bridge Research, and a Senior Research Fellow at London South Bank University. She is a public health researcher and policy evaluation expert with experience in designing and implementing evaluation projects for local authorities, academic institutions, and community-based organisations. Gemma has successfully led and contributed to projects on public health policy, sustainability, and food systems. Gemma is

passionate about co-production, and collaborating with stakeholders to develop, implement, and evaluate impactful community health interventions aimed at reducing health inequalities within marginalised communities. She enjoys writing and communicating for different audiences with over 40 peer-reviewed publications, written reports for a range of organisations, and has presented in various forums, supporting public health evidence use in policy and practice.

- Dr Tara Young

Tara Young is an experienced qualitative and creative methods research leader who has a proven track record of working with law enforcement agencies, local authorities, and community-based organizations. She has designed, managed and successfully completed many research projects on youth and gang-related violence commissioned by central and local government departments and agencies (including the Crown Prosecution Service, The Metropolitan Police and the Youth Justice Board). More recently, Tara co-led a ESRC funded study using creative methods within prisons to explore young people's conception of friendship, violence and legal consciousness in the context of joint enterprise and is part of the team evaluating the Prison Leavers Project commissioned by the Ministry of Justice. Her research has been published in national and international criminology journals.

- Miss Lucy Watson

Lucy Watson is a health economist with extensive experience in health economic modelling in both the pharmaceutical industry and public health research. She has contributed to the design and implementation of projects for local authorities, community health trusts, and the NHS. Lucy is passionate about addressing health inequalities and applying health economic methods within wider public health research to evaluate the value for money of interventions and their impact on reducing inequality.

ANNEX 2: Terminology Table

(Adapted from Adisa et al 2023)

Use of terminology in this report	**Reasoning**
• Person who has caused harm • People who have caused harm • Those who have caused harm • Those who use harmful • behaviours • Those using harmful Behaviours • Service user	• Language regarding domestic abuse perpetration remains contested, and researchers acknowledge this is far from a settled debate • The term 'perpetrator' is viewed as problematic by many researchers, professionals, and advocates, particularly when used in relation to racialised communities (see Adisa & Allen, 2020; Adisa & Redgwell, 2023) • There are also research, policy, practice, and victim-survivor voices who argue that the term 'perpetrator' is fitting given the nature of the behaviour and the gravity of harms caused • Authors recognise that language is contextual, and that the term 'perpetrator' may be employed in some settings as it is the most widely understood and accepted term when referring to those who cause harm e.g. in practice and policy environments. • Where the word 'perpetrator' is included or commonly referenced as part of a name, e.g. when referring to 'Domestic Abuse Perpetrator Panels' (DAPPs) and where stated specifically in Drive's documents (e.g. NSC objectives) authors will use this name without modification • Authors have adopted the 'person- first' language used throughout this report; not to excuse, or minimise the actions of those using harmful behaviours, but because we recognize that language matters and 'labelling' can have unintended consequences (Willis, 2018) – particularly for marginalised groups • Service user is used as an umbrella term in the report for people who have caused harm that are on the three CIFA programmes for this group (including APFA and FADA).

• Victim-survivor • Those experiencing DA • Those who have experienced DA	• Authors employ these terms rather than speaking about 'victims' or 'survivors' because we reject binary 'either/or' framings which position individuals' experiences of victimisation and harm, and their strategies of resistance, coping and surviving/thriving, as chronologically or conceptually distinct, or which posit a linear journey from victimhood to survivorship (Kelly et al, 1996; SafeLives, 2023) • Authors' use of these terms is inclusive of children who have witnessed or been otherwise impacted by domestic abuse
• LGBTQ+ individuals/communities	• Authors employ this commonly understood and widely used 'umbrella' term when talking about the experiences of lesbian, gay, bisexual, trans,* queer and/or other gender and sexual minorities • Authors recognise the heterogeneity of identities and experiences within these marginalised groups (Donovan & Barnes, 2019), and use this term to acknowledge the fact that people within the wider LGBTQ+ community are affected by a common axis of oppression and therefore have common needs and interests that are relevant when discussing DA
• Black, Asian and racially minoritised individuals/communities • Racialised individuals/communities	• Authors use the terms 'racialised' and 'minoritised' to reflect the active and ongoing societal processes of oppression and marginalisation which designate global majority populations as 'ethnic minorities' (Imkaan, 2022) • Authors recognise the heterogeneity of identities and experiences within racialised communities, and use this term to acknowledge the fact that racialised individuals are affected by a common axis of oppression in relation to 'race' and therefore have common needs and interests that are relevant when discussing DA. • 'Ethnic minorities' are used when this refers to a category in the quantitative data.

ANNEX 3: Interview topic guides

ANNEX 3a: Service User/Client Interview Schedule

Introduction

Thank you for agreeing to participate in an interview. Have you had a chance to read over the information sheet and do you understand what the research is about? Would you like to continue with the interview?

Before we start, I want to reassure you that anything you say in this interview will not be shared directly with anyone outside the research team. The research is entirely independent of any statutory or criminal justice organisations and the responses that you give will not be passed on. Whilst the interview is confidential, I am obliged to inform a third party (e.g., your case manager and/or the police) if you disclose any offence that you have not yet been convicted for or if you imply that you are a threat to yourself or to others.

Any data we use in our reports will not be linked to your name as you will be given a fake one and the interview will be numbered. Please try to avoid using people's names in the discussion. If you do, don't worry as we will remove this material at the transcription stage. Likewise, if you include any other personal information about yourself or others, this will be removed too.

You are free to withdraw from participating in this interview at any time without explanation. Do you have any questions before we begin?

Is it ok to audio-record the interview (either via Dictaphone or in note form on Teams)?

Background questions
Tell me a little bit about you. • *Probe: What is your cultural background?* • *Where were you born?* • *Arrival into Britain (if appropriate)?* • *Length of time living in London?* • *What type of community connections?* • *Age*
Intervention questions
Can you tell me how you came to be involved in the CIFA programme? • *Probe: Advert? WOM? Recommendation/referral?* • *What was the referral process like for you?* • *Was there anything about the referral process that could have been better?* • *Did you face any barriers to participating in services previously, or in the CIFA programme?*

- *Did CIFA reduce or remove those barriers? (e.g. language)*

What, if any, expectations did you have about what the CIFA programme could do for you?

- *Probe: Were you keen to take part?*
- *How did you hope it would help you?*
- *Any worries or hesitations about receiving support through the CIFA programme?*

What was (is being) offered to you as part of the CIFA programme?

- *Probe – type of provision/support, length of support etc.*
- *Complete it all?*
- *What were your thoughts about the types of activities you took part in?*
- *What practical support was offered?*
- *How was your experience with CIFA practitioners? What was good about your relationship with them and what could be improved?*
- *Did you stay with the programme until the end? Were there any points where you felt you didn't want to continue?*

Have you been engaged with a service like CIFA in the past? If yes, how does CIFA compare to previous services?

- *Probe: Difference? Better? Why?*

CIFA offers a culturally-integrated family service. What do you think this means?

- *Probe: Did you feel that the CIFA programme resonated with your experience and understood your needs?*
- *Did you feel that your culture was being considered? In what ways?*
- *Did this make a difference as to your participation in the CIFA programme?*
- *Do you feel like you are receiving/received a culturally-sensitive service through CIFA? Probe: Why?*
- *Do you think that CIFA's cultural approach helped you to engage with the programme, and to stay with the programme to the end?*

What parts of the CIFA programme did you find most/least useful?

- *Probe: Would you change anything?*

Would you feel confident and comfortable accessing support services in the future if you needed to? • *Prompt: Knowledge of system and provision, who to contact and how, trust in practitioners*	
CIFA has some specific aims, let's go through them and think about how they resonate with your experience	People who have harmed others will show an increased knowledge and understanding of their behaviour
	People who have harmed others will take [increasing] responsibility for their actions
	People who have harmed others have increased awareness of the impact their behaviour is having on their partners and children
	People who have harmed will be able to better manage their emotions and self-regulate.
	Partners and children of those who have harmed them will have an increased perception of safety and well being
	There will be a reduction in harmful incidences
	The family as a whole will experience incidences of well-being
	There will be a cultural shift in attitudes towards domestic abuse.
How would you summarise your experience with CIFA? • *Probe: How useful was your involvement in the CIFA programme?* • *Have any changes taken place in your life and home because of the CIFA programme?*	
Is there anything you'd like to add to / or subtract from the CIFA project to make it more effective?	
Would you recommend this programme to others? If so, why?	
Any other reflections you wish to share?	

Ending the interview

Thank you very much for your contribution to the evaluation. Please feel free to contact the research team at rachel@hearthconsultancy.org / t.l.young@kent.ac.uk if you have any other thoughts/questions that come to mind later or if you would like to receive a copy of the published findings.

ANNEX 3b: Victim/Survivor Interview Schedule

Introduction

Thank you for agreeing to participate in an interview. Have you had a chance to read over the information sheet and do you understand what the research is about? Would you like to continue with the interview?

Before we start, I want to reassure you that anything you say in this interview will not be shared directly with anyone outside the research team. The research is entirely independent of any statutory or criminal justice organisations and the responses that you give will not be passed on. Whilst the interview is confidential, I am obliged to inform a third party (e.g., your case manager and/or the police) if you disclose any offence that you have not yet been convicted for or if you imply that you are a threat to yourself or to others.

Any data we use in our reports will not be linked to your name as you will be given a fake one and the interview will be numbered. Please try to avoid using people's names in the discussion. If you do, don't worry as we will remove this material at the transcription stage. Likewise, if you include any other personal information about yourself or others, this will be removed too.

You are free to withdraw from participating in this interview at any time without explanation. Do you have any questions before we begin?

Is it ok to audio-record the interview (either via Dictaphone or in note form on Teams)?

Background questions
Tell me a little bit about you. • Probe: *What is your cultural background?* • *Where were you born?* • *Arrival into Britain (if appropriate)?* • *Length of time living in London?* • *What type of community connections?* • Age
Intervention questions
Can you tell me how you came to be involved in the CIFA programme? • *Probe: Advert? WOM? Recommendation/referral?* • *What was the referral process like for you?* • *Was there anything about the referral process that could have been better?* • *Did you face any barriers to participating in services previously, or in the CIFA programme?*

- *Did CIFA reduce or remove those barriers? (e.g. language)*

What, if any, expectations did you have about what the CIFA programme could do for you?

- *Probe: Were you keen to take part?*
- *How did you hope it would help you?*
- *Any worries or hesitations about receiving support through the CIFA programme?*

What was / is being offered to you as part of the CIFA programme?

- *Probe – type of provision/support, length of support etc.*
- *Complete it all?*
- *What were your thoughts about the types of activities you took part in?*
- *What practical support was offered?*
- *How was your experience with CIFA practitioners? What was good about your relationship with them and what could be improved?*
- *Did you stay with the programme until the end? Were there any points where you felt you didn't want to continue?*

Have you been engaged with a service like CIFA in the past? If yes, how does CIFA compare to previous services?

- *Probe: Difference? Better? Why?*

CIFA offers a culturally-integrated family service. What do you think this means?

- *Probe: Did you feel that the CIFA programme resonated with your experience and understood your needs?*
- *Did you feel that your culture was being considered? In what ways?*
- *Did this make a difference as to your participation in the CIFA programme?*
- *Do you feel like you are receiving/received a culturally-sensitive service through CIFA? Probe: Why?*
- *Do you think that CIFA's cultural approach helped you to engage with the programme, and to stay with the programme to the end?*

What parts of the CIFA programme did you find most/least useful?

- *Probe: Would you change anything?*

Would you feel confident and comfortable accessing support services in the future if you needed to? • *Prompt: Knowledge of system and provision, who to contact and how, trust in practitioners*	
CIFA has some specific aims, let's go through them and think about how they resonate with your experience	People who have harmed others will show an increased knowledge and understanding of their behaviour
	People who have harmed others will take [increasing] responsibility for their actions
	People who have harmed others have increased awareness of the impact their behaviour is having on their partners and children
	People who have harmed will be able to better manage their emotions and self-regulate.
	Partners and children of those who have harmed them will have an increased perception of safety and well being
	There will be a reduction in harmful incidences
	The family as a whole will experience incidences of well-being
	There will be a cultural shift in attitudes towards domestic abuse.
How would you summarise your experience with CIFA? • *Probe: How useful was your involvement in the CIFA programme?* • *Have any changes taken place in your life and home because of the CIFA programme?*	
Is there anything you'd like to add to / or subtract from the CIFA project to make it more effective?	
Would you recommend this programme to others? If so, why?	
Any other reflections you wish to share?	

Thank the respondent for taking part and (if appropriate) refer them to some support services.

ANNEX 3c: Practitioners/Referrer Interview Schedule

Introduction

Thank you for agreeing to participate in an interview. Have you had a chance to read over the information sheet and do you understand what the research is about? Would you like to continue with the interview?

Before we start, I want to reassure you that anything you say in this interview will not be shared directly with anyone outside the research team.

Any data we use in our reports will not be linked to your name or job title. To preserve anonymity of others working in the service, please try to avoid using people's names or specific job titles in the discussion. If you do, don't worry as we will remove this material at the transcription stage. Likewise, if you include any other personal information about yourself or others, this will be removed too

You are free to withdraw from participating in this interview at any time without explanation. Any questions before we begin?

Is it ok to audio-record the interview (either via Dictaphone or in note form on Teams)?

Background questions
Can you tell me how you came to be involved in the CIFA programme and how long you have been in your role? • *Probe: Motivation?* • *Role (duties/key areas of responsibility) and length of service with CIFA, employment type (full/part time).*
Intervention questions
What is your understanding of the overall aim of the CIFA programme? • *Probe: Knowledge of the theory of change? The ecological model? Systems thinking? Trauma-informed approach?* • *What is distinctive about the CIFA programme compared with others you know about? How does CIFA differ from non-culturally specific service provision?*
Can you walk me through the referral process for the CIFA programme? • *Probe: Who is the target client/audience?*

- *Referrals into the programme (engagement, success rate, how are decisions made about referrals?)*
- *Barriers and facilitators to accessing target audience, engaging them?*
- *What would you change about this process?*
- *Are referral pathways always clear? Are referrers sufficiently aware of what CIFA offers and the programme's focus? How well is CIFA promoted in your area of work?*

How well do you think the programme works?

- *Probe: What are the key barriers /facilitators?*
- *Are there any gaps in support needs or areas that require improvement?*
- *How sustainable is the CIFA model?*

How would you describe your clients engagement with the programme?

- *Probe: Facilitators and barriers to engagement? Denial/stigma/culture/resistance.*
- *How do you maintain engagement and motivate clients/service users to continue with the programme? Any particular techniques or tools?*
- *Sometimes participants do not complete the CIFA programme. Can you identify some of the reasons why?(Participant withdrawal, case closed)*

CIFA offers a culturally integrated approach. What does this mean in practice?

- *Probe: To what extent do you think that the culturally integrated approach to domestic abuse is apparent in the programme? How important, or not, is the cultural element of provision for you?*
- *Do you think the programme's focus on culture contributes to its effectiveness? In what ways?*
- *Does the cultural approach facilitate better engagement and outcomes? How and why?*
- *CIFA staff: What are your thoughts on the cultural diversity training offered to you?*
- *Non-CIFA e.g. referrers, IDVAs, social workers): As part of your role, do you receive cultural diversity training? What are your thoughts on that training?*
- *Any cultural barriers to engagement / completion? (e.g., working with specific groups/extended family members) Does CIFA overcome these barriers and how?*

In your opinion, what parts of the CIFA provision do clients find most/least useful?

- *Probe: What type of feedback do you get from clients?*
- *What would you change?*
- *Any collaboration/shared best practice between you as practitioners? Examples.*

How does CIFA contribute to the overall DA system? • *Probe: is CIFA a useful or necessary addition to existing provision? Any conflicts / overlaps? Are there ways that it could be better integrated?* • *Are there any bureaucratic/structural issues that act as barriers or facilitators to CIFA's work?*	
CIFA has some specific aims, let's go through them and think about how they resonate with your experience (When working through this section probe for examples/evidence)	People who have harmed others will show an increased knowledge and understanding of their behaviour
	People who have harmed others will take [increasing] responsibility for their actions
	People who have harmed others have an increased awareness of the impact their behaviour is having on their partners and children
	People who have harmed will be able to better manage their emotions and self-regulate.
	Partners and children of those who have harmed them will have an increased perception of safety and well being
	There will be a reduction in harmful incidences
	The family as a whole will experience incidences of well-being
	There will be a cultural shift in attitudes towards domestic abuse.
What would be a successful outcome for CIFA? • *Probe: Effectiveness of the programme, how success can be measured.*	
What do you think are the biggest challenges for the CIFA programme going forward? • *Probe: Is there anything you'd like to add to CIFA to make it more effective?*	
Any other reflections you wish to share? • *Probe: thoughts on language? perpetrator, service user, denial, etc*	

Ending the interview

Thank you very much for your contribution to the evaluation. Please feel free to contact the research team at rachel@hearthconsultancy.org / t.l.young@kent.ac.uk if you have any other thoughts/questions that come to mind later or if you would like to receive a copy of the published findings.

ANNEX 3d: Community Member Interview Schedule

Introduction

Thank you for agreeing to participate in an interview. Have you had a chance to read over the information sheet and do you understand what the research is about? Would you like to continue with the interview?

Before we start, I want to reassure you that anything you say in this interview will not be shared directly with anyone outside the research team.

Any data we use in our reports will not be linked to your name or job title. To preserve anonymity of others working in the service, please try to avoid using people's names or specific job titles in the discussion. If you do, don't worry as we will remove this material at the transcription stage. Likewise, if you include any other personal information about yourself or others, this will be removed too

You are free to withdraw from participating in this interview at any time without explanation. Any questions before we begin?

Is it ok to audio-record the interview (either via Dictaphone or in note form on Teams)?

Background questions
What is your current role? Do you work with specific community members? Can you tell me how long you have known about the CIFA programme? ● *Probe: Motivation?* ● *Role (duties/key areas of responsibility) and length of service with CIFA, employment type (full/part time).*
Intervention questions
What is your understanding of the overall aim of the CIFA programme? ● *Probe: Knowledge of the theory of change? The ecological model? Systems thinking? Trauma-informed approach?* ● *What is distinctive about the CIFA programme compared with others you know about? How does CIFA differ from non-culturally specific service provision?*
Are you involved in referring people to the CIFA programme? If so, what is the process for this? ● *Probe: Who is the target client/audience?* ● *Referrals into the programme (engagement, success rate, how are decisions made about referrals?)* ● *Barriers and facilitators to accessing target audience, engaging them?* ● *What would you change about this process?*

- *Are referral pathways always clear? Are referrers sufficiently aware of what CIFA offers and the programme's focus? How well is CIFA promoted in your area of work?*

How well do you think the programme works? Have you received any feedback from people you've worked with?

- *Probe: What are the key barriers /facilitators?*
- *Are there any gaps in support needs or areas that require improvement?*
- *How sustainable is the CIFA model?*

What are your thoughts/ experiences with regard to engagement with the CIFA programme?

- *Probe: Facilitators and barriers to engagement? Denial/stigma/culture/resistance.*
- *How do you maintain engagement and motivate clients/service users to continue with the programme? Any particular techniques or tools?*
- *Sometimes participants do not complete the CIFA programme. Can you identify some of the reasons why?(Participant withdrawal, case closed)*

CIFA offers a culturally integrated approach. Is this something that you are aware of? What does this mean in your experience?

- *Probe: To what extent do you think that the culturally integrated approach to domestic abuse is apparent in the programme? How important, or not, is the cultural element of provision for you?*
- *Do you think the programme's focus on culture contributes to its effectiveness? In what ways?*
- *Does the cultural approach facilitate better engagement and outcomes? How and why?*
- *CIFA staff: What are your thoughts on the cultural diversity training offered to you?*
- *Non-CIFA e.g. referrers, IDVAs, social workers): As part of your role, do you receive cultural diversity training? What are your thoughts on that training?*
- *Any cultural barriers to engagement / completion? (e.g., working with specific groups/extended family members) Does CIFA overcome these barriers and how?*

In your opinion, what parts of the CIFA provision do you think people find most/least useful?

- *Probe: What type of feedback do you get from clients?*
- *What would you change?*
- *Any collaboration/shared best practice between you as practitioners? Examples.*

How do you think CIFA contributes to the overall support system for domestic abuse?

- *Probe: is CIFA a useful or necessary addition to existing provision? Any conflicts / overlaps? Are there ways that it could be better integrated?*

• *Are there any bureaucratic/structural issues that act as barriers or facilitators to CIFA's work?*	
CIFA has some specific aims, let's go through them and think about how they resonate with your experience (When working through this section probe for examples/evidence)	People who have harmed others will show an increased knowledge and understanding of their behaviour
	People who have harmed others will take [increasing] responsibility for their actions
	People who have harmed others have an increased awareness of the impact their behaviour is having on their partners and children
	People who have harmed will be able to better manage their emotions and self-regulate.
	Partners and children of those who have harmed them will have an increased perception of safety and well being
	There will be a reduction in harmful incidences
	The family as a whole will experience incidences of well-being
	There will be a cultural shift in attitudes towards domestic abuse.
What do you think would be a successful outcome for CIFA? ● *Probe: Effectiveness of the programme, how success can be measured.*	
What do you think are the biggest challenges for the CIFA programme going forward? ● *Probe: Is there anything you'd like to add to CIFA to make it more effective?*	
Any other reflections you wish to share? ● *Probe: thoughts on language? perpetrator, service user, denial, etc*	

Ending the interview

Thank you very much for your contribution to the evaluation. Please feel free to contact the research team at rachel@hearthconsultancy.org / t.l.young@kent.ac.uk if you have any other thoughts/questions that come to mind later or if you would like to receive a copy of the published findings.

ANNEX 4: Ecological model elements against the REAIM-C framework

Ecological Model Elements	RE-AIM (C) Dimension	Clarifications	Element	Methodology
Systemic change System coordination; Collaborative approach; Systems capability (culturally informed provision) Complexity; Cultural safety; Accepting of complexity; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; partnership	**Reach**	Who is the target audience? Is CIFA/RISE reaching its target audience? How does RISE Mutual advertise the CIFA programme?	Awareness of CIFA Stakeholder 'buy-in' Referral process Eligible pool of participants & characteristics	Semi-structured qualitative interviews. Case study analysis Quantitative analysis
Behavioural change Collaborative approach Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Support; Engagement; Cessation; Evidence / insight	**Effectiveness**	How effective is the CIFA programme? Has the CIFA programme met its aims and objectives? To what extent does the CIFA programme lead to a reduced strain on other services?	No. of Completions and recidivism rate Impact of CIFA on participants (e.g., behavioural/attitudinal change) Impact of CIFA on the community Reduction of the risk posed by participants Increased safety and or better quality of life for victims/ survivors/ community	Semi structured interviews Case study analysis Quantitative data analysis Economic cost analysis
Systemic change Cultural and intersectional factors; Collaborative approach; Ripple effects; System coordination; Systems capability (culturally informed provision) Suitability assessments; Complexity; Cultural safety; Accepting of complexity; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; partnership	**Adoption**	Where is CIFA being implemented? Where are the referrals coming from? Who are the stakeholders and what is their investment?	Location of the CIFA programme No. of referrals to the CIFA programme Practitioner perception of the CIFA programme	Semi-structured interviews Quantitative data analysis
Cultural change of domestic abuse behaviour and attitudes; Behavioural change Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Neurodiversity; Cultural and intersectional factors; Collaborative approach Denial; Silencing / collusion; Country of origin; Support; Engagement; Diversity; Vulnerability; Immigration; Suitability assessments; Complexity; Cultural safety; Accepting of complexity	**Implementation**	Is the CIFA programme being implemented as intended? What are the parts of the CIFA programme? Is there consistency in delivery across the boroughs? Any adaptations made to the CIFA programme?	Operationalisation Staffing and skill set Quality of practitioner/participant relationship. CIFA and stakeholder communication	CIFA manuals Semi-structure interviews Case study analysis Quantitative data analysis
Systemic change Collaborative approach; Ripple effects; System coordination; Systems capability (culturally informed provision) Suitability assessments; Referral pathways; Resources; System-wide adoption / adaptation; Agency buy-in; Inclusive dialogue; Awareness-raising; Partnership	**Maintenance**	How sustainable is the CIFA project? Has the CIFA project become part of the local provision? To what extent does CIFA produce sustained behaviour and attitudinal change in the participants? What funding is available to sustain the CIFA programme? How cost-effective is CIFA in comparison to similar service provision?	Available budget and resources Embedded in existing provisions Long-term delivery and sustainability Policy change and/or innovation	Semi-structured interview Quantitative data analysis Economic cost-analysis
Cultural change of domestic abuse behaviour and attitudes Norms and beliefs; Safety, self-determination of VS; Reduction in harmful behaviours; Neurodiversity; Cultural and intersectional factors; Systems capability (culturally informed provision) Country of origin; Denial; Silencing/collusion; Diversity; Vulnerability; Immigration; Suitability assessments; Complexity; Cultural safety	**Culture**	To what extent is culture integrated into the CIFA programme? To what extent do service users feel culturally safe and understood? To what extent does the cultural approach facilitate service user engagement and retention? To what extent does the cultural element add value?	Focus on culture Practitioner skills Stakeholder understanding of the role of culture in the CIFA programme Importance of culture for service users	Literature review CIFA manual Semi-structured interview data