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Abstract

Most research on domestic violence perpetrator programs has been carried out in North America. It does not yet provide a clear picture on what works with these offenders and cannot be generalized to other cultural and legal systems. Therefore, in Part I of this article, we present the results of a survey of 54 programs that were in place in 19 European countries that addressed the programs' practice and effects. The survey captured data about program design, delivery, administration, infrastructure, and other features. Most programs applied cognitive-behavioral, profeminist, or psychodynamic treatment, or a combination of multiple treatment types. There was a wide disparity in approaches to handling domestic violence perpetrators, and a particular dearth of high-quality evaluation throughout the continent. Possible explanations for this disparity and avenues for improvement are discussed, related to a systematic review of European outcome evaluations (Part II).

Keywords

domestic violence, survey, intervention, cross-cultural, rehabilitation

Introduction

Recent estimates of the lifetime prevalence of domestic violence among European women report that roughly 12% to 16% of women throughout the continent have experienced an episode of physical abuse at the hands of their partner since reaching the age of 16 (Council of Europe, 2008). Domestic violence victimization has been associated

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with an increased likelihood of substance abuse, depression, posttraumatic stress, suicidal ideation, injury, and death (Alhabib, Nur, & Jones, 2009; Campbell, 2002; Golding, 1999). Therefore, in addition to primary prevention and victim support, dedicated programs seeking to reorient perpetrators' violent behaviors, attitudes, and beliefs have emerged as a promising approach to reducing the incidence of victimization.

Gondolf (2002) enumerates the three prevailing paradigmatic approaches to domestic violence perpetrator programs as cognitive-behavioral, psychodynamic, and profeminist treatment. Although these treatment modalities have limited and mixed support, they appear to be the most commonly used approaches to domestic violence perpetrator interventions (Scourfield & Dobash, 1999). Cognitive-behavioral programs attribute violence to learned behaviors that perform an expressive, instrumental function. Consequently, they emphasize that desistance must be *learned* through a process of cognitive restructuring. Psychodynamic approaches emphasize the personality and emotional disposition of the perpetrator as being central to desistance, by facilitating the recognition and reconciliation of latent feelings of emasculation that precipitate abusive impulses. Profeminist approaches view violence as originating from patriarchal values about women's roles, and typically aim to reorient the way men exert power and control over their partner. Although other treatment approaches to dealing with domestic violence perpetrators also exist, they are rare and contain various flaws (Barnish, 2004).

There is some discussion in the literature about whether the distinction between these treatment categories is clearer in theory than in practice. In actuality, many programs, such as the popular Duluth Model (Pence & Paymar, 1993), overlap and coalesce around unitary principles of how to reduce repeat abusive behavior (Dalton, 2007; Scourfield & Dobash, 1999). In light of this, recent advances in the literature have provided fruitful suggestions for the possible differentiation of treatment approaches to correspond more closely with variations along observed situational, cultural, and psychological dimensions such as gender roles and comorbid disorders (e.g., Gilchrist & Kebbell, 2010; Graham-Kevan, 2007; McMurran & Gilchrist, 2008).

However, we have little knowledge of whether practitioners across Europe choose to apply similar or varied treatments, nor do we have a refined understanding of the quality of program delivery. This is especially noteworthy considering the diminished "effectiveness" of rehabilitation programs when delivered in routine practice settings, as opposed to their "efficacy" when evaluated in demonstration projects under optimal conditions (e.g., Koehler, Lösel, Akoensi, & Humphreys, 2013; Lipsey & Cullen, 2007; Lösel, 2012). Because relatively few criminological studies have investigated programs for domestic violence perpetrators, the gap between research and practice may be even greater than what has been observed in treatments for other offender groups.

The state of the evidence base is lacking in two significant aspects: First, we do not yet know what types of domestic violence perpetrator programs and delivery styles are currently practiced throughout Europe. Second, we do not yet know how well those programs "work" in a scientifically rigorous sense. Part I of this article will address this first question; we will turn in Part II (Akoensi, Koehler, Lösel, & Humphreys, 2012) of this article to the second question.

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To date, there have been a few attempts to gather information on domestic violence perpetrator programs in single countries; for example, see Debbonaire (2004) in Ireland, and Scourfield and Dobash (1999) in the United Kingdom. In addition, there have been two projects on the state of routine practice in perpetrator programs throughout Europe. In the first study, the World Health Organization (WHO) surveyed 20 programs in 9 European countries as part of a wider international survey of perpetrator programs throughout the world (Rothman, Butchart, & Cerdá, 2003). The second study was conducted as part of the Daphne II Work With Perpetrators (WWP; 2008) project. It comprised a survey of European programs and prevention measures that had general or specific application to domestic violence. It therefore included efforts ranging from narrowly circumscribed programs to primary prevention measures such as hotlines and awareness campaigns. Although both of these studies gathered information of commendable quality and detail, they focused on the description of the programs' theoretical principles, and did not capture information regarding the concrete implementation of the sampled programs.

To address the need for a more refined picture of routine practice, we present the results of an international survey of perpetrator treatment programs that were implemented throughout the European Union (EU). We were principally concerned with the way that those programs were organized, administered, and monitored in routine practice. We were therefore particularly keen to capture a faithful assessment of what was *in fact* being implemented, rather than an impression of what practitioners were *aiming* to achieve.

Method

We searched for programs that were designed to address the reduction of abuse (interpreted broadly) by perpetrators of domestic violence. Primary awareness or prevention measures such as hotlines and victim services were excluded. We focused instead on circumscribed programs delivered to participants who had had interaction with the criminal justice system (e.g., official charges, arrest, or warnings from police or other justice representatives) or who had referred themselves to treatment for domestic abuse.

The survey gathered information on five themes: First, the model of change, including items pertaining to the program's main aims, underlying theoretical model and design. The second section concerned administrative data such as the program's funding sources, deliverers and participants, and potential accreditation. The third section covered content issues such as the type of treatment modality, the use and level of sophistication of any risk assessment procedure, and the structure of the treatment sessions. The fourth section covered aspects of process evaluation, such as what measures were taken to maintain program fidelity and participants' attendance. The fifth section concerned outcome evaluation, and asked whether program effectiveness was measured, and if so, what type of evaluation design had been used. Multiple-choice and semistructured questions were used in each of these sections. These semistructured questions were included to elicit greater detail on program design, implementation and evaluation that might not be captured in the multiple-choice questions. Ample

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opportunities were provided during our data collection phase for respondents to inform us whether their national strategy for addressing domestic violence perpetrators emphasized an approach that would not have been captured easily within our questionnaire (e.g., case management methods, etc.).

Procedure

We recruited respondents through four main information streams. First, we contacted the ministry of justice in each EU country. Where the ministry was responsible for treatment programs, we were connected with the responsible person or division within the ministry to gather program data. If another ministry was responsible for domestic violence interventions (e.g., in instances where the social welfare ministry held primary responsibility), we requested to be put directly in contact with the relevant party at the appropriate ministry. Second, we contacted third-sector and/or private organizations to locate community-based programs. Third, we contacted European experts in domestic violence research and related fields such as general offender programming and European justice policy. This was supplemented by contacts made during the project *Strengthening Transnational Approaches to Reducing Reoffending* (STARR), in particular at the project's conferences and by its concurrent surveys on other offender groups. Finally, we contacted pan-European practitioner networks such as C.E.P. (the European Organisation for Probation), the UN Secretary General's Database on Violence Against Women, and the WAVE Network. Each of these sources provided contact details of program administrators, or connected us with appropriate experts who had local knowledge of national or regional programs. These various streams of recruitment often fed into each other and informed us of more programs located within different sectors and in different countries or regions.

Questionnaire distribution began in November 2010. We contacted potential participants by telephone or email, at which point we asked the respondents a series of screening questions to determine whether their program was eligible for our survey. The questionnaire was initially written in English; however, if a respondent requested the survey in their native language or it became apparent that translation was necessary to elicit a complete response, we translated the questionnaire. After initial contact, we made fortnightly follow-ups with the respondents on their progress until we collected their completed questionnaires. Most respondents returned completed questionnaires in one to two months and were in contact with the research staff multiple times. Occasionally, this process took many months with frequent contacts. All responses were completed and returned by the end of June 2011, whereupon they were coded and analyzed by the authors. Multiple-choice questions were coded directly from the questionnaire. Semistructured questions were analyzed for common themes by the research team and coded ex post facto. These findings were used to supplement the multiple-choice findings.

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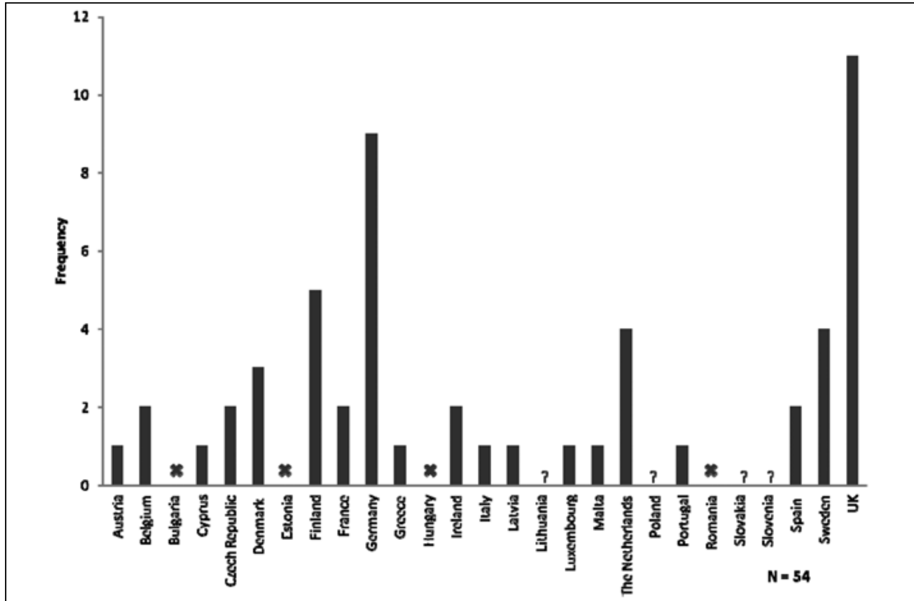

Figure 1. Number of programs for domestic violence perpetrators in different countries.

Results

Four countries in the EU (Bulgaria, Estonia, Hungary, and Romania) did not deliver any domestic violence perpetrator programs during the time period of our search. Within the remaining 23 EU countries, we gathered responses from 54 distinct programs in 19 countries (see Figure 1). Despite strong efforts, we did not receive replies from four countries.

Mode of Treatment

The treatment modality was coded according to established frameworks in the domestic violence perpetrator program literature (e.g., Gondolf, 2002; MacKenzie, 2006; Scourfield & Dobash, 1999). These approaches included cognitive-behavioral, psychodynamic, and profeminist treatment. We accommodated combined treatment approaches when respondents explained that the theoretical model of change and techniques for treatment delivery were not fully captured by any singular approach.

Although most respondents reported the use of multiple treatment modalities in the delivery of their program, the most common approach (observed in 70% of the sample) was cognitive-behavioral therapy (see Figure 2). Fifty-four percent of respondents claimed that their program used profeminist methods, and 31% said that their program adopted a psychodynamic approach. The majority (54%) claimed that their program applied a combination of various treatment approaches. The most common single

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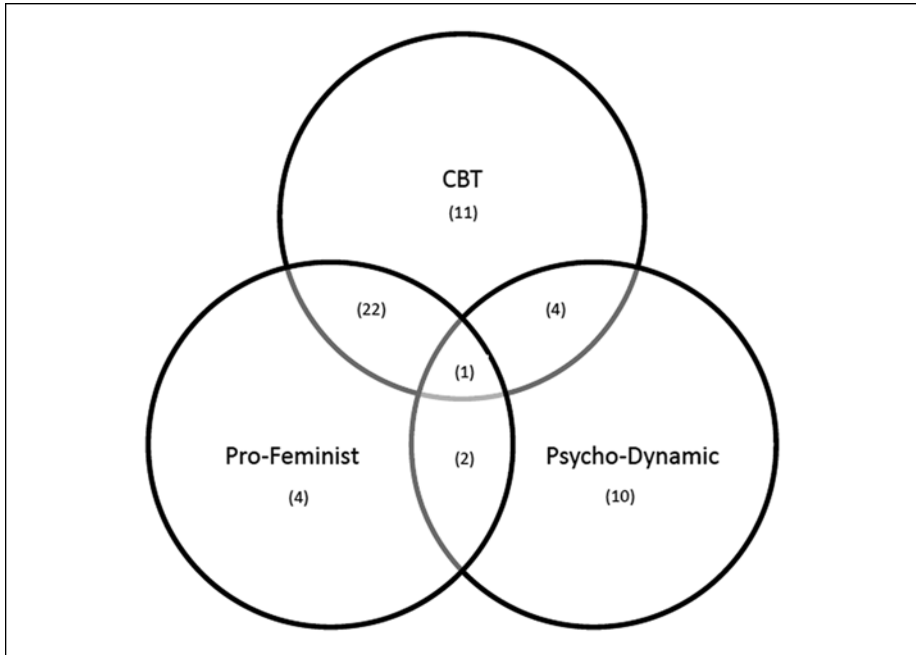

Figure 2. Perpetrator program treatment modality.

form of treatment comprised cognitive-behavioral and profeminist techniques (41%). Although many countries offered various combinations of these treatment modalities, there was a preference for cognitive-behavioral programs and less use of psychodynamic programs in Northwest Europe. The relative paucity of responses from Mediterranean and Eastern European countries precluded identifying clear trends on treatment modality preferences in those parts of the continent.

As can be seen in Table 1, 18 (34%) programs had been transferred from another country. The most frequently transferred program type was the Duluth model from the United States (Pence & Paymar, 1993), which had been lifted directly and transferred in five instances and had formed the basis of a newly conceived program in many others. Program developers were involved in the implementation of the treatment in 85% of the sample.

Treatment Delivery

On average, domestic violence programs in the sample had been running for approximately 8 years (M = 98.6 months, SD = 74). The longest continuously running program was established 25 years ago in the United Kingdom. Governments provided the most prominent source of program funding: 44 programs received some form of

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Table 1. Domestic Violence Program Characteristics.

Program component	n	Program features	Frequency	%
Transfer	53	Not transferred	35	66
		Transferred	18	34
Accreditation	51	Accredited	20	39
		Not accredited	31	61
Treatment location	53	Criminal justice facilities	10	19
		Residential care center	20	38
		Community	17	32
		Hospital/health care facility	6	11
Assessment	54	General intake assessment	36	67
	36	Actuarial[a]	16	44
	36	Clinical[a]	25	69
	54	Tailored to risk	39	72
	53	Tailored to learning style	45	85
Structure	53	Little to none	4	8
		Somewhat	23	43
		To a great extent	26	49
Recruitment	53	Voluntary	12	23
		Mandatory	12	23
		Mixed	29	54

[a]Subset analysis of those programs that performed an intake assessment.

government funding, whether from the local, state, or federal level. The majority of these programs (55%) received their total funds from government, and 80% received at least half from government. Twenty relied on funding from nonprofit agencies such as trusts, charitable institutions, nongovernmental organizations, and private contributions. Thirteen programs received some funding from clients who participated in the program. These latter two sources comprised a small proportion of programs' total funding. We present the mean percentage of programs' operational budgets received from various funding sources in Table 2.

Thirty-nine percent of respondents indicated that their programs were accredited, although the form that this accreditation took varied from governmental oversight to nongovernmental membership associations, to *ad hoc* committees of experts and practitioners.

Nineteen percent of programs were delivered in criminal justice facilities such as prison or were part of a probation service. Thirty-eight percent of programs took place in residential care centers, 32% in the community, and 11% in hospitals or health care centers. The average length of a treatment session was almost two hours (M = 112 min, SD = 64), and there was an average number of 26 total sessions in a complete treatment program (SD = 17), administered over the course of M = 29 weeks (SD = 20).

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Table 2. Mean Percentage of Programs' Annual Operational Budgets Received From Various Funding Sources.

	n	*M*	*SD*
Government	44	78.8	30.8
Nonprofit	20	54.1	34.1
Client fees	13	22.9	32.6

General intake assessments of participants were conducted in 36 programs. Of these, 25 involved clinical discretion and expert judgment, and 16 comprised empirically validated diagnostic assessment instruments specific to domestic violence such as Spousal Assault Risk Assessment (SARA) and general risk level of reoffending such as the Level of Service Inventory–Revised (LSI-R). Some programs administered both forms of intake assessment. Seventy-two percent of respondents reported tailoring their programs to participants' risk levels of reabuse, and 85% reported that their program was at least somewhat tailored to participants' learning styles and abilities. The majority of respondents (92%) reported that the delivery of treatment was at least somewhat structured around a predefined protocol.

Participant and Recruitment Characteristics

The age of eligibility to participate in the programs varied widely from a minimum age of 18 years to a nonspecified maximum age. One program was designed exclusively for female perpetrators of domestic violence; the remaining programs in our sample were designed either for exclusively male perpetrators (44%) or a combination of males and females (52%). Due to differences in data protection and collection practices between countries, only 61% of respondents were able to provide information on the nationality of the program participants. The mean proportion of local national residents participating in programs was 76% (*SD* = 18).

Participants were referred to 22% of programs from purely mandatory sources, and 22% operated on an exclusively voluntary basis. Most programs (54%) recruited participants from a mixture of both voluntary and mandatory sources, although many of the mixed participation programs received the majority of their referrals from a mandatory (court) order. Nearly all the programs applied treatment to a combination of first time and repeat or persistent abusers (91%). Two programs were designed specifically for first time abusers (i.e., perpetrators attending the program as a result of their first interaction with the criminal justice system, or as part of their first self-referral to a program's services) and two programs were designed exclusively for persistent perpetrators.

Process and Outcome Evaluation

Eighty percent of respondents indicated that some measures were taken to ensure and maintain program integrity. Thirty-one percent indicated that they gathered data on

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participant attendance and 44% reported that they recorded program completion. Usually, quality assurance measures comprised a combination of staff training and oversight during treatment delivery, and client and staff feedback measures to assess the adherence to predefined treatment protocol.

Fifty-seven percent (n = 31) of respondents stated that their program had either been subjected to some form of outcome evaluation or that an evaluation was ongoing. These responses originated from 12 countries, which were almost entirely concentrated in Northwest Europe. Of these, 13% (n = 4) of evaluations employed at minimum a comparison group research design, all of which were ongoing at the time of our data collection period (two from Spain, one from Sweden, and one from the United Kingdom). They therefore could not be included in our systematic review (Part II of this article). None of the outcome evaluations in our sample used a randomized controlled trial design. The evaluations employed a variety of outcome measures with which to ascertain effectiveness. These included measures of incidences of reabuse, collected from either official or self-report sources (n = 16); measures of psychological change, such as increased self-awareness and cognitive skills to cope with anger (n = 15); and measures of behavioral change such as improvements in communication skills and admissions of guilt (n = 15). In eight cases, the outcome measurements relied on nonquantified or nondocumented measures of change. The data were often triangulated by complementing multiple data types from various sources (i.e., from justice officials, perpetrator self-reports, and victims).

Program Quality

We provided respondents with a series of semistructured items in which they were prompted to express further thoughts and experiences of delivering perpetrator programs. Frequently identified themes dealt with the importance of staff training and competence, acquiring the finances necessary to sustain services, ensuring strong interagency cooperation, and the need for more high-quality evaluation of perpetrator program effectiveness. Other concerns related to the appropriateness of the offenders selected to participate in the program and the level of program fidelity. For example, respondents often reiterated the necessity of addressing the "right" participants in the form of limiting the application of treatment either to perpetrators with specific profiles of criminogenic need (as opposed to delivering "one size fits all" treatment), or to perpetrators with a threshold level of motivation to participate in the program.

> One of the weak points in the treatment of batterers is that we assume that one size of the programme fits for all perpetrators. Research has shown that this group can be divided in subtypes with specific needs, so curriculums should be tailored to these needs with regard to contents and length of treatment. (Case 1)

Respondents expressed their thoughts concerning both the purposes of perpetrator programs, and the ways that program effectiveness should be measured. For example, in some instances respondents underscored the need to attend to a perpetrator's sense of accountability, rather than concrete measures of observable change:

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> It's more important to evaluate the individual's awareness of their actions and their accountability than to base a final evaluation on the absence of recidivism. (Case 2)

> The central aim of [this program] is to ensure . . . that men accept responsibility, learn about respectful communication, equal relationships, and accept the possibility of change. (Case 28)

This was often directly offset by other respondents' beliefs in the primacy of behavioral or attitudinal indicators such as violent behavior change or acceptation of blame and guilt:

> The aims of the program are to change . . . individual vulnerabilities such as personal beliefs about the self, instrumental cultural beliefs and strategies, attitudes, and behaviors. (Case 54)

In contrast to the therapeutic program aims highlighted by many respondents, we observed instances in which such programming was intended to be more disciplinary:

> The underlying aim of the program is to have at least a minor sanction for perpetrators . . . So the program is a good alternative to show him that there are consequences to this kind of behavior . . . I believe that if there are no consequences for the perpetrator he will go on and the violence might even escalate. The consequences have to escalate too! (Case 18)

Some respondents noted that particular cultural aspects affected program delivery and effectiveness:

> [I]t is important also to take into account culturally specific factors that influence the improvement of offenders . . . and to approach individuals with a sensitivity towards this. (Case 4)

Finally, we observed in some instances that respondents framed their programs' aims primarily in terms of victims', rather than perpetrators', needs:

> Most importantly, we see it as crucial that more perpetrators are participating in anti-violence programs . . . However, this should never be done at the expense of programs for women victims of violence and their children . . . the support of the victim should always have priority! (Case 1)

Discussion

There have been repeated efforts to synthesize the various evaluations of domestic violence perpetrator programs to outline principles of good practice. However, most

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of this work addressed North America (e.g., Davis & Taylor, 1999). There is not yet systematic knowledge on programs for domestic violence perpetrators in many European countries, and how they are delivered in routine practice. This study has provided an overview of the forms that such programs have taken across Europe, by collecting detailed information about aspects of treatment design, delivery, and the administration of work with perpetrators.

All the countries in our sample in which measures existed to reduce the incidence of repeat abuse by perpetrators of domestic violence applied an exclusively program-based therapeutic delivery that was fully captured within our questionnaire. Consequently, we are confident that the general picture resulting from our survey provides the most comprehensive overview to date of routine practice across the continent. However, as in every survey, there are some methodological problems: First, respondents were usually practitioners who had intimate knowledge of the program—in many cases, they had even been instrumental in the original development of the program. Consequently, a social desirability bias might have propended respondents to make "leniency assessments" (Lösel & Schmucker, 2003) in which they embellished or exaggerated the true state of the program in question. Second, the respondents may have interpreted some items differently (e.g., with regard to the degree of program structure or treatment modality). Third, variation in professional expertise could have led to information gaps or inconsistencies across specific questionnaire items. Although we cannot exclude such problems, we attempted to control for them: we included multiple items in our questionnaire that enabled us to cross-reference whether the respondent had misinterpreted an item or had inaccurately elaborated their description of the programme.

The results showed that perpetrator programs exist in the majority of countries throughout the continent and that they adopt diverse approaches to delivering treatment. In some countries, we received many responses, whereas in others, we were able to locate only one or two programs. In part, this variation related to the national structure for administering programs. For example, centralized, state-based structures and practitioner networks extant in some countries facilitated locating respondents. Conversely, in some countries, there were no national practitioner networks that could have provided information on further programs. In four countries (Bulgaria, Romania, Hungary, and Estonia), we discovered that no programs existed to address domestic violence perpetrators.

Some of the differences in response rates relate to the maturity of domestic violence advocacy in each country. For example, many of the better-represented countries in our sample were places where domestic violence advocacy has long been a part of the social consciousness (e.g., the United Kingdom, Germany, and Sweden; Appelt & Kaselitz, 2000). On the other hand, all four countries in which no programs existed were countries in which third-sector civic society organizations have historically been slow to develop (Howard, 2003). Although the majority of programs were primarily funded by governmental agencies, this speaks to the centrality of community-level organization in delivering perpetrator treatment.

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The programs in our sample delivered traditional or modified versions of the three prevailing treatment modalities in the perpetrator program literature (cognitive-behavioral, profeminist, and psychodynamic treatment). Despite continuing debate concerning whether the theoretical principles operating within various treatment approaches complement or conflict with one another (e.g., Day, Chung, & O'Leary, 2009; Dutton & Corvo, 2007; Gondolf, 2007; Graham-Kevan, 2007), we found that the majority of programs delivered a combined application of multiple treatment modalities. In particular, we observed that cognitive-behavioral approaches were implemented more frequently as a complement, rather than as an alternative, to the profeminist approach (contra Babcock, Green, & Robie, 2004). The high prevalence of this particular combination was largely attributable to the popular exportation of the Duluth Model of perpetrator treatment from the United States to Europe, which advocates elements of cognitive-behavioral treatment within a principally profeminist model (Gondolf, 1997; Pence & Paymar, 1993). Although the combination of different theoretical models of change seems to meet practical needs, it should be based on a clear specification of elements. Otherwise, outcome evaluation is confronted with rather heterogeneous concepts.

Programs rarely limited the application of treatment to participants with a particular profile of abuse, age, or level of motivation to complete treatment. There are two plausible explanations for this: Either programs may intentionally be designed to accommodate a wide variety of offender types or they may have no clear criteria on which to exclude ineligible or inappropriate prospective participants prior to treatment. Although previous research supports the view that domestic violence abusers can be differentiated along various dimensions (Cavanaugh & Gelles, 2005), and that these typologies can result in correspondingly varied levels of treatment effectiveness (Feder, Wilson, & Austin, 2008), it is not clear whether this important research is really guiding programs' recruitment and delivery procedures in Europe. For example, many program administrators recognized the need to avoid "one size fits all" programs and claimed to tailor their programs to participants' varying profiles of risk and need. However, our results indicate that this tailoring was rarely based on systematic and empirically validated assessment tools. Instead, we observed that unstructured expert judgment was the most common assessment method. The reliance on clinical discretion as opposed to systematic assessment instruments in tailoring program delivery to offenders has been criticized elsewhere (Andrews, Bonta, & Wormith, 2011; Bonta, 2002). Rather than subscribe to all aspects of this critique and repeat the findings on actuarial versus clinical prediction (e.g., Grove & Meehl, 1996), we merely emphasize that sound clinical discretion impedes the collection of a systematic evidence base to ensure a sufficiently structured and replicable approach to the treatment of domestic violence perpetrators. The semistructured items in our survey also revealed that the lack of a clear offender selection process was a concern for the effective delivery of treatment.

Our findings showed that perpetrator programs were delivered less frequently in criminal justice facilities than in community settings. However, the prominence of court-mandated participation in both criminal justice and community settings suggests that these programs are mainly seen as a criminal justice response in Europe.

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Furthermore, although many programs were community based, the majority were funded by the government, and accredited programs often received their status from government bodies. In contrast to the United States, where programs are largely autonomous and operating without the support of partner organizations (Dalton, 2007), European perpetrator programs are usually embedded within a dense collaborative network of practitioners with a strong governmental influence.

A particularly important finding of our survey concerns deficits in sound evaluation. Process and outcome evaluations were conducted rarely and in very few countries across Europe. Moreover, the standard of those evaluations was usually too low to enable practitioners to monitor systematically how reliably programs were being administered and what effect they ultimately had on their participants. For example, the collection of process data such as attendance and completion was infrequent, as was the practice of taking steps to ensure treatment integrity. Similarly, although practical limits to conducting high-quality evaluation must be taken into account (Lösel, 2007), the quality of outcome evaluations was relatively low (i.e., showed many threats to internal validity).

The methodological problems endemic to research on domestic violence perpetrator program effectiveness are well noted elsewhere (Graham-Kevan, 2007; Rosenbaum, 1988; see also Part II of this article). In particular, respondents highlighted the choice of an appropriate outcome measure. The diverse outcome measures employed in the evaluations and the semistructured item responses indicate that despite decades of scholarship, there still remains as yet no clearly recognized directive concerning how practitioners should best capture perpetrator program effectiveness. This relates, at least in part, to the differently stated purposes of perpetrator programs expressed by respondents in the sample. Sound comparisons of effectiveness would require more consensus on this issue (Westmarland, Kelly, & Chalder-Mills, 2010).

There is also a lack of evaluations of transferred programs once they have been transported to another country. Although transferred programs were more structured than the rest of the sample, such a transfer may precipitate three potential problems: First, the cultural context may require significant modifications to the program, thus rendering it an essentially different program. Second, if a program is not adapted to the new context, it may contain culturally irrelevant and thus ineffective elements (e.g., Sundell et al., 2008). Finally, there may be problems taking the program to scale, especially without developer involvement (Petrosino & Soydan, 2005; Welsh, Sullivan, & Olds, 2010). In light of the mixed effects observed in replication studies of the most commonly transferred program in our sample (the Duluth Model; for example, Babcock et al., 2004; Dobash, Dobash, Cavanagh, & Lewis, 1999), we emphasize the need to evaluate newly adapted or transferred programs.

The significant role that governments play in providing financial and administrative support for European perpetrator programs holds promise for the future establishment of good practice standards and monitoring routine program delivery throughout the continent. For instance, financial awards and accreditation procedures are currently not contingent on incorporating evaluation as a routine feature of treatment

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delivery. If evaluation were to be required for government funding and accreditation, the "what works" evidence base could benefit (Gendreau, Goggin, & Smith, 2001; Roberts, 1995).

Finally, we note the politically and ideologically charged issues in the work with domestic violence perpetrators; for example, the comment made by a respondent who asserted that perpetrator programs should "never be done at the expense of programs for women victims of violence and their children." This underscores that the maintenance of perpetrator programs is an essentially precarious and sensitive endeavor. Accordingly, treatment delivery in this field is often fraught with political turmoil, as practitioners must negotiate the competing demands of delivering therapeutic services for abusers while accommodating the need expressed by various interest groups to "see justice done" (Graham-Kevan 2007; United Nations Office on Drugs and Crime [UNODC], 2008). This balancing act may make an evidence-oriented policy more complicated than in other fields of offender treatment.

In light of the above findings, we investigated whether European correctional treatment of domestic violence perpetrators is sufficiently evidence based to guide effective practice. This will be the focus of Part II of this article, in which we present a systematic review of European outcome evaluations.

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Authors' Note

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