Durham University

Inspiring the extraordinary

Domestic violence perpetrator programmes and neurodiversity

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UKRI Economic and Social Research Council

MONASH GENDER AND FAMILY VIOLENCE PREVENTION CENTRE

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A brief note on language and terminology

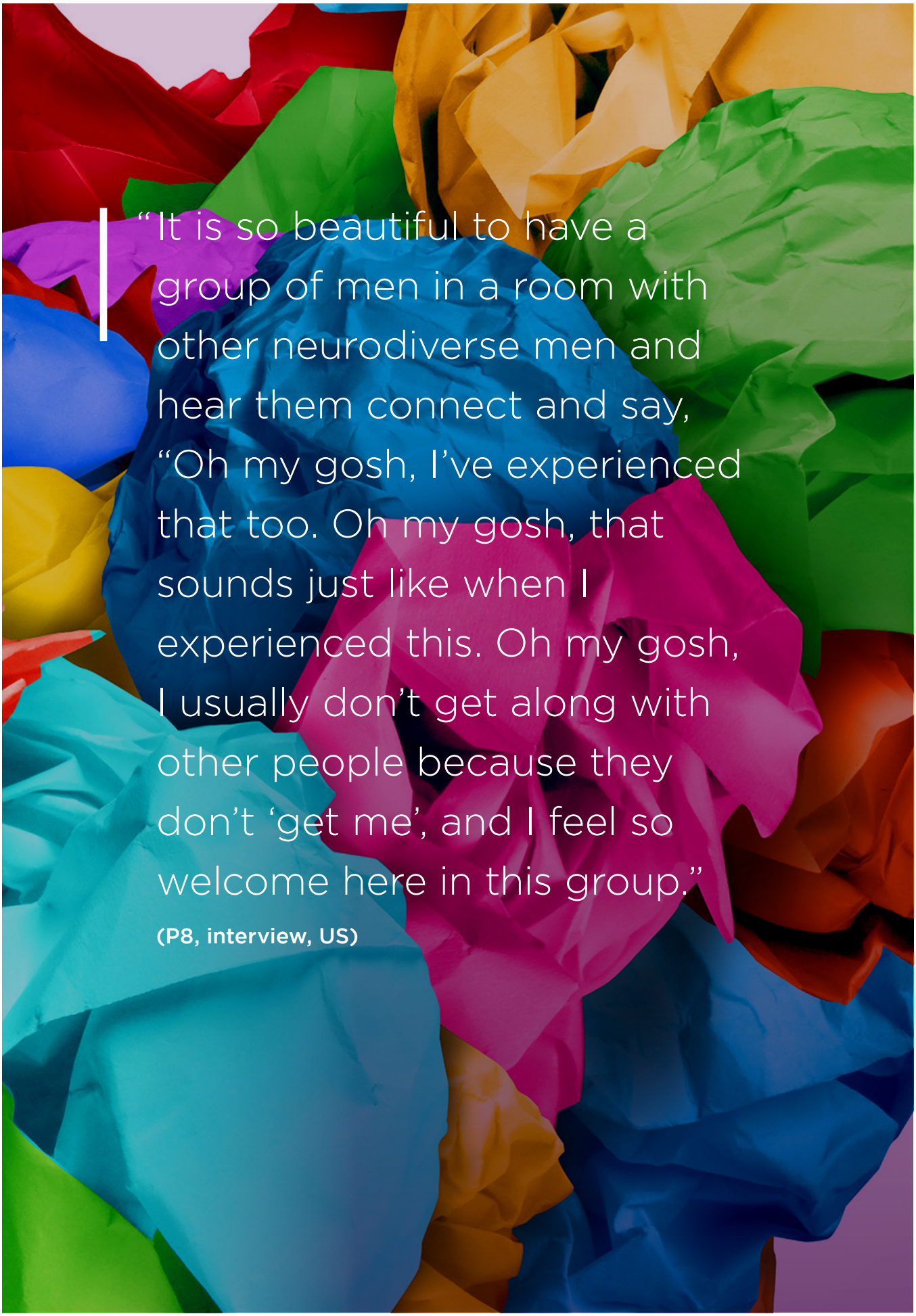
I would like to provide some clarification on the terms *neurodiversity* and *neurodivergence*, and where I position myself in this emerging area of research.

Neurodiversity refers to all of us, in all our neurological differences. Much like biodiversity, neurodiversity sees these differences as important for human diversity while acknowledging individual strengths and struggles[1].

Neurodivergence is the term used for people who diverge from an assumed neurotypical/neurological norm. This can include people with learning disabilities, learning difficulties (such as dyslexia), acquired brain injury, depression, and neurodevelopmental differences such as autism and attention deficit hyperactivity disorder (ADHD).

Neurodiversity can be contrasted with a medical model. While the former advocates *differences*, the latter focusses on *deficits* and identifying symptoms and traits. Depending on one's knowledge, experience, and training, the language used in this report will vary.

While I position myself within the neurodiversity paradigm and use language that resonates with this, I have presented the quotes as they were expressed. I do not intend to cause harm or upset to anyone reading this report; nor do I believe anyone who participated in this research did. I encountered only enthusiasm to drive forward responsive and safe services. During my research, I have encountered many individuals who share my desire to learn and to continue to develop the appropriate language and practices to support neurodivergent people.



> "It is so beautiful to have a group of men in a room with other neurodiverse men and hear them connect and say, "Oh my gosh, I've experienced that too. Oh my gosh, that sounds just like when I experienced this. Oh my gosh, I usually don't get along with other people because they don't 'get me', and I feel so welcome here in this group."
>
> **(P8, interview, US)**

Executive summary

This project is the first international study to explore the experiences and perspectives of domestic abuse practitioners who work with autistic and/or ADHD men. Further, findings revealed that there are only two studies internationally that have researched the experiences, views, and/or outcomes of neurodivergent autistic and/or ADHD men who attended a domestic violence perpetrator/men's behaviour change programme (DVPP/MBCP).

Findings on current practices

There was a broad consensus amongst practitioners that understanding the experiences of neurodivergent men was important when working with perpetrators, but they were clear that domestic abuse and the drivers of violence should not be medicalised as autism and/or ADHD. Practitioners were concerned that ADHD in particular could be mislabelled as and/or mask childhood trauma and neglect.

Practitioners relayed that autistic/ADHD men face many challenges. Firstly, screening and diagnosis are often not available which sometimes led programme practitioners with limited, if any, training on neurodiversity to mistakenly view neurodivergent men as 'belligerent and disruptive' or disengaged. Secondly, sensory sensitivities, programme structure, and comprehension of programme content presented challenges. However, practitioners also recognised that these men had individual strengths to support their own engagement, and that of neurotypical men in groupwork. A tailored and flexible approach to programme delivery was viewed as important.

Practitioners suggested a range of reasonable adjustments to programme delivery and content that are simple to implement and at little cost. However, practitioners' views also highlight that meaningful engagement requires programme providers to go beyond what are considered reasonable adjustments to address the many 'wounds and intersectionalties' neurodivergent men present with. This includes, for example, being able to disentangle abusive controlling behaviours from control that provided predictability, while being trauma informed.

Neurodivergence trained and highly-trained neurodivergent programme practitioners are of central importance to the quality and effectiveness of this complex work, but the dearth of skills in this area poses a significant challenge for future practice.

Future practice and research considerations

There is a dearth of service provision in Australia and England for this cohort and what exists is patchy. Government and commissioners have a key role to play in ensuring additional resources are made available and commissioned to facilitate domestic abuse service providers and specialist services to be responsive and to enhance collaborative practice.

Further, the research identified few examples of work undertaken specifically with domestic abuse victim-survivors of neurodivergent men. There was, however, a consensus among practitioners on the need to explore how to manage expectations around aspects of behaviour that was related to neurodivergence, and what could and could not be changed. *Who* should do this work and *how* it should be done safely was a key concern.

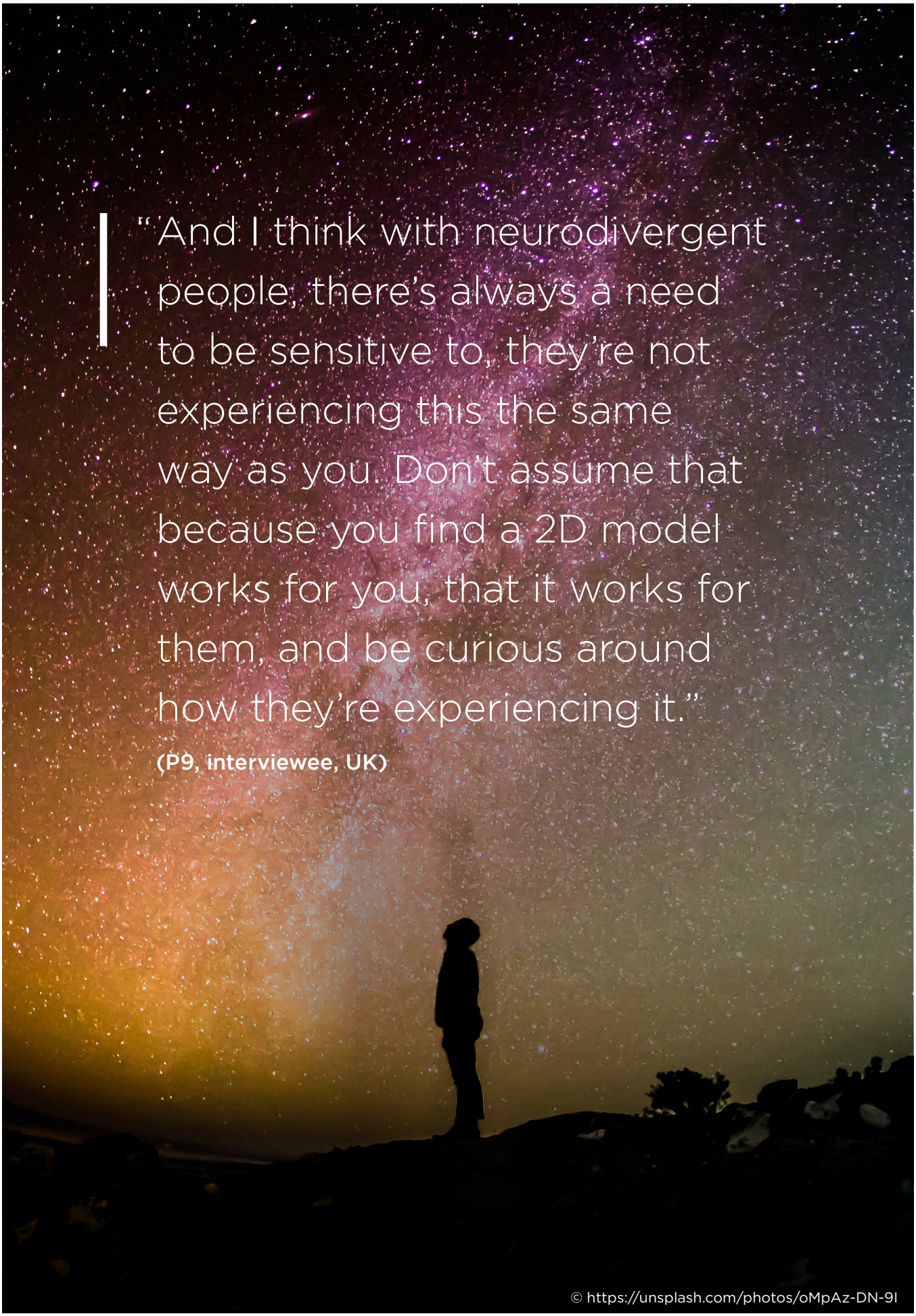
There is still much research to be done academically and practically in this under-researched area in respect of perpetrators and victim-survivors, including to consider the role of children, and the need to enhance current policy and practice responses.

Background to the study and rationale

Domestic violence perpetrator/men's behaviour change programmes have been in operation internationally for four decades. Programmes vary in respect of their understanding of domestic abuse perpetration and the models of change they adopt to challenging and changing abusive behaviours. Intimate partner abuse is one form of domestic abuse and is disproportionately (although not exclusively) perpetrated by men against their current and former female intimate partners with significant impacts[2]. There is however a broad consensus amongst practitioners and researchers alike that men who use violence are not a homogenous group and differ in respect of risk and needs. Typological approaches have identified differences in respect of their psychological profiles and violence patterns that require a tailored response rather than a one size fits all approach[3 4 5].

Despite this recognition, typological approaches have thus far overlooked the profiles, violence patterns, and experiences of neurodivergent men while DVPPs/MBCPs have been almost exclusively developed with a neurotypical perpetrator population in mind. This is important because the doctoral research that provided the foundations for the current study identified several neurodivergent men who experienced adversities and barriers to engagement that were both similar and above those of neurotypical men attending a criminal justice DVPP in England[6]. That project represents the first study internationally to obtain the views of neurodivergent men who perpetrate domestic abuse and to detail the challenges they faced. Given this was an unanticipated finding, practitioners were not asked specifically asked about working with neurodivergent men.

This project is the first international study to explore the experiences and perspectives of domestic abuse practitioners who work with autistic and/or ADHD men who do not have learning disabilities. The reasons for studying this specific group of neurodivergent men are twofold. Firstly, autism and ADHD could be described as an *invisible disability*. The specific risks and needs of neurodivergent men who use violence may therefore be overlooked by systems and practices developed with neurotypical men in focus. Further, a recent review of neurodiversity in the criminal justice system in the UK found interventions for *non-learning disabled* neurodivergent people were scarce[7]. Building on this work, this study focuses on obtaining practitioners' perspectives and experiences of working with this cohort, the challenges faced, the individual strengths they bring, and the adaptations necessary to make DVPPs/MBCPs and other interventions more responsive to neurodivergent men and provide safety to victim-survivors.


"And I think with neurodivergent people, there's always a need to be sensitive to, they're not experiencing this the same way as you. Don't assume that because you find a 2D model works for you, that it works for them, and be curious around how they're experiencing it."
(P9, interviewee, UK)
© https://unsplash.com/photos/oMpAz-DN-9I

Methodology

There is little known about the experiences of neurodivergent men who perpetrate domestic abuse, and even less so about those who work with them to address their behaviour. This study aims to build the evidence on:

- The experiences and perspectives of programme providers/practitioners,
- The challenges, needs and strengths of neurodivergent men attending DVPPs/MBCPs,
- Programme adaptations made and/or resources needed to better meet the needs of neurodivergent men who use domestic abuse,
- Workforce skills and development considerations, and
- Implications for victim-survivor safety, support and co-located/integrated services and multiagency working.

Research design

This research was carried out across three stages of data collection:

1. a systematic international literature search to identify studies that reported on the experiences, challenges, needs, and outcomes of ADHD and/or autistic men attending a DVPP/MBCP;
2. an online survey for programme providers in the UK and Australia to identify the availability of services adapted to work with this cohort; and
3. semi-structured interviews with international experts, practitioners and organisation representatives working in the field of domestic abuse, including consultancy services and organisations focused on stalking in the context of domestic abuse.

Ethical approval for the study was obtained via Durham University (UK) and Monash University's (Australia) respective research ethics committees[1].

A participant information sheet, privacy notice and consent form were provided via email and were also made available on the project website and survey instrument. All the interviews were anonymised, and each interviewee was given the option to comment on a draft of this report ahead of its finalisation. The mapping services survey provided respondents with the option to remain anonymous, permission for the use of extended quotations, and whether they wanted to have their details published on a directory of services. A further report will be produced with these details in due course and published via the project website.

Participant recruitment

A project website page was designed outlining the project details, participant information, privacy policy, how to contact the lead researcher and access the survey. The project was distributed via social media and professional contacts and organisations known to the project researchers. In total, 262 organisations and individuals were contacted across the United Kingdom, Ireland, Europe, the Netherlands, the United States and Australia.

Systematic literature search

Firstly, a systematic literature search was undertaken. This was intended to be a systematic scoping review, but the dearth of studies internationally rendered that approach impossible. Variations of the terms 'domestic violence perpetrator programme', 'perpetrator', 'domestic abuse', 'autism' and 'ADHD' were used to search seven databases and 20 relevant individual journals. A hand search of article references and google searches was also carried out. Inclusion criteria was limited to adult DVPPs/MBCPs, male perpetrators, and empirical studies published in English.

Interviews

In accordance with the scope set out for the project in the research grant and to deliver upon the project aims, 10 semi-structured interviews were undertaken with international experts who were or had been previously involved in frontline work with men who perpetrate domestic in the context of an intimate partner relationship. Two of these interviews were conducted as joint interviews, where the practitioners had different roles and responsibilities in the same organisation.

All interviews were carried out online via MS Teams or Zoom and audio recorded. Each interview lasted between 40 minutes and 2 hours. The interviews were transcribed in full and anonymised at the point of transcription.

Interviewees (practitioners hereon in) were asked about their professional background and experience, details of their organisation and services, and an overview of the domestic abuse perpetrator programme or work undertaken within their organisation. Practitioners were then asked about their experiences of working with autistic and/or ADHD men, the challenges faced by this cohort as well as their needs and strengths. They were then asked about adaptations they had made to make these services more responsive to neurodivergent men and the barriers they faced in doing so. Finally, practitioners were asked specific questions about the needs of affected family members, including partners and children as well as questions about multiagency working, and what future practice should look like when making services responsive to neurodivergent men specifically and men who have perpetrated abuse, more widely.

Interview participants

10 interviews were conducted with practitioners from Australia, the UK, the US and the Netherlands. Of the 10 interview participants:

- six were from the UK (England and Northern Ireland),
- two were from Australia (Victoria and New South Wales),
- one was from the US, and
- one from the Netherlands.

All interview participants had professional experience providing perpetrator programmes/ services and/or therapeutic services to men who had perpetrated abuse. One participant specifically provided perpetrator work to neurodivergent people, and another participant delivered counselling/psychotherapy specifically to neurodivergent people which included perpetrators of abuse. One participant provided consultancy and training as well as delivering programmes for other providers. Those practitioners involved in delivering perpetrator programmes specifically also provided parallel sessions, support, risk assessment and management which centred victim-survivors. Most of the practitioners involved in the interviews provided services nationally and one practitioner provides international services. Some participants were exclusively delivering in remote settings, and one to one, while others were a combination of both group work, one to one, in person, and online.

Similarly, to the survey respondents (below), the perpetrator work delivered by the organisations which the participants came from entailed a combination of psychoeducational, pro-feminist, and cognitive behavioural approaches. Where they differed was the extent to which psychotherapeutic, psychiatric, and/or other dialectical behavioural therapy approaches informed and featured in the work.

Survey

The survey sought to identify existing service provision for the cohort of interest. Respondents were asked similar questions to those utilised during the interviews (as above), as well as additional questions relating to referral quantities and long-term sustainability. The survey received a total of 14 responses. Nine were from the UK (the South, the West, and providers providing services nationally) and five were from Australia (New South Wales, South Australia, Victoria, and Queensland). A further brief email response was received from an organisation that was unable to complete the survey due to time pressures. That the survey received so few responses was not surprising given the dearth of research and practice in this particular area at present. It does however raise issues about the availability of vital services.

Survey respondents

Overall, the survey received 14 respondents from practitioners based in the UK and in Australia. Of the nine survey respondents from the UK, one practitioner worked in the public sector, four practitioners were from the English specialist domestic and family violence sector, three practitioners from the English criminal justice sector and one practitioner from the Scottish criminal justice sector.

Of the five survey respondents from Australia, one practitioner worked in the public sector in South Australia, two practitioners were from the specialist domestic and family violence sector, one in NSW and one in Queensland, and two practitioners worked in the specialist men's service sector in Victoria and NSW.

The main function of the organisations within which survey respondents were working varied from stalking, mentoring, early intervention and behavioural change programmes which were undertaken in one to one or group format, or a combination of them both. The main function for five of the survey practitioners was 'perpetrator work' while the remaining practitioners selected a combination of perpetrator work, children's and other advocacy and/or specialist family violence services. One survey respondent also addressed sexual violence. All practitioners were involved in the delivery of perpetrator programmes, three of which focused solely on this and mental health services and counselling. All other practitioners who responded to the survey provided women's safety work or risk assessment (depending on the function of their service), and support for children, men's health services, mental health and/or signposting services.

Perpetrator work broadly consisted cognitive behavioural and/or pro-feminist power control models/approaches, though two survey respondents also nominated that in addition the work they were involved in also used attachment theories, psychodynamic and other psychological therapeutic approaches, or mentoring. Eight survey respondents nominated in the survey that they provided tailored services to neurodivergent individuals, as well as individuals with learning disabilities/difficulties, black and or other ethnic minoritised and First Nation communities, LGBTIQA+, faith groups, high harm and/or perpetrators with mental health and/or substance abuse issues.

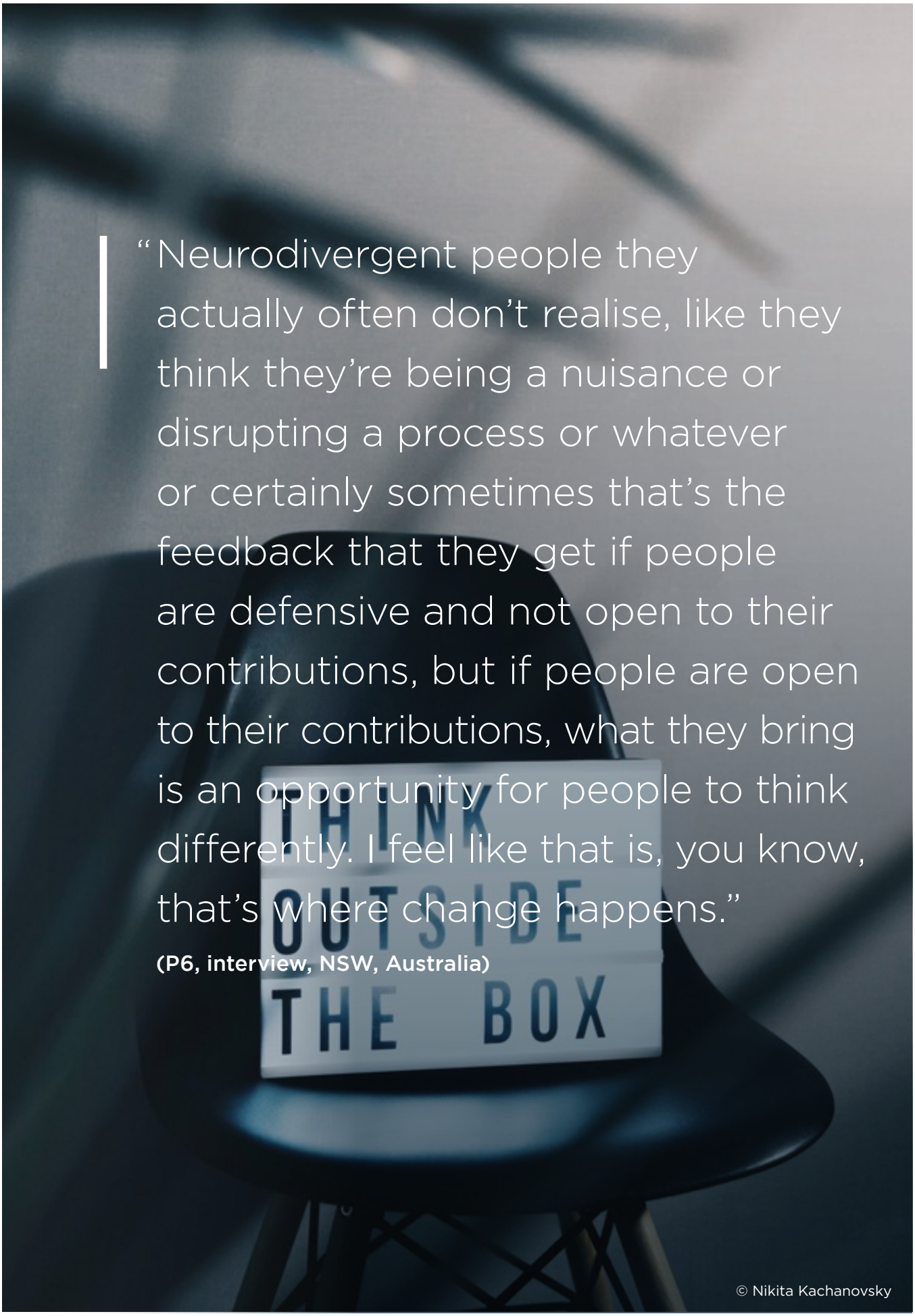
For those respondents who answered, typical referral rates each year ranged between 40–260 people, and those not meeting criteria resulting in exclusion from an intervention ranged between 5–50 people. Funding sources included police and crime commissioners, local authority, central/state government, commonwealth/federal government funding, charitable and/or philanthropic grants. Four of the survey respondents noted that they received funding for specialist services for unborn babies and young children (Home Office), high-risk, high harm serial perpetrators, case work, or to work with men at risk/excluded from the home. For those who answered, seven survey respondents had secured consecutive/rolling funding of more than 12 months, two for 12 months only, and two for less than 12 months.

Systematic literature search results

In this section we provide an overview of the systematic literature search.

The systematic literature search on the criteria outlined above yielded a total of 1,362 publications which were reduced to four after duplicates were removed and following a title and abstract search. These four publications were read in their entirety but only two publications met the search criteria. The first publication was a study that explored the impact of ADHD treatment (according to the European Consensus) alongside a one to one and/or couple domestic abuse intervention within a forensic psychiatric setting in the Netherlands[8]. This was an observational study and while causation could not be established, the results showed that ADHD treatment can reduce intimate partner abuse more effectively when combined with a DVPP/MBCP intervention.

The second study[9] was the lead researcher's own PhD thesis. This included one chapter that foregrounded 'meaning and motive in the domestic abuse perpetration' of three case studies of neurodivergent men attending the criminal justice, Building Better Relationships programme, in England. This research found that men's behaviour was still meaningful (that is domestic abuse was not attributed to their neurodivergence) though they did experience additional adversities, structural inequalities, and barriers to engagement above those of the other men on the programme. Programme content, structure, a lack of planning and assessment, and assumptions about neurotypical ways of thinking and understanding relationships and programme material were all identified in this study as potential barriers to engagement and change.



> "Neurodivergent people they actually often don't realise, like they think they're being a nuisance or disrupting a process or whatever or certainly sometimes that's the feedback that they get if people are defensive and not open to their contributions, but if people are open to their contributions, what they bring is an opportunity for people to think differently. I feel like that is, you know, that's where change happens."
>
> **(P6, interview, NSW, Australia)**

Qualitative interviews and survey findings

In the following section we present the experiences and perspectives of practitioners as gleaned from the interviews completed and the qualitative survey data collected. Our findings are organised thematically, into six sub sections: (1) how domestic abuse perpetration and neurodiversity was understood; (2) the challenges experienced by organisations and individuals, and individual strengths of this cohort; (3) the adaptations (or reasonable adjustments) they made to the programme; (4) adaptations that went beyond what would generally be considered 'reasonable adjustments' and workforce development; (5) partner support; and (6) the importance of multiagency, integrated services and, co-located working.

Practitioner perspectives on neurodiversity and domestic abuse perpetration

There was a broad consensus amongst practitioners interviewed that understanding the experiences of autistic and/or ADHD men was important when working with perpetrators. However, practitioners were clear that such neurodivergences do not *cause* domestic abuse. Concerns were raised that using autism and ADHD as a mitigating or explanatory factor was unnecessarily stigmatising to neurodivergent people who get 'associated with that behaviour' (P3, Interviewee, UK) or could diminish accountability for abuse. As two practitioners explained:

> *"For me it's being mindful that ADHD or autism or any, any disability or, you know, neurodiverse, I don't know what to call it, condition, is not a reason for a family violence situation."* (P7:2, interview, Victoria, Australia)

> *"So, they have autism and they stalk, or they have a mental illness and they stalk, or they have ADHD and they stalk. It's not a 'because' as the defence often try to portray this. So we try and understand the nature of their condition, if it's diagnosed."* (P2, interview, UK)

Some practitioners were similarly concerned that misdiagnosis of ADHD could have implications for working with men who had perpetrated abuse. For example, childhood trauma and neglect may be mislabelled as, or masked by, ADHD, meaning the complexity of the abusive behaviour could be medicalised and left unaddressed. As one practitioner commented:

> *"So how much of that [ADHD presentations] is a biological tendency and how much of that is the result of the childhood neglect and trauma I wouldn't know, but I – usually I think it's probably a bit of a mix. And that's what we're not addressing. And I think that's one of the problems with ADHD is that it's sometimes used as a way of dealing with – as a label for dealing with some of these issues without having to really address the fact that there's kind of trauma at the root of this."* (P1, interview, UK)

These practitioner accounts underscore the need to be aware of the nuances around the nature of domestic abuse, its causes, and the need to avoid medicalising behaviour which stigmatises neurodivergent people, and absolves the perpetrator of accountability. It was well recognised among practitioners' interviews that to do so could ultimately limit the effectiveness of behavioural change interventions. Practitioners did, however, agree that understanding how neurodivergent people perceive and experience the world was crucial for developing effective programmes that are responsive to their individual needs. Supporting previous research[10], this included unique lived experiences embedded within layers of intersectionality such as gender, class, race, ethnicity, and sexuality.

Operational and individual challenges, and strengths

Through the interviews and the survey, many practitioners identified the absence of a known diagnosis for autism/ADHD as a key challenge. It was noted that this did not determine whether someone was excluded from participating in a programme, with all survey respondents accepting self-diagnosis. Only one practitioner used a screening tool (previously 'Genius') and were now trialling the Do-It Profiler[11]. Three practitioners said diagnosis was embedded as part of their referral and/or signposting process. However, a common issue raised amongst interviewees was that a diagnosis was not always shared or known by the client or professional which meant the practitioner often would not know if someone 'may be experiencing things from a history of undiagnosed neurodivergence' (P9, interviewee, UK). This raised several issues.

Firstly, without awareness of a diagnosis, it was difficult for practitioners to make a case for relevant resources, as one interview participant explained:

> *"So, no, I think that's the main thing for me. You know, those structures that exist have got to be able to cope because there is – it does seem that there is so much more awareness about it and you hear of more and more people, you know, with neurodivergent conditions, the increased prevalence. Whether resources and systems and structures are also increasing at the same rate, I'm not sure* (P2, interview, UK)"

Secondly, there was a concern amongst autism/ADHD trained practitioners, and those with lived experience (had neurodivergent children and/or were neurodivergent themselves) that other programme facilitators did not readily recognise that some of the men they worked with were autistic and/or ADHD. Several practitioners commented that this led to neurodivergent men being mistakenly viewed as deliberately disruptive or disengaged, as captured in this reflection:

> *"I think that often the ones in the group programme that dominate the space, over-talk and interrupt because their thought processes are operating at a very different speed and there's that impulsive kind of nature to how they want to contribute to the space, and that's often perceived by practitioners as belligerent or disruptive, and I think I just view that in a very different way because I understand ADHD."* (P6, Interviewee, NSW, Australia)

Another practitioner said that misreading a neurodivergent client could also affect the therapeutic (or working) alliance:

> *"Men can be misunderstood in their demeanour and general engagement which can in turn cause difficulties when facilitators are trying to force their participation."* (survey, Victoria, Australia)

Thirdly, there was a concern held by several practitioners that mainstream programmes were not developed to cater for the needs of autistic and/or ADHD men without learning disabilities. Therefore, if practitioners, or indeed the men themselves, were not aware of a diagnosis and/or were not specialised or experienced in this area, practitioners were not able to tailor the programme to meet their diverse needs.

Challenges raised by practitioners in respect of groupwork environments included sensory sensitivities, group dynamics and relating, and emotional sensitivity to other group members' reactions. For ADHD clients, challenges included 'escalated thinking and trigger responses' and a 'lack of concentration, focus and irritability' (survey respondent, UK). Programme content and pace were also key considerations, with some neurodivergent men able to grasp the material with much more ease than neurotypical group members, while others needed more time to process, 'dissect', and make sense of what they were learning (P7 Interview, Victoria, Australia; P10 Interview, UK).

One practitioner explained that inflexibility in practice could otherwise result in echolalic responses (P10:2, interview, UK) due to differences in processing of information and understanding. One practitioner who had previously delivered criminal justice programmes suggested that this kind of masking might lead practitioners to falsely believe the client was following the material as presented. As they explained:

> *"I've worked with individuals who've really struggled in the sort of more general offending programmes who get left behind by, you know – because it's going too quickly, they can't even process the information coming in or the difference between that, you know, expressive and receptive language capability. So they appear to be understanding when actually, what they're really sort of – kind of parroting back, or they – you know, they pick the keywords to say – and that understanding is assumed rather than actually checked out."* (P4, interview, UK)

Participants were also divided and/or undecided on the suitability of groupwork verses one-to-one case management. However, there was a shared view among practitioners that either or both were useful depending on the perpetrator's individual needs. One practitioner said that neurodivergent-only groups were beneficial. They claimed there were 'more strengths than challenges' to working with this cohort and that neurodivergent men often felt a sense of belonging and acceptance with each other:

> *"It is so beautiful to have a group of men in a room with other neurodiverse men and hear them connect and say, "Oh my gosh, I've experienced that too. Oh my gosh, that sounds just like when I experienced this. Oh my gosh, I usually don't get along with other people because they don't 'get me', and I feel so welcome here in this group." (P8, interview, US)*

Further, practitioners reflected that neurodivergent men also benefited and contributed a great deal to mainstream programmes. Some practitioners relayed that the frankness and factual communication of some neurodivergent, particularly autistic, men provided a productive environment for new ways of thinking 'outside the box' (survey respondent, Victoria, Australia) and challenging the status quo. This practitioner went on to explain:

> *"Neurodivergent people... they actually often don't realise, like they think they're being a nuisance or disrupting a process or whatever or certainly sometimes that's the feedback that they get if people are defensive and not open to their contributions, but if people are open to their contributions, what they bring is an opportunity for people to think differently about things that have been thought about in the same way for an incredibly long time, and I love that. I feel like that is, you know, that's where change happens, when people have an opportunity to think differently about something, it presents an opportunity. And I really enjoy and value how neurodivergent clients can do that. "*(P6, interview, NSW, Australia)

Neurodivergent men were also seen to have other strengths to support them (and others) with programme engagement such as a 'willingness to learn', 'focus on detail', 'logical thinking', great visual and memory skills, creative thinking and 'less filter' which could 'disrupt image managing' and offered 'very good challenges to men in group' (survey respondents, UK and Australia).

These examples suggest that there is no 'one size fits all' approach to engaging perpetrators in behavioural change and that interventions should be individualised to identify the most effective tailored response. Further, it was evident from practitioner experience that having greater flexibility in delivery, whether individual, group, online and/or in person, was centrally important to achieving engagement. We elaborate on this further in the next section.

Needs and reasonable adjustments

Practitioners suggested a diverse range of needs of neurodivergent groups and how these could be accommodated within interventions. For ADHD men specifically, ADHD treatment alongside a perpetrator programme, such as medication, psychoeducation and therapeutic input, was seen as necessary for helping some clients with ADHD. One practitioner did express concern that in their experience many ADHD men were solely prescribed medication which was not good practice, nor was it compliant with the European Consensus and NICE guidelines (P1, Interviewee, UK)[12 13]. To this end, ADHD treatment was not viewed as a panacea for addressing abusive behaviour. Further, being 'flexible' with ADHD clients around appointments, sending reminders and removing 'three strikes' clauses from programmes were seen as important accommodations for ADHD clients, as well as flexibility in delivery. As one practitioner explained:

> *"When we see that it's too difficult for them to follow the programme, we have a lot of online therapy as well, so people can read at home things, we'll make exercises, but most ADHD people don't do that, they forget it or – and then we say, okay come to us and we do it together…And I think that's very important, to be very flexible and don't expect – "so okay, this is our programme and you have to fit in", I think that's very difficult for them."* (P5, interview, the Netherlands)

Practitioners also suggested simple and reasonable adjustments (a requirement of UK equality legislation) to create 'neurodivergent friendly' (P3, interview, UK) environments and more inclusive delivery options. Practitioners set out adjustments that could be incorporated such as smaller groups, individual work or additional support, including the use of story boards, 'multisensory tools', providing fidget gadgets, allowing 'stimming', 'bite-size modules', 'frequent breaks', 'pacing' sessions, preparing people in advance and meeting them in what could be busy reception spaces to acclimatise the setting and reduce the potential for sensory overload and stress. While these adjustments were viewed as important to consider, practitioners acknowledged there is also a need to be attuned to what is going on in the room. As one practitioner commented:

> *"I think in tailoring the programme or working, even in one-on-one with men who have autism or ADHD or the like, it's really about making, for me, anecdotally, it's about making the environment in which we're speaking comfortable, minimal distractions, making sure that they're, they're in a frame of mind where they can be attentive. Making sure that we are aware of ourselves and how we hold our space, but also recognising their body language, you know, are they paying attention, are they dozing off, are they distracted by something else? We really need to be on the ball with this, because if we lose them, they're going to disengage."* (P7:2, interview, Victoria, Australia)

Practitioners also stressed the need to be able to adapt their delivery and approach 'on the fly' (survey respondent, Victoria, Australia). This involved using creative tools such as 'visual displays', drawing, and using personalised metaphors or personalising the content to individual meanings and experiences to ensure the message was understood by all group members. The importance of flexible delivery and adjustments is well captured in the comments shared by one Australian practitioner:

> *"Normally, I use a lot of emotional focus therapy in the work I do, I really connect with the emotions that we hold; and with him, I couldn't use that because he didn't connect with his emotions and that's not something you can teach very quickly. So I had to use [personal] examples for him to connect with because they were real to him."* (P7:2, interview, Victoria, Australia)

Another practitioner said:

> *"As far as education and support around relationship dynamics, identifying the relationship rules that each relationship or client was founded on is impactful. Clients often have different relationship rules and being able to talk about those things openly in group, and have clients recognise, "Oh, this is a different relationship rule from mine. You have this relationship rule. I don't." What are the risks to that rule? How do clients handle it when that relationship rule is violated? It is psycho education in the way that's personal to each client, but really helping individuals understand the foundation or driver of the existence of the rule, in this example. I do not provide treatment through an 'umbrella discussion' in effort to try and encapsulate everything and make it relevant to each person. It is often not possible, but personalised group treatment is possible and impactful based on the flexibility and adaptability of the clinician providing the treatment."* (P8, interview, US).

Other accommodations described by practitioners included those specific to online and/or one-to-one groups, depending on the individual. One survey respondent suggested that to date they worked with their autistic clients in one-to-one format only, though they had been able to accommodate and adapt their programme for 'mild' ADHD clients. As they explained:

> *"Initially time is spent understanding how the individual perceives their own behaviours and interacts within their relationships. We would explore their personal triggers, emotions and thoughts. Once we felt we had a good understanding of the client we would then decide which tools would be helpful. There is much focus on discussion and exploration, using motivational interviewing skills to better understand the individual."* (survey respondent, UK)

The benefits and limits of online options for programme delivery and perpetrator engagement were discussed by practitioners. They were viewed as positive in respect of technological tools such as captions, chat and messaging, and utilising smaller break out rooms to personalise and provide practical support. Positives also included accessibility for people who live in remote locations; where neurodivergent specialist providers were not available locally; and for those who found it easier to build relationships at a distance and/or manage their own sensory environment. The cons identified by practitioners included difficulties in relating, noticing body queues and emotional states. As one practitioner described:

> *"And with both of those you've got the same disadvantages around relational stuff. Although that start of it might be easier with somebody with neurodiversity, the fact that is that, in the end it's about relating with people who are in the same room as you, it's a part of the problem, you know. And you need to get to that place where you're practising that and you're engaging positively in that kind of experience of actually being in the same physical space as somebody and relating with them in that same physical space. That's, that's going to be – that's a key part of what we're trying to support, I think, isn't it?"* (P1, interview, UK)

In agreement, another practitioner commented:

> *"One of the cons, it's not quite the same as that human touch of being in a room and seeing someone in the 3D. And I think with neurodivergent people, there's always a need to be sensitive to, they're not experiencing this the same way as you. Don't assume that because you find a 2D model works for you, that it works for them, and be curious around how they're experiencing it. Also as if they're in a room, you know, the training, the supervision of practitioners is always to be curious about what you see in front of you, and don't let the moment slip. You know, it's more difficult to do online I think."* (P9, interviewee, UK)

These findings reinforce the need for an individualised assessment and tailored response. But these final quotes also raise a further issue. What neurodivergent people need from a programme goes beyond the scope of what would be considered a 'reasonable adjustment' to make environments more conducive to learning. Making programmes responsive to neurodivergent men requires more than just dimming lights, providing fidget gadgets, turning on captions, or drawing out a scenario, useful as these adjustments may be. Being responsive requires skilled practitioners who can adapt their approach in ways that are attuned to the individuals in front of them, their layers of intersectionality, and how to disentangle abusive behaviours from neurodivergence amongst all this complexity.

"You have to meet people where they're at": Beyond reasonable adjustments, and workforce development

Practitioners raised that neurodivergent clients presented with 'many wounds and intersectionalities' (P6, interviewee, NSW, Australia) that need to be addressed. This supports previous findings in respect of working with neurodivergent men[14] and research with domestic abuse perpetrators more broadly[15 16 17 18]. Neurodivergence was viewed as another layer of complexity to be unpicked and addressed within the context of gender-based abuse. As one practitioner explained:

> *"I was just thinking through like, back to kind of all the layers and everything that everybody has. So we understand... onions have layers; we understand, like as I say there's the patriarchal side of things, and then you add... coming down into kind of like, so femininity is seen as lesser, we'll look at the layers that are then on top of that male privilege and that is, yeah, obviously, I'm white, so I've got less layers than, than somebody that's a person of colour and all the extra bits. So then if you think of the lens of neurodivergence being another layer for these men, they already have that impulse of not knowing, or not being able to kind of control their emotions and the way in which they do things, especially because it's an external environment, environmental kind of pressure that's adding to that."* (P7:2, interview, Australia).

In doing this kind of work, a phrase (and theme) that repeatedly came up among practitioners was the need to 'meet people where they are at' (P3, interviewee, UK; P9, interviewee, UK). This involved being 'curious' and 'attuned' to the many complexities in domestic abuse perpetration, understanding the patterns of how each participant 'related' to their partners, and being able to separate out the 'blur in the lines between what's caring and controlling' (P10), and helping men with 'making sense of the power and control model versus need for control as a means of maintaining predictability' (survey respondent, NSW, Australia). This meant being able to hold all of these things in tension, avoid potential for collusion, and balancing the needs of the client verses the risk they posed to their partner in respect domestic abuse. As one practitioner commented:

> *"So, for me, it's always about attunement. It's always about – and I think for the guy [current client]... I think there's probably some ADHD traits there, and there's massive, massive trauma, and when those two things, you know, it's like what came first, the chicken or the egg, and how do you sift through it? I tried to attune with him but as soon as I – so it's like that balance between empathy and accountability, so I tried really hard to attune with him, but as soon as I presented any firm boundary around, you know, what we would consider inappropriate or controlling, he just couldn't be held accountable at all."* (P6, interview, Australia)

Similarly, another practitioner noted the need to avoid falling into the trap of trying to change behaviours that might appear to be controlling but were necessary to provide structure and order for neurodivergent people, and to prevent 'spilling over into meltdowns' (P10:2, Interview, UK). The work was further complicated where there was a dual diagnosis of autism and ADHD, something the same practitioner said she came across a lot. The challenge,

on the one hand came from referring professionals who did not understand the complexity of working with such men and, on the other, that behaviour change and safety planning is different and may take more time. That practitioner reflected on the challenges unique to that context:

> *"And actually my difficulty is safety planning, trying to get a safety plan that suits both of those conditions, knowing that someone who – I'm not going to say the word lacks empathy, because they don't lack empathy, their empathy is just different, towards their partner. Trying to build that into a safety plan and trying to get them to recognise their triggers and trying to get them to work on their emotions and feelings of what's going on at the moment, when you've got the impulsive side of ADHD sitting there as well. So it's trying to incorporate those two together is quite a challenge. But it can be done. Just got to find a way – got to find that right window – but it takes time.* (P10:2, interview, UK).

A key point stressed by practitioners was not just about *what* was delivered, but *how* it was delivered. This was viewed by practitioners as critical to inclusive and responsive practice. As one practitioner described:

> *"As providers, we know what needs to be taught, but the 'what' falls flat without specific attention to the 'how'. How are we providing the treatment? How are we adjusting our delivery? How are we communicating information? I have recognised in myself this is how my brain functions now, too. Let's say we're all sitting around a table in a group room. I purposely take up a lot of space in the room. I pace around, so I know I'm increasing your effort for physical attention on me and the discussion because you have to visually follow me. When I am standing at a podium it may be easier for your attention to zone out, right? If I'm starting to lose somebody with their thoughts zoning or perhaps they are not understanding the information, I know I can do a firm – with their permission – I do a firm shoulder press to bring them back into this group with grounding and respectful refocus. There are many little things that I do during my therapy and treatment sessions and groups that are actually accommodations and adaptations to treatment. I do not think some of these treatment efforts are as easily identifiable with other clinicians who don't have this specialty, experience or training. I mean, this is just training on the 'how.' If you are able to figure out how to apply it and practice this, then it becomes natural to how you provide services. It is not extra work, it is just more intentional treatment efforts with investment in providing equitable, accessible, and accommodating treatment to meet the needs of the clients in your agency."* (P8, interview, US).

What also became apparent was the perceived value that neurodivergent practitioners brought to perpetrator work, where first (as opposed to second) nature thinking was used to connect with the experiences and thinking of neurodivergent clients. One autistic practitioner explained how the men she worked with 'don't have to translate' (P3, interviewee, UK) as she was naturally attuned to their presentations and thinking patterns. Two ADHD diagnosed practitioners were able to recognise other neurodivergent men and adapt their response; skills that also benefited the wider group. When asked for an example, one practitioner commented that it was 'hard to explain' how they just connected with neurodivergent men:

> *"He was like, nah, nah, that doesn't make sense, but then finding one that, then he does, actually "no I get that now, I can understand that"; and yeah seeing him connect and, yeah working out, hey that's actually something I can work on and how I can do that, so it was good to, I don't know if it was just because it's my neurodivergent side of me or it's my personality side of me that wants to help get the connection for them, for any men I mean, and yeah working through his particular black and white thinking to be able to connect something that's not necessarily personal in what he has done, but being able to connect it to something he can understand as to why he wouldn't want to continue to do that or not do it at all in the future."* (P7:2, interview, Victoria, Australia)

Their colleague went on to further explain:

> *"For an outsider if they came and saw his particular presentation and how we work with him, they would be like, he's not engaging with that at all, like he's not picking up any of those tools. We ended up actually being able to do some, what we call catch-up sessions where it was a bit more intimate so to speak and it was the two facilitators and only a couple of men involved, and he was in one of those and he came out of his shell and was talking about those things and what happened was, it was, and I think it's part of my neurodivergent skills set that came here, is thinking of scenarios that would, he would be able to connect with."* (P7:1, interviewee, Victoria, Australia)

Another organisation was fortunate to have an autistic practitioner working with them who was able to advise the team at large. This was seen as beneficial to raising awareness and understanding across the team:

> *"We have a facilitator who is self-identified ASD, which also helps knowledge sharing within the team."* (survey, QLD, Australia).

These practitioners' accounts suggest that a skilled and neurodivergent workforce who have the knowledge and (lived) experience to work with neurodivergent men who perpetrate abuse can work in ways that go beyond what would be considered a 'reasonable adjustment'.

Recognising, understanding, and being responsive to neurodivergent presentations was viewed as a key skill among practitioners, and importantly a necessary one to engage neurodivergent men in meaningful change. Of the 14 survey respondents, more than half said that their staff would benefit from more neurodivergence and/or trauma informed training in respect of this cohort. However, one practitioner cautioned against organisations developing or sending staff on inadequate training and said that neurodiversity was not just a 'new fad to be trained in'. As they explained:

> *"It is a foundation of good practice for clients with any variety of learning differences and learning strengths – as that is the greater majority of the population."* (P8, interviewee, US)

Another practitioner stated that domestic abuse practitioners needed to be ready to obtain such training to incorporate it into daily practice. They commented:

> *"There is work to do to influence mainstream DA work to accept that work in this specific area [neurodiversity] needs to be seen as part of what they do, not as a specialism which is nearly unobtainable."* (survey, UK)

The conundrum presented here is how to ensure that experienced domestic abuse practitioners have the necessary skill set to work with neurodivergent people, without underestimating the challenge this presents, or diluting training to a tick box exercise.

A final but important point to note is that only one survey respondent was able to offer any concrete evidence regarding outcomes (or evaluation) for reoffending. Only one survey respondent whose mentoring service worked with high risk, high harm domestic abuse perpetrators provided data in respect of reduced reoffending rates, though the results were not disaggregated according to neurodivergence. The dearth of data makes understanding the effectiveness and impacts of different approaches impossible to measure.

Anecdotally, practitioners believed that the adaptations made, including the contributions of their trained and/or neurodivergent workforce, increased engagement amongst neurodivergent clients, which ultimately translates into better programme outcomes and partner safety if the programme is completed[19]. As one practitioner described:

> *"Yes I do believe that adjustments have supported men who are living on the Autism Spectrum to engage more effectively with the learning and transfer their learning to their usual environments to reduce recidivism and adhere to ADVO (Apprehended Domestic Violence Orders) conditions."* (survey, NSW, Australia).

Partner needs and support

A skilled workforce was not just considered important in the context of working with neurodivergent men, but also for supporting their (ex)partners. While most interviewees said that their organisation provided partner support, not all were able to provide specific examples of the experiences of victim-survivors of neurodivergent clients, or in what ways their support needs differed from non-neurodivergent clients' partners. This was, to some extent, reflective of the limits of their own experience and/or role, given that programme facilitators/practitioners often do not oversee or carry out work with victim-survivors as this can heighten risk. One interviewee whose service did have integrated support and expertise in neurodivergence stated that psychoeducation for neurodivergent clients and their partners was the 'most important' aspect of the intervention 'so there are no expectations which the patients cannot fulfil' (P5, interview, the Netherlands).

The need to manage partners' expectations was noted by a UK practitioner who had previously worked as a partner support worker and now worked with perpetrators. This practitioner provided an example of the complexity of working with a current autistic/ADHD client which provides some insight into the complexities of working with mixed neurotype couples and the need for further research in this area. They described:

> *"So one of the things that – the struggles that he's having is he likes his partner to help him with order. He's very ordered in that way. And that's part of who he is, and we can't change that. But it's also about the grey areas, which we spoke about today. When is it okay to order it for you and when is it not? How is she going to know that? She isn't. So this grey area, the black and the white's a bit – this big grey area, this normal speak that we have, the body language, is just not there."* (P10:2, interview, UK)

Throughout the interviews, practitioners considered – often for the first time – how the needs of partners of neurodivergent men could also be multiple and complex. As outlined above, practitioners said this was about managing expectations about what could and could not be changed. But they also reflected their concerns that victim-survivors may carry an additional burden when there was a diagnosis and the potential for abusive behaviour to be medicalised, or alternatively instil hopelessness that the perpetrator could not change. As one practitioner described:

> *"I really think that that's probably an area for growth in our practice that what do we then do to support female victims to develop an understanding of, if they're still in a relationship, develop an understanding of him and his needs because of his neurodiversity without encouraging them to take more responsibility for that person because they're already overburdened."* (P6, interview, NSW, Australia)

Another practitioner reflected:

> *"Families may minimise his responsibility for the violence, blaming him being autistic/ADHD. They may also not see him in having the ability to change." (survey respondent, QLD, Australia)*

While practitioners began to consider the importance of their organisations working with (ex)partners to understand neurodivergence and the differences between relevant presentations and domestic abuse, who should do this work was another area of contention. Acknowledging the level of skill and risk management required to ensure no harm was caused was viewed as critical. As one practitioner explained:

> *"Because I can very easily see how talking about somebody's diagnosis or presentation could actually really encourage survivors to further remove the accountability and the blame for where that behaviour is coming from the perpetrator. That may encourage people to stay in relationships whereas otherwise they wouldn't necessary have done. Or to make excuses or to continue to blame themselves for triggering behaviours, because actually it's not their fault, it's their diagnosis."* (P10:1, interview, UK)

Integrated services, co-located models and multiagency working

Co-located/integrated services consisting of people with a variety of skills, training, experience and qualifications was viewed by practitioners interviewed as one way of working with the 'nuances' of a neurodivergent cohort and managing risk. One organisation which worked with neurodivergent men who stalked in the context of domestic abuse, noted they were able to overcome some of the limitations of mainstream services and programmes by meeting regularly, working flexibly, and incorporating reflective practice. Co-located services have the benefit of protecting the 'psychological safety' of staff who delivered the interventions, while providing a case-by-case formulation of each clients' risks and needs. As one practitioner described:

> *"And also having significant support as well. I think the supervision and the reflective sort of case support is really key as well. So we obviously – we have with our service, we have sort of a weekly meeting for our health team who are doing the interventions, where we'll sort of talk about cases, we'll reflect on things that are going well, we'll – we've also, you know, brought in other types of supervision to help us think about those cases more broadly. So we've just, you know, had to, you know, a big input in terms around sort of schema therapy, you know, for six months, to help us just think about the sort of – a slightly different way of the cases that we're working with, because of the complexity we're often kind of faced with really."* (P4, interview, UK)

However, such services are not common practice in either Australia nor England and Wales. There was a concern among practitioners from both jurisdictions that the dearth of skills presented a challenge for the effectiveness of perpetrator work with neurodivergent men. One interviewee suggested that organisations may need to look outside of their own structures to involve specialised services:

> *"It's like, how do we get to this place where the actual – the really key thing we haven't got skills in? So then when it comes to more specialised stuff around things like ADHD and with neurodiversity, I think it is really specialised work. And we're a long way from having anybody who's really – you know, enough people who are really specialised in that. So, there are people who have a lot of expertise around neurodiversity, but they're not engaged with anything to do with domestic violence perpetrator work. So there's a gap, you know, I think it feels like there's two separate worlds there that aren't communicating with each other and that's a real issue."* (P1, interview, UK)

However, the same interviewee was also concerned that clients faced a postcode lottery in this respect too:

> *"I've been doing around case management of high harm perpetrators, sometimes there are specialised services that we can get involved. And it depends a lot on what's available in a geographical area. And sometimes there's very little available. And what you've got left is the GP, and that's about it really in some places, because there's no specialised services available."* (P1, interview, UK)

A similar concern regarding multiagency working was mirrored by one survey respondent whose organisation worked alongside specialist ADHD/autism services in respect of the consequences of the time it takes for diagnosis and thus understanding their clients' support needs. They explained:

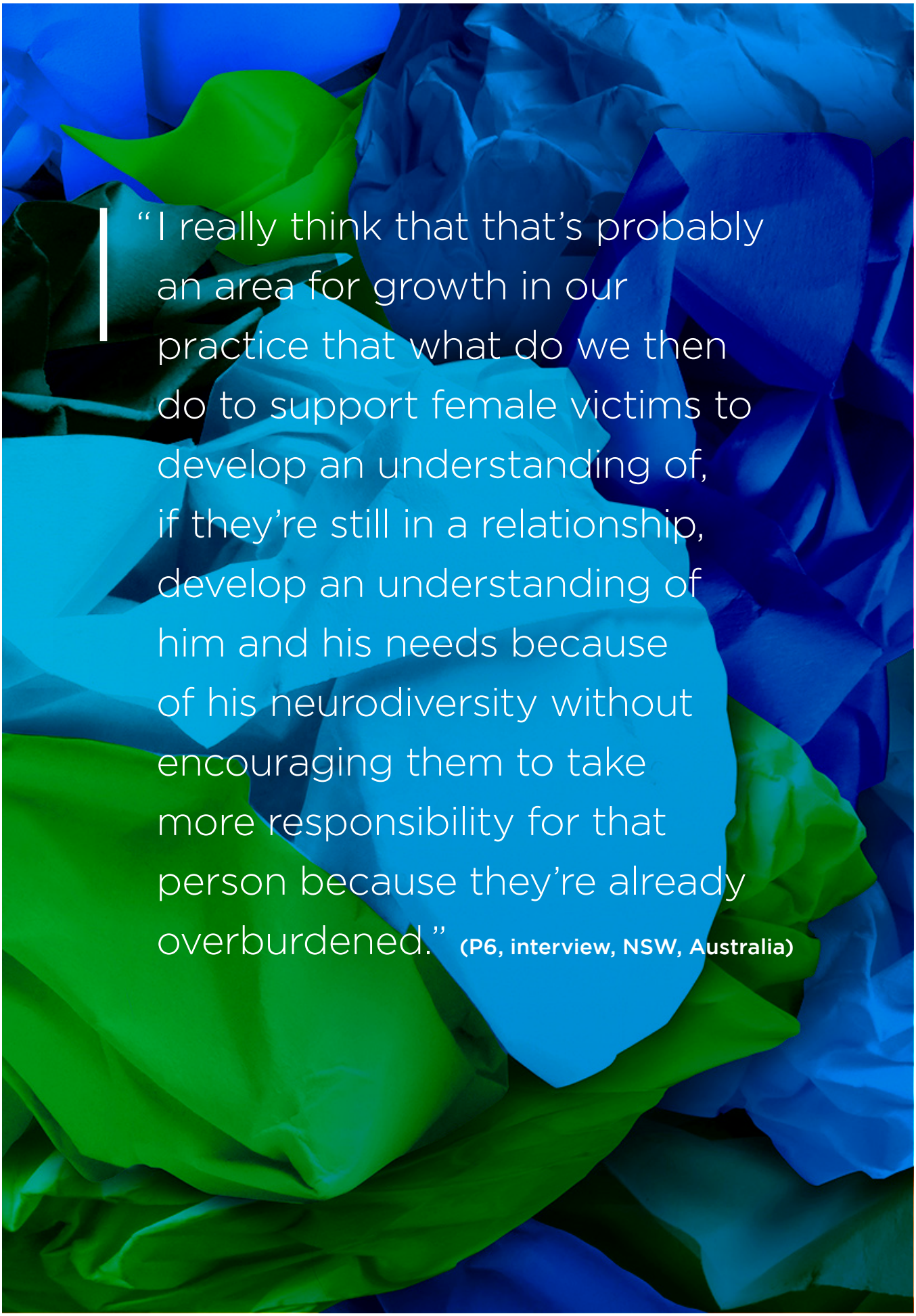
> *"Multiagency working [is needed] with Autistic/ADHD professionals involved. However, in my experience the people we have had referrals for that have been diagnosed with Asperger's and ADHD rarely seem to have the sufficient support in place that they feel they need or they are endlessly waiting for a referral to be processed. One person had been waiting over 2 years from GP referral while open to us."* (survey, UK)

Another survey respondent within the criminal justice sector was able to provide a more positive account regarding multiagency working, where there was prior diagnosis, and how this contributed to a more responsive and meaningful service response:

> *"If someone is diagnosed then we ask if the psychologist doing the assessment whether or not they would be able to engage with the programme and also if it would be meaningful for them, and what we need to do work wise to best engage them. We can also refer to local services who specialise with ASD to ensure we are working as responsively as we can with the individual and they can adapt work/exercises etc accordingly if needed."* (survey, UK)

Finally, one interviewee whose organisation reportedly had all the skills, training, and knowledge required to work with neurodivergent people and manage risk to (ex)partners, said she was often questioned about the cost by referrers, had to justify and/or reduce, fees and run free services to ensure that her clients had the follow-on support they needed. They explained:

> *"It's very complicated too because we'll get referrals for treatment and then referring professionals will say to me, "Why are your services so expensive? I could just send the client to so-and-so and they are half your cost," which is likely an exaggeration to the price difference, but, the "They're half your cost," framework is an evident priority to initial consideration of services. What is the least expensive agency? Our response is, "Well, that's not best practice, is it?" To send clients to a treatment provider who lacks the specialty training simply because they're a lower fee'd agency shows lack of priority for clients to receive services that meet their learning and/or other specialised needs. It is difficult, at times, because there's also barriers above us in other systems saying, 'You need to keep your fees down or we will not contract with you.' So it just results in us waiving our services and/or feeling forced to reduce our fees to near unmanageable levels to match costs to agencies who provide services to clients without neurodiversity or non-traditional learning needs just to be able to be considered to serve the population we specialise in treating."* (P8, interview, US)



> "I really think that that's probably an area for growth in our practice that what do we then do to support female victims to develop an understanding of, if they're still in a relationship, develop an understanding of him and his needs because of his neurodiversity without encouraging them to take more responsibility for that person because they're already overburdened." **(P6, interview, NSW, Australia)**

Conclusion

This research was undertaken to build current understanding on how practitioners working in family violence perpetrator interventions can be more responsive to neurodivergent, autistic and/or ADHD men, without a learning disability. The study sought to document current practices as well as explore the merits of practice enhancements and amendments to better meet the needs of this perpetrator cohort.

Through the survey and during the interview, practitioners acknowledged the individual challenges experienced by neurodivergent men, as well as the operational challenges in providing the services needed by this group of perpetrators. Crucially, practitioners emphasised that the lack of awareness of diagnosis meant that these needs were not always addressed and, that neurodivergent men may wrongly be perceived by practitioners as deliberately disruptive or challenging.

Practitioners suggested a variety of simple 'reasonable adjustments' that could be made to ensure the environment and programmes were more 'neurodivergent friendly'. This included flexibility in programme structure such as one to one and/or online formats, although remote access also presented some challenges that need to be considered within the context of complex domestic abuse perpetrator work. Evident throughout the interviews and survey, was a realisation amongst practitioners that each person's circumstances are different, and that group work or one to one should not be seen as the first or only option. Each person should be consulted and assessed on their own merit; neurodivergent men should not be excluded on a pre-set of assumptions. Though it was recognised as not constituting the deciding factor, practitioners noted that neurodivergent men can strengthen mainstream groupwork because they can encourage the wider group (including practitioners) to 'think outside of the box' regarding discussing problems and creating solutions. This was viewed as particularly valuable where there is a neurodivergence-knowledgeable practitioner in the room to recognise and facilitate such discussions.

That said, practitioners readily recognised that this cohort of perpetrators need much more than what would be considered reasonable adjustments to their environment and programme structure, which is of theoretical and practical importance. Firstly, and supporting previous research[20] practitioners said that domestic abuse cannot and should not be medicalised as autism and/or ADHD as this can lead to unnecessary stigmatisation of neurodivergent people and runs the risk of absolving abusive men of responsibility. This can, ultimately, limit the effectiveness of perpetrator programmes. Practitioners said that understanding what constitutes abusive behaviour and being able to disentangle this from neurodivergent presentations and other 'wounds and intersectionalities' is of central importance. As suggested by them,this clearly has implications for working with neurodivergent men and their (ex)partners, to ensure that expectations around what can and cannot be changed is managed, and to avoid placing unnecessary burden on victim-survivors who may inadvertently take on more responsibility for the perpetrator.

Effective intervention and engagement require a highly trained and supported workforce with significant therapeutic, neurodivergence, gender and risk informed skills and experience. According to this research, neurodivergent practitioners also significantly enhanced the quality of the service on offer. Unfortunately, the dearth of skills and/or neurodivergent people working in this area was viewed as a challenge for the future, although one that those who participated in this study were willing to take on.

There were other examples from which current practice in the UK and Australia can learn and build upon. Integrated services/co-located were viewed favourably by practitioners where teams of varied skills, qualifications and experience came together to work in ways where each individual worked to their strengths and knowledge and met regularly to discuss cases, provide tailored responses and manage risk. This finding supports previous research

that integrated and/or tailored responses, including ADHD treatment, can reduce intimate partner abuse[21]. There was evidence that case work and multiagency working could combine various services to ensure an individuals' needs and risks were met including domestic abuse and specialised services in supporting neurodivergent people. Unfortunately, practitioners recognised that a postcode lottery of services can hinder such as response.

This research is the first to undertake a systematic literature search on the evidence base of perpetrator programmes for autistic and/or ADHD men. It is also the first to explore the availability of such programmes in the UK and Australia, and to obtain the experiences and perspectives of international practitioners and experts who have worked with this cohort. That said, it has raised more questions than answers, highlighting that there is much more research needed in this space.

Further research is needed to examine the experiences of neurodivergent men beyond a handful of case studies[22]. As is more research on the effectiveness of programmes for this cohort of men. Crucially, there is presently no research on the experiences of victim-survivors, including children, who live with neurodivergent men who perpetrate abuse against them. Given that victim-survivors may carry an additional burden, this research should be undertaken as a matter of urgency to ensure policy and practice in this space is informed by lived experience.

The final word is a positive one. Many of those who participated in this study expressed excitement and were keen to carry on the conversation beyond the data collection formalities to ensure, moving forward, services are more responsive to the men they work with and to improve the safety of victim-survivors. One interviewee stated she had 'waited 20 years for this research' to be undertaken. Our hope is that in the 20 years to come, we have the resources available to match the passion and enthusiasm of those who have dedicated their time to this research and shown commitment to progressing this vital work.

Recommendations

This research raises several issues which have important policy and practice implications, and point to the need for further research. The following recommendations emerge from the findings of this study:

1. Assessment and referral processes should include information sharing about autism/ADHD where it is known (unless the individual concerned has requested otherwise) and/or include this question to prospective programme participants.
2. Screening and/or assessment in this area needs further exploration and specific guidelines and training around assessment processes are needed.
3. Neurodivergent programme participants should be provided with a tailored and flexible response to their specific needs including preparation and support for programme engagement. This could include one to one work, but this should not be considered as the first or only option where the individual would be better suited to groupwork.
4. Practice standards in respect of perpetrator programmes should, at the very minimum, include reasonable adjustments that all programme providers can provide at a relatively small cost. This should also be accompanied by basic neurodiversity training.
5. Meaningful engagement means services will need to extend beyond reasonable adjustments. A diverse, competent, and supported workforce are required to untangle and address the range of lived experiences, neurodivergence and other intersectionalities from abusive behaviour that is controlling and harmful. This will also contribute to reducing the risk of misinterpreting behaviour and motivations for behaviour.
6. Recruiting and upskilling neurodivergent people to work within interventions will enhance the quality of perpetrator interventions. Recruitment adverts/strategies should reflect this. In order to achieve this, and build the workforce in this way, job advertisements should encourage neurodivergent people to apply for posts so that programmes are run by people who are representative of their client base.
7. The dearth of skills is a significant challenge. Academic departments, programme providers, policy makers, and specialist organisations, including neurodivergent people, should collaborate to develop a training, recruitment, and retainment strategy to fill this gap
8. Programme providers and specialist organisations should come together to design interventions, programmes and pathways that are responsive to the needs of neurodivergent people. This could operate on a multiagency model and/or via an integrated/co-located service design approach. Research based around pilot specialised interventions could be a way to stimulate this.
9. Government, policy makers, and commissioners have a role in ensuring that programme providers and relevant organisations have the resources needed to make sure their services are responsive to neurodivergent men who perpetrate domestic abuse, and to enhance safety for the victim-survivors of their abuse. This should be acknowledged and reflected in policy.
10. More research on the specific needs and outcomes for neurodivergent men attending perpetrator programmes is needed. This should include the voices of programme participants, victim-survivors, and practitioners.
11. Research is urgently needed on the experiences of victim-survivors, including children, who reside/have contact with a neurodivergent perpetrator of abuse. This research should be designed and carried out to inform enhanced perpetrator programme content and family safety contact work.

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Full project details available at www.nicolerenehan.com

About the researchers

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References

1. Singer, J. (2017). *Neurodiversity: The birth of an idea.*
2. World Health Organisation https://www.who.int/news-room/fact-sheets/detail/violence-against-women
3. Holtzworth-Munroe, A. and Stuart, G.L. (1994). Typologies of male batterers: three subtypes and the differences among them. *Psychological bulletin*, 116(3), p.476.
4. Holtzworth-Munroe, Amy and Jeffrey C. Meehan. (2004). "Typologies of Men Who Are Maritally Violent Scientific and Clinical Implications." *Journal of Interpersonal Violence* 19(12):1369–1389.
5. Kelly, J.B. and Johnson, M.P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family court review*, 46(3), pp.476-499.
6. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme' (available at https://www.research.manchester.ac.uk/portal/en/researchers/nicole-renehan(bc450141-f355-4c47-b674-731284e4796f)/theses.html)
7. Neurodiversity in the Criminal Justice System: A review of the evidence https://www.justiceinspectorates.gov.uk/hmicfrs/publications/neurodiversity-in-the-criminal-justice-system/
8. Buitelaar, N.J., Posthumus, J.A., Bijlenga, D. and Buitelaar, J.K. (2021). The impact of ADHD treatment on intimate partner violence in a forensic psychiatry setting. *Journal of attention disorders*, 25(7).
9. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme' (available at https://www.research.manchester.ac.uk/portal/en/researchers/nicole-renehan(bc450141-f355-4c47-b674-731284e4796f)/theses.html)
10. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme' (thesis).
11. See here for information regarding the Do-It Profiler https://doitprofiler.com/
12. Updated European Consensus Statement on diagnosis and treatment of adult ADHD https://pubmed.ncbi.nlm.nih.gov/30453134/
13. Attention deficit hyperactivity disorder: diagnosis and management https://pubmed.ncbi.nlm.nih.gov/30453134/
14. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme: thesis summary and key findings report (available at https://www.research.manchester.ac.uk/portal/en/researchers/nicole-renehan(bc450141-f355-4c47-b674-731284e4796f)/theses.html)
15. Renehan, N. (2021). Building Better Relationships? Summary of thesis and key findings report (available at https://www.research.manchester.ac.uk/portal/en/publications/building-better-relationships-interrogating-the-black-box-of-a-statutory-domestic-violence-perpetrator-program(55e4ffe1-d031-4728-95ad-bc2164750a00).html)
16. Ellis Devitt, K. (2022). Understanding men who perpetrate domestic abuse (available at https://www.russellwebster.com/understanding-men-who-perpetrate-domestic-abuse/)
17. Gadd, D. and Corr, M.L. (2017). Beyond Typologies: Foregrounding Meaning and Motive in Domestic Violence Perpetration (available at https://www.tandfonline.com/doi/full/10.1080/01639625.2016.1197685)
18. Gadd, D., Corr, M.L., Fox, C.L. and Butler, I. (2013). From Boys to Men: Phrase Three Key Findings (available at http://www.boystomenproject.com/phase-3-research-findings/)
19. Jones, A.S., D'Agostino Jr, R.B., Gondolf, E.W. and Heckert, A. (2004). Assessing the effect of batterer programme completion on reassault using propensity scores. *Journal of Interpersonal Violence*, 19(9).
20. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme' (thesis).
21. Buitelaar, N.J., Posthumus, J.A., Bijlenga, D. and Buitelaar, J.K. (2021). The impact of ADHD treatment on intimate partner violence in a forensic psychiatry setting. *Journal of attention disorders*, 25(7).
22. Renehan, N. (2021). Building Better Relationships? Interrogating the 'black box' of a statutory domestic violence perpetrator programme (thesis).

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