WHAT WORKS IN DV PREVENTION - CONTEXT

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Evidence for the Prevention of Domestic Violence & Abuse, November 2015

BACKGROUND

EARLY INTERVENTION FOUNDATION

EIF report:
EARLY INTERVENTION IN DOMESTIC VIOLENCE AND ABUSE

NSPCC

Cruelty to children must stop. FULL STOP.

CONDUCIVE FACTORS

- Cultural, historical, economic structures
  - Eg gender inequality, media violence
- Community-level factors
  - Eg poverty, ‘failed sanctions’
- Peer and family interaction
  - Eg gender stereotypes, family stress
- “Life history”
  - Eg early trauma, substance abuse

Taken from: *Factors at play in the perpetration of violence against women, violence against children and sexual orientation violence,* Hagemann-White et al

STAGES OF PREVENTION

Range of interventions with reduction/ prevention of DV as target outcome:

- Universal services/ primary prevention
  - *Eg awareness raising campaigns with young people*
- Early intervention/ secondary prevention
  - *Eg focus on families at risk*
- Late intervention/ tertiary prevention
  - *Eg perpetrator programmes, work with victims*

"Late" intervention with families (inc. work with children)

Early intervention against intergenerational DV

KEY QUESTIONS FOR TODAY

How can we improve high-quality evaluation learning?

How do we build shared learning among different methodologies and perspectives?

Work with Perpetrators – Project Mirabal

Professor Nicole Westmarland (@Nwestmarland)
and Professor Liz Kelly (@ProfLizKelly)

Durham University

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The story so far …

- Widespread skepticism, from multiple directions, about the ability for men who use violence to change.
- DVPPs subject to more intense scrutiny than other responses.
- Internationally, research shows mixed results.
- Limited research in the UK – particularly Scotland - is fairly positive.
- UK specific model – both inside and outside the CJS.

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Istanbul convention

State parties should –

- ‘Set up or support programmes aimed at teaching perpetrators of domestic violence to adopt non-violent behaviours.’

- ‘Shall ensure that the safety of, and support for, the human rights of victims are of primary concern and that, where appropriate, these programmes are set up and implemented in close coordination with specialist services for victims.’

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Project Mirabal

- Broad and long programme of research.
- Main aim – to understand what DVPPs contribute to coordinated community approaches to domestic violence.
- Other benefits
- Today – to measure change among men on non CJS DVPPs.

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What counts as success?

1. An improved relationship between men on programmes and their partners/ex-partners which is underpinned by respect and effective communication.
2. For partners/ex-partners to have an expanded ‘space for action’ which empowers through restoring their voice and ability to make choices, whilst improving their well being.
3. Safety and freedom from violence and abuse for women and children.
4. Safe, positive and shared parenting.
5. Enhanced awareness of self and others for men on programmes, including an understanding of the impact that domestic violence has had on their partner and children.
6. For children, safer, healthier childhoods in which they feel heard and cared about.

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Research design

- Longitudinal telephone survey (quantitative)
  - 100 women whose partners or ex-partners had attended a programme
  - Women whose partners or ex-partners had not attended a programme
  - Before the programme to 12 months after the start date.
  - 5 interviews covering 6 time points.
- Longitudinal in-depth interviews (qualitative)
  - 64 men on programmes
  - 48 partners or ex partners of men on programmes
  - 2 interviews near the start and the end of the programme

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For the majority of women whose partners and ex-partners attended a DVPP, the physical and sexual violence stopped completely.

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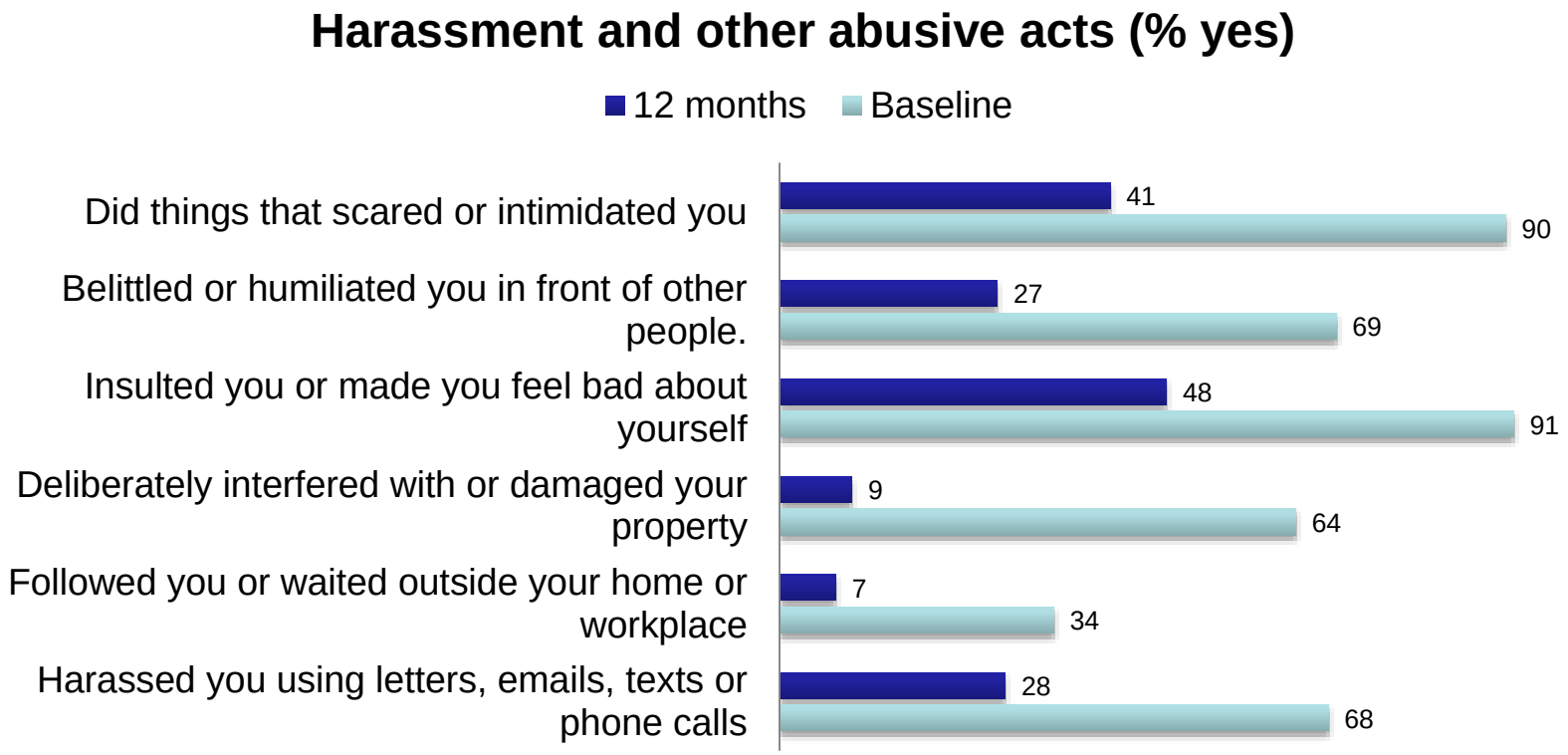
Whilst the use of harassment and abuse also showed strong and consistent decreases, it remained in the lives of around half the women.



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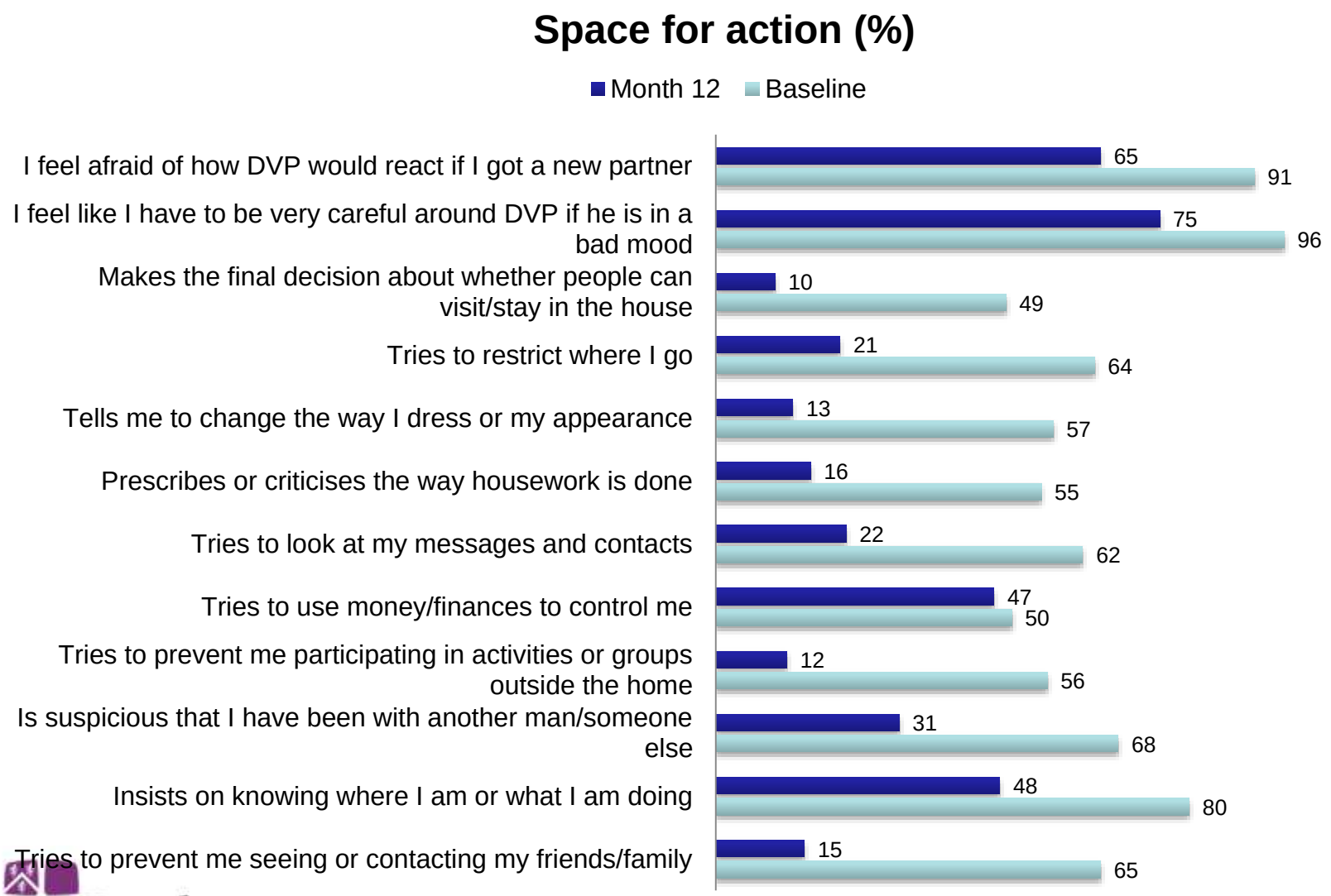
Expanded space for action



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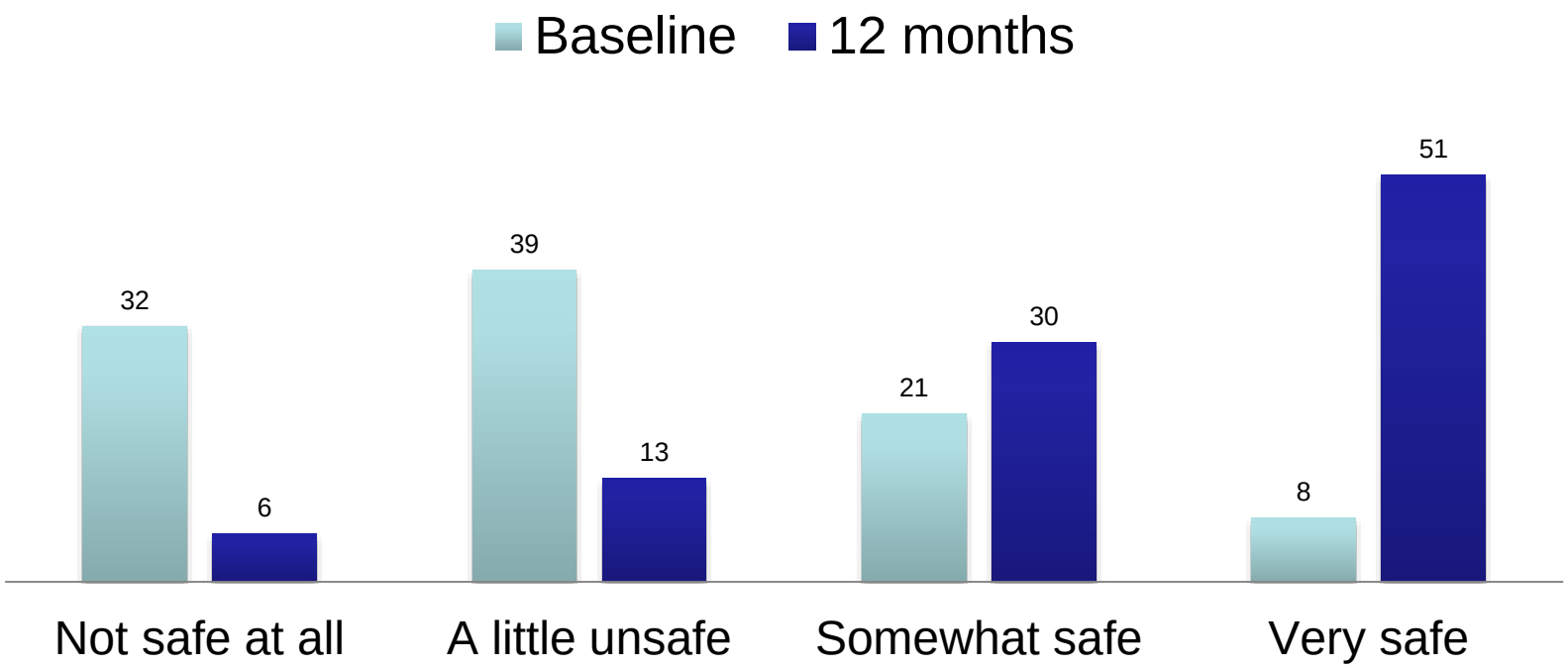
Self-perceived safety

Figure 6. How safe do you feel? (%)



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Project Mirabal strengths

- Multi-site study
- Similar programme types
- Independent
- Significant qualitative element
- Critical incident analysis/everyday incident analysis
- High levels of disclosures
- Not just does it work, but how and why?
- Located within CCR
- Broader measures of ‘success’ grounded in stakeholder views
- Openness of research tools
- Echoes much of what we know about domestic violence from interventions with victim-survivors
- Feminist perspective

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Project Mirabal Limitations

- Some of the measures of success in the quantitative study have internal validity issues
- The comparison group was differed in two key ways –
  - Separation
  - Reasons for no child contact
- Quantitative sample size has limited our statistical analyses
- Some groups of women may be less likely to access women's support and therefore be less likely to be in our sample
- A large proportion of the study considers post separation violence and abuse rather than current/next partner violence and abuse.
- Ethical issues related to placing an additional burden on women to report upon/monitor men's behaviour

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What are we aiming for?

Where is our line on whether something is worthwhile?

The lives of nearly all the women and children in our study were better ‘to some extent’.

An electronic copy of this report and other Project Mirabal publications are available at:

www.dur.ac.uk/criva/projectmirabal

To join Durham University Centre for Research into Violence and Abuse

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MENTALIZATION-BASED TREATMENT FOR ANTISOCIAL PERSONALITY DISORDER

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DSM-5 criteria for ASPD

A. Pervasive pattern of disregard for and violation of rights of others since age 15:

- Failure to conform to social norms
- Deceitfulness
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness
- Reckless disregard for safety of self and others
- Consistent irresponsibility
- Lack of remorse

B. At least 18 years old

C. Conduct disorder < 15 years

D. Antisocial behaviour not due to schizophrenia or mania

Why care about ASPD?

Why care about ASPD?

- Common condition – general prevalence 2-3%; up to 70% prison population
- Associated with considerable morbidity and mortality
- Up to 60% of studies of male perpetrators of domestic violence show antisocial personality pathology
- Costly both to the individual and to society
- Preventable and treatable (NICE Guidelines, 2009) but current lack of effective treatments and services

Current treatment approaches

- Not specifically for ASPD, but anger management, violence, general and sexual offending
- Most based in Criminal Justice System
- Mostly CBT
- Focus on high risk offenders e.g. DSPD, Offender PD Pathway
- Lack of treatment provision in the community

Untreatable or untreated?

NHS
National Institute for
Health and Clinical Excellence

ANTISOCIAL PERSONALITY DISORDER

Implementing NICE guidance

Lack of evidence base

- Only small number of studies have been conducted among people with ASPD
- Challenges of working with ASPD – engagement, risk, substance misuse, co-morbidity
- Confusion over diagnostic criteria and conceptualisations of psychopathy versus ASPD
- Differences in defining and measuring outcome
- Focus on behavioural and symptomatic change rather than personality traits.

Cochrane review (2010)

- Review of all prospective RCTs for individuals with ASPD
- 11 studies involving 471 individuals with ASPD
- Only 2 studies focused solely on ASPD sample
- 11 different psychological interventions examined
- Only 2 studies reported on reconviction, only one on aggression

Cochrane review conclusion

- Significant improvements confined to outcomes related to substance misuse
- No study reported change in any antisocial behaviour
- ‘Further research is urgently needed for this prevalent and costly condition’

Diagnostic confusion

- ICD-10 and DSM-5 describe constellations of behaviours that may be the outcome of different aetiological pathways
- Psychopathy and ASPD not synonymous
- Only 1/3rd individuals with ASPD have severe psychopathy,
- Assess psychopathy independently as a separate dimension
- Higher psychopathy scores predict poorer response to treatment
- Presence of anxiety and depression predict better response to treatment

What is MBT?

What is MBT?

- Psychodynamic treatment developed by Bateman and Fonagy for Borderline Personality Disorder
- Integrates cognitive, psychodynamic and relational components of therapy
- Enables individuals to better examine their own states of mind, understand the minds of others and behave more prosocially
- Mentalization model based on attachment theory
- Increasing evidence that a sub-group of ASPD is a disorder of attachment
- Ability to mentalize protects against violence

Why MBT?

- Trials of MBT for BPD have included patients with ASPD.
- In a trial comparing MBT with structured clinical management (SCM) which included problem solving and social skills, MBT was found to be more effective than SCM in patients with ASPD for reduction in hospital admissions, self-harm and suicide incidents and use of psychotropic medication.
- However, effectiveness of both was reduced when compared with BPD patients without ASPD.

What is mentalization?

- A focus on mental states in oneself and others, especially in explanations of behaviour (Fonagy, 2002)
- "The process by which we interpret the actions of ourselves and others in terms of underlying intentional states such as personal desires, needs, feelings, beliefs and reasons" (Fonagy and Bateman, 2008).
- An essential human capacity underpinning interpersonal relations

Development of mentalization

- Developmental process –normal mentalization develops in the first few years of life in the context of safe and secure child-caregiver relationships
- The infant finds its mind represented in the mind of the other, and develops a sense of self as a social agent, learns to differentiate and represent affect states, and regulate his impulse control.

Abnormal development

- Childhood neglect, emotional, physical or sexual abuse disrupt this developmental process.
- Inadequate maternal responses and disorganised attachment undermine the capacity to mentalize, so that internal states remain confusing, unsymbolised and difficult to regulate.

The antisocial mind

- Primitive emotions, defences, and modes of thinking
- Inadequate regulation of emotions
- Emotions of toddler – envy, shame, boredom, rage and excitement
- Lack of guilt, fear, depression, remorse and sympathy

Mentalizing in ASPD

- Antisocial characteristics stabilize mentalizing by rigidifying relationships e.g. gang hierarchies
- But when relationships are challenged, mentalization collapses exposing feelings of shame, vulnerability and humiliation, which cannot be controlled by representational and emotional processing, but only by violence and control of the other person

Mentalization and violence

- Violence in ASPD is a defensive response to feelings of shame and humiliation, which have their roots in disorders of attachment.
- Violence occurs when there is an inhibition in the capacity for mentalization
- Mentalization protects against violence.

Pilot trial over 2 community sites

Participants

Inclusion criteria

- Men over 25
- SCID-2 diagnosis of ASPD
- Evidence of aggressive acts in 6 months prior to assessment
- Willing to accept treatment
- Able and willing to provide written informed consent

Exclusion criteria

- Current diagnosis for schizophrenia or bipolar disorder
- Substance or alcohol dependence
- Psychopathy score above 25
- Learning disability or significant cognitive impairment
- Inadequate English to participate in informed consent and group therapy

The patients

- Age – thirty to fifty
- Depression and anxiety prominent
- Moderate psychopathy scores
- History of drug and alcohol abuse, some still abusing
- All report difficulties in interpersonal relationships
- Many are socially isolated, afraid to go out for fear they will act on violent impulses

Structure of MBT-ASPD

- Initial assessment including psycho-education
- Group therapy weekly for one hour plus individual therapy monthly for one hour
- Crisis and risk management and psychiatric review
- Psychotropic medication only for co-morbid conditions, not ASPD per se
- Manualised treatment, video recording of sessions and supervision to ensure adherence to model

Principles of treatment

- Focus on techniques that facilitate mentalizing
- Focus on violent and aggressive behaviours and link to mental states
- Focus on improving self-regard and social and interpersonal awareness
- Avoid interventions aimed at considering effects of actions on others e.g. victim empathy
- Link group attendance to provision of individual session

Who's is in charge?

Hierarchy and power

- ASPD patients experience relationships in terms of power and control
- Avoid assuming position of power in relation to patient, by readily apologising for perceived errors and accepting criticism
- Developing shared code of conduct is key task of group
- Highlight and explore their own code of conduct by discussing interactions with others and what leads to violence

Group cohesion

Shame and disrespect

- Anger easily activated when describing emotive topics –mentalization stops at this stage
- Threat to self-esteem and shame common trigger for violence 'walking on egg shells'
- Need to be careful about expecting patients to examine their feelings – often feel stupid or unable to put feelings into words
- Hypersensitivity to being criticised or corrected - 'narcissistic fragility'

Pilot results

- Problems with engagement, drop-out, attendance, minor boundary violations
- 1/3 drop out rate
- Those that do complete treatment show significant decrease in self-reported aggression on OAS-M, and scores on Brief Symptom Inventory

UK PD Offender Pathways Strategy

- Coalition Government's strategy for offenders with personality disorders after decommissioning of DSPD programmes
- Public consultation 2011, piloted 2012, national implementation commenced in April 2013
- Services jointly commissioned by NHS and Ministry of Justice (National Offender Management Service)
- Overall aim of new strategy is to improve public protection and psychological health

Aims of PD Offender Pathways Strategy

- Improved identification, assessment and case formulation of offenders with severe PD
- Improved risk assessment, sentence planning and case management of offenders in the community
- New treatment services in prisons and community environments
- New progression environments in prisons and approved premises
- Workforce development

Principles of PD Offender Strategy

- Strategy underpinned by attachment theory
- PD offender population is shared responsibility of NOMS and the NHS
- Whole systems approach across the criminal justice system and the NHS recognising all stages of offender's journey
- Treatment and management is psychologically informed and led by psychologically trained staff
- Focuses on relationships and the social context
- Experiences and perceptions of offenders and staff important in developing services

Furthering the PD Offender Pathways Strategy: MBT/ASPD

- Development of new MBT/ASPD community services across 13 sites in England and Wales funded by NHS England and MoJ
- Sites are current National Probation Service /Health Service Providers delivering the PD community service specification for high risk offenders
- Services delivered jointly in probation premises by probation staff and health service provider clinicians
- Tavistock and Portman NHS FT is lead coordinating site for service implementation, delivery and project management
- Training and supervision provided by Anna Freud Centre

Challenges to date

- Privatisation and restructuring of probation service: low staff morale, increased work loads, chaos
- Poor data systems
- Changing existing anti-therapeutic probation culture
- Governance issues: risk/confidentiality/disclosure/record keeping/incident reporting
- Engaging most high risk subsection of ASPD offender population
- Persuading offenders and offender managers to randomise

Multi site RCT

- Research led by Professor Peter Fonagy, UCL
- Initial pilot feasibility RCT in 4 sites with view to expanding RCT to all sites
- Research Question: Is Probation As Usual (PAU) supplemented with Mentalization Based Treatment (MBT) more effective and cost-effective than PAU only for reducing aggressive antisocial behaviour in offenders under probation who meet DSM-5 criteria for ASPD?

Participating sites

LONDON

- East London
- North London
- Southeast London
- Southwest London

SOUTH

- Bristol
- Devon and Cornwall
- Wales

MIDLANDS

- Nottinghamshire
- Lincolnshire
- Staffordshire

NORTH

- Yorkshire
- Lancashire
- Merseyside

Collaboration for Leadership in Applied Health Research and Care East of England

NHS National Institute for Health Research

IMPRoving Outcomes for children exposed to domestic VIolencE (IMPROVE)

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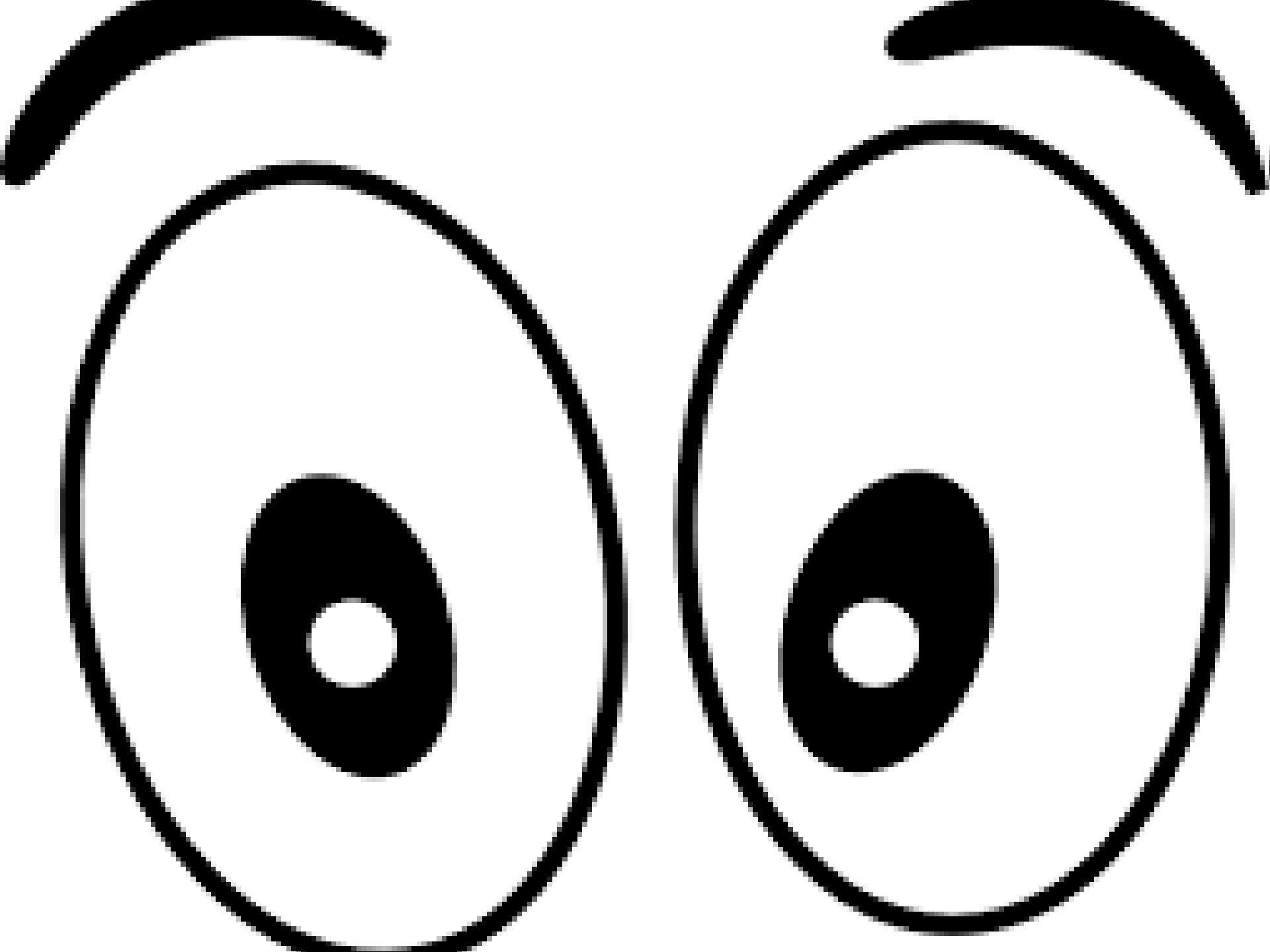


3% of children and young people aged <18 witness DVA each year

Radford et al 2011


Wait…what about a trial? It'll only take 3 years.


GOOD
BEST
BETTER


priorities

What is already known?

- Systematic review trials
- Systematic review qualitative
- Modelling

What is relevant to users?

Qualitative studies

UK service evaluation

Consultation

Broader context?

- Qualitative studies
- Consultation
- UK specialist service provision

Findings

Quantity of evidence

Quality of evidence

Evidence gaps

‘Best bet’ interventions

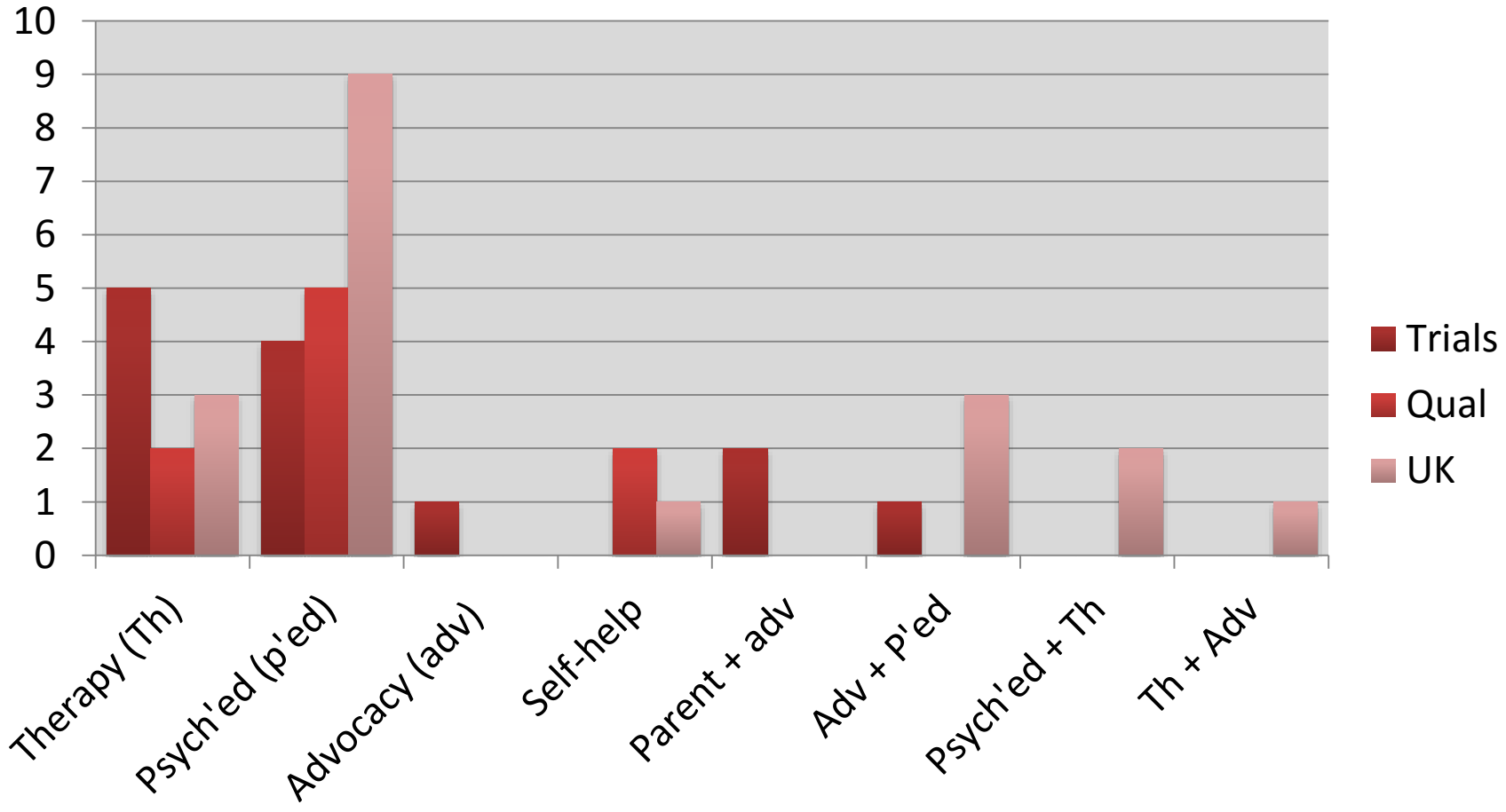
Evidence base

13	9	0	2	19
Trials	Qual. studies	UK trials	UK qual. Studies	Service evals

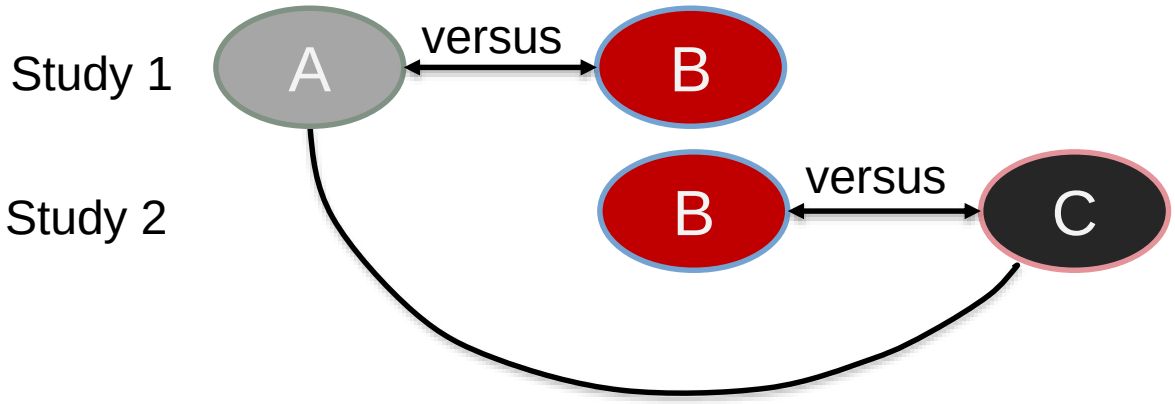
If we want more evidence based practice, we need more practice based evidence

Larry W. Green (2004)

Breadth and depth



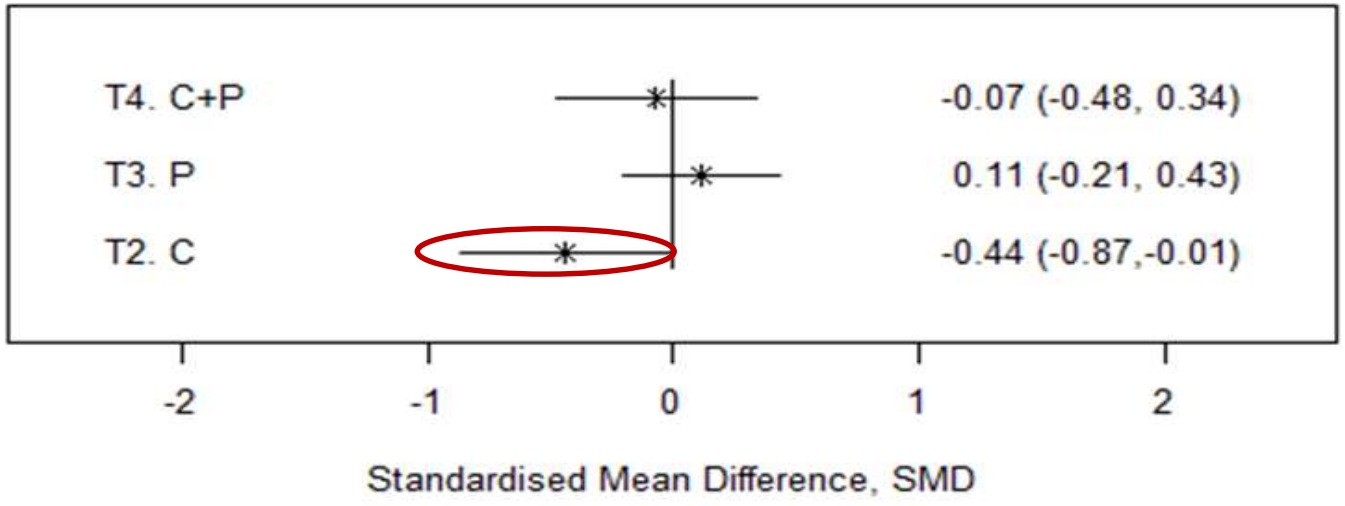
Modelling relative effects of interventions



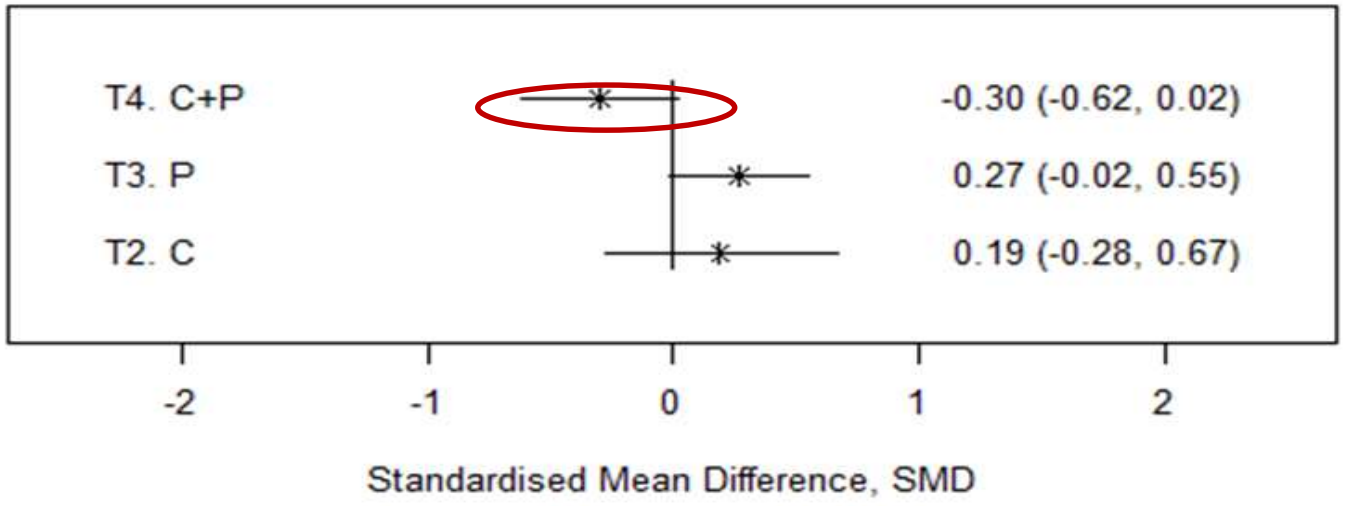
Assumptions

- people are similar in all studies
- setting of the studies are similar
- interventions classified as the same are similar

RCTs Only, MH Outcomes



RCTs Only, BEH Outcomes



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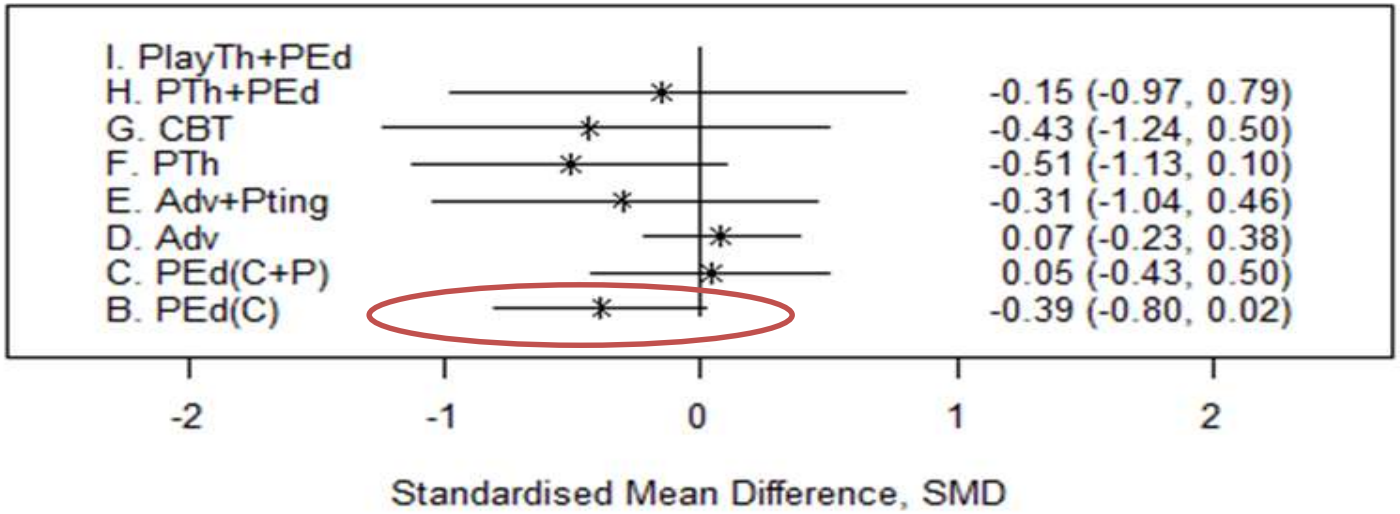
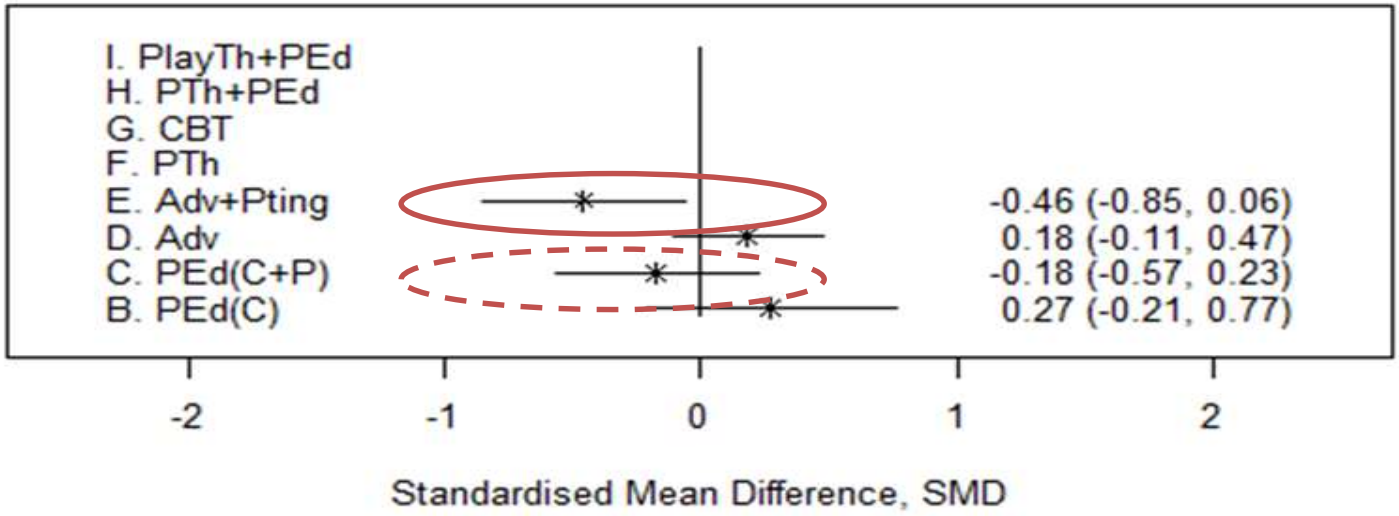


RCTs Only, BEH Outcomes



Best bets?

Mental Health

Delivered to children

Group based

Psychoeducation

Behaviour

Delivered to parent + child

Parent skills + advocacy

Parallel group based psychoeducation

Acceptability of Psychoeducation

Assimilating experiences

- I am not alone
- Talking about abuse
- Abuse is not ok
- Attribution of responsibility
- Safety planning
- Impact on children

Readiness

'One step in a long journey'

Adjustment

- Self worth
- Self esteem
- Reduced behavioural problems

Parent-child relations

- Communication
- Sensitive parenting

Emotional literacy and regulation

- Understanding emotions
- Empowerment to express self
- Adaptive coping strategies
- Ability to regulate negative emotions

Positive experiences

- Having fun
- Making friends

?


TWO WAY
TRAFFIC


priorities

?

Focus?

Funding?

Culture?


THIS
DOOR
LEADS
TO
NOWHERE

What is my role?

Evaluation of NSPCC Domestic Abuse Interventions

Nicola McConnell and Emma Smith

NSPCC Evaluation Department

2nd November 2015

Evidence for the prevention of Domestic Violence & Abuse

NPC New Philanthropy Capital

EARLY INTERVENTION FOUNDATION

www.nspcc.org.uk/evidencehub

Improving the evidence : our priorities

- **Evaluation design**
- Mixed methods
- Before T1 and After T2
- Post intervention follow up T3
- Clinical significance
- Comparison groups
- Outcomes and process
- Multiple participants

- **Ethical issues**
- REC
- Guidance and training
- Safeguarding
- The child's voice
- Multiple perspectives
- Practice based research
- Service development

Evaluation of Caring Dads: Safer Children

Caring Dads – Scott & Kelly

5 NSPCC service centres
50+ groups delivered
300+ fathers started CDSC
190+ completed programme
500+ evaluation participants

Summary of quantitative findings

- Fathers reported statistically significant improvements in:
  - his stress experienced as a parent
  - his perceptions of his child's strengths and behavioural difficulties
  - his behaviour towards his child or children

- Children's reports suggest improvements in his behaviour toward them.

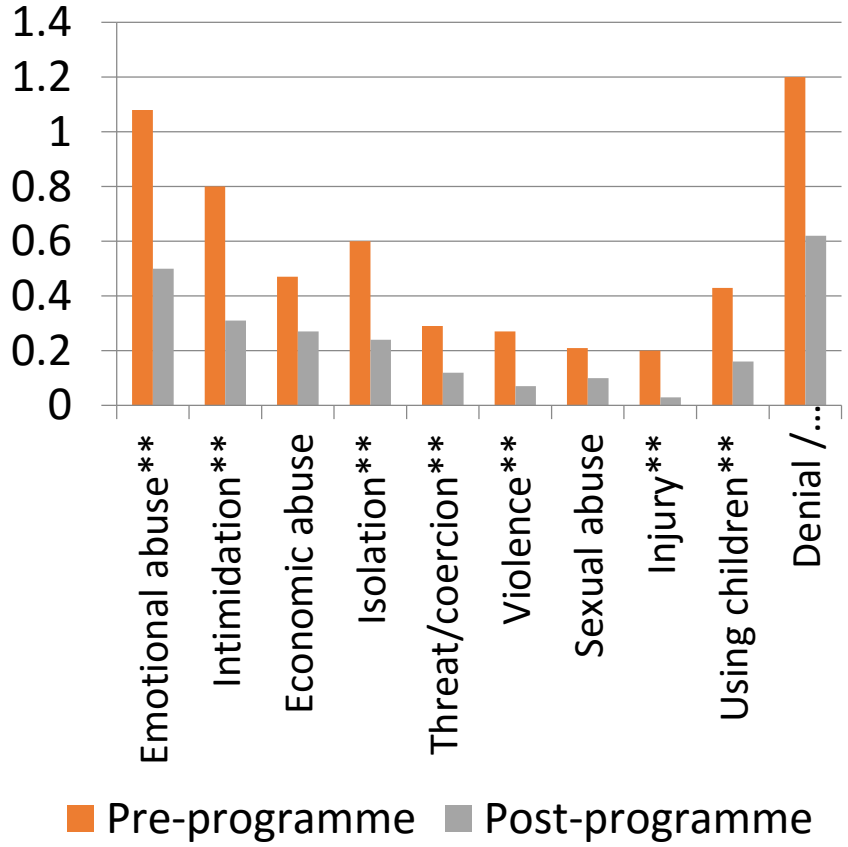
- Partners and fathers reported statistically significant improvements in:
  - his behaviour towards her

- Partners reported statistically significant improvements in
  - her depression, anxiety and inward directed irritability

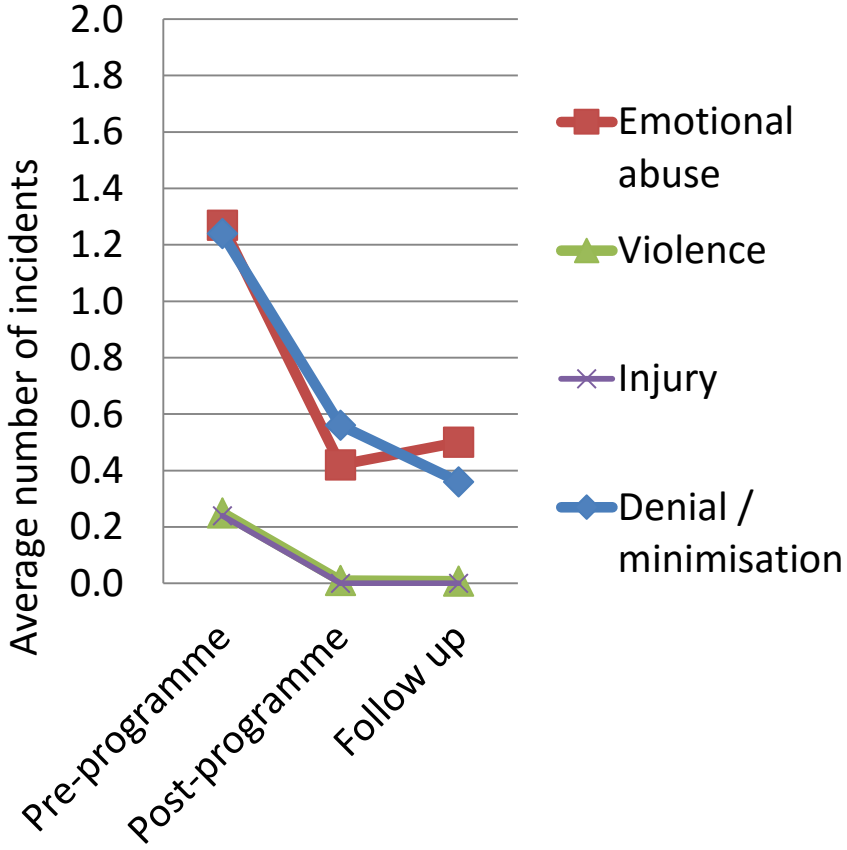
- Child wellbeing results suggest improvement but not statistically significant

Incidents of controlling behaviour

Average number of incidents reported, pre- and post-programme scores



Average number of incidents reported at each time point.



Outcomes recorded in case notes

When fathers demonstrated learning:

- Child removed from CP Register or Plan
- Frequency of contact increased
- Contact no longer supervised
- Maintenance of positive contact
- Father returned to family home
- Child returned to father's care

If not:

- Child remained on register, plan or in care
- No changes to supervised contact
- Recommended continued services involvement
- Safety planning
- Referrals to other services

Positive changes: partners

- Additionally partner also noticed he was:
  - Calmer and more thoughtful
  - Willing to talk through problems
  - Insightful about his own behaviour
  - Aware of the impact of domestic abuse
  - Less likely to escalate arguments or be annoyed by others
  - Able to apologise

- With the children he was:
  - More confident
  - Giving more of his time
  - More knowledgeable about what they needed
  - Giving more praise
  - More supportive of her

Positive changes: children

- Children noticed that their father was changing in the following ways:
  - Kinder, nicer
  - Playing and doing more with them
  - Easier to get on with, less moody
  - Treating them appropriately for their age
  - Listening and trying to understand them
  - Shouting less
  - Arguing less with their mother
  - More interested in their school work

However..

- Some partners could not comment (limited contact with their partner).

- Some fathers did not change or did not change sufficiently:
  - Still shouting or being threatening
  - Unreliable, e.g. not turning up to agreed contact
  - Still blaming others for circumstances created by his behaviour
  - Criticising or undermining her parenting
  - Expecting her to trust him too soon

- Some fathers only partially or temporarily changed
  - Homework instigated false hopes that he might change
  - Better with children but still trying to control partner
  - Initially much better but starting to return to old behaviour

DART: Domestic Abuse Recovering Together

DART aims:

- Rebuild mother/child relationship
- Support other aspects of recovery

Theory of change:

Child recovery from DA facilitated by non-abusing parent Mother/child relationship may need strengthening to support this

Innovative programme with:

- Joint and separate sessions
- 2.5 hour sessions for 10 weeks
- Developed by Gwynne Rayns

Key improvements and statistical findings

DART Mothers

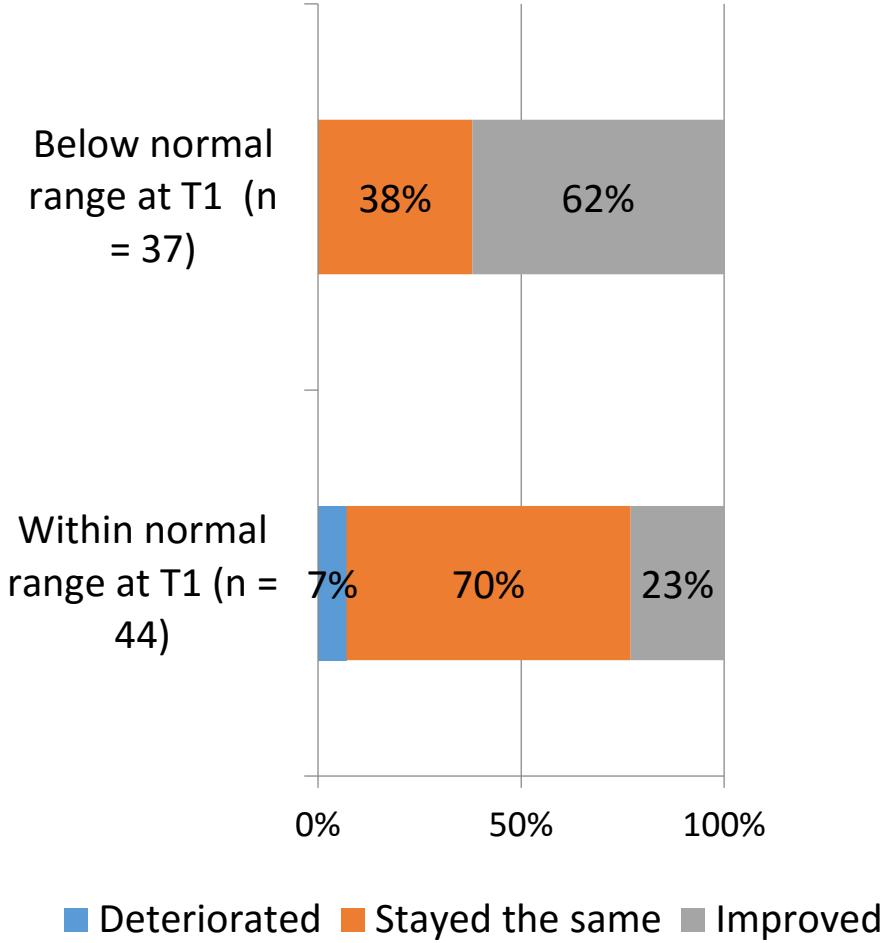
- Greater self esteem
- More confidence in parenting
- Warmer and more affectionate to child
- Fewer ‘rejecting’ parenting behaviours
- Rated DART highly (4.8 out of 5)
- Most improvements maintained at T3

DART Children

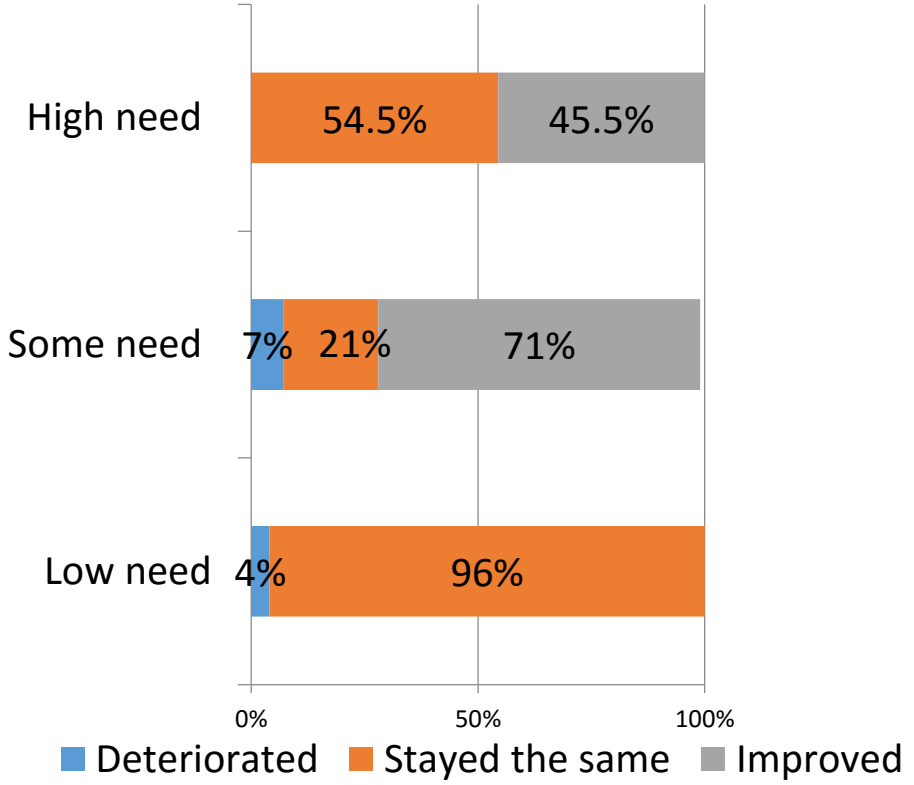
- Fewer emotional and behavioural difficulties
- Greater improvements than comparison group
- Reported mother as warmer and more affectionate
- Rated DART highly (4.7 out of 5)
- Most improvements maintained at T3

Changes to clinical categories:

Mother's self-esteem



Children's 'total difficulties' (SDQ)



What worked well?

Joint sessions:

Bonding activities, tailored parenting advice, discuss abuse

Creative activities:

Child-friendly, suitable for sensitive topics, considered fun, child able to illustrate experience of DA (very powerful)

Skilled practitioners:

Open-minded, non-judgemental, safe environment created

Separate sessions:

Peer support, experiences shared in more depth

What were the barriers?

Initial lack of flexibility

- Original manual ‘too prescriptive’ need to adapt to individual needs

Contact with perpetrator

- Could disrupt progress when child hears negative things about mother. Some mothers resumed abusive relationship.

- **Disruptive group members**
- Some overly dominant, inappropriate comments

Mothers not ready for group work

Anxious, overwhelmed, not ready to focus on child’s needs

Improving the evidence base: CDSC

- **Measuring change: what to measure and according to whom?**
- Accessible respondents or reliable respondents
- Ethical considerations
- Data quality – internal training and review
- **Operational and practice priorities versus evaluation priorities**
- Balancing rigour with timescales and costs
- Allocation of practitioner time to tasks
- Obstacle to motivation and engagement

Improving the evidence base: DART

- **Select measures with clinical categories**
- Can inform what works for whom
- More useful for practice interpretation
- **Recruit comparison/control group from the outset**
- Sample size and characteristics
- Organisational policy revised to allow waiting list designs
- **Consider measurement of cost effectiveness at design stage**
- Informs research design and outcomes measured

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- Smith, E. et al (2015) **Strengthening the Mother-Child Relationship Following Domestic Abuse: Service Evaluation**. Child Abuse Review 24: 261-273.

- Forthcoming final reports: **http://www.nspcc.org.uk/evidence**

Preventative Work on Domestic Abuse with Children and Young People in Schools

Nicky Stanley, Professor of Social Work, Connect Centre, University of Central Lancashire, UK

Interventions to Prevent Domestic Abuse – Key Questions

Who's it for? Can one size fit all? Are we addressing victimization/perpetration/both?

When? At what developmental stage should interventions be delivered?

Where? Most interventions developed in domestic abuse sector but delivered by and in the context of education

By Whom? Teachers? Domestic abuse specialists? Actors? Young people themselves?

What? What type of change are we seeking? Are we preventing children from domestic abuse in the future or seeking to protect from current exposure in their own or parents' relationships?

How? What works in what context? What makes it work?

Preventing Domestic Abuse for Children and Young People (PEACH): A Mixed Knowledge Review

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Available at:
http://www.journalslibrary.nihr.ac.uk/phr/volume-3/issue-7#abstract

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University of BRISTOL

NHS National Institute for Health Research

PSHE Association

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women's aid until women & children are safe www.womensaid.org.uk

PEACH study – a mixed methods review

- Informed by realist principles – what works for whom in what setting?
- Online mapping survey - 18 local authorities across 4 UK nations
- Systematic review of existing peer reviewed and UK grey literature
- Consultation with key stakeholders: nine expert group meetings (media, education, young people) and 16 individual interviews in UK, Australia, New Zealand, Canada & US

The UK Context: Mapping Survey Findings

- 59 % respondents (232) reported recent/current local programmes/campaigns
- 98 programmes identified
- Majority delivered in secondary schools but nearly a third of school programmes under 11s
- Small number of community-based

or media campaigns reported

Patchy Picture

- Lack of sustainability – over half programmes ran for less than 2 years
- Length of programmes varied – lack of rationale for length and dose
- Funding short-term & unpredictable
- Main funders – community safety, independent sector, little investment from health.

Context Matters

National policy: framing delivery of preventive interventions as a statutory requirement assists implementation.

Regional implementation: differing conceptions and awareness of domestic abuse & levels of gender equality can make transfer across cultures and populations difficult (see Miller et al 2014; Hamby et al 2012).

School implementation: organisational readiness embracing parents, school management, local community and relevant local agencies ('whole school approach').

Linking school interventions to local support

- Interventions to be linked to appropriate services for those who disclose experiences of abuse:

'it makes people aware but then they need the help afterwards' (Young People's Consultation Group 1)

- Services should be confidential and can be accessed without scrutiny
- Availability of support in case of disclosure reassuring for schools
- Link between primary prevention and early intervention

Audiences

- Nearly a third of UK school programmes aimed at under 11s but no controlled studies with children aged under 10
- Boys increasingly identified as key target for change:

'…these programmes that are trying to somehow help girls be victimised less then it's tough because really it's totally up to whoever might victimise them to change their behaviour…Primarily, you want to target potential perpetrators…' (Expert 1, USA)

- Some boys reported finding the programmes 'anti-men' or 'sexist' and resisted programme messages.
- Little attention paid to addressing complexities for marginalised children and young people; lack of attention to LGBT young people
- Small groups of students at higher risk at baseline may have skewed data - programmes may be more/less effective for certain sub-groups. Role for programmes in identifying those already exposed to domestic abuse.

Programme Outcomes

- Systematic review produced 28 quantitative papers, 6 qualitative studies = 22 programmes
- Most programmes aimed to improve knowledge and awareness rather than achieving behavioural change
- Largest effect sizes found in measures of knowledge, tho' differences tended to decrease over time
- Wolfe et al.'s (2009) Fourth R programme only controlled study to show significant and sustained behavioural change - physical dating violence by boys decreased 2.5 years after the programme

Mechanisms and Processes

- Length and structure of interventions varied, some evidence that longer, better resourced programmes = more impact
- Most programmes addressing social norms, explicit in 'bystander programmes' (Katz et al 2011; Miller et al 2012)
- Young people and experts consulted argued for the value of drama/theatre and narrative
- Authenticity achieved through material that delivered emotional charge, which was meaningful to young people and made '*it real*'.
- Authenticity enhanced when interventions delivered by those with relevant expertise or experience including young people themselves.

Authenticity

'We had a fire fighter come in school once and talk to us about fire safety …and he was talking and suddenly…he's seen so many horrific things that he started like properly crying and everything in front of us and he was very embarrassed about it …and, yeah, that changed my opinion …seeing real emotion.'

(Young People's Consultation Group 2)

'It's like in front of you and then you realise, actually, it doesn't happen miles away, you know, it happens here. And it's so close to home and it happens to people that you might know…And so I think drama kind of conveys that a bit more.'

(Young People's Consultation Group 3)

Authenticity and Expertise

Both celebrities who front media campaigns and those delivering schools work need to be perceived as genuine:

'Because you can tell when someone's like bluffing it… especially like teachers, especially when they've been given briefs that they don't know anything about …so obviously whoever's doing it got to have the knowledge… makes more impact.' (Young Peoples's Consultation Group)

Who Should Deliver?

- Domestic abuse specialists offer knowledge and expertise
- But less likely to impact on school culture or provide continuity
- Teachers possess expertise in work with, and have on-going relationships with children
- Some school staff resist teaching on domestic abuse as lack confidence
- Need for training and collaboration in delivery – 45% of programmes delivered by multi-agency teams

Media Campaigns

- Achieve reach: penetrate popular culture, contribute to climate in which interventions are delivered
- Address social norms, used to 'start a conversation'
- Increasingly provide materials for interventions
- Can use narrative as mechanism
- Speak to young people in medium and language where they are proficient and can have ownership
- Pros and cons in using celebrities
- Challenges - cost and 'noise'
- Difficult to evaluate

Key ingredients

- Home-grown programmes more likely to reflect local cultural understandings of domestic abuse and to take account of current awareness
- Whole population interventions harness peer group power but can also identify those at risk who need services – these need to be available
- Interventions need to take account of power differentials particularly in relation to gender and sexuality
- Messages should be positively framed avoiding the blaming that can provoke resistance from some boys
- Teachers need training and support to deliver these programmes – required at the qualifying and post-qualifying levels. School inspection also has a role.
- Children's and young people's perceptions and experiences should be incorporated into interventions and evaluations

Challenges for Research

- Lack of funding for long-term follow-up – only 3 evaluations followed up for 12 months+
- Few evaluations explicit about theories and mechanisms of change – 3 of 22 programmes used logic models
- Using schools for trials makes for difficulties re contamination. Difficult to determine what control arm might be exposed to in class.
- Interventions delivered to 'whole class' – little control re baseline characteristics of samples – group imbalances found in 5 papers (where reported).
- Media campaigns increasingly used but expensive to evaluate robustly

Research gaps = opportunities for incorporating range of methods and perspectives

- Lack of evidence re interventions for younger children – research will require new approaches to capturing children's outcomes and experiences
- To date, little evidence on mode of delivery/who delivers (preoccupation with fidelity) – more use of observation and ethnographic methods?
- Need for more understanding of role of context – requires process data
- Insufficient understanding of optimum length/dose/timing of intervention – need to compare models – researchers need to collaborate

Research gaps = opportunities for incorporating range of methods and perspectives continued

- Little evidence on costs or cost benefits – partnerships with health economists?
- Lack of evidence on relationship between changing attitudes and knowledge and behaviour change – longitudinal studies?
- Different outcomes matter to different stakeholders – programme designers, teachers, dv specialists, parents, children and young people - build these perspectives into research designs.

Measuring success in Domestic Violence Services

MARAC

Becky Rogerson
Chief Officer

My Sisters Place
Domestic Violence Service

Outcomes measures

- **What are we measuring and who for?**

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MARAC Pilot 2013 -2014
Purpose:

- Reduce repeat victimisation to below 40% by March 2014.
- Identify practice indicators to increase the efficiency and effectiveness of the MARAC
- Gain a better understanding of the cases that fail to progress through the MARAC
- Share learning with partners

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Criteria

- More than two repeat referrals in the last 12 months and to have been within the MARAC process for over 12 months.
- Children remain in the property/relationship and/or still open to children's services
- The victim retains a very high risk status
- Victims are prepared to 'engage' at some level (voluntary)

Resources …

- IDVA's
- Practical Support
- Counselling
- EMDR Therapy
- Outreach
- Sanctuary Scheme
- Group work

- Legal Advice
- Homeless Link
- Accommodation
- Training
- Volunteers
- Campaigns
- Men's Worker (new post)

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women's aid
until women & children are safe

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Our Principles…

- Engagement
- Accessability
- Responsivity

The Relationship

Needs Led - Trauma informed

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39 ‘Intractable’ MARAC cases

Adult profile

- 39 Cases = 356 DV Police incidents
- 37 Perpetrators = 500 convictions (variety of offences)
- None of the cases were in the Criminal Justice System.

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Related Children

- 67 Children relate to these 39 cases
    - 20 children have been ‘removed’
    - All children were ‘active’ within Children’s safeguarding

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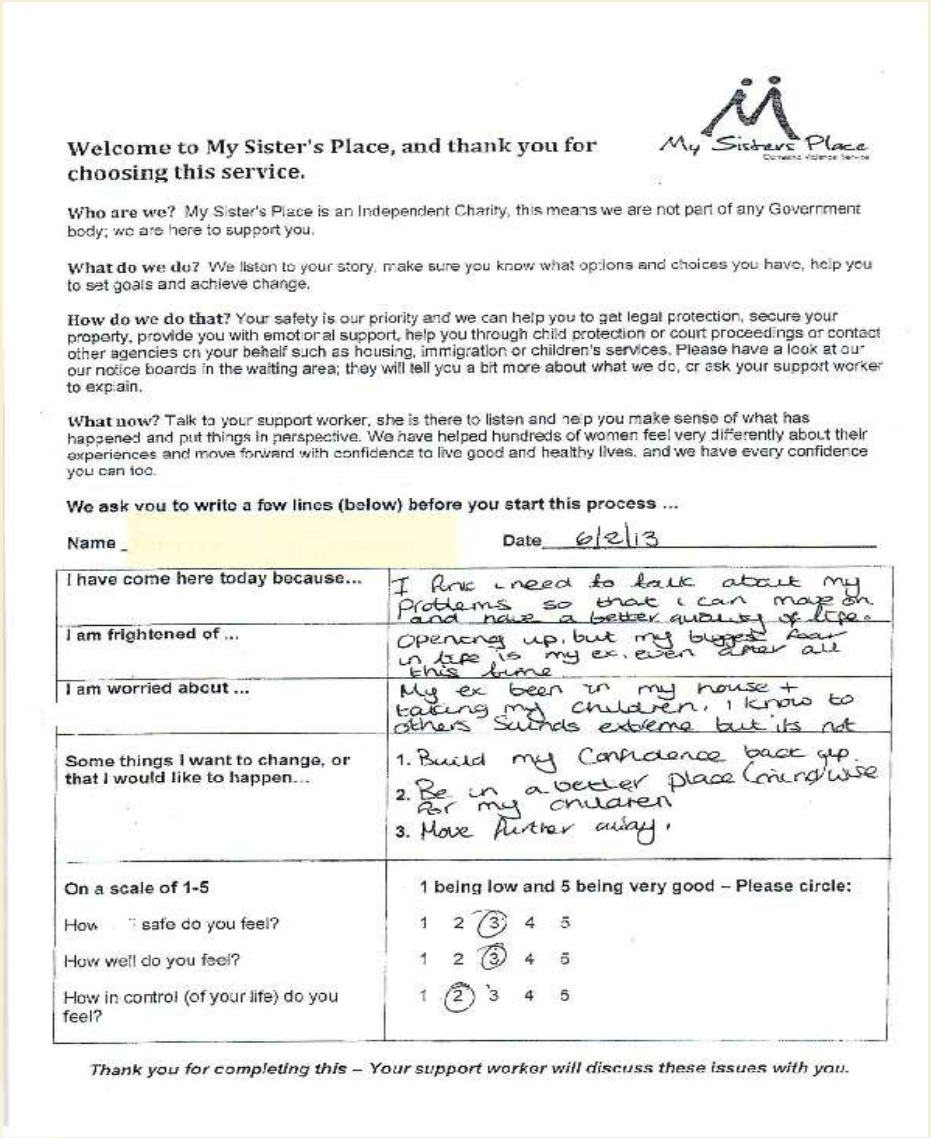
Starting point

- Entry sheet
- Understand her history
- What's important to her?
- Can we make things easier?



Welcome to My Sister's Place, and thank you for choosing this service.

My Sisters Place

Who are we? My Sister's Place is an Independent Charity, this means we are not part of any Government body; we are here to support you.

What do we do? We listen to your story, make sure you know what options and choices you have, help you to set goals and achieve change.

How do we do that? Your safety is our priority and we can help you to get legal protection, secure your property, provide you with emotional support, help you through child protection or court proceedings or contact other agencies on your behalf such as housing, immigration or children's services. Please have a look at our our notice boards in the waiting area; they will tell you a bit more about what we do, or ask your support worker to explain.

What now? Talk to your support worker, she is there to listen and help you make sense of what has happened and put things in perspective. We have helped hundreds of women feel very differently about their experiences and move forward with confidence to live good and healthy lives, and we have every confidence you can too.

We ask you to write a few lines (below) before you start this process ...

Name _ Date 6/2/13

I have come here today because...	I think I need to talk about my problems so that I can move on and have a better quality of life.
I am frightened of ...	Opening up, but my biggest fear in life is my ex, even after all this time
I am worried about ...	My ex been in my house + taking my children, I know to others Sounds extreme but its not
Some things I want to change, or that I would like to happen...	1. Build my confidence back up. 2. Be in a better place (mind/wise for my children 3. Move further away.
On a scale of 1-5	1 being low and 5 being very good – Please circle:
How safe do you feel?	1 2 (3) 4 5
How well do you feel?	1 2 (3) 4 5
How in control (of your life) do you feel?	1 (2) 3 4 5

Thank you for completing this – Your support worker will discuss these issues with you.

My Sisters Place

Repeat incident rate

	12 Months Pre-intervention	12 Months Post-intervention	% Reduction
Quarter 1 (n=10)	43	6	86%
Quarter 2 (n=10)	39	23	41%
Quarter 3 (n=8)	33	18	46%
Quarter 4 (n=6)	29	18	38%
Total	144	65	55%

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12 Months post intervention…

- 12 Cases (30%) reported no further incidents
- 6 Cases reported further incidents and breach proceedings have been activated on 5
- 16 Cases progressed to Court resulting in 12 convictions (7 received custodial sentences).
- 16 Cases have Restraining/Non- Molestation Orders in force.

Key principles for practice…

- Accessability – Remove barriers to access
- Responsivity - Focus on immediate needs (includes safety) - Make a difference
- Be trauma aware – engagement is the key and this is achieved through good quality casework.
- Use resources and partnerships in an integrated (rather than staged) way

Cost savings…

Additional Investment (Public Health) £30,000			
	No of Police Incidents	Costs £	Savings
12 Months Pre intervention	144	£408,384	
12 Months Post intervention	65	£184,340	£224,000

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Average cost of support per person:

Unit costs	Costs per person 2014/15	MSP Costs 39 cases
MSP - average cost of an engaging case with access/use of all services	£427.00	£16,653
Additional investment from Public Health - £30,000	£770.00	£30,030
Total	**£1,197**	**£46,683**

Learning

1. Complex multi-agency systems can be useful but the ‘person’ can get ‘lost’ in the process.
2. Demonstrated we can make a difference by taking a needs led approach with sustainable change
3. Used measures that have real relevance to commissioners and show the cost effectiveness of investing in person centred work with survivors
4. Impacted on partner agencies and produced cost savings
5. Replicated in 2015 with similar results

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