Improving outcomes
for children
WITH CHILD PROTECTION CONCERNS WHO HAVE BEEN EXPOSED TO DOMESTIC ABUSE

Foundations
What Works Centre for Children & Families

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Authors

Professor Jane Barlow and Dr Anita Schrader McMillan
Department of Social Policy and Intervention
University of Oxford, 32 Wellington Square, Oxford OX1 2ER

Dr Erica Bowen, University of Worcester, Worcester WR2 6AJ

Author contributions

Jane Barlow – Principal Investigator
Anita Schrader McMillan and Erica Bowen – Co-investigators

About Foundations - What Works Centre for Children & Families

At Foundations, the national What Works Centre for Children & Families, we believe all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home and lead happier, healthier lives.

Foundations was formed through the merger of What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF).

About Department of Social Policy and Intervention

The Department of Social Policy and Intervention is an interdisciplinary centre for research and teaching in social policy and the systematic evaluation of social intervention based in the Social Sciences Division of the University of Oxford.

The Department of Social Policy and Intervention
University of Oxford, 32 Wellington Square, Oxford OX1 2ER

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ACRONYMS

Abbreviation	Description
ACe	Adverse childhood experience
BCCEWH	British Columbia Centre for Excellence in Women's Health
CAMHS	Children and adolescent mental health services
CBT	Cognitive behavioural therapy
Cedar	Children Experiencing Domestic Abuse Recovery
CPS	Child Protective Services (United States)
DAN	Domestic abuse navigator
DART	Domestic Abuse Recovering Together
DEI	Diversity, equity and inclusion
DfE	Department for Education
EIF	Early Intervention Foundation
IPP	Infant-parent psychotherapy
IPP	Infant-parent psychotherapy
KCMEP	Kids Club and Moms Empowerment Programme
MARAC	Multi-Agency Risk Assessment Conference
MMAT	Mixed Methods Appraisal Tool
MOVE	Mothers Overcoming Violence Through Education and Empowerment
NICE	National Institute for Health and Care Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
PCIT	Parent-child interaction therapy
PTSD	Post-traumatic stress disorder

QED	Quasi-experimental design
RCT	Randomised controlled trial
SFBT	Solution-focused brief therapy
TF-CBT	Trauma-focused cognitive behavioural therapy

Plain English summary

Children who are exposed to domestic abuse are at risk of emotional and behavioural problems that can affect all aspects of their lives. Several reviews have identified ways of working with children and parents, children alone, or whole families, to end children's exposure to domestic abuse and to improve children's wellbeing. However, these reviews have not reported specifically on ways of working when children are on a Child in Need or Child Protection Plan, or are looked after children.

This review has three objectives. The first objective is to identify "what works" in improving outcomes for children (for example, children's emotional wellbeing). The second objective is to identify barriers and facilitators to implementing services for children exposed to domestic abuse and their families and what is needed to help achieve fundamental changes. The third question is to identify what makes it more difficult or easier for parents, children or families to get involved in a service, complete it and achieve their goals.

To address the first question, "what works", we summarised findings from 20 studies that examined the impact of four different ways of working: (1) interventions designed for mothers who have been victims of domestic abuse and their children together; (2) interventions that work with children alone, with some additional support for parents; (3) interventions for the whole family; and (4) interventions for fathers, and sometimes mothers, who have used violence towards their partner. However, only two of the included studies were evaluated using a design that is sufficiently rigorous to be confident about the findings, and these focused on two models of working. These two models were:

1. A psychoeducational service called Project Support, which focused on helping mothers with the parenting of children. It was effective in reducing the need for social care in the United States (the rate of re-referral to Child Protective Services was 5.9% for families receiving Project Support and 27.7% for families receiving Usual Care). However, the study does not report changes in children's mental health.
2. A "trauma informed" model called Fathers for Change, which targeted fathers. It was effective in significantly reducing domestic abuse and children's exposure to parental violence, as well as improving fathers' emotional regulation, mentalisation and hostile outlook – all of which are associated with the risk of domestic abuse and child maltreatment, and in reduced need for social care in the United States (US).

Studies that report on children's mental health and behavioural problems indicate that children with trauma symptoms are likely to need interventions that explicitly address those symptoms, such as parent-child interaction therapy (PCIT) or trauma-focused cognitive behavioural therapy (TF-CBT). These interventions are promising. Interventions also need to focus not only on

children's mental health and wellbeing but also the mental health of parents for improvements to be sustained.

The remaining studies show that a range of new approaches to working with the whole family when children are exposed to domestic abuse have been developed in the United Kingdom (UK), but that further evaluation of their effectiveness is needed.
One of the core messages from the qualitative studies is the importance of the relationship between the parent, child or family and the practitioner who works with them. These studies also suggest some important factors in terms of developing this relationship, developing services, strengthening the workforce and improving research.

Finally, our review identified a number of groups of people and families who are not always included in these services, and for whom further support is still needed.

EXECUTIVE SUMMARY

Background

A range of domestic abuse interventions has been developed over the past two decades, many of which aim to improve outcomes for children exposed to domestic abuse. Some effective interventions and practice models have been identified. However, review-level evidence has not yet focused on interventions for children, parents or families in which the child is on or above the threshold for children's social care services.

The objective of this review was to address this current knowledge gap by focusing on interventions **that aim to improve outcomes for children who have been exposed to domestic abuse and who have social care involvement – that is, in the UK, children who are on a Child in Need or Child Protection Plan, or are Children Looked After,** or the equivalent in high-income countries with child protection systems comparable to those in the UK.

Research questions

1. What is the **state of the evidence on the effectiveness of interventions for families where the child has been exposed to domestic abuse and also has current involvement with children's social care services (that is, a Child in Need or Child Protection Plan)?**
2. What are the **facilitators and barriers to implementing and evaluating** the above group of interventions?
3. What are the **mediators and moderators of the above group of interventions**?

Methods

We undertook a rapid systematic search and review to identify both published and grey literature, summarising either quantitative or qualitative data that address the above questions. The review only included studies that targeted children (aged 18 years or under) who had been exposed to domestic abuse and where at least 50% of the sample also had a social worker (that is, where the child was on a Child in Need Plan, Child Protection Plan or in Local Authority Care).

Studies were included irrespective of who delivered the intervention (that is, children's social care services or other agencies) and whether it could be delivered to the child alone, the parent and child together, with one or more parents, or with the whole family, provided the study reported outcomes for children.

Studies were also included if they reported on factors (facilitators, barriers, mediators and moderators) associated with the delivery or effectiveness of the intervention. All study designs were rated using the Early Intervention Foundation (EIF) criteria and critically appraised. Findings are reported in a narrative summary.

Findings

What is the state of the evidence?

Twenty-one papers (20 studies) were included in the review. Evidence of effectiveness is assessed from 20 studies categorised EIF 1 to 3. Three studies are randomised controlled trials (RCTs), 10 are non-randomised trials, and seven are mixed-method studies. Findings from one qualitative study are reported in Section 6.

Studies were organised into the following categories:

> 1. **Parent and child-focused interventions** (n=6)
> 2. **Child-focused interventions** (n=4)
> 3. **Whole family interventions** (n=6)
> 4. **Interventions for fathers** (n=5)

What works

Parent and child-focused interventions
Interventions for mothers and children, or children alone, within this category were delivered by specialist agencies as part of a Child Protection Plan.

Psychotherapeutic interventions
Two dyadic interventions, evaluated in one-group pre-post studies, are targeted at infants or young children who have been exposed to domestic abuse and manifest behavioural challenges, trauma symptoms, or both, and their mothers:

1. *Infant parent psychotherapy:* One pre-post study evaluated the effectiveness of the Peek-a-Boo Club, a group-based, 11-session infant child psychotherapy intervention that reported no significant results in children's social and emotional functioning, maternal attachment and the parent-infant relationship.
2. *Attachment and behavioural interventions*: One study of quasi-experimental design evaluated parent-child interaction therapy (PCIT), a parenting programme underpinned by both attachment and behavioural theories of change. The findings suggest that PCIT can improve trauma-related behaviours and mental health outcomes for children exposed to

domestic abuse, including children in families with current or previous involvement with US Child Protective Services as well as children with no exposure to domestic abuse.

Psychoeducative interventions

One RCT reported on Project Support, an intensive psychoeducative intervention with an advocacy component. Project Support is designed for domestic abuse exposure and adapted for mothers and children with Child Protective Services involvement. The study found evidence that Project Support can help improve parenting, improve parents' management of child behaviour, and reduce Child Protective Services involvement.

Contrasting psychotherapeutic and psychoeducative interventions

One quasi-experimental design study compared a group-based psychoeducational intervention with a trauma-focused psychotherapeutic programme of comparable length and intensity. The study reported improvements in both groups on child trauma symptoms but better outcomes for children in the therapeutic group compared to those in the psychoeducational intervention. In both cases, a proportion of children remained above the clinical cut-off for trauma symptoms.

Interventions for children

Trauma-focused programmes

Two pre-post studies evaluated the effectiveness of trauma-focused cognitive behavioural therapy (TF-CBT) with art or play therapy. Both studies suggest that TF-CBT can reduce depression and anxiety in children exposed to domestic abuse and improve children's trauma symptoms, although the age range of children included in these interventions varies, and it is unclear whether older and younger children benefit to the same extent.

Interventions for looked after children

We identified two pre-post studies that evaluated interventions for looked after children, i.e., those in Local Authority care. Camp HOPE is a therapeutic summer camp for children exposed to domestic abuse who have other adverse childhood experiences (ACEs). Findings from the Camp HOPE study indicated promise in terms of children reporting improving feelings of hope and other positive emotions associated with resilience. The second intervention used expressive writing therapy to help adolescents cope with life stresses, and it reported increased positive emotions and reduced depression post-intervention. Both interventions are part of longer-term support for children in care.

Whole family and multi-component interventions

Six evaluations, all grey studies, reported on interventions that aim to work with the whole family. One study is an RCT, five are mixed methods, one group pre- and post-studies.

Two categories of intervention were identified. Family systemic approaches (For Baby's Sake, NewDAy and SafeCORE) are delivered by a team of practitioners from the same service. The

interventions evaluate different outcomes, but show indicative evidence that all three practice models can reduce the need for social care, with reported improvements in children's emotional and behavioural outcomes and couple or family functioning. One study measured and reported improvements in parental mental health and observed parenting, while another also measured and reported children's educational outcomes.

The second group of multi-component/multi-agency practice models (Project Crewe, Opening Closed Doors, and Growing Futures) are not explicitly informed by family systems theory. These interventions have a named coordinator and key workers, with may include volunteers, but also refer family members to other services designed to meet the goals of a CiN or child protection plan. One RCT of Project Crewe found reduced child risk factors associated with domestic abuse but no significant change in children's social care involvement. Opening Closed Doors coordinates services to families which are delivered by different specialist agencies to children, victim-survivors and perpetrators of domestic abuse. A second, mixed-methods study (Opening Closed Doors) reported reductions in the need for children's social care, reduced domestic abuse and improved indicators of child behavioural outcomes and parent wellbeing. The third evaluation (Growing Futures) is of a practice model involving a key worker who provides direct work with children and coordinates referrals and services. Growing Futures reported some reduction in children's social care involvement and child risk factors. Overall, there is indicative evidence that multi-agency/multi-component models can reduce social care involvement with families and reduce re-referrals for domestic abuse.

Programmes for fathers

Three interventions for fathers were identified (one of which is also offered to women who have perpetrated domestic abuse). Although all interventions are trauma-informed, one is psychoeducational, and two are primarily therapeutic. Only Fathers for Change was evaluated with sufficient rigour (that is, one RCT and a further, large-scale non-randomised study) to be confident about the findings. Both of those studies reported significant reductions in domestic abuse and children's exposure to parental violence, and improvements in the father's emotional regulation, mentalisation and hostile outlook – all of which are associated with the risk of domestic abuse and child maltreatment. However, neither of these papers or any other study of fathers/perpetrators, report on outcomes such as child behaviour, emotional wellbeing or trauma symptoms.

Two separate pre-post studies evaluations of Caring Dads are included. One study found indicative evidence of reduced need for social services involvement, and the second found improvement in men's parenting, couple functioning, and relationships with professionals, and a consequent reduction in the risk of abusive behaviour.

The evaluation of a third intervention, Inner Strength, found indicative evidence of a decrease in domestic abuse perpetration, general offending, and the need for social services involvement with families.

What are the facilitators and barriers to implementing and evaluating domestic abuse interventions in children's social care?

The findings for this section are primarily drawn from evaluations conducted in the UK.

Implementation

Barriers to implementation include funding, time constraints, and the allocation of funds that do not consider hidden costs to delivering the intervention; for multi-agency/multi-component practice models, barriers include the challenges of building and sustaining relationships among partner agencies.

Facilitators of implementation include a supportive organisational culture, workplace climate, and high-quality supervision with the opportunity for critical reflection – all of which were viewed as central to generating non-routinised, relationship-based responses to children and families. The resilience and stability of the workforce were also seen as foundational to the development of the therapeutic relationship upon which the effectiveness of all interventions is based. Studies included in our review highlighted the relationship between how the service is organised, whether practitioners were fully supported by a team, the existence of multi-disciplinary perspectives within a service, and the resilience, confidence and stability of the workforce. Some "whole family" interventions employ clinicians, including family therapists, in the team. Qualitative findings indicate the value of social work professionals having access to training, support and supervision by professionals with clinical training. Clinicians can also work directly with families when necessary.

Referrals

Barriers to referral include resistance to the new intervention by other agencies; a lack of clarity, by other agencies, on the intervention's inclusion and exclusion criteria; and the intervention's lack of visibility in the area.

Facilitators of referral comprise the absence of the barriers identified above rather than a separate category of factors.

Challenges to evaluation

We identified several challenges to evaluation quality. First, engaging service users in evaluation can be difficult as requests for information (for example, pre-intervention measures) prompt anxiety and fear among participants. Also, post-intervention, participants may not wish to take part in evaluation because they would need to revisit painful past events. Second, it can be difficult to obtain reliable data on outcomes for young children, as parents are the "gatekeepers" to children's participation and this is especially true of younger children, and if a child is subject to a Child Protection Plan. Third, therapeutic work with families often took longer than anticipated, and it was often impossible to include families still in receipt of services in the evaluation. Fourth, all evaluations faced difficulties in interviewing families (specifically parents) who declined the service or withdrew early. However, some studies were able to analyse differences between completers and non-completers by looking at baseline data or social care case files. Fifth, data sources were sometimes unreliable. For example, maternal reports of child behavioural difficulties and trauma-related symptoms are prone to reporting bias, possibly because of parents' anxiety about further involvement of Child Protective Services or children's social care with their families. Several studies included in our review used social care data to measure child outcomes. However, child protection cases can be closed for reasons other than the intervention. Studies in the US and UK also reported that social care data is of uneven quality and sometimes unreliable. Finally, there are particular challenges in evaluating multi-agency/multi-component practice models because of the complexity of evaluating outcomes at both the systems level and clinical/functional level.

Mediators and moderators of effectiveness

None of the studies included in our review evaluated the mediators and moderators of programme effectiveness, but the broader evidence on comparable interventions suggests some mediators and moderators. For example, some of the critical moderators of intervention effectiveness for TF-CBT are: the parents' or caregivers' mental health and trauma-related maladaptive cognitions and depression; the language proficiency and cognitive abilities of the young child or caregiver or both; and the broader context of the family, culture, and the capacity of practitioners to work with young children with symptoms of post-traumatic stress.

A review of interventions for children exposed to domestic abuse below the threshold for children's social care found that interventions benefit from being tailored to children's specific needs, incorporating trauma-specific and non-trauma-specific content, and a greater focus on ensuring the maintenance of treatment gains. Other mediators and moderators include enhancing caregiver support of the child.

Diversity, equity and inclusion

A number of diversity, equity and inclusion issues were identified for the following groups of people: parents with severe mental health problems; minority ethnic and cultural groups;

individuals with disabilities or special needs; lesbian, gay, bisexual, transgender plus (LGBT+) people; and other under-represented groups (such as male victims of domestic abuse, or women who perpetrate domestic abuse). Caregivers, including victimised parents, with severe untreated mental health problems (such as psychosis or schizophrenia) are often explicitly excluded from interventions. It is not clear that these parents or their children receive the long-term, indicated support they need. Similarly, some interventions exclude parents with learning difficulties or cognitive delays. One study that examined referrals to the Multi-Agency Risk Assessment Conference (MARAC) identified low numbers of referrals of parents with physical disabilities despite their increased risk of victimisation.

All included interventions seek to make provisions for the diversity of potential service users. However, the degree to which this is achieved is not clear. Further research is necessary into effective and sensitive ways of working through interpreters, and to increase referrals and engagement of people from minority ethnic groups. There also appear to be gaps in service provision for LGBT+ parents, male victims of domestic abuse, female perpetrators of domestic abuse, and situational couple violence.

Some interventions promote inclusivity through their delivery by working closely alongside community organisations that serve particular client groups. The wider literature also highlights the importance of aligning such interventions with valued religious and cultural norms. While a diverse team is ideal, cultural competence is essential, and practitioners can be trained to integrate an intersectional lens and other strategies in case formulation. Culturally specific services for parents whose children are on a CPP exist in the UK and merit further evaluation, focusing on child outcomes.

Implications for research

Previous reviews have called for RCTs to be commissioned as the evaluation methodology of choice. (Our review contains only two RCTs, one a small pilot, and both with risk of bias).   There are challenges in conducting RCTs in this context. Where it is not possible to have an RCT with no-treatment controls, participants can be randomised into two or more interventions (Overbeek et al., 2013). Moreover, RCTs need to be one component of realist evaluation designs that can provide more understanding about how interventions should be targeted, and identify the optimal implementation processes and verify change mechanisms.

Taken together, findings highlight the need for better quality studies and reporting of studies that evaluate the effect of interventions on children and young people exposed to domestic abuse, and their parents. A key message is to embed evaluation design within the commissioning of programmes to ensure that appropriate data are collected and that evaluation is used to inform outcomes and support continuous improvement in service development and implementation.

It is therefore vital that interventions have a clearly specified theoretical framework and a theory of change, and for programme sites to be supported to ensure the collection of good quality and complete data directly aligned to the hypothesised outcomes.

Conclusion and recommendations

Children exposed to domestic abuse and on or above the threshold for child protection services are likely to have faced multiple forms of adversity and require significant support. Many interventions in this report (particularly those involving mothers and children or children alone) focus on improving children's trauma symptoms and externalising and internalising behavioural problems. While there is some evidence of effective treatments that work with the child directly (for example, TF-CBT with additional components), other approaches designed for children on or above the threshold for children's social care need to be more rigorously evaluated. Interventions developed in the UK over the past decade also require further rigorous evaluation. The available evidence regarding barriers and facilitators provides some examples of promising methods of working, but these also need further evaluation.

There continues to be a pressing need for further, high-quality research, especially in the UK. Going forward, a framework for the development of complex interventions can be used to evaluate and refine interventions for children exposed to domestic abuse.

INTRODUCTION

The impact on children of exposure to domestic abuse

The need to prevent domestic abuse[1] is a matter of urgent concern for children's social care as a result of steadily growing evidence about the impact of domestic abuse on children's emotional, social and cognitive development and physical health (Chan and Yeung, 2009; Dong, 2004; Herrenkohl, 2008; Levendosky et al., 2003; Stanley, 2011). Moreover, the scale of the problem is significant; in the UK, police made almost 235,868 referrals to social services for domestic abuse in 2021/22 alone.[2] The impact of domestic abuse on children follows direct and indirect pathways (MacDonell, 2012; Stanley, 2011). Children can be directly or accidentally injured or manipulated to abuse the victimised parent (Stanley, 2011). Since 2022, children exposed to domestic abuse have been recognised as victims in their own right (Crown Prosecution Service, 2022). The indirect pathway refers to the way in which intimate partner violence undermines children's functioning as a result of its impact on the caregiver's capacity for parenting (Sturge-Apple et al., 2010), which in turn impacts child development. In reality, these pathways are difficult to separate; children can be harmed by being drawn into hostile alliances, being forced to be active perpetrators of violence by the abusive parent, or witnessing traumatising events.

Although there is mixed evidence on the impact of domestic abuse according to children's age, there is emerging evidence that early and prolonged exposure potentially creates the most severe problems because it affects the child's subsequent development trajectory (Holt et al., 2008: 802; see also Cunningham and Baker, 2004; Chan and Yeung, 2009). Disruptions in attachment due to early exposure to domestic abuse, often coupled with childhood maltreatment, can profoundly impact the developing brain and neurobiological systems. Schore (2001) suggests that early trauma alters the development of the right brain, which processes social-emotional information and bodily states. This developmental impairment severely impacts a child's ability to cope with stress and emotion regulation. Loss of the ability to regulate the intensity of feelings has been described as the most extensive effect of early trauma exposure (Van der Kolk and Fisler, 1994). Thus, infants who hear or see unresolved angry conflict or witness a parent being hurt may show symptoms of post-traumatic stress disorder (PTSD) and may even lose developmental skills they have already acquired (Bogat et al., 2006; De Bellis and Thomas, 2003; Scheeringa and Zeanah, 1995; Schore, 2001; see also Carpenter and Stacks, 2009). There is robust evidence that the impairment of developmental milestones in infancy is predictive of difficulties in emotional, social and cognitive

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[1] Domestic abuse is defined by the Home Office (2013: 2) as "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence, or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional."

[2] Office for National Statistics (ONS) dataset, "Domestic abuse and the criminal justice system", to November 2022 (www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/domesticabuseandthecriminaljusticesystemappendixtables)

development in childhood and beyond (Holt et al., 2008; Repetti et al., 2009; Sturge-Apple et al., 2010).

Domestic abuse may have differential effects as children grow older – for example, where (as often happens) children take on a quasi-parental role as protector of the victimised parent (Hester, 2006; see also Stephenson, 2009). Adolescents may have difficulty forming healthy intimate relationships with peers due to the models they experienced in their family (Levendosky et al., 2002). Adolescents exposed to domestic abuse are at increased risk of: perpetrating violence against peers and romantic partners, or being victims of violence; running away; self-harming thoughts and behaviours; and risk-taking behaviours and delinquency (MacDonell, 2012). Coping strategies for this developmental stage may involve experimentation with alcohol and other mood-altering substances (Cunningham and Baker, 2004; Mullender et al., 2002). The effect of early exposure to intimate partner violence is not always immediately evident, and there may be sleeper effects, particularly in terms of aggressive behavioural problems that emerge when children are of school age (Holmes, 2013).

However, there is considerable variation in the effect of childhood exposure to domestic abuse, with a proportion of children and young people experiencing no long-term harm. Qualitative work on children's lived experience shows a range of coping strategies (see, for example, Arai et al., 2021). As the broader literature on resilience shows, children's capacity to do well despite adversity depends to some extent on the child's temperament and cognitive ability, as well as the existence of other sources of consistent, reliable emotional support – from at least one caregiver, extended family members, school, or peer groups (Masten, 2001; see also Chan and Yeung, 2009). Unlike older children, for whom the school may offer a refuge from a distressing home, babies and toddlers cannot escape from violence, nor do they have the capacity to verbalise or make sense of their experience alone. There is also variability in the strengths and coping mechanisms of individual children. For young children exposed to domestic abuse, the most consistently reported protective factor is maternal warmth (Levendosky et al., 2003; 2006; see also Graham-Bermann, 2009; Margolin et al., 2003; Mullender et al., 2002). Involved parenting can also protect older children and young people from engaging in behaviours that increase the risk that they will either perpetrate or experience domestic abuse, such as involvement with negative peer groups in adolescence (see Capaldi et al., 2012; Yule et al., 2019). One meta-analysis of over 100 studies shows that the factors consistently associated with resilience in children exposed to any form of violence (direct maltreatment, exposure to intimate partner violence, or community violence) are security in school, children's friendships and relationships with peers, and children's ability to self-regulate emotion (Yule et al., 2019). Protective factors may, however, change as children grow older.

Interventions for children who have been exposed to domestic abuse

An "intervention" is defined as "intentionally implemented change strategies, which aim to impede or eradicate risk factors, activate and/or mobilise protective factors, reduce or eradicate harm, or introduce betterment beyond harm eradication" (Sundell and Olsson, 2017). Guidelines produced by the National Institute for Health and Care Excellence (NICE) (2014) acknowledge the complexity of interventions to prevent and end the perpetration of domestic abuse, recommending an inter-agency approach that can provide a coordinated package of care and support for children and families, and works with parents who perpetrated domestic abuse while prioritising the safety of children and victim-survivors. For this to be possible, practitioners need to have an understanding of all aspects of the presenting problem and what factors are contributing to the situation.

A range of domestic abuse interventions has been developed over the past two decades, with many aiming to improve outcomes for both parents and children (Austin et al., 2019; British Columbia Centre for Excellence in Women's Health (BCCEWH), 2013; Guy et al., 2014; Howarth et al., 2016). The two most comprehensive studies since 2010 are the **Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence** (BCCEWH, 2013), commissioned by NICE; and the multi-component **IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE)** study, which includes a synthesis of evidence on the effectiveness of interventions for children exposed to domestic abuse (Howarth et al., 2016).

The BCCEWH review (2013) concluded that evidence was strongest for psychotherapeutic interventions (for example, child parent psychotherapy, parent-child interaction therapy) delivered to mothers and children, with moderate evidence on parenting-focused programmes and psychoeducation offered to children alone, and mixed evidence relating to psychoeducation for mothers and children. Drawing on the BCCEWH review, NICE (2014) guidelines support interventions that focus on strengthening the relationship between the child or young person and their non-abusive parent or carer:

> This may involve individual or group sessions, or both. The sessions should include advocacy, therapy and other support that addresses the impact of domestic violence and abuse on parenting. Sessions should be delivered to children and their non-abusive parent or carer in parallel, or together. (NICE, 2014: 17).

Unlike BCCEWH, which drew on 14 studies of varying designs, the IMPROVE review (Howarth et al., 2016) only included controlled trials (n=13). These trials primarily involved psychotherapeutic and psychoeducational interventions delivered to the non-abusive parent and child, and were usually based on the child's exposure to DA (not the child's specific clinical or broader social

needs). The primary outcomes of interest in all trials were children's mental health and behavioural symptoms and disorders. Eleven of these trials reported improvements, with modest effect sizes, in children's behavioural or mental health outcomes. The conclusions from the IMPROVE study differed somewhat from those of the earlier BCCEWH study. They found that psychoeducative interventions for children alone were reported to be most effective in improving child mental health. In contrast, psychoeducational interventions delivered to the (non-abusive) parents and children together were most effective in improving child behavioural outcomes. However, neither finding pertained specifically to children on or above the threshold for children's social care.

The Children Act (1989) gives local areas a statutory responsibility to safeguard children in need, including a duty to investigate if a child is suffering or likely to suffer "significant harm". Children and their families may need extra help for the child to have the same health and developmental milestones as other children – for example, if the child has a disability – but there is no obligation for families to take up the offer of assistance (see Table 1). However, social services have a statutory (that is, legal) obligation to intervene when a child has been exposed to harm that is likely to continue or escalate if no action is taken, and this can result in a Child Protection Plan or, ultimately, the child's placement in out-of-home care. Within the UK, exposure to domestic abuse featured in 51.1% of child and family assessments from 2017 to 2018 (Department for Education (DfE), 2018). Similarly, more than a third of US children who need Child Protective Services have been exposed to domestic abuse (Casanueva et al., 2014; Hamby et al., 2011).

Children above the threshold for a statutory Child Protection Plan (or the equivalent in other high-income countries) are likely to have experienced polyvictimisation; that is, multiple forms of adversity (ACEs), which in this context generally includes direct physical or emotional abuse, or chronic neglect, as well as exposure to domestic abuse (Finkelhor et al., 2007, 2011). The literature on ACEs and trauma generally shows that polyvictimised children and young people are at the highest risk of difficulties in social and emotional functioning and even physical health (Bellis et al., 2023; Hughes et al., 2017). Furthermore, it cannot be assumed that interventions for families or children below the threshold for a Child in Need Plan are equally effective for those who have experienced polyvictimisation and multiple compounded ACEs.

The focus of this review is on children who are on or above the threshold for social care (or, in the US, Child Protective Services).

Box 1: Children in need of help and protection

Children in need of help and protection make up a small minority of all children assessed and supported through children's social care (CSC). Over the course of a year, it is estimated that around 6% of all children in England will be in need of protection at some point. Each of the UK's four nations has a slightly different child protection system.
Children in need are a group supported by children's social care, who have safeguarding and welfare needs, including:

/   people or groups from participating.
/   Children on a Child in Need plan
/   Children on a Child Protection plan
/   Children who are Looked After
/   Children with disabilities.

These children have needs identified through a children's social care assessment or because of their disability, meaning they are expected to require services and support so that they have the same opportunities for health and development as other children.

Within ten days of receiving a referral (often from the police or the child's school), local authority children's services conducts an initial assessment of the precipitating event. They hold a strategy meeting to decide whether any further investigation is necessary, and if so, a full assessment is completed within 35 working days. If the initial assessment shows that a full assessment is needed, the local authority sets up a child protection conference within 15 days.

The information gathered at the child protection conference is used to decide whether the child (or children) should be subject to a Child in Need Plan or a Child Protection Plan, or no plan at all.

/   **A Child in Need Plan** is drawn up if the child and family need further support, but there is no risk of continuing harm. A Child in Need Plan is voluntary, so parents and children do not have to accept the support that is offered.
/   **A Child Protection Plan** is drawn up if the child protection conference believes there is a risk of continuing harm through neglect, physical, emotional or sexual abuse. The Child Protection Plan is incorporated into a written agreement, which lays out the expectations of parents and the local authority to work together to ensure that the terms of the Child Protection Plan are met.
/   **A Child who is Looked After** has been placed in local authority care if children's social care has intervened because the child is at risk of significant harm despite the Child Protection Plan. Children Looked After live with foster carers, in a residential children's home or in residential settings such as secure units. A child may also be looked after if a parent is unable to care for them – for instance, because of serious illness, or if the child is an unaccompanied asylum-seeker.

A child stops being looked after when they are adopted, return home or turn 18. However, local authorities in all four nations of the UK are required to support children leaving care at 18 until they are at least 21. This support may involve the young person continuing to live with their foster family. (Adapted from https://learning.nspcc.org.uk/child-protection-system/england)

OBJECTIVES AND RESEARCH QUESTIONS

The objective of this review was to address this current knowledge gap by focusing on all interventions **that aim to improve outcomes for children who have been exposed to domestic abuse and who have social care involvement – that is, children who are on or above the threshold for such services, with a Child Protection Plan or Child in Need Plan,** or the equivalent in high-income countries with comparable child protection systems.

Research questions

1. What is the **state of the evidence on the effectiveness** of interventions **for families where the child has been exposed to domestic abuse and also has current involvement with children's social care services (that is, children with a Child Protection Plan or Child in Need Plan)?**
2. What are the **facilitators and barriers to implementing and evaluating** the above group of interventions?
3. What are the **mediators and moderators of the above group of interventions**?

Question 1 (Q1): To address this question, we: (a) conducted a review of recent reviews to identify studies on the domestic abuse interventions that measure outcomes for children with an allocated social worker; and (b) conducted a search of the published and grey literature for all primary studies that evaluate relevant interventions that have been published since 2013.

Questions 2 and 3 (Q2 and Q3): To address these questions, we: (a) examined studies included in reviews that address Q1 for discussion of facilitators, barriers, mediators or moderators; (b) searched for primary studies, including process evaluations that explicitly address these issues in domestic abuse interventions for children with a social worker; and (c) conducted an extensive search of the grey literature for relevant evaluations.

Facilitators and barriers include but are not limited to: the referral process, screening and assessment, and pre-intervention contact; engagement; structure and delivery; funding; and organisational factors.

Mediators and moderators include individual-level factors (such as child and family characteristics) and contextual factors (location of the service, duration of the service, form of delivery) that could influence desired outcomes.

> ### Box 2: Definition of terms used in this review
>
> The term "**domestic abuse**" is used throughout this review because it aligns with the Domestic Abuse Act (2021). The Act defines domestic abuse as: "(2) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if (a) A and B are each aged 16 or over and are personally connected to each other, and (b) the behaviour is abusive. (3) Behaviour is "abusive" if it consists of any of the following– (a) physical or sexual abuse; (b) violent or threatening behaviour; (c) controlling or coercive behaviour; (d) economic abuse; (e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct." The focus of this review is on violence towards a parent or primary carer, or between parents or primary carers.
>
> The term "**family**" refers to any combination of family members, such as a mother and the index child. A "**whole family**" practice model works with all family members separately or together. A whole family approach does not separate the abusive behaviours of the parent from the impact on children. It considers the parenting of the abuser, as well as the impact of their abuse on the non-abusing parent and their care for the children (Adapted from Child Safeguarding Review Panel (CSRP) 2022).

METHODS

Study design

A rapid review of the literature.

Study eligibility criteria

The following eligibility criteria were applied:

Inclusion criteria

Population: Children of any age (0–18) about whom there are child protection concerns related to domestic abuse and who therefore have a social worker, and the parents or caregivers of these children.

Q2 and Q3 only: Practitioners, project managers and other key stakeholders within, or linked to, children's social care.

Intervention: Interventions whose primary goal is to improve outcomes for children exposed to domestic abuse. Interventions can be delivered either directly by working with the child or indirectly by working with the parents or caregivers.

Q2 and Q3 only: Studies that have evaluated intermediary factors (facilitators, barriers, mediators and moderators) associated with the effectiveness and sustainability of the intervention.

Comparator: Studies with and without a comparator were included.

Outcomes: *Q1: Impact of interventions*

Primary outcomes were specific to children. Outcomes of interest varied by the child's age and social care status, and included: (1) children's mental health and wellbeing; (2) children's cognitive and developmental milestones; (3) social care status pre- and post-intervention; (4) exposure of children to domestic abuse and compounded risk pre- and post-intervention. Secondary outcomes included: (1) mental health of the parent or parents; (2) quality of parenting or co-parenting; and (3) cessation of domestic abuse perpetration by parent(s).

Q2 and Q3:

Facilitators and barriers included but were not limited to: the referral process, screening and assessment, pre-intervention contact; engagement; structure and delivery; and organisational factors.

Mediators and moderators include individual-level factors (such as child and family characteristics) and contextual factors (location of the service, duration of the service, form of delivery) that could influence the desired outcomes.

Study location: As well as the UK, studies were selected from countries or regions with a child protection orientation similar to that of the UK (Gilbert et al., 2012). These are the European Union (EU), the USA, Canada, Australia and New Zealand.

Date: 2013 to 2022.
Articles hand searched in systematic reviews: 2002 – 2022.

Language: Studies with an abstract in the English language.

Exclusion criteria

Population: Children and families in the general population who are not on or above the threshold for statutory children's services. Studies were excluded if less than half the sample was above the threshold for children's social care.

Intervention: Interventions that: (1) do not involve children exposed to domestic abuse or their parents; (2) interventions that do not report on outcomes for children; (3) interventions that were not delivered by, or not delivered in conjunction with, social care; (4) interventions primarily designed to address other forms of domestic abuse, such as teenage relationship violence or child/adolescent-to-parent violence and abuse.

Comparator: Studies with and without a comparator were included.

Outcomes: To increase the sensitivity of the search, no outcomes were specified.

Study type: Commentaries, narrative reviews, case studies, book reviews, book chapters, conference proceedings, opinion pieces, and best practice guidance.

Dissertations were excluded because of constraints on the time available for full-text review and analysis.

Study location: Interventions conducted outside the UK, the European Union, Norway, Switzerland, Iceland, the US, Canada, Australia and New Zealand.

Date: Individual studies published before 2013. Studies identified in systematic reviews published before 2002.

Language: Studies without an abstract in the English language.

Search strategy

Search of systematic reviews

The first iteration involved all the existing search terms but narrowed the scope to systematic reviews or reviews of reviews conducted between 2013 and 2022 (see Appendix 5). The 2013 cut-off date was selected because two important systematic reviews were published in 2013 and 2016 and were likely to have captured the most relevant studies conducted to that point (BCCEWH, 2013; Howarth et al., 2016). One author hand-searched these and other relevant reviews (to identify articles that met the inclusion criteria for this study (for example, that specifically included children on or above the threshold for statutory social care) (see Appendix 5). Articles published in systematic reviews could be dated from 2002 to the time of publication.

Grey literature search

Grey literature was identified by searching Google and Google Scholar, Social Care Online, Social Science Research Network (SSRN) and the World Health Organization (WHO) International

Clinical Trials Registry Platform (ICTRP) search portal, the <u>NSPCC Library and Information service | NSPCC Learning</u>, the Early Intervention Foundation (EIF), the California Evidence-Based Clearinghouse for Child Welfare (cebc4cw.org), and Promising Futures Without Violence (<u>https://promising.futureswithoutviolence.org/</u>). Our Advisory Group was asked to recommend grey studies.

Electronic database search

Dates: Searches were conducted between 15 May and 31 May 2022. An example of a search strategy is included in Appendix 1. One author received weekly notifications from ProQuest on articles that matched search terms and weekly notifications from the NSPCC (National Society for the Prevention of Cruelty to Children) library, so other papers were screened for inclusion until July 2022.

Electronic databases: PsycINFO, MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, <u>Applied Social Sciences Index and Abstracts</u> (ASSIA), Social Services Abstracts, Social Care Online, Sociological Abstracts, Social Sciences Citation Index and clinicaltrials.gov. We searched for systematic reviews within the Cochrane Library, PROSPERO, and the Joanna Briggs Institute (JBI).

Authors of relevant research protocols published before 2020 were contacted directly to request copies of the final report if it was available or for as-yet grey outcome evaluations.

Overview of search terms

Development of search terms: The search involved an iterative process that involved developing and testing keywords related to the different aspects of each research question and conducting preliminary searches on multiple databases. Truncations and asterisks were used to allow for variations of the words to be identified. Most terms were searched in title, abstract and keyword. A combination of free-text terms and controlled vocabulary words was adopted based on the functionality of each database.

Google Scholar does not have the same functionality as electronic databases, and the search string was adapted accordingly. Examples of search strings (PsycINFO and ASSIA) and Google Scholar are included in Appendix 1. For other specialised databases (for example, the NSPCC online resource centre, or the California Evidence-Based Clearinghouse for Child Welfare, only the terms "domestic violence" or "intimate partner violence" were used to identify potentially relevant studies.

To increase the sensitivity of the search, we did not include outcome terms. However, only studies that included child outcomes in the full text were included.

Search terms

Question 1

social services or community services or family preservation or outreach programs or protective services or social programs or child welfare or human services, or social casework

exp Perpetrators/ or exp Domestic Violence/ or exp Intimate Partner Violence/ or exp Battered Female

adolesc* or preadolesc* or teen* or pre-adolesc* or boy* or girl* or child* or prenatal* or perinatal or postnatal or post-natal or baby or infant* or preschool*

intervention or practi$e model or treatment or program*

quality or effective* or evaluat* or efficacy or success* or improv* or enabl* or chang*

Questions 2 and 3

moderat* or mediat* or barrier* or obstacle* or enable*

train* or fund* or supervis* or management* or staff or worker or professional or clinic* or practitioner or facilitator.

Study selection

Selection of studies

One author (ASM) screened publications by title. Citation records from searches were imported into Covidence (specialist software for collaborative reviews). Once duplicates were removed, two authors (ASM and EB) independently screened publications by abstract and by full text and selected publications for inclusion.

ASM and EB also examined publications retrieved through other sources (for example, reference lists of systematic reviews sent by authors or grey literature). This included data collated by the EIF as part of a linked research project.

Where there was disagreement about the social care status of included children, or the proportion of children exposed to domestic abuse in the full papers, ASM contacted the lead author or the co-author to establish what proportion of families had had exposure to such abuse or involvement with statutory children's social care. If it was not possible to contact the author, or if the author did

Data extraction

Data were extracted independently by two reviewers (ASM and EB). Full-text data were extracted using a pre-designed proforma in Excel. The proforma was designed to capture the range of data needed to answer the three research questions.

The following data were extracted for each study: author; year; country; participants; intervention/ programme; inclusion and exclusion criteria; study design, **which is used as a proxy for quality; outcomes, outcome measures, comparators; main findings; and limitations.** Each paper was searched separately for data relevant to diversity, equity and inclusion.

To answer questions 2 and 3, barriers, facilitators, moderators and mediators were identified. The following data were extracted for all studies: (1) practical barriers to enrolment, participation and completion; (2) other barriers to enrolment, participation and completion; (3) facilitators of enrolment, participation and completion; (4) lessons learned about increasing enrolment, retention and completion; (5) organisation of the workforce; (6) other factors that contribute to the resilience of the workforce; and (7) observations and recommendations. Any data from any study that addressed these questions were captured in the data extraction tables.

Study design categorisation

The study design has been used as a proxy indicator of quality. Using the EIF ratings on impact data, studies are ranked from 3 to 0.[3]

- 3 - Robust randomised controlled trial/ quasi-experimental design
- 2 - Studies with pre-post outcome data
- 1 - Limited outcome data (for example, post-intervention only)
- 0 - No outcome data.

Risk of bias assessment

The quality of RCTs, including potential sources of bias, was appraised using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018).   The main report will only refer to risk of bias in RCTs, because it is not possible to compare studies with such highly varied outcome variables and participant samples. Please see Appendix 3 for details on the risk of bias in all included studies.

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[3] Available online: EIF evidence standards.

Data analysis and synthesis

Because studies were too heterogeneous in terms of the interventions, populations, and outcomes measured to combine in a meta-analysis, a narrative summary was used.

Analysis of qualitative data combined integrative and inductive approaches. Findings from qualitative data were summarised thematically, beginning with pre-set headings contained in the data extraction forms. Next, findings were analysed to identify major themes that emerged under each heading. This inductive approach allowed for new themes to emerge.

Quantitative and qualitative material was analysed separately using a narrative approach (Elliott, 2005).

RESULTS

Search results

The online database search identified 13 systematic reviews published since 2013.   The search identified2,474 individual studies of of which 1,107 were duplicates. The remaining 1,367 articles were screened on title and abstract, of which 39 met the criteria for full-text eligibility and 9 were included (see Prisma chart, Appendix 1).

Nineteen studies were assessed on full text, and eight were selected for inclusion. Three further articles were identified by hand-searching existing
systematic reviews, and the author provided one additional article.

Fifty-five items of grey literature were identified from non-academic databases and, in one case, direct contact with authors.

Two or more articles reporting on aspects of the same study (Pernebo et al., 2018, 2019) are treated as a single paper.

Papers that did not meet the inclusion criteria are listed in Appendix 6. The primary reasons for exclusion were that children were below the threshold for children's social care or Child Protective Services, or that the proportion of children with social care or Child Protective Services involvement was unclear from the article and could not be confirmed by the author.

Characteristics of included studies

Twenty-one papers (20 studies) were included in the review.

Study design: Thirteen included papers (twelve studies) were published in peer-reviewed journals, while eight papers were grey evaluation reports. Three studies were RCTs, 10 were non-randomised trials, seven were mixed methods, and one was qualitative.

Location: Of the published journal articles, nine studies were conducted in the US, one in Australia, one in Canada, and one study (two papers) in Sweden. One pre-post study was conducted with two groups, one in the US and one in South Africa, but is included on the strength of the US sample (Woollett et al., 2020). Of the grey literature, seven studies were conducted in England and one in Wales.

Sample size: Sample size varied considerably, with 18 fathers in a pilot RCT study by Stover (2015) and 126 families in the largest RCT (Heal et al., 2017). Numbers in pre-post studies also varied, with 15 in one study (Parker et al., 2006) and 229 in the largest (Hellman and Gwinn, 2017). One study separately reported outcomes for four families above the threshold a statutory intervention (for a Child Protection Plan) within a cohort of 139 families (Schrader McMillan, 2022).

Focus of included interventions: Included interventions have been developed for parents, parents and children, and children alone, and vary in length, structure, and in the outcomes measured.

Although there is some crossover among practice models, studies have been organised as follows in the section, "Summary of main findings", and in tables in Appendix 4.

1. Interventions for mothers and children

- **Psychotherapeutic interventions** Infant-parent psychotherapy (IPP) and parent-child interaction therapy (PCIT) (n=2)
- **Psychoeducational interventions** (Project Support) (n=1)
- **Interventions that combine psychoeducational and psychotherapeutic components:** Mothers Overcoming Violence Through Education and Empowerment, (MOVE) (n=1)
- **Comparing psychotherapeutic and psychoeducational interventions:** Child and Adolescent Mental Health Service Intervention (CAMHSI) and Children are People Too (CAP) (n=2).

2. Child-focused interventions

- **Trauma-focused cognitive behavioural therapy** (TF-CBT) with additional components (n=2)
- **Interventions for looked after children** Camp HOPE and Write On (n=2).

3. Whole family interventions

- **Family systemic interventions** For Baby's Sake, NewDAy, SafeCORE (n=3)
- **Multi-agency/multi-component interventions** Growing Futures, Project Crewe (now called FACT) and Opening Closed Doors (n=3).

4. Father/perpetrator programmes

Fathers for Change (n=2), Caring Dads (n=2) and Inner Strength (n=1).

SUMMARY OF MAIN FINDINGS

1. Interventions for mothers and children

Psychotherapeutic interventions – mothers and infants

Two studies involved dyadic interventions with mothers exposed to domestic abuse and young children who showed behavioural challenges, trauma symptoms or both, and include infant-parent psychotherapy (IPP) (Bunston et al., 2016), and parent-child interaction therapy (PCIT), which is a parenting programme that is underpinned by both attachment and behavioural theories of change (Timmer et al., 2010).

Both psychotherapeutic interventions were delivered by therapists.

One intervention was evaluated using a one-group pre- and post- design, and one was a quasi-experimental design (EIF=2). For further detail on the content and results, see Appendix 2, Tables A1.1. and A1.2, and Appendix 4.

Intervention description
Child-parent psychotherapy or infant-parent psychotherapy
Child-parent psychotherapy (Bunston et al., 2016) was designed for children from birth through to age five who have experienced at least one traumatic event (for example, maltreatment, the sudden or traumatic death of someone close, a severe accident, sexual abuse, or exposure to domestic violence) and, as a result, experience behaviour, attachment and/or mental health problems, including post-traumatic stress disorder (PTSD). Child-parent psychotherapy is delivered by therapists with additional support from social workers or trainee clinicians with clinical supervision. Its primary goal is to improve the developmental pathway of the infant and the infant/mother relationship by building healthy attachments. The relationship between a child and his or her parent (or caregiver) is seen as the vehicle for restoring the child's sense of safety, attachment, capacity for appropriate affect (the expression of mood or feeling that is in harmony with the accompanying thought, action, reaction, or verbal expression) and improving the child's cognitive, behavioural and social functioning.

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The type of trauma experienced and the child's age or developmental status determine the structure of the child-parent psychotherapy sessions. For instance, when the child is an infant (typically under age 2), treatment focuses on helping the parent understand how the child's and parent's experience may affect the child's later functioning and development. Toddlers (that is, children typically aged 12 to 36 months take a more active role in the treatment, as play is used to facilitate communication between child and parent. When the parent has a history of trauma that interferes with their response to the child, the therapist helps the parent understand how this history can affect perceptions of and interactions with the child, and helps the parent interact with the child in new, developmentally appropriate ways.

The Peek-a-Boo Club is informed by attachment and object relations frameworks. The intervention has been delivered in three core phases following two sessions of one-to-one assessment with the mother and child. The phases are: weeks 1-3, "Encouraging engagement, motivation and creating safety"; weeks 4-6, "Encouraging reflection"; and weeks 7-9, "Consolidating learning". A newsletter summarising group activities and learning was shared with participating mothers and staff to model "being kept in mind". Mothers were referred to community groups and helped to access resources. The intervention has been delivered in groups, typically of four mothers and four children.

Inclusion and exclusion criteria: Children aged 0-4 exposed to domestic abuse, and their mothers (Bunston et al., 2016).

Outcomes of interest: Infant social and emotional functioning; maternal postnatal attachment; parent-infant relationship (Bunston et al., 2016).

Exposure to domestic abuse and children's involvement with statutory social care/Child Protective Services: Practitioners relied on mothers' reports for information on children's exposure to DA, and involvement of social care (in this context, CPS) with the child, a proportion of women in this high risk group did not respond, so figures are likely to have been underestimated (Bunston et al., 2016). Forty-three per cent reported involvement of social care with their children; 8.6% did not respond; 6.3% of children had been in foster care, and 7% did not respond.

Parent-child interaction therapy
Parent-child interaction therapy (PCIT) was developed for young children with externalising behaviour problems that stem from exposure to trauma (see Hood and Eyberg, 2003). The underlying model of change is similar to that of other parent training programmes that provide parents with behaviour modification skills to help them become an agent of change in reducing their child's behaviour problems, which in turn is aimed at promoting more positive parenting.

PCIT aims to improve the quality of the parent-child relationship by helping caregivers adopt an authoritative parenting style that meets the child's needs for nurture, psychological autonomy, and appropriate limit-setting. PCIT is delivered by therapists from a range of backgrounds, including clinical social work.

PCIT incorporates both parent and child in the treatment sessions and uses live coaching by the therapist as part of an individualised approach to changing the dysfunctional parent-child relationship (Timmer et al., 2010: 489). The intervention integrates components of social learning theory, attachment theory, developmental theory, behavioural principles, and traditional play therapy. Attachment theory principles used in PCIT focus on helping the parent facilitate a warm, supportive relationship as a basis for developing social skills and emotional regulation. From a social learning perspective, PCIT uses differential attention to address behavioural problems by having the parent model calm, desired behaviours during parent-child interactions.

The intervention is conducted in two phases. Phase 1 (child-directed interaction) aims to enhance the parent-child relationship. Phase 2 (parent-directed interaction) focuses on improving child compliance. The intervention involves training, coaching, feedback, mother-child play, and homework assignments. PCIT can be of varying lengths, but in the included study (Timmer et al., 2010), it lasted between 14 and 20 weeks. Dyads were considered to have completed treatment after the parents were able to meet mastery criteria for the child-directed interaction portion of PCIT, able to handle their children's non-compliance using the strategies they learned in PCIT without being coached, and children responded to their parents' efforts to manage their behaviour.

Inclusion and exclusion criteria*:* Children between 2 and 7 years of age with externalising behaviour problems.

Outcomes of interest*:* Child behaviour, parenting, parent mental health, barriers to treatment.

Exposure to domestic abuse and children's social care status*:* All children exposed to domestic abuse; 77% referred by Child Protective Services, 40% court mandated.

Results
Effective models of working
No evidence.

Promising models of working
The Timmer et al. (2010) study of **PCIT** is a quantitative non-randomised study (EIF=2). This study compares the effectiveness of PCIT in reducing behaviour problems (such as aggression,

(domestic abuse) with a group of similar children with no exposure to domestic abuse. The findings

suggest that PCIT appears to improve trauma-related behavioural and mental health outcomes for children exposed to domestic abuse, including children in families with current or previous involvement with Child Protective Services. The results also showed decreases in child behaviour problems and caregivers' psychological distress from pre- to post-treatment with and without exposure to domestic abuse. The mother's sense of stress, (related to the quality of the relationship with the child, and the child's difficult behaviour) decreased from pre- to post-treatment, but mothers overall distress did not decrease significantly over the course of PCIT. Results of an analysis comparing the benefits of engaging in the first phase of treatment only and completing a full course of treatment over showed that mother-child dyads who completed the full course of treatment reported significant improvements in children's behaviour problems compared to those receiving only the first phase.

The authors draw attention to the degree to which children's symptoms can be reduced by improving the parent-child relationship. Further research is needed to know whether improvements are sustained at follow-up.

No evidence of effectiveness

Bunston et al. (2016) is also a quantitative non-randomised design (EIF=2). Although the **Peek-a-Boo Club** (IPP for mothers and infants) (Bunston et al., 2016) was beneficial in the short term to a minority of mothers and infants, no significant evidence of effectiveness is reported on the Reliable Change Index. Several participants, particularly those with low literacy, were anxious and reluctant about completing measures and data were not collected for these families. Practitioners' concerns about beginning therapeutic work without further delays meant that not all pre-measures were completed, particularly by some of the most vulnerable participants, and as such the effectiveness of the programme may be underestimated.

Qualitative data from the end-of-service questionnaire indicated that mothers felt that the intervention had been too short. Authors identified the need for further research on the optimal number of sessions for interventions that target infants and mothers affected by family violence, since child-parent psychotherapy has shown evidence of effectiveness in infants exposed to domestic abuse who are not necessarily above the threshold for Child Protective Services (see, for example, Ghosh Ippen et al., 2011; Lieberman et al., 2005, 2006).

Psychoeducative interventions for mothers and children

One paper reported on Project Support for mothers and children with Child Protective Services involvement (Jouriles et al., 2010). Project Support was evaluated using an RCT (EIF=3). For further details, see Appendix 2, Tables A1.3 and A1.4, and Appendix 4.

This version of Project Support was delivered by a therapist and clinical psychology graduate students.

Intervention description

Project Support

Project Support was designed in the US for women leaving domestic abuse refuges and their children aged 4-6 years (Jouriles et al., 2009; McDonald et al., 2006). Since these children are at high risk for conduct problems, the objective of the programme is to reduce conduct problems in these children, reduce harsh parenting, and improve the mother's relationship with her children by increasing her capacity to provide nurture and set limits. The programme provides practical and emotional support for mothers during their transition away from an abusive partner.

The intervention generally begins when women and children are in the refuge, and is then delivered in the home over approximately 20 sessions lasting 90 minutes each, although this varies according to the family's needs.

Project Support is grounded in behavioural theory (Patterson, 2002) and has two primary components: teaching mothers child management skills; and advocacy, providing practical support as needed. The first component is designed to help improve mothers' problem-solving and child management skills and to nurture children so that the parent-child relationship improves and child behaviour improves. The child management skills component is also the primary mechanism hypothesised to reduce child maltreatment, and this is particularly relevant to working with children on the Child Protective Services register (Jouriles et al., 2010). Mothers are taught a sequence of learning theory principles and skills through intensive, hands-on practice to reward and reinforce prosocial child behaviour and ignore or sanction antisocial child behaviour. As they begin to master each skill, mothers demonstrate their ability to use it in interactions with their children during the treatment sessions. When mastery is achieved, the next skill is introduced.

Alongside psychoeducation, Project Support provides practical support and advocacy, helping families with matters such as housing, financial and legal assistance, and liaison with the police. Project Support is manualised but adapted to the needs and circumstances of individual families, and extended family members can take part.

Project Support has been robustly evaluated in the US with families at high risk but without Child Protective Services involvement (see, for example, Jouriles et al., 2001; Jouriles et al., 2009; McDonald et al., 2006). The study included here (Jouriles et al., 2010) is for children with Child Protective Services involvement because of child maltreatment as well as domestic abuse exposure, but whose mothers were not in shelters at the outset of the intervention.

Inclusion and exclusion criteria in this study: Children aged 4-6 years exposed to domestic abuse, and their mothers. Mothers with significant untreated psychopathology or substance abuse disorders were excluded.

Outcomes of interest: Children's safeguarding status (that is, Child Protective Services case files), measures of parenting, and maternal mental health.

Exposure to domestic abuse and children's social care status: All children exposed to domestic abuse or family violence as well as direct maltreatment.[4] All children with Child Protective Services involvement.

Results

Project Support was evaluated using an RCT (EIF=3) with a low risk of bias (MMAT 4*)[5] (Jouriles et al., 2010).

Effective models of working

The evaluation of **Project Support** (Jouriles et al., 2010) measured parenting and changes in Child Protective Services status. Child Protective Services allowed the children to remain in the family home while the family enrolled in Project Support. Thirty-five families with a child between 3 and 8 years old were randomly assigned to receive either Project Support or Child Protective Services as usual. Families who received Project Support services showed more significant decreases than families who received Child Protective Services as usual in the following areas: mothers' perceived inability to manage childrearing responsibilities; mothers' reports of harsh parenting; and observations of ineffective parenting practices. The effect sizes for each outcome were large. Improvements in parenting were most rapid during the intervention and were maintained during the follow-up period. This study used social care case files to measure the change in the need for statutory safeguarding. Sixteen months post-intervention, the rate of re-referral to Child Protective Services was 5.9% (1/17) for families in the Project Support condition and 27.7% (5/18) for families in usual care.

There is, therefore, evidence that Project Support may help improve the parenting of mothers/parents whose children are involved with Child Protective Services and their management of child behavioural problems.

Psychoeducational and psychotherapeutic intervention for mothers and children

Mothers Overcoming Violence through Empowerment and Education (MOVE) (Ermentrout et al., 2014) was designed for mothers who have perpetrated some level of domestic abuse (but are not the primary perpetrators) and who have been court-mandated to the intervention (Macy et al., 2012; Rizo et al., 2018). MOVE was expanded to include a parallel group for their children aged 5 to 13.

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[4] Exposure to domestic abuse does not require intervention by Child Protective Services unless the child is also directly maltreated. Communication with Ernest Jouriles, 23 February 2023.

[5] See Appendix 3.

MOVE groups are co-facilitated by a clinician with a master's level education (for example, in social work or counselling) and a social work student intern or volunteer with training in domestic abuse.

The study is qualitative (EIF=0). For further details, see Appendix 2, Tables A1.5 and A1.6 and Appendix 4.

Intervention description
Mothers Overcoming Violence through Empowerment and Education (MOVE)
MOVE combines a psychoeducational, therapeutic parenting group for mothers and a concurrent therapeutic support group for their children. MOVE is informed by Bandura's (1991) social cognitive theory and the empowerment philosophy used in delivering intimate partner violence safety services for victims. It has two main components: a psychoeducational, therapeutic parenting group for the mothers; and a concurrent therapeutic support group for their children. A detailed biopsychosocial assessment by a social worker with family violence expertise is used to assess safety at intake.

Once enrolled, participants meet together one evening a week at the location of one of the participating agencies for 1.5 to 2 hours. The mothers' psychoeducational group emphasises participants' strengths by encouraging women to serve as models for their peers and by encouraging self-assessment of their skills, resources and sources of support. Practitioners use modelling and reinforcements to facilitate learning.

The children's therapeutic group involves work on self-esteem, safety planning, anger management, conflict resolution, communication, good and bad touches, and goal formation and attainment. Sessions are designed to build upon one another. Each session follows a specific format combining free play and dinner, curriculum-based activities and closure.

Beyond the group meetings, MOVE also offers dinner for the families, transport if needed, childcare for children under the age of 5, and security services to ensure staff and participant safety. These forms of support are used to help facilitate participation and provide a safe environment for families.

Inclusion and exclusion criteria: Participation is based on three eligibility criteria: having been mandated by the court and/or Child Protective Services; identifying as the biological mother, adoptive mother, foster mother or stepmother to a child or acting as the primary caregiver to a related or non-related child; and having been screened positively for past or present domestic abuse victimisation. Mothers cannot have been the primary perpetrators of abuse in the relationship.

Outcomes of interest: The included study (Ermentrout et al., 2014) reports on the feasibility study for the children's component of the intervention to understand the perspective of mothers, children and practitioners.

Exposure to domestic abuse and children's social care status: All children exposed to domestic abuse. All mothers are court-mandated, indicating high child protection concerns. Descriptive data on child participants were not collected due to concerns it could affect recruitment among families who are described as having ongoing court, Child Protective Services or child custody dispute involvement.

The evaluation of MOVE is wholly qualitative (EIF=0) (Ermentrout et al., 2014). Qualitative findings are incorporated in the sections on "Barriers and facilitators" (page 76), and Children's perspectives (page 108).

Comparing psychotherapeutic and psychoeducative interventions

One included study, reported in two papers (Pernebo et al., 2018, 2019), compared a psychotherapeutic intervention with one that is psychoeducational. The psychotherapeutic intervention is delivered by psychologists or social workers, and the psychoeducational intervention by social workers.

Intervention description
Child and Adolescent Mental Health Service Intervention (CAMHSI) or Children are People Too psychoeducational programme
Pernebo et al. (2018, 2019) compared psychotherapeutic and psychoeducational programmes of similar length and format for mothers and children aged 4-16 years. Both interventions involved parallel groups for mothers and children. The study was carried out in two major urban areas in Sweden and delivered by two agencies specialising in interventions for children suffering from the consequences of domestic violence: one community-based agency offering psychoeducational interventions; and the other a child and adolescent mental health (CAMHS) outpatient unit that offers psychotherapeutic interventions. Both agencies already had experience in delivering these two services.

The Child and Adolescent Mental Health Service Intervention (CAMHSI) is a psychotherapeutic intervention grounded in trauma, attachment and psychodynamic theory, which was developed in Sweden (based on work by Brager and Lichtenstein, 2015). The CAMHSI aims to decrease children's psychiatric symptoms, help children express and understand their feelings, thoughts, and experiences, and reduce their feelings of alienation and shame. The parents' groups aim to increase mothers' knowledge and skills, reduce their feelings of shame and alienation, and strengthen the parent-child relationship. Like the psychoeducational programme Children Are

People Too, the CAMHSI followed a fixed structure. Both children's and parents' groups focused on themes such as violence within the family, separation, visitations, fears, grief, and conflicts in daily life. These themes are approached using dialogue, exercises, and trauma-focused and free play with children.

Children are People Too was first developed for children whose parents abuse alcohol or drugs, and it has been revised and adjusted for use with children exposed to intimate partner violence (Hawthorne, 1990). Its objectives are: to increase children's capacity to cope with their experiences and to reduce the risk of them being negatively affected by those experiences in the future; to help children express and understand their feelings, thoughts and experiences; and to decrease their feelings of alienation and shame.

Parents' groups aimed to increase parenting knowledge and skills and reduce parents' feelings of shame and alienation. The programme's core focus for intimate partner violence includes: education about violence; safety planning; feelings; reactions to intimate partner violence/ domestic abuse, family relationships; and communication. Themes in the parents' groups paralleled those in the children's groups. The programme involves a range of techniques, including play, drawing, discussions and taught material.

Inclusion and exclusion criteria: To be included in the intervention, children needed to be aged 4-16, and mothers needed to have enough Swedish language skills to understand and answer the questionnaire (two families were excluded because of their limited Swedish). Both interventions offered treatment for children accompanied by mothers or non-offending fathers, but only mothers attended the interventions during the time of the study.

Outcomes of interest: Child mental health, stress symptoms, emotionality and emotional regulation. Child/ parent exposure to violence; maternal mental health and PTSD symptoms.

Exposure to domestic abuse and children's social care status: The majority of mothers had contact with children's social care (67% in the psychoeducational group, 100% in the psychotherapeutic group), although the level of intensity of that involvement varied within each group.[6]

Results

Pernebo et al. (2018, 2019) is a pre-post study with data collection at four time points (EIF=2). For further details on the intervention, see Appendix 2, Tables A1.7 and A1.8, and Appendix 3.

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[6] Level of children's social care involvement is based on mothers' self-report only and was not checked against records. Communication with Karin Pernebo, 8 June 2022.

Effective models of working:
No evidence.

Promising models of working

The comparison study with no randomisation or control group by Pernebo et al. (2018, 2019) concludes that both the **trauma-informed therapy** and **psychoeducational programme** are safe and that outcomes showing reduced child symptoms and protection from exposure to violence are sustainable. However, intervention effects were stronger in the therapeutic group.

It is interesting to note that the therapeutic intervention may have had a late effect, as mothers reported a decrease in children's symptoms six months post-intervention and that treatment gains were sustained at 12 months. Children with severe trauma symptoms benefited the most from trauma-informed psychotherapy. Mothers' psychological problems may hinder children's recovery, so the authors emphasised the benefit of focusing on maternal psychological functioning.

Despite these improvements, a proportion of children in both interventions continued to manifest trauma symptoms at clinical levels post-treatment, particularly in symptoms of PTSD, although these symptoms had been reduced for both intervention and control group children six months post-intervention (Pernebo et al., 2018, 2019). The authors recommended the integration of a focus on children's experience of trauma and using techniques like imaginal exposure (such as engaging in narratives and play focused on the individual trauma). Neither the therapeutic nor the psychoeducational programmes included these components, and severe symptoms of trauma (specifically avoidance and intrusion) are not well treated without imaginal exposure and a focus on memory processes. These components may be difficult to include in group interventions with traumatised children, especially young ones, who may therefore require one-to-one treatment.

The authors, therefore, recommend routine assessment of children's and mothers' symptoms and needs during the intervention so that adjustments can be made at follow-up assessments.

2. Child-focused interventions with additional components for parents

Two papers evaluate trauma-focused cognitive behavioural therapy (TF-CBT) with expressive therapies for children who have been exposed to domestic abuse, with some parallel sessions with their mother or other non-offending caregivers.

Interventions were delivered by therapists trained in TF-CBT and art or play therapy.

Both studies were of one-group pre-post design (EIF=2), with one study including qualitative components (Woollett et al., 2020). For further details, see Appendix 2, Tables A2.1 and A2.2, and Appendix 4.

Intervention description

Trauma-focused cognitive behavioural therapy (TF-CBT) with art or play therapy

TF-CBT is a type of cognitive behavioural therapy initially designed for children and adolescents who had been sexually abused, but its use has since been expanded to young people with other traumatic experiences. Although the primary focus of the intervention is the domestic abuse-exposed child or adolescent, the non-offending parent or caregiver is involved in some conjoint sessions. TF-CBT usually involves between 8 and 16 sessions. Core elements of TF-CBT include psychoeducation, relaxation techniques, cognitive processing of the trauma, child-parent sessions grounded in family therapy, and skill-building, including developing plans to enhance future safety. The intervention is tailored for people who have experienced different traumatic events.

The early phase of treatment focuses on establishing safety, and developing and stabilising core emotional and behavioural regulation competencies. Attachment-focused approaches view the therapist-client relationship as a vehicle for healing by creating a safe, predictable and structured space. Therapists aim to support the child to develop the skills needed for tolerating and managing overwhelming emotions and for the child to experience the caregiver as safe and healing. The second phase focuses on processing trauma by breaking the association between thoughts and reminders of the traumatic experience and the overwhelming negative emotions of terror, helplessness, shame and rage.

Both included interventions used TF-CBT with expressive, nonverbal therapies (Dauber et al., 2015; Woollett et al., 2020), because expressive techniques such as art, play and music can help children to express memories and emotions in a nonverbal way.

The Trauma Recovery Programme (Dauber et al., 2015) combines cognitive-behavioural interventions and creative art therapy within an attachment-based approach. One hundred and eighty-four children were enrolled in the programme, and 122 completed at least 12 sessions over 3 months. However, only 31 children and adolescents completed measures pre- and post-intervention, and these were included in the study. The primary outcome measured was child trauma symptoms.

The model described in Woollett et al. (2020) integrated TF-CBT with art therapy and structured play therapy (Drisko et al., 2019; Goodyear-Brown, 2019) across 12, 1-2-hour, group-based sessions delivered in the refuge. At the end of the intervention, the children's artwork was exhibited in the

refuge to encourage conversations about children's experiences between parents and children and the refuge community. Mothers took part in three group sessions focused on parenting.

Inclusion and exclusion criteria: Children aged 5-15 with trauma symptoms (Dauber et al., 2015), or children aged 4-14 in shelters for high-risk victims of domestic abuse (Woollett et al., 2020).

Outcomes of interest: Child trauma symptoms, PTSD, depression.

Exposure to domestic abuse and children's social care status*:* The study by Dauber et al. (2015) involved 52% of children with CPS involvement and 68% who had witnessed domestic abuse or other forms of family violence. All children in the study by Woollett et al. (2020) were in high-risk domestic abuse refuges. Families' "typical" levels of involvement with Child Protective Services was confirmed by the author.[7]

Results

Study type: One study (Dauber et al., 2015) involved a one-group pre-post design (EIF=2). The second study (Woollett et al., 2020) was mixed method, a one-group pre-post study with a qualitative component (EIF=2). For further details, see Appendix 2, Tables A2.1 and A2.2, and Appendix 4.

Effective models of working

No evidence.

Promising models of working

The strength of the evidence is weak, but both studies suggest that TF-CBT can reduce depression and anxiety in children who have been exposed to domestic abuse and can improve trauma symptoms. However, the age range of children included in these interventions varies, and it is unclear from these studies whether older and younger children benefit to the same extent.

These findings are consistent with the broader evidence on the effectiveness of TF-CBT; NICE guidelines recommend TF-CBT as the first-line intervention for children and young people with PTSD.

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[7] Communication with Nataly Woollett, 10 June 2022. This qualitative study involved two groups, in both cases domestic abuse shelters, in the US and in South Africa.

3. Interventions for Looked After children or adolescents

Only two interventions were identified for adolescents or children in out-of-home care (typically in foster care or group homes): Camp HOPE America (Hellman and Gwinn, 2017) and Write On writing therapy (Parker et al., 2006).

Camp HOPE is delivered by a combination of therapists and camp counsellors. There is no information about who facilitates the Write On expressive writing intervention.

Both interventions were evaluated with a one-group pre-post design (EIF=2). For further details, see Appendix 2, Tables A2.3 and A2.4, and Appendix 4.

Intervention description

Camp HOPE
Camp HOPE America (Hellman and Gwinn, 2017) is part of Alliance for HOPE International, the umbrella organisation for all Family Justice Centres and similar multi-agency models that serve victims of domestic violence and their children throughout the US. Children are referred to these services by the courts or Child Protective Services.

Camp HOPE itself is a six-day summer camp for children who have experienced abuse or neglect – in this instance, exposure to domestic abuse – and are now in foster care or group homes. This evaluation measures outcomes associated with participation in a single summer camp. Participating children and adolescents are divided into ages 7-11 and 12-17. However, Camp HOPE is part of a long-term programme of support for children and adolescents in out-of-home care. During the school year, children and adolescents participate in monthly peer activities led by a mentor, and they can return to Camp HOPE every summer.

This intervention is trauma-informed and grounded in positive psychology and hope theory (Snyder, 2002). In this context, hope is defined as a future-based orientation that helps identify goals, pathways to achieve goals, and confidence in one's sense of agency. Snyder (1995) proposes that the process of nurturing hope for a child should begin with goal-setting strategies. Here, a child starts to experience the possibility of a positive future; this attention to a newly considered goal results in a short-term increase in agentic thinking. During this increase in the agency, the practitioner can work with the motivated child to identify pathways to achieving the goal while considering likely barriers.

Camp HOPE programme activities are site-specific and age-appropriate, and include recreational hiking, canoeing, horseback-riding, campfires and games. These activities foster creative thinking, problem-solving, teamwork, mutual support, self-esteem, self-management, and goal-setting. In addition to the challenging outdoor activities of their choice, children participate in routine group activities and other recreational events. The programme of activities is delivered by camp counsellors who routinely work with children who have not been exposed to domestic abuse or severe adversity, with training by specialist therapists who work directly with the young people in the camp.

Inclusion and exclusion criteria: Children are in foster care or group homes, or the equivalent. No reference is made to exclusion criteria. There is evidence of a high level of trauma exposure among children and adolescents enrolled in Camp HOPE, with a median ACE (adverse childhood experience) score of 5.51 (Standard deviation =2.38), which is significantly higher than the US national average (Ford et al., 2014).

Outcomes of interest: Children's sense of hope; character associated with resilience.

Exposure to domestic abuse and children's social care status: All children had been exposed to domestic abuse before entering foster care (that is, becoming looked after).

Expressive writing therapy

Expressive writing is a technique used to improve mental and physical health in adults and has been used with adolescents to help cope with life stresses. Expressive writing may aid emotional disclosure of traumatic events.

Expressive writing therapy is delivered in four 90-minute sessions to 15 adolescent girls aged 12-17, all in out-of-home care (for example, foster care) who had previously been exposed to domestic abuse. Participants' emotional states were rated pre-intervention using a form called "How's it going?". Participants then wrote for 15 minutes about a personal traumatic experience related to domestic abuse. Activities were then aimed at targeting self-esteem and relationship skills. The intervention group combined Write On with Positive Points – a list of words to describe positive qualities and strengths which could be incorporated into the written piece. In contrast, the control group used the Write On intervention alone. Following writing sessions, activities targeting self-esteem and relationship skills were conducted. Self-esteem materials and positive affirmations were given to teens to place in a notebook.

Inclusion and exclusion criteria: Included children are in foster care, group homes, or equivalent. No reference is made to exclusion criteria.

Outcomes of interest: Capacity to express emotion, proxy measures for positive emotion; anger, depression and self-concept.

Exposure to domestic abuse and children's social care status: All children had been exposed to domestic abuse before entering foster care (that is, becoming looked after).

Results

Study design: Both interventions were evaluated with a one-group pre-post design (EIF=2). For further details, see Appendix 2, Tables A2.3 and A2.4, and Appendix 4.

Effective interventions: No evidence.

Promising interventions

Following **Camp HOPE,** Hellman and Gwinn (2017) reported a significant increase in children's sense of hope as reported by the 229 children who completed pre-post measures, and this improvement was observed separately by camp therapists. Children's sense of hope is defined as their capacity to envisage the possibility of a positive future, and it is the core outcome of interest in this practice model. The clinicians who co-delivered the camp activities also completed a measure on children's character development (that is, qualities associated with resilience) and reported a moderate and significant increase in children's sense of "zest", gratitude and curiosity, with smaller but significant increases in scores for self-control, optimism and social intelligence. There was a correlation between children's self-reported hope and clinician's scores in children's character strengths.

It is important to note that Camp HOPE is part of a longer-term service that includes peer support, mentoring, and the possibility of returning to a Camp HOPE summer camp over several years. Parker et al. (2006) found a 67% increase in positive emotions for both the experimental and the control conditions at the end of the **Write On** programme, and there was a significant increase in the number of words related to self in the experimental group. There was a small, non-significant reduction in measures of depression and sadness in the intervention group compared to the control group, but this was not statistically significant. There were no differences in pre-post measures of anger, self-concept or dating attitudes. No follow-up was conducted.

4. Whole family interventions

This section includes six grey evaluations of interventions designed to be delivered to all family members. Although there is some overlap among them, the interventions are described as either "family systemic" or "multi-agency/multi-component". As the name suggests, Family systemic interventions are explicitly grounded in famly systems theory. These services are delivered by a single team embedded within local authority children's services (as in the case of NewDAy and SafeCORE) or by skilled practitioners from a voluntary sector organisation that works closely alongside children's services (as in the case of For Baby's Sake). Three further studies are described as multi-agency/multi-component because as they do not work from an explicitly systemic orientation, do not include family therapists, and in two cases (Opening Closed Doors and Growing Futures) refer family members to a range of services delivered by other agencies.

The three family systemic interventions are of mixed-method design (EIF=2). Two of the three multi-agency/multi-component interventions are also of mixed methods (EIF=2). The third study (Heal et al., 2017) was evaluated with an RCT (EIF=3) with no identified risk of bias. For further detail, see Appendix 2, Tables A3.1 and A3.2, and Appendix 4.

It is important to note that these practice models have undergone further adjustment, often in response to the problems identified through routine monitoring or the evaluation itself.

Intervention description
Family systemic interventions
Three studies focus on a systemically-informed service delivered by a single team. Two interventions, NewDAy and SafeCORE, are part of children's services in two London local authorities – NewDAy in Newham, and SafeCORE in Greenwich. For Baby's Sake is managed and funded by the For Baby's Sake Charitable Foundation, but practitioners are co-located in children's services and the wider inter-agency network in several local authorities.

The number of children on the edge of, or on, a Child Protection Plan varies across the three studies. At baseline, 34% of the children in the NewDAy sample and 22% of those in For Baby's Sake were on a Child Protection Plan. A further 69% of children in NewDAy and 27% in For Baby's Sake were on a Child in Need Plan. The SafeCORE model was designed for families currently below the threshold for children's social care to prevent the escalation of violence and the need for expensive statutory interventions. In the third year of operation and as the evaluation concluded, SafeCORE tested what was described as a "bolt-on" intervention that could run alongside a Child Protection Plan. The evaluation includes only four families who had been on a Child Protection Plan and were close to completion at the time of the evaluation.

All three interventions are delivered by multi-disciplinary teams with training, support and supervision from family therapists embedded in the service. For Baby's Sake staff and SafeCORE managers also benefit from coaching and supervision from an external clinician with expertise in the therapeutic approach. Since NewDAy has an important component of work in schools, the team includes teachers.

SafeCORE and NewDAy teams are part of children's services in their respective local authorities, while For Baby's Sake professionals work with adult and children's services but are employed by the For Baby's Sake Foundation.

For Baby's Sake
For Baby's Sake was designed for co-parents who are expecting a child, and the service continues up until the child is aged 2.

The focus from conception to age 2 is critical because of the impact of domestic abuse on babies, starting in the womb, the plasticity of the infant's brain, the importance of attachment security and the motivation of parents to make changes when expecting a child. Both parents join during pregnancy (whether together as a couple or not) and the intervention is offered from the antenatal period up until the child reaches age 2. The objective is to help families bring an end to domestic abuse, recover from its impact, and improve outcomes for children. The intervention is informed by attachment and trauma theory and incorporates behavioural, gestalt and psychodynamic elements, and mindfulness practice.

For Baby's Sake is designed in a modular format and delivered flexibly to meet individual needs. The mother engages in psychoeducation, TF-CBT exercises for anxiety and depression. The father engages in separate sessions involving a TF-CBT framework to address negative thinking and patterns of denial and blame. However, components of the intervention are adapted for either or both parents and differ in relationships where violence is bidirectional or if women primarily perpetrate violence.[8] After birth, both parents participate in conjoint work to enhance their understanding of the infants' communication and to set the foundations for early parenting. Additional support is offered to parents to aid their sustained recovery from mental health problems.

As with all whole family intervention models, services were initially delivered face-to-face and through video or audio calls during the Covid-19 pandemic.

Inclusion and exclusion criteria*:* For Baby's Sake is designed for parents where there is domestic abuse in the relationship, they are expecting a child and are committed to co-parenting, whether or not they stay together. There can be other children in the family and/or from previous relationships. Parents cannot continue if the index child (that is, the unborn baby) is taken into care at birth.

Outcomes of interest: The social care status of children, perpetration and child exposure to domestic abuse, quality of parenting, parenting stress, parental anxiety and depression, and parental PTSD symptoms.

Exposure to domestic abuse and children's social care status*:* For Baby's Sake begins in the antenatal period when there is evidence of domestic abuse. Seventy per cent of parents had children's social care involvement at baseline.

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[8] Communication with Amanda McIntyre, 20 October 2022.

SafeCORE

SafeCORE (Compassion, Openness, Relationships and Engagement) was designed to be a whole family approach to working with families in which children are exposed to the most common form of domestic abuse – situational couple violence (Johnson, 2008).

SafeCORE's whole family intervention applies compassion-focused therapy (Gilbert, 2010) with family-led systemic concepts, relational approaches, and practical support. Compassion-focused therapy integrates techniques from cognitive behavioural therapy with concepts from evolutionary psychology, social psychology, developmental psychology, mindfulness and neuroscience. One of the concerns of compassion-focused therapy is to aid individuals in building their capacity to develop and work with experiences of warmth, safety and soothing via compassion and self-compassion. The key intermediate aims of SafeCORE are therefore to create a compassionate stance among the self and others, and to give family members skills for better emotion regulation and interpersonal communication.

Responsibility for each case (each family) is shared by five staff and a clinician who form part of a systemic unit, although the direct work is generally conducted by two, sometimes three, team members.

The whole team, including the administrator, is trained in the SafeCORE model. Sessions are provided in the home, in other community locations, and (like the other interventions in this section), since the Covid-19 lockdown, a combination of face-to-face work and online platforms. SafeCORE has a practice manual designed to be delivered over 24 sessions, but the form of delivery and, to some extent, the length are adapted to the needs of each family.

The overarching aim of SafeCORE is to reduce the likelihood of families re-entering or escalating through the children's social care system with more severe needs. It also aims to break through a cycle of shame and emotional dysregulation that could lead to incidents of domestic abuse.

Initially, SafeCORE worked with families whose difficulties did not, at that point, require statutory intervention by children's social care. From 2019, families were accepted who presented with other forms of chronic violence. In 2020 and 2021, SafeCORE expanded to include a "bolt-on" intervention for families with children subject to a Child Protection Plan, and other services, including a post-intervention parents' group and a men's and fathers' group.

Inclusion and exclusion criteria*: Decisions on inclusion are made on a case-by-case basis by the service lead, but the primary reason for exclusion is evidence of coercive control, severe violence or sexual abuse/violence. SafeCORE teams and clinicians have worked with families where a parent has severe mental health problems and substance abuse.

Outcomes of interest: Child safeguarding status, family functioning, understanding and practice of principles of compassion as defined in compassion-focused therapy, and achievement of family goals.

Exposure to domestic abuse and children's social care status: All children in the year 3 "bolt-on" service had been exposed to domestic abuse alongside other forms of family violence and were on a Child Protection Plan.

NewDAy

NewDAy, based in Newham Children's Services, is a non-statutory service offered to families in which children are exposed to situational couple violence (Johnson, 2008). The service is designed to operate in multiple domains, including the home, school and community.

The overarching aim of NewDAy is to reduce the risk of domestic abuse and improve child wellbeing and other outcomes for families. Outcomes of interest were child behaviour, family functioning, and social care status of children pre- and post-intervention.

NewDAy involves four core services:
1. Three sessions aimed at providing preliminary support to children and young people and victims-survivors, and engaging users of abuse including: (a) children and young people's wishes and feelings; (b) talking about emotions; and (c) engaging users of abuse.
2. Caring Dads: a 17-week group work programme focused on gender-based violence (see section on Interventions for Fathers, page 68) that aims to increase child-centred fathering, encourage responsibility for abuse or neglectful fathering, and rebuild trust in father-child relationships.
3. Inter-parental relationships (IPR) weekly or fortnightly sessions with parents for up to 6 months. IPR is informed by systemic therapy. Sessions are delivered to each parent separately and then together when safe to do so. IPR consists of a "discovery" phase, followed by a "risk analysis, safety planning, and self-soothing" phase and a "family trial" where families test out the strategies provided.
4. Schools and learning intervention: school-focused support for children and young people aiming to improve participation, engagement, attainment and wellbeing at school delivered over three terms.

Inclusion and exclusion criteria: Families of children aged 4-17, who have been exposed to situational couple violence, and their parent(s).

Outcomes of interest: Child behavioural outcomes; social care status of children and families; wellbeing and safety of children; educational outcomes.

Exposure to domestic abuse and children's social care status*:** All children exposed to domestic abuse. Sixty-nine per cent of children were on a Child in Need Plan, and 31% had children's social care involvement at baseline.

Whole family interventions – multi-component/multi-agency

The multi-agency/multi-component models in this section are for families with varying degrees of involvement with children's social care. One intervention (Growing Futures) was designed only for families with a Child in Need Plan, but the evaluation measures changes in safeguarding status, including escalation to Child Protection plans, and is included in this section. Opening Closed Doors (Barnardo's Cymru, 2021) and Project Crewe (now Families Achieving Change Together) in Cheshire included a proportion of children on the threshold of children's social care.

Project Crewe (now Families Achieving Change Together – FACT) is coordinated by a social work consultant based in Children's Services**,** family practitioners, frontline workers, volunteer peer mentors and family role-models.   Growing Futures is delivered by a small specialist team based in children's services. The team includes social workers and domestic abuse navigators who are not necessarily trained social workers. Barnardo's Opening Closed Doors is coordinated by key workers based within five local authority children's services teams and other workers who provide cross-authority "floating" support.

Project Crewe

Project Crewe is aims to improve the outcomes for children on a Children in Need plan by offering a more personalised and intensive support model. Although the intervention is designed for families on a Child in Need Plan, the evaluation evaluates families above the threshold for statutory services. The service works at times that suit the family, including early mornings and weekends; personalised family budgets help families achieve the goals on the Child in Need Plan.

Project Crewe is coordinated by a social work consultant who supports 'pods' of (i) four family practitioners who are responsible for delivering the Child in Need Plan and who work directly with families to build resilience, maintain positive change, and prevent relapse; (ii) frontline workers who deliver solution focused brief therapy (SFBT) with adults; and (iii) volunteer peer mentors and family role-models, who work with children and parents to sustain change after case closure.

Inclusion and exclusion criteria: The intervention is designed for children on a Child in Need Plan, and therefore on the threshold for statutory social care.

Outcomes of interest: Child risk ratings, social care status of children, educational outcomes (using the national pupil database).

Exposure to domestic abuse and children's social care status: All children on a Child in Need Plan. Forty-seven per cent of children on a Child in Need Plan had been exposed to domestic abuse.

Growing Futures

Growing Futures was established in Doncaster to improve outcomes for children and young people (children and adolescents) who have experienced domestic violence and abuse through a multi-agency approach led by the Doncaster Children's Services Trust. The overarching aims are: to reduce emotional harm to children and adolescents caused by domestic abuse exposure; to directly support recovery from domestic abuse for victims and their children; to significantly reduce repeat victimisation; to challenge the acceptance of domestic abuse among families and the wider community; and to reduce the likelihood that children and adolescents will be exposed to, or perpetrate, partner violence. The specific goals are: to reduce repeat MARAC referrals by 25%; to reduce the proportion of repeat referrals to social care in which domestic abuse is a factor by 30%; and to reduce the number of children admitted to care by reducing the number of Children in Need where DVA is a factor by 10%.

Work is delivered by Domestic Abuse Navigators (DANs), key workers who work directly with children and coordinate support for the whole family to ensure that adults can access support and services for abusive male partners and for female victim-survivors of domestic abuse.

Much of the work of this project has focused on training, coaching and equipping service leaders and professionals. This has included but is not restricted to embedding Signs of Safety, helping Parenting and Family Support Services to respond to families experiencing domestic abuse (including those with multiple and complex needs), outreach and communications work within the community to tackle perceived widespread acceptance of domestic abuse, and work with young people and in schools. The evaluation of Growing Futures focused primarily on the impact of a new model of working with families, enacted by the DANs.

Inclusion and exclusion criteria: Children aged 5-13 exposed to domestic abuse, and their families.

Outcomes of interest: Reduction of MARAC re-referrals, reduction of MARAC referrals in the area, social care status of children.

Exposure to domestic abuse and children's social care status: All children had been exposed to domestic abuse, Of the children who received a service (n=266) 35% (n=92) were on a Care and Support Plan other than for Child Protection, 39% (n=105) were on the Child Protection

Register and 12% (n=33) were Looked After Children. Only 14% (n=36) of children were not receiving a statutory service.

Opening Closed Doors is a whole family practice model developed by Barnardo's Cymru in partnership with the police and five local authorities. The overarching aim of the programme is to create a stable and safe home environment, improve parent-child relationships, reduce the emotional stress experienced by children and adolescents, improve school attendance, help families recover from domestic abuse, and to stay together safely following a reduction/cessation of domestic abuse. Work with children aims to raise awareness and understanding of domestic violence and help children manage their emotions.

The practice model combines direct, one-to-one support for individual families with three structured interventions delivered either one-to-one or in groups, depending on the family's circumstances. These interventions are: a 20-week programme for fathers who have perpetrated domestic abuse; a 10-week integrated Women's Support programme aimed at helping women recover and build their resilience, with additional group work for women who want to develop greater confidence and wellbeing; and the 10-week, group-based Safety, Trust and Respect (STAR) programme to help children and young people understand their experiences and develop coping strategies, safety plans and support networks.

Key workers based at the local authority receive referrals, provide support to the whole family and the social work team(s) involved, and conduct some direct work, and ensure that all family members have access to group-based support.

Inclusion and exclusion criteria: Children aged 3-9 with behavioural problems exposed to domestic abuse, and their families.

Outcomes of interest: Child behavioural outcomes, social care status, educational outcomes/school attendance; parenting/carer wellbeing, cessation of domestic abuse.

Exposure to domestic abuse and children's social care status*:* All children exposed to domestic abuse. Thirty-five per cent of families on a Care and Support plan, 39% of families had a child on a Child Protection Plan and 12% had Children Looked After.

Results
Study designs: Of the six interventions in this section, only one was evaluated using an RCT (EIF=3) with no risk of bias (MMAT 5*) (Heal et al., 2017). The remaining five interventions used mixed-method pre- and post- designs (EIF=2) (Barnardo's Cymru, 2021; Langdon-Shreeve et al., 2020; McCracken et al., 2017; Schrader McMillan, 2022; Trevillion et al., 2020). (For further

details, see Appendix 2, Tables A3.1 and A3.2 and Appendix 4, and risk of bias assessment in Appendix 3).

The service models in this section have been developed and tested in England or Wales, and are, in each case, the first intervention of its kind, so the findings are particularly relevant to the UK. As well as reporting on outcomes, these evaluations synthesise learning on the process by which the intervention was introduced in a local area and on the factors that hindered or contributed to the project's success. These findings are reported in more detail in the section, "Barriers and facilitators", but are briefly summarised here. There were no evaluations of interventions underpinned by whole family systemic approaches that were sufficiently strong to be confident about the outcomes. There are, however, a number of promising models of work that justify further evaluation.

Family systemic models

Effective models of working:
No evidence.

Promising models of working
Completion of the **For Baby's Sake** programme was associated with de-escalation from children's social care to universal services or case closure among the 27 children in the sample and a reduction from 70% to 33% in the percentage of children who required safeguarding measures 24 months post-intervention. For Baby's Sake also shows a decline in the percentage of mothers reporting abuse, from 59% at baseline to 33% at two-year follow-up.

Positive changes were observed in parental mental health outcomes, especially maternal depression and PTSD of both mothers and fathers. Parenting stress mean scores changed very little across the two time points, and no one scored in a range suggesting problematic parenting stress. In contrast, several respondents had unexpectedly low scores, including some being identified as "defensive responding". "Defensive responding" is defined as a highly positive score that could indicate that the parent is making an effort to portray themselves as competent or that the parent is not invested in the parenting role, although it is also possible that the parent is coping exceptionally well. Child development outcomes at one and two years post-intervention were mainly in the normal range. Co-parents often separated during their participation in the programme. While over two-thirds of all women and all men in the evaluation were in a relationship with their co-parent at baseline interviews, only a third (of women and men) remained in these relationships at the two-year follow-up interviews.

The **NewDAy** evaluation concluded that the therapeutically informed approach was the driver of positive outcomes for families, including reduced need for social care, improved emotional and behavioural outcomes for children, and improvements in outcomes related to participation in school and learning (Langdon-Shreeve et al., 2020). There was a counterfactual comparison group for the inter-parenting relationships (IPR) and Caring Dads group. However, there was no counterfactual comparison group to compare outcomes on the Strengths and Difficulties Questionnaire (SDQ) for the Schools and Learning cohort, so it is difficult to attribute the impact to the intervention alone.

Based on social care case file data, 81% of children and young people whose families received support had a reduced level of social service risk six months post-intervention relative to 57% of the comparison group. The largest improvements were seen by children and young people moving from a Child in Need Plan to the case being closed to children's services. A substantial proportion of the NewDAY cohort also de-escalated from being subject to a Child Protection Plan to being closed to children's services (9%) or moving from being subject to a Child Protection Plan to a Child in Need Plan (12%). The difference between the comparison group and the NewDAY cohort was most prominent between the start and end of the intervention, suggesting that NewDAy accelerates de-escalation and increases the number of families who de-escalate.

Case file analysis also suggests that 60% of children who had received support had a high-to-medium improvement in anxiety; 74% overall improvement in wellbeing; 80% improvement in family relationships; 77% in educational engagement and achievement; a 65% reduction in witnessing domestic abuse; and in 60% of cases, improvement in children's feelings of safety. Data collected from SDQs showed that children who had received support through the Family and Schools programme improved in all measures of behaviour and emotional wellbeing, a finding supported by data from interviews. The largestaverage changes were in decreased hyperactivity and improved prosociality. The smallest average changes were in emotional symptoms and peer problems. The number of families to complete a measure of family functioning was relatively small, but findings showed improved family functioning, particularly in reducing overwhelming difficulties and improving communication and adaptability.

A distinctive feature of NewDAy is its Schools programme, and outcomes of interest, assessed by teachers and other school staff, were children's engagement in class, and interaction with peers and teachers. Data were available for 58% of those who completed the interventions, and analysis of the data showed that in the majority of cases, the NewDAy children's participation and engagement improved between the start and end of the Schools and Learning intervention; only 4% deteriorated. However, for a substantial minority of children and young people (38%), their engagement in school did not change.

The analysis also suggests improvement in children and young people's attainment; between the beginning and end of the Schools and Learning intervention. Younger children improved the most: out of 14 children, 77% (n=10) improved in Reading, 71% (n=10) improved in Writing and 71% (n=10) improved in Maths. In comparison out of the 36 children in Key Stage ,only 49% (n=17) improved in Reading, 47% (n=17) in Writing, and 56% (n=20) in Maths (although the differences in sample size should be noted).

There was little evidence to suggest that NewDAy had a strong impact on attendance, but truancy was not a significant challenge at baseline.

The **SafeCORE** programme comprised a whole family service that was delivered by a team within children's services and worked exclusively with families below the threshold for a Child in Need Plan at the point of referral in the first two years of operation. In year 3, the model was adapted to work with families above the threshold for a Child Protection Plan.

Eight families on Child Protection Plans were enrolled in SafeCORE at the time of the evaluation, and four were approaching completion so they could take part in interviews. Analysis of case file data showed that all four cases were scheduled to close to social care. Interviews with parents whose children had been on a Child Protection Plan show that parents perceived there to have been improvements in family functioning and the understanding and practice of compassion – a core objective of the intervention and central to its theory of change. However, follow-up is needed to ascertain whether changes have been achieved and sustained in a larger cohort of families involved with children's social care.

All three services are reported to have worked slightly below capacity. Further work is needed to increase parents' motivation to engage with the service. These and other findings on the process are summarised in in the section on Barriers and facilitators, page 76 below).

Multi-component, multi-agency models

Effective models of working:
No evidence.

Promising models of working
Although **Project Crewe** was evaluated using an RCT, the sample size was 50% smaller than anticipated, so it was not possible to undertake an intention-to-treat analysis. The findings suggest that children in the intervention and control group (families who received usual care) were at reduced risk post-intervention and that the reduction was greater among intervention group

children and most marked among children at the highest level of risk. Authors of this evaluation recommend tracking outcomes for families for longer, and in particular, to monitor re-referrals to children's social care to assess whether changes are sustained after the intervention has ended.

The evaluation of **Opening Closed Doors** suggests that the programme may be associated with reduced social care involvement with families, and that it contributed to statistically significant improvements in emotional and behavioural outcomes for children and to parents' subjective wellbeing. Integrating findings from all sources, the authors concluded that the intervention improved safety and stability in the children's home environment for a high proportion of participating children, and reduced the emotional stress experienced by children in the majority of cases. The programme also appeared to have a positive impact on the child's emotional health and wellbeing, including a medium decrease in the child's emotional problems, conduct problems and total difficulties scores between the start and end of the programme interventions. There is evidence that domestic abuse has reduced or stopped in most cases. The suggested reasons for this included that the perpetrator's behaviour had changed due to having a greater understanding of abusive behaviour and its impact, and being able to engage in more constructive conflict resolution, and that mothers were better equipped to recognise and de-escalate situations.

Findings from the SDQ suggest limited improvement in children's peer relationships. It was also not possible to get reliable data on children's school attendance.

A proportion of children and adolescents in this sample had experienced early childhood trauma and "*the problems facing these children are known to be significant*" (Barnardo's Cymru, 2021: 47). The authors conclude that recovery from domestic abuse is likely to be a long and complex process that can extend over years, that families typically had additional needs and vulnerabilities and were therefore likely to need ongoing support beyond the end of specific interventions offered by the programme.

The evaluation of **Growing Futures** reported a reduction in risk factors for 45% of included children and a reduction in the number of families re-referred for domestic abuse.

Overall, there is indicative evidence that multi-agency/multi-component models can reduce social care involvement with families and reduce re-referrals for domestic abuse. Qualitative findings, summarised in the section "Barriers and facilitators" (page 76), show that despite difficulties in implementing and running multi-agency networks around domestic abuse, this model is valued by the agencies involved and by frontline practitioners. However, it is possible that some individual intervention components are more effective than others. For example, Project Crewe used solution-focused brief therapy (SFBT), but (drawing on existing evidence) the evaluation concluded that SFBT may be less effective with people who have multiple, complex needs and trauma histories (Woods and Green, 2011; see also Eads and Lee, 2019).

The evaluation of multi-agency/multi-component models can be complicated.   As Lowell et al. (2011: 194) observed with reference to the comparable "systems of care" approach in the US, "*Empirical evidence of the effectiveness of this approach has been constrained partially due to the complexity of evaluating both systems- and clinical/functional-level outcomes.*"

Interventions for fathers

Five studies evaluated interventions for parents who had perpetrated domestic abuse. Two interventions (Fathers for Change and Caring Dads) were designed for fathers only, and one (Inner Strength) for fathers or mothers who have perpetrated domestic abuse or general violence outside the home. A further, qualitative intervention (Ermentrout et al., 2014) for mothers who have perpetrated domestic abuse is included in the section on Barriers and facilitators, page 76.

Fathers for Change (US) has been offered in community settings and led by child protection social workers and facilitators from community agencies. Inner Strength was delivered by a team comprised of social workers and community police officers, with training and some external supervision from the psychologists who co-authored the programme. Caring Dads was delivered by social workers.

One study of Fathers for Change (Stover, 2015) is an RCT with low risk of bias. Two studies are one group pre- and post-test (EIF=2). Two further studies used mixed methods (EIF=2). For more details, see Appendix 2, Tables A4.1 and A4.2, and Appendix 4.

These interventions combine therapeutic and psychoeducational components and can be delivered in groups (Caring Dads, Inner Strength) or the home and one-to-one (Fathers for Change). Although it is primarily psychoeducational, Caring Dads is trauma-informed, and Fathers for Change is grounded in trauma theory. Additionally, NewDAy (described in the previous section) offers Caring Dads.[9]

Intervention description
Fathers for Change
Initially developed for fathers in outpatient substance use treatment programmes, Fathers for Change has been modified for residential treatment programmes, outpatient community mental health settings, and other community settings. Fathers are referred by Child Protective Services or the courts after Child Protective Services has determined that children do not need to be placed in out-of-home care immediately. Participating fathers have children aged under the age of 12.

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[9] These studies do not specifically report on the outcomes for Caring Dads.

Fathers for Change has a systemic orientation that combines attachment and cognitive behaviour theories with a focus on emotion regulation and reflective functioning. The practitioner works one-to-one with the father and includes children or both parents in conjoint sessions with the father if it is safe and the mother agrees. Work begins with a comprehensive assessment using a range of measures to assess the history of intimate partner violence, substance misuse, co-parenting, mental health symptoms, emotion regulation difficulties, and childhood history of trauma. The intervention is structured in four progressive phases: assessment and motivation; self-focused emotion regulation and reflective functioning; co-parenting communication; and restorative parenting. The intervention aims to strengthen fathers' skills in understanding emotions, emotional strength and skill, distress tolerance, reflexive functioning, communication skills and problem-solving, and restorative parenting, including making amends and emotion coaching. If the co-parent (usually the child's mother) wants to participate and the clinician feels it is safe, fathers can progress to optional co-parent communication-focused sessions. There is also the option of restorative father-child parenting sessions when mothers consent to their child's participation.

Inclusion and exclusion criteria*:* Fathers could not take part in the intervention if: they reported suicidal or psychotic symptoms or had a history of bipolar or psychotic disorders, which would require different treatment; there was evidence of significant use of coercive control based on a review of police records and an interview with the female co-parent; they had a history of severe violence (strangulation, use of or threats with a weapon, threats to kill); or if female co-parents reported fear of the father or stated that they did not want their child participating in the intervention.

Outcomes of interest*:* The father's abusive behaviour, depression and anxiety, emotional regulation and mentalisation, use of drugs or alcohol, child exposure to conflict, quality of parent-child relationship and quality of co-parenting.

Exposure to domestic abuse and children's social care status*:* All children had been exposed to domestic abuse. All fathers in the Fathers for Change studies had children with Child Protective Services involvement (Stover, 2015; Stover et al., 2022).

Caring Dads

Caring Dads (Scott et al., 2021; Youansamouth et al., 2022; see also Langdon-Shreeve et al., 2020) is a group-based intervention that combines motivational interviewing, psychoeducation, cognitive behavioural therapy and trauma theory, and aims to leverage men's role as fathers to motivate behavioural change. Fathers can have children of any age.

Caring Dads involves 15 group-based and 2 individual sessions, usually over 17 weeks. Group work with fathers focuses on: child-centred fathering; recognising unhealthy, hurtful, abusive and neglectful fathering behaviours; the relationship with their child's mother; and rebuilding trust and healing. Goals target empirically supported risk mechanisms for domestic abuse or child

maltreatment, including: high reactivity, anger and hostility; perceptions of the child as a problem; use of corporal punishment, harsh discipline and other aversive parenting behaviours; self-centredness; and misuse of substances. In addition, the intervention aims to improve the overall quality of parent-child relationships, family cohesion and co-parenting, and end domestic abuse and the risk of direct maltreatment of children.

While the father attends the programme, practitioners within the Caring Dads team try to engage with his partner and children to provide information about the programme, make referrals for further support and provide immediate safety planning if required. Caring Dads is aligned with children's social care, domestic abuse services, family courts and criminal justice systems to ensure that child safety remains paramount.

Two evaluations of Caring Dads were included in our review. Scott et al. (2021) is a quasi-experimental study in Canada with 185 fathers enrolled in the intervention. Eighty-five fathers (45%) completed the intervention, so they became the experimental group, and the remaining non-completers (55%) were treated as a comparator group. The other two studies are grey evaluation reports of Caring Dads in the UK. Youansamouth et al. (2022) used a mixed-methods design, involving the collection of anonymised case file data pre and post-intervention. A total of 181 fathers enrolled in Caring Dads, and 91 (50.5%) completed the required sessions. Caring Dads is also a component of the NewDAy project (see Langdon-Shreeve et al., 2020).

Inclusion and exclusion criteria: Fathers must currently care for or have contact with their children and have some (however limited) acknowledgement of their abusive behaviour. Any history of sexual offending precludes participation in the intervention. The evaluation by Youansamouth et al. (2022) recommends screening for severe alcohol or substance abuse, and notes that very low cognitive functioning may be a barrier to participation in the group. Fathers at low risk with strong positive connections to their children and generally cooperative relationships with the children's mother are generally excluded since they may not need such an intensive intervention.

Outcomes of interest: Social care status of children, quality of the father-child relationship, effect of the intervention on the family; fathers' abusive and controlling behaviour, parenting stress, and fathers' overall wellbeing. Stakeholders' perceptions of the service.

Exposure to domestic abuse and children's social care status: All children had been exposed to domestic abuse. All children of fathers in Caring Dads were on or above the threshold for children's social care in both evaluations.

Inner Strength / Positive Futures

Inner Strength (Schrader McMillan & Rayns, 2019) is a group-based, 26-session therapeutic intervention delivered bi-weekly in community settings or prison for people with emotional dysregulation often associated with borderline personality disorder (BPD) traits who have perpetrated domestic abuse, often in conjunction with other offending. Parents can have children of any age.

Both men and women could take part in Inner Strength, but in same-sex groups. The programme's authors hypothesised that approaches that have proved successful in treating borderline traits could also be used with people who have perpetrated and for those who have survived intimate partner violence, so Inner Strength combines elements of dialectical behavioural therapy (Linehan, 2015; see also guidance in NICE, 2018). Inner Strength also has elements of mentalisation-based therapy (MBT)and practical support/advocacy as needed. The intervention is designed to be delivered by a three-person team with diverse backgrounds but involves at least one man and one woman.

Inner Strength was evaluated using a mixed-methods pre-post study that combined case file analysis with semi-structured interview (Schrader McMillan and Rayns, 2021)..   This retrospective study analysed data from seven cohorts (31 men and three women) who completed the Inner Strength intervention in Lancashire. Eight men randomly selected men and two women also took part in one to one interviews. .

Inclusion and exclusion criteria*:* Participants were excluded from this group-based intervention if they had any history of sexual offending or if they had a mental illness so severe (such as schizoaffective disorder or psychosis) that they would not be able to engage with the programme. Those with low motivation to change were also screened out.

Outcomes of interest*:* Social care status of children; domestic abuse perpetration based on social care and police records; general offending based on police records. Stakeholders' perceptions of the service.

Exposure to domestic abuse and children's social care status*:* All children had been exposed to domestic abuse. Eighty-two per cent of the sample had a child above the threshold for a Child Protection Plan or in local authority care.

Results

Study design: Fathers for Change was evaluated using an RCT (EIF=3) with a very low risk of bias (MMAT 4.5*)[10] (Stover, 2015) and a single group, pre-post evaluation (EIF=2) (Stover et al., 2022).

Caring Dads is evaluated in two papers. Scott et al. (2021) is a quasi-experimental design (EIF=2), and Youansamouth et al. (2022) is a mixed-methods study (EIF=2). Inner Strength (Schrader McMillan and Rayns, 2021) used mixed methods (EIF=2). For further details, see Appendix 2, Tables A4.1 and A4.2, and Appendix 4.

Effective models of working

The pilot study of Fathers for Change compared results for men in the intervention with those in the control group, who received individual drug counselling (IDC). Compared to men in the control group, those who took part in Fathers for Change group (i) were more likely to complete treatment; (ii) reported a trend towards greater reduction in violent behaviour; (iii) exhibited significantly less intrusiveness in coded play interactions with their children following treatment and (iv) expressed significantly higher level of satisfaction with the programme (Stover, 2015).

The second study of Fathers for Change included in our review (Stover et al., 2022) involved a much larger evaluation in six government agencies across the state of Connecticut. That study also found a significant reduction in domestic abuse and children's exposure to parental violence, as well as improvements in fathers' emotional regulation, mentalisation and hostile outlook – all of which are associated with the risk of domestic abuse and child maltreatment. Authors observe that a focus on increasing fathers' motivation to change, helping improve their communication skills, and the intervention's focus on the father-child relationship may have contributed to the fathers' reduction of violence. Findings also show that the intervention had lower levels of attrition, and better outcomes, than standard Batterer Intervention programmes and Department of Children and Families-funded programmes. Mothers reported significantly reduced intimate partner violence and children's exposure to parental conflict after fathers had completed six months of treatment. Fathers for Change is informed by family systems theory, and it includes conjoint sessions for fathers with their children if this is safe and if the mother agrees. The dual focus on what kind of father men wanted to be and the direct work on strategies to improve their relationship with their children through child-directed play and restorative communication sessions appears to have been essential in achieving the desired change.

Further, the authors noted a subset of violent individuals who present as highly controlled and not emotionally dysregulated. An assessment of these traits could help better understand for whom the

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[10] See Appendix 3.

intervention is working best and which components of the intervention are most helpful in reducing domestic abuse.

Promising models of working

In Scott et al.'s (2021) evaluation of **Caring Dads**, in Canada, 3.6% of children in the intervention group and 8.1% in the comparison group had been placed in permanent out-of-home (that is, adoption) care by two-year follow-up. Children of 20.5% of fathers who had completed the intervention were re-referred to Child Protective Services because of their father's behaviour, compared to 36.0% of re-referred children in the comparison group – a statistically significant difference. However, in both intervention and comparison groups, the rate of re-referral remained high. Although the results are encouraging, the authors noted limitations in the design and lack of consistency in the Child Protective Services case file data used to assess child outcomes.

The evaluation of Caring Dads in the UK by Youansamouth et al. (2022) provides indicative evidence of improvement in men's parenting, couple functioning, and relationships with professionals, and a consequent reduction in the risk of abusive behaviour. The study also examines changes in children's social care status. In this study, the majority of fathers had children who were on or above the threshold for a statutory social care plan, with 61% of children on a Child Protection Plan and 37% on a Child in Need Plan. A 66% reduction in children's social care involvement was reported post-intervention for fathers who completed the intervention.

Conversely, children whose father did not complete the programme had much worse outcomes than children of fathers who completed Caring Dads. The most common worsened outcomes for children whose father withdrew from the programme were a deterioration in their relationship with their father (26%), an increase in professional concerns (26%) and an escalation in children's social care status. There was no inferential analysis of these changes, so their statistical significance is not known, despite their evident practical importance.

Thirty-one men and three women completed the **Inner Strength** programme (Schrader McMillan and Rayns, 2021). Between baseline (at the point of their parent's referral) and follow-up (between 6 and 38 months after completion of the programme), the number of Children Looked After by the local authority decreased from 19 to 9. All children who had been in local authority care were returned to the care of the parent who had completed Inner Strength. Of the 66 children subject to Child Protection Plans when their parent was referred to Inner Strength, 44 were closed or scaled down to universal services post-intervention. The evaluation of Inner Strength (Schrader McMillan and Rayns, 2021) provides indicative evidence of a reduction in domestic abuse perpetration and a significant reduction in the need for social services involvement with families. Findings also suggest a reduction in general offending outside the home.

All evaluations, therefore, report on changes in children's child protection status. However, the continued involvement of children's social care in a family could be unrelated to the person who completed the intervention (Schrader McMillan and Rayns, 2021; Youansamouth et al., 2022). For example, some fathers who completed Inner Strength had access to their children, but children remained on a Child Protection Plan if the child's mother had severe untreated drug dependence or had met a potentially dangerous new partner. Therefore, interventions for a father who perpetrates violence may need to be accompanied by parallel, trauma-informed work with partners, children and other family members to ensure that the intervention ensures good co-parenting (even if the couple has separated) and the safety and wellbeing of children.

There is no information in evaluations of Caring Dads, Fathers for Change or Inner Strength on how interventions have been adapted for situational couple violence, despite the fact that this was identified (for example) in one evaluation of Caring Dads (Scott et al., 2021). This report found that fathers and mothers perpetrated domestic abuse in 32% of cases in the intervention group and 23% of the comparison group.

Finally, only one intervention identified for domestically abusive mothers met the inclusion criteria – the qualitative study of Mothers Overcoming Violence and Empowerment (MOVE) (Ermentrout et al., 2014), reported in the section "Barriers and facilitators", p. 76. Some whole family systemic approaches, such as SafeCORE (Schrader McMillan 2022) and NewDAy (Langdon-Shreeve et al., 2020) include work with mothers who have perpetrated domestic abuse and, in some cases, are the primary or sole perpetrators.

Overall, the included evaluations show evidence that trauma-informed interventions that build on men's motivation to be better fathers can bring about positive behavioural change and improved relationships with children and families. It is important to stress again the need for careful assessment and screening, as described in individual studies (see also McConnell et al., 2020). It is important to note that any included studies that reported on men's experiences of ACEs found significant evidence of multiple adverse experiences in their childhood that are predictive of trauma and of multiple and complex needs in adult life (Schrader McMillan and Rayns, 2021; Youansamouth et al., 2022; see also Trevillion et al., 2020). However, only one study (Stover, 2015) evaluated the intervention using a design that was sufficiently rigorous to be confident about the findings. The remaining findings are, as such, indicative of potentially promising models of working.

BARRIERS AND FACILITATORS

This section addresses the following two questions about the facilitators, barriers, mediators and moderators of domestic abuse interventions that involve children on a statutory Child Protection Plan delivered by or alongside children's social care. **Facilitators and barriers** include, but are not limited to: the referral process, screening and assessment, and pre-intervention contact; engagement; structure and delivery; funding; and organisational factors that affect the implementation and evaluation of domestic abuse interventions.

The findings on barriers and facilitators draw primarily from grey studies that have a qualitative component (see the section on "Data extraction" on page 32). However, reference is sometimes made to studies that were excluded because a minority of children were above the threshold for children's social care, or the proportion could not be confirmed (for example, Callaghan et al., 2019; Nolas et al., 2012; Sharp et al., 2011). These studies provide relevant insights into barriers and facilitators, as well as reporting on children's experiences of services.

Mediators and moderators include individual-level factors (for example, characteristics) and contextual factors (such as location and duration of the service, and form of delivery) that could influence desired outcomes for families.

Barriers to implementation

Two broad and multi-faceted factors influenced the success of programme set-up and implementation: funding, and management of relationships among agencies.

Funding

While financial resources are always allocated to visible, "foreground" activities associated with delivery, funders sometimes need to understand the costs involved in less visible but essential and time-consuming "background" work, such as managing referrals, and assessment and promotion of the groups (Nolas et al., 2012). Consequently, practitioners have to work overtime beyond their contracts to do the "background" work, a commitment that could be more sustainable in the long term.

> "Those running groups had managed to tap into budgets from other projects enabling them to cover initial staff training and set-up costs. They also reported giving their time 'for free' because they felt the Programme was relevant and interesting to current work. Nevertheless, such strategies were viewed as unsustainable for moving forward and

embedding the groups in the local area. In addition, a number of boroughs mentioned that it was difficult even to release staff for the necessary training days because this too has a cost implication."
(Nolas et al., 2012: 100)

The funding landscape is critical not only to implementation but also to maintaining the quality of service beyond the pilot stage if initial funding has come from philanthropic sources or grants, as was the case with For Baby's Sake. Pressures on local authorities could lead to a crisis-focused response to domestic abuse, a tendency towards work of lower intensity, or local authority attempts to introduce untested adaptations to whole family (or indeed, any) practice model (Trevillion et al., 2020). Alternatively, the continuation of these or indeed any carefully designed and evidence-based models "…will depend largely on local abilities to retain the expertise developed and the outcome of national funding bids to charitable trusts" (Sharp et al., 2011: 122).

NewDAy staff and stakeholders felt that programme implementation was hindered by the time constraints of the Department for Education's Children's Social Care Innovation Programme, which funded the project. The first year of NewDAy (as with other services) focused on introducing, setting up and testing the new model. Moreover, attrition was highest in the pilot phase, as with SafeCORE (Edbrooke-Childs et al., 2020). NewDAy staff felt that by the time the model was settled and families achieved change, the service only had one year left of guaranteed funding. As a result, "many children, young people and families saw significant positive changes in their lives, but the scale and length of the programme were not sufficient to substantially impact on the wider domestic abuse problem in Newham long-term" (Langdon-Shreeve et al., 2020: 30).

Relationships

The quality of relationships among organisations is vital for successfully setting up and implementing multi-agency practice models, but such relationships can be challenging.

When introducing a new service, it is essential to avoid creating further demands on partner agencies by ensuring that their role in facilitation "…is integrated into their work rather than being an addition for the workloads" (Nolas et al., 2012: 104).

Other agencies may be less able or willing to become involved if asked to take on additional work without the resources to support it. For example, one practitioner reported that "I have had feedback with people that have said… 'we're not going to make a referral because we just haven't got the time to do the CAF [Common Assessment Framework]'" (Nolas et al., 2012: 11). This quotation comes from an intervention for families below the threshold for children's social care and the social workers tasked with making the assessment would have felt greater urgency if the child were at a higher level of risk. However, in practical terms, it is necessary to build in resources

to cover less visible "background" work by the other agency, as well as funding more visible work with families.

A second difficulty in sustaining multi-agency networks is the turnover of practitioners in partner agencies – something that especially affects the flow of referrals: "[one of the] key challenges… identified in relation to obtaining referrals from colleagues [was] when there was a large and frequent turnover of staff in key services…" (Trevillion et al., 2020: 93). In addition, the turnover of senior leaders can stall efforts to embed and scale up new interventions:

> "The [NewDAy] programme was hindered by wider challenges across Newham children's services, including… high social worker turnover, and churn in senior leadership. This reduced the programme's ability to embed and sustain improvements in mainstream practice."(Langdon-Shreeve et al., 2020: 11).

The loss of a senior leader is likely to be particularly difficult if their successor has yet to be briefed or has other priorities. As one practitioner observed, "we were unable to take it to the next stage because senior managers just weren't able to get their heads round… how much time they would need" (Nolas et al., 2012: 101). While this observation was again made about a service for families below the threshold for safeguarding services, it echoes a conclusion in the NewDAy evaluation – that "churn" in senior leadership can affect the programme's ability to embed and sustain improvements in mainstream practice.

One way of pre-empting the loss of a senior leader who had helped set up the project was to develop a range of "service champions" within lower strata of management who could act as ambassadors to promote the project and help sustain and increase referrals. In addition, project champions needed to share the passion, as one facilitator involved in the Caring Dads intervention described it: "Get the people involved that are going to love it and nurture it… and that's a ripple effect, isn't it?" (Youansamouth et al., 2022: 22).

Barriers to referrals

Two linked factors reduced the likelihood that other organisations would refer clients to the projects: resistance to the new intervention; and lack of clear information about it.

Resistance to the new intervention

Interventions that involved working with the whole family appeared to have encountered resistance from some colleagues in other agencies or even within the same local authority, who may have disagreed with this approach or were wary of what was achievable (Trevillion et al., 2020). These concerns may have derived from a lack of certainty about the effectiveness of whole

family practice models and the potential risk to victimised partners and children (Howarth et al., 2016).

> "Practitioners reflected, however, that although the two groups have been in discussions about their respective programmes, some services within the women's sector continued to feel unable to endorse the programme [For Baby's Sake]. Practitioners commented that this outcome had affected team morale. Some practitioners reflected that the reservations raised by the women's sector groups were in relation to the work that the programme is doing with men. They acknowledged that the [Stefanou] Foundation was a new organisation in this field and that the work with men was not accredited by the benchmark organisation, Respect."(Trevillion et al., 2020: 93)

There was evidence from the For Baby's Sake evaluation that this resistance to whole family systemic practice models may ease after the first iteration of an intervention. As the authors noted, "Practitioners commented that, since starting the programme, some women's sector organisations have also started to explore whole-family approaches around DVA [domestic violence and abuse]" (Trevillion et al., 2020: 93).

Lack of understanding of inclusion and exclusion criteria

A second and often related referral barrier is that partner agencies have fundamental misunderstandings about the intervention. For example, NewDAy was designed for situational couple violence. However, despite its high prevalence in community settings and the risk it presents to children, situational couple violence is less likely to come to the attention of clinical and social services than male-to-female violence and coercive control. Consequently, practitioners are less familiar with this form of domestic violence and cannot confidently screen for it.

Misunderstandings about the nature and objectives of the intervention can lead to inaccurate information to families and consequent difficulties in engaging people who could benefit from what the intervention is offering. For example, For Baby's Sake had to dispel misinformation that the programme only worked with couples who committed to stay together, as opposed to couples who wanted to co-parent: *"We're working for them to be the healthiest co-parents they can be. The together bit isn't a factor"* (Trevillion et al., 2020: 93).

However, the most significant difficulties ensue if families believe the intervention is an arm of children's social care as one frontline practitioner (a domestic abuse navigator) explained:

> "We have a common misconception that we are social care because obviously we work for children's services. We come under the same bracket, and [there is] almost like a fear... Sometimes I go in there [to a family] and say, 'we are a voluntary service, you don't have to

engage with us.' Then the social worker goes in there and says, 'if you don't engage with the DAN [domestic abuse navigator], this happens', which isn't helpful to therapeutic work." (McCracken et al., 2017: 23)

Parents may fear that social care wants to remove their child. Therefore, it was important for agencies who make referrals to explain that the objective of the service was to help the family achieve positive changes and (if this is the case) that the service is not mandatory. It often requires a great deal of persistence, from the referrer, and the practitioner who first contacts the parent, to persuade them that they can safely explore the services on offer (Schrader McMillan, 2022).

Lack of visibility

Across projects, referral routes often included police, social services, schools, support workers, courts, MARAC or Multi-Agency Safeguarding Hubs. In some instances, parents reported that the referral had been serendipitous rather than the consequence of pre-existing service engagement, often through the actions of a single, persistent worker. In addition, service users sometimes drew attention to scant information about the service that had helped them. For example, one man interviewed for the evaluation of the Inner Strength programme for parents who had perpetrated violence stressed that "there's lads out there that are ready and need the help and are willing to go for it but [information] is not there to be shown [to] em" (Schrader McMillan and Rayns, 2021: 41). That same man and other service users who were interviewed advocated for advertising Inner Strength through leaflets in the courts and health centres, primarily material that incorporated quotations or video clips from service users, "so that people who have done it... can say, this is brilliant, this will help, you, here's the number, call here" (ibid.).

In summary, evaluations that include interviews with practitioners identify several factors that affect the ability to set up and implement a new service successfully. These factors include funding, communication, staff turnover, misunderstanding of the objectives of the intervention, and of the inclusion and exclusion criteria, and to some extent, anxiety about a new practice model (particularly whole family, systemic practice models).

Facilitators of implementation

A supportive organisational culture, workplace climate, and high-quality supervision with the opportunity for critical reflection are central to generating non-routinised, relationship-based responses to children and families. Stability is essential for the therapeutic relationship upon which all interventions are based. A practitioner involved with Growing Futures reflected on the importance of a stable workforce to maintain relationships with families: "the balance of the staff and the retention of the staff makes a massive difference because our frontline teams need to make relationships and you can't do that if people are changing every week" (McCracken et al., 2017: 26).

Studies included in our review highlight the relationship between how the service is organised, the resilience, confidence and stability of the workforce, and outcomes for families.

Networks of interdisciplinary collaboration and mutual support

Practitioners are part of a multi-disciplinary team

Interventions that work with the whole family have multi-disciplinary teams that share responsibility for case formulation, case management and direct work with the family. The SafeCORE practice model is delivered by small inter-disciplinary units comprised of social work practitioners with different backgrounds and roles, an administrator and a clinician. All staff, including administrators, receive Compassionate Mind Training, which includes learning about self-compassion, compassion towards others, and compassion flows, which were reported to increase trust within the team.

All staff stressed that multiple professional perspectives result in better case formulation, better planning, and more creative approaches to working with a family:

> "...staff described the multi-disciplinary skills, afforded by the team approach, as increasing the expertise, perspectives and experiences that underpin care. Some staff noted that prioritising [weekly] unit meetings and time to collectively discuss family needs requires particular attention as caseloads increase."
> (Edbrooke-Childs et al., 2020: 27)

Being part of a unit was reported to increase practitioners' confidence and willingness to test new approaches to work with families: "Staff described having a team around them as promoting reassurance and confidence and as being especially useful to draw on when queries arose or additional support was required" (Edbrooke-Childs et al., 2020: 27). Interestingly, some SafeCORE service users interviewed also observed the benefits of having a unit around their family:

> "[practitioners] communicated with each other, so they knew where they were at... They all knew [where our family] was at" (Schrader McMillan, 2022: 39).

In For Baby's Sake, each family is supported by two practitioners (one for each parent) who work closely together to achieve a whole family response. The practitioners are part of tight-knit teams that also comprise a team manager and programme officer. Practitioners are drawn from different backgrounds and are trained and supported to work therapeutically, with teamwork that includes group case management and group clinical supervision by an external therapist:

"The programme's approach to recruiting practitioners with a range of related experiences and professional backgrounds (e.g. domestic violence sector, child development, social care, substance misuse, probation) helps to promote inter-disciplinary shared learning within the team."
(Trevillion, 2020: 97)

Interagency coordination

The facilitators of Caring Dads (Doncaster) reported that the multi-agency context and strength of professional relationships with members of other agencies helped to support men and maintain their engagement with the programme. It also helped to ensure that the father or family could get additional support when necessary, as one facilitator noted:

"Most of those dads that access the Caring Dads programme have got a family support worker that's within our service – So, the facilitator's then having conversations to say, 'This week he was really quiet. Next week's programme is about – you know, I'd really suggest that you help preparing with this', or 'He's thinking about' – so just, you know, that support again."
(Youansamouth et al., 2022: 29)

Some reports highlighted the value of inter-agency networks, including probation, health, drug and alcohol services, schools, family support workers, family time workers, independent reviewing officers and social workers. These models are designed to provide "joined-up" services to families. Some of the difficulties involved in inter-agency collaboration were identified and outlined in the subsection on Barriers to Implementation, page 77). However, the evaluation of Opening Closed Doors shows that inter-agency networks where a key worker coordinates can result in good relationships and fluid communication, with benefits for the workforce and families:

"Social workers in particular praised the close links [with Opening Closed Doors practitioners]. 'If there are any issues, she rings or emails me'. 'They are undertaking some truly meaningful work with parents and children… Most important, however, is the quality of the feedback that we are receiving and the way that the information is bringing the child's voice into the decision-making process. Their presence in the office with us also makes us feel like a multi-disciplinary team."
(Barnardo's Cymru, 2021: 34)

Co-location within children's services

Co-locating the team with children's services enabled stronger working relationships, allowing knowledge-sharing among staff (Barnardo's Cymru, 2021; Langdon-Shreeve et al., 2020; Schrader McMillan and Rayns, 2021; Schrader McMillan, 2022; Trevillion et al., 2020). This arrangement

can lead to shared but demarcated responsibility for work with families and benefits all workers and the family. There are advantages for teams that are employed directly by the local authority and are part of children's services, including access to the shared database system. It is also likely that teams co-located within children's services benefit from having a leader (such as the Director of Children's Services) who can promote their service, and facilitate internal communication and access to social care case files.

A SafeCORE practitioner observed that working alongside statutory children's social care reminds all concerned that "there is a risk that needs to be managed and reduced". At the same time, "SafeCORE offers a solution" (children's social care social worker). But working alongside social care can also strengthen the therapeutic alliance between SafeCORE practitioners and the family, because:

> "The fact that Statutory Children's Social Care may have more directive conversations with the family means that SafeCORE comes across as gentler and more inviting and therefore [we have] a greater opportunity to establish a rapport, and build a trusting relationship with the family." (Schrader McMillan, 2022: 73)

Having clinical expertise within the service

Three whole family intervention models designed in the UK (For Baby's Sake, NewDAy and SafeCORE) include clinicians, of whom at least one is a family therapist. Clinicians help practitioners to develop reflective and reflexive practice, contribute to case formulation and planning, and provide support if there are problems that practitioners feel they cannot overcome. Enrolment reflected the interaction between individual motivation and circumstances.

All interventions experienced attrition; participants disengaged early if they were not intrinsically motivated or not ready to address their difficulties. However, there were also instances in which families engaged for a short time to achieve an objective, such as practical assistance, before withdrawing (Schrader McMillan, 2022). Low family engagement and retention are often problematic for mental health prevention and intervention programmes, and research has shown that 20% to 80% of families drop out prematurely, receiving only half the planned intervention (Ingoldsby, 2010). Services therefore need to balance an awareness of "what works best for whom" with strategies to increase motivation to enrol and complete planned work.

Barriers to enrolment

Hostility towards social care

The primary reason why parents with a child on a Child Protection Plan do not get involved is their anxiety about their child being removed, especially if the parents had "lost children through social services" or knew others who had (Schrader McMillan, 2022). A point that comes across from interviews with parents in several studies is the sense that they were being treated unjustly by social care, and this was true for both mothers and fathers. . For this reason, one of the outcomes of interest in an evaluation of Caring Dads was increased contact between fathers and social workers two years post-intervention, as was the case (Scott et al., 2021). Better communication was, in turn, associated with a reduced risk of re-referral to Child Protective Services (ibid.). The degree of mistrust towards social care is illustrated by findings in the evaluation of MOVE (Mothers Overcoming Violence Through Education and Empowerment) for court-mandated mothers and children, as children had been coached not to talk about problems in their family:

> "One of the child participants did not enjoy sharing about 'family and stuff like that' and described her experience of the program this way, 'You have to tell secrets and stuff sometimes. Secrets that you don't want to tell.' One provider echoed the child's concerns: 'I felt the kids were pretty suspicious coming in and didn't really want to share what seemed like positive or innocuous things about their family. They did not want to talk about their family at all for probably a few good sessions. I later found out that these kids weren't supposed to talk about what was going on at home'."
> (Ermentrout et al., 2014: 664)

As well as being anxious about social care in general, individuals interviewed sometimes referred to a particular animus towards a specific social worker, as illustrated by the following quotation from a man who completed Caring Dads: "I never wanted to do it. I've turned it down for the past two years. I had resistance with that Social Worker, so I didn't want to do anything she wanted to tell me to do" (Youansamouth et al., 2022: 51). That father also disliked the name Caring Dads, which he experienced as a form of oblique criticism:

> "It was also the name. At first, that made me hesitant. I thought, are you trying to make me out like I need to go on a course about how to become a caring dad? I used to think automatically in me head, 'I am a caring dad!'"
> (Ibid.)

Conversely, a single face-to-face meeting with Caring Dads practitioners and clear, practical information galvanised the decision to join the group. "What would have also made a difference is having the information that I had when I first went to my pre-appointment. That's when they told

me more about it. I was like, yeah, I'll do it" (ibid.). This father's reflections show how different factors combined in his initial response to the suggestion that he take part in Caring Dads: conflict with a social worker and the name of the programme, as well as a lack of understanding about its ethos or objectives. Factors that enable participation will be outlined in greater detail below.

Rebuilding trust is, therefore, fundamental to securing engagement. As well as having a complicated relationship with social care and unsatisfactory experiences with other services, one mother who took part in work with Project Crewe felt suspicious of any new offer of help, "Because when I first saw her I thought, 'ah, here we go again, another one, going back to square one again'. And it wasn't" (Heal et al., 2017: 32).

Parents might feel coerced into taking part in an intervention if this is (technically) voluntary, as was the case in NewDAy:

> *"That is probably the dynamic of having children subject to a CPP [Child Protection Plan], particularly if you don't agree with it or if you don't see the risk to your children. You then won't be committed to engage with the services to end the violence."*
> *(Langdon-Shreeve et al., 2020: 33)*

NewDAy social workers observed that some families only participated when they were on the cusp of court proceedings. However, initial "false compliance" can turn into genuine interest and commitment, and as NewDAy staff observed, once they have started with the programme, parents who were previously reluctant have engaged well.

Already having a service, or too many services, in place

Growing Futures found that fathers already involved in substance abuse treatment were not motivated to engage with Caring Dads (one of the interventions offered by this multi-agency/multi-component model) (McCracken et al., 2017).

> "An important aspect to multi-agency working was ensuring that there was a coordinated approach to working with fathers... so that, for instance, men were not being expected to engage in multiple programmes at the same time, thereby avoiding imposing unreasonable expectations and further eroding trust and cooperation." (Youansamouth et al., 2022: 29)

Child Protection Plans typically involve a raft of interventions, and parents may feel overwhelmed by their options. As a therapist involved with SafeCORE observed, the Multi-agency Core Group responsible for a Child Protection Plan would benefit from thinking "systemically about what support is offered to a family at any one time" (Schrader McMillan, 2022: 76).

Barriers to adherence

Barriers to enrolment and participation are not necessarily the same as barriers to adherence. For example, when personal stressors (such as low social support or family conflicts) are high, families' attention may be focused on these concerns, reducing their commitment and capacity to continue and complete the intervention (Dadds and McHugh, 1992; Prinz and Miller, 1994).

Mental health problems and substance abuse

Studies that identified why parents dropped out highlight the prevalence of more severe and chronic mental health problems, and addiction, in parents who disengage (Draxler et al., 2019; Pernebo et al., 2019; Schrader McMillan, 2022). This finding is congruent with studies on attrition from community-based mental health services (Miller and Prinz, 1990; Snell-Johns et al., 2004).

Maternal mental health – specifically maternal post-traumatic stress symptoms (Graham-Bermann et al., 2011) or depression (Danzi and La Greca, 2021) – is the most frequently identified mediator of the effect of dyadic interventions for mothers and children (see the section on Mediators and Moderators, page 115.

Most services are unable to work with parents with untreated, severe mental illness (see the section on Diversity, Equality and Inclusion, page 118. SafeCORE clinicians do work one-on-one with children and adults with PTSD traits, social anxiety, eating disorders, trichotillomania, and many other struggles. However, as *some work around mental illness and complex trauma could take years,* the focus is to ensure that people who need it have access to longer-term, possibly psychiatric, support (Schrader McMillan, 2022).

Significant drug misuse was the only factor associated with a greater likelihood of programme attrition from Fathers for Change (Stover, 2015). Characteristics like the father's age, the severity of intimate partner violence, the severity of alcohol misuse, race/ethnicity, employment and education are often associated with attrition from Batterer Intervention programmes (DePanfilis and Dubowitz, 2005; Gomby et al., 1999), but these were not associated with attrition from Fathers for Change, which suggests that the intervention is effective in engaging and retaining men (Stover et al., 2022).

Practical challenges: timing, transport, childcare

The other most commonly identified barriers to engagement are practical, including potential participants' problems with transport, childcare, the location of the service, and work commitments.

Participants who live in rural areas can find it difficult to take part in programmes that are delivered in city centres. As one practitioner observed:

> "Changing Lives, which is the women's centre, and Foundation 4 Change, which works with perpetrators, are based in the town centre. They don't have any satellites... that's quite a barrier sometimes."
> (McCracken et al., 2017: 25)

The importance of the setting, help with transport, the offer of light meals, and time for breaks was noted by participants in some qualitative evaluations, including the Cedar (Children Experiencing Domestic Abuse Recovery) project evaluation: "Mothers often commented on how helpful the taxis were. They also commented on things like temperature, food, venue, cigarette breaks, which indicated that these things mattered to them" (Sharp et al., 2011: 60).

Flexible delivery (discussed below) can alleviate practical barriers.   It is therefore essential for practitioners to learn about the circumstances of individual participants before the intervention starts:

> "With advance knowledge of family circumstances, facilitators might be better prepared to respond to families, ensure their understanding of the program's purpose, establish the buy-in of involved family members, and attend to any known logistical obstacles with program resources (e.g., transportation)."
> (Ermentrout et al., 2014: 671)

Interventions included in our review often developed practical solutions, such as offering home-based services at times that suited parents best (such as early mornings or weekends), offering a choice of group work in the evening or during the day, securing discretionary funds for transport, or helping participants organise lifts:

> "We made the commitment that wherever the dads predominantly lived or if the dads were in work or had commitments throughout the day because [of] attending child protection conferences, child in need meetings, we would do that outside of core hours."
> (Youansamouth et al., 2022: 26)

During the Covid-19 pandemic, many interventions were delivered via electronic platforms or telephone. Parents liked choosing the online platform that works best for them, as was the case with a mother who completed SafeCORE:

"Before Covid-19, we did it in the house. Then with Covid-19, we did it on FaceTime. . But I don't like FaceTime so they said, 'can we call you?' They asked me what a convenient time is and what suited me, so it was all based on what worked for me." (Schrader McMillan, 2022: 42)

However, some parents noted that it was difficult for SafeCORE to engage children after work moved online. Limited evidence suggests that children, especially young children, are less likely to engage through online platforms: "If the session had been face-to-face – in person – it might have worked better for my boy" (Schrader McMillan, 2022: 43). Going forward, hybrid forms of service delivery can sometimes work better around families' schedules.

Language

The need for an interpreter poses challenges to practitioners and participating families. A lack of proficiency in the country's primary language is one of the barriers to accessing services at all (see also the section on Diversity, Equality and Inclusion, page 118). Service users need to be comfortable with the interpreter, and fear of gossip has led some families to withdraw from services (Edbrooke-Childs et al., 2020). Larger teams can include practitioners who, to some extent, reflect the area's demographic make-up, but this is more difficult when multiple minority languages are spoken and local authorities lack resources for interpreters.

Good practice identified in one Caring Dads project included having the same interpreter for one participant throughout their entire engagement with the programme (Youansamouth et al., 2022). Deployed this way, interpreters can develop the skills needed not only to translate, but to communicate with sensitivity and skill. Experience elsewhere has shown the possibility of using tools like Google Translate as aids when working with clients who speak some English but are not fluent (Schrader McMillan and Barlow, 2019). One study involving families largely below the threshold for children's social care (Draxler et al., 2019, 2020) describes increasing the use of non-verbal techniques in the Swedish version of Project Support, to make it more accessible to families from a range of minority ethnic groups who spoke some Swedish but were not fluent.

Facilitators of engagement

Across all qualitative studies, parents' interviews stressed the importance of the bond they experienced with the facilitator or team. The therapeutic alliance is the factor that was most consistently associated with adherence.

The therapeutic alliance[11]

According to interdependency theory, individuals bring a dispositional tendency to (dis)trust into a relationship, and the activities within the relationship can influence the levels of trust over time (Rempel et al., 1985).

The consensus in the literature is that parents with more anxious and avoidant attachment styles, which often arise from early life trauma, are more prone to distrust others in relationships (Fitzpatrick and LaFontaine, 2017), and high levels of trauma are common in the developmental histories of parents with Child Protective Services/ children's social care involvement (see, for example, Philip et al., 2021). Well-functioning programmes provide a secure and psychologically safe space, and can empower participants to trust themselves and others (King, 2002). Trusting the practitioners was essential to feeling hope in the possibility of change:

> "I didn't feel like they were doing a job of work. I could chat to them, it was confidential. I could tell them or ask them anything without feeling they were judging me. They were friendly and open-minded. I felt so comfortable."
> (Barnardo's Cymru, 2021: 33)

As noted earlier, parents contrasted the service they had liked with a sense of being coerced by social care: "With social [social services] it felt like they were very attacking… [For Baby's Sake] was just very welcoming and inviting" (Trevillion et al., 2020: 145). A mother who worked with Project Crewe described being ignored by a social worker:

> "Before, I'd had social workers come in who… started ringing up their dad in front of the kids [the father has a restraining order against him and is not allowed any contact with the family due to violence and domestic abuse]. That's just ridiculous. I phoned them up and said 'don't you dare come around my house again, you make things worse'. But no, Project Crewe's been really good… They [Project Crewe practitioner and social work consultant] are really funny, and the children like them, and that's really important for me. Because if the kids don't like you, we ain't going to work with you."
> (Heal et al., 2017: 32)

According to Glasman and Albarracín (2006) attitudes based on second-hand information are less predictive of later behaviour than attitudes based on direct experience. Therefore, "parents who participated in other kinds of support programs and found such services beneficial should have favourable perceptions of a family support program and a greater willingness to consider

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[11] Some services prefer not to use the term "therapeutic alliance" if the intervention is delivered by social workers or others who are not trained therapists. However, in this context, the term refers to a strong, comfortable and trusting bond between the practitioner and service user.

enrolment" (McCurdy and Daro, 2001). The challenge for practitioners is rebuilding the trust of people who are wary, not least because of negative experiences of services in the past.

What builds the therapeutic alliance?

A referral from someone who is already trusted

A message that emerged from the evaluation of Inner Strength is that participants were more likely to enrol if the intervention was recommended by someone they trusted (Schrader McMillan and Rayns, 2021). This might include probation officers, their doctor, or even a social worker with whom the parent already had a good relationship. For example, one relatively young man had a fraught relationship with social care workers and was on the verge of losing custody of his child, but changed when he was assigned a new social worker: "Tanya [the new social worker] was really amazing... she fought for me to get on Inner Strength... She wanted us out of social services" (ibid.). In addition, the person who made the referral reminded them that participation was voluntary.

Fathers for Change was recommended by the courts and fathers may have felt pressure to attend, but their participation was voluntary. In contrast, men in the US can be court-mandated to participate in a Batterer Intervention programme (BIP) and face criminal penalties if they do not attend. Stover et al. (2022) concluded that Fathers for Change may be engaging fathers more effectively than standard BIPs because it focuses on emotional strength and skills, reflective functioning and parenting, and because the intervention is voluntary. This approach differs from that of BIPs, which focus primarily on the gendered use of violence and on anger management, and generally work with groups of men.

Building a relationship with the practitioner or team before the service starts

Several studies drew attention to the importance of pre-group assessments to get to know the individual or the family. Depending on the orientation, pre-group meetings could also focus on observing parent-child interaction (Bunston et al., 2016), conducting a functional assessment of problem behaviour and identifying personalised goals (Schrader McMillan and Rayns, 2021), and in every case having the opportunity to talk through the intervention (Youansamouth et al., 2022).

Pre-group interventions can help put participants at ease, as parents are often profoundly anxious about joining a group. Before the father, or more rarely, the mother who had perpetrated DA joined the Inner Strength group, a practitioner met them, in their home, to complete a functional assessment of an incident of problem behaviour (typically the incident that had led to a police call-out). Functional assessment involves examining the immediate and longer term antecedents of an incident of problem behaviour and uses the information to develop hypotheses about the functions of that behaviour (for example, the perpetration of DA) for the person (see Dixon and Graham-

Kevan, 2020). This information is used to create a plan that can help the person communicate their needs, change their environment to decrease the risk of reoccurrence, and improve the person's skills. The conversation around the Functional Assessment also helped the person set their goals.

For many participants, this exercise was illuminating, and it also involved a personal exchange with the facilitator that created the foundations for a therapeutic bond. Having completed this exercise, fathers were less apprehensive about the group, as they knew at least one person – the facilitator:

> "Well, you're going to the room [full of people], [if] you've already met leaders of the course and this... gives you an idea about what you're about to do on the course... So, it's not as daunting just walking into a room with everyone's a stranger."
> (Schrader McMillan and Rayns, 2021: 28)

Caring Dads usually includes pre-programme meetings with the father, the facilitator and the social worker. These initial meetings provided an opportunity to set clear expectations and have direct conversations about the reasons for the referral.

> "A frank and open approach sets a precedent for respectful, non-shaming and honest dialogue with men... The pre-programme meetings are also used to explain the nature, structure, and content of the programme to fathers, and to encourage fathers to ask questions or raise any concerns."
> (Youansamouth et al., 2022: 63)

One facilitator explained that Caring Dads was "not just a course on domestic abuse, it's not just one on parenting; it's not just one that focuses on building relationships – it covers everything!" (ibid.).

Although in one case, where a mother's child was not on a Child Protection Plan, the mother (who was a victim of domestic abuse) reflected that it was difficult to join a group together with her child because she felt unable to trust anybody. Another woman highlighted her fear of self-exposure: "That's the worst part, it's coming into here and thinking that you're going to be judged and singled out, and it's not like that at all" (Heal et al., 2017: 70).

Pre-programme meetings are also an opportunity to assess the parent's motivation, and, if a parent shows no genuine interest, to postpone their invitation to join the group. Participants who are fundamentally not motivated (as opposed to being uncertain or afraid about the group) can affect others, as respecting the social contract formed within groups is vital for engagement and creating group cohesion – a potent therapeutic factor (Yalom, 1985). Furthermore, high levels of attrition can have a destabilising effect on those that remain (Nolas et al., 2012).

Clear, accessible and repeated information about the service

Parents who were interviewed sometimes reported that it would have been helpful to have more in-depth information about the intervention and what was expected of them. Such information could involve written material and video clips, but parents stressed the value of hearing from other parents who had completed the intervention. For instance, one man who was hesitant about Inner Strength was introduced to a group that was then coming to an end so that he could speak, in private, "with a couple of lads who were doing the [Inner Strength] course" (Schrader McMillan and Rayns, 2021: 28). It is therefore critical to provide clear and consistent information to participants (and to organisations that refer people to services).

Practitioners who delivered the MOVE programme, for court-mandated mothers and their children, illustrated several strategies to address the attendance issue. For example, the children's group facilitators highlighted: (1) engaging the children; (2) calling recently absent children between group sessions to let them know that they were missed; (3) providing mothers with weekly written updates to keep them abreast of their children's activities; and (4) connecting with mothers after the group to discuss the topics covered and recommendations for ongoing care.

One of the critical lessons learned was to provide mothers with detailed information about the children's programme (e.g., purpose, structure, and what to expect). Participants offered several suggestions to ensure that mothers understood and were updated on activities for their children. In the first place, participants recommended that all mothers attend an intake assessment with a practitioner who would lead the mothers' group. As well as gathering the mothers' and children's biopsychosocial histories, this first meeting could be used to explain the structure, goals and purpose of the children's programme. Participants also recommended an orientation session for mothers, and that mothers receive weekly Parent Notes (that is, updates on the topics addressed in the children's groups, and on their child's progress).

Learning about the effect of past trauma

Central to For Baby's Sake is the "Inner Child" module, designed to help parents explore and engage meaningfully with the impact of past trauma. Parents had generally never done this before. Many fathers and mothers identified this module as particularly beneficial because it enabled them to become free of their inner burdens – to "put upstairs to sleep" (Trevillion et al., 2020: 143).

Similarly, Fathers for Change has initial motivational sessions to examine multigenerational patterns and experiences in men's lives, and 'these initial motivational sessions serve to increase engagement in the subsequent reflective, emotion regulation and communication-focused sessions of [Fathers for Change]." (Stover, 2022: 450)

The desire to be a better father

Across the three interventions for men, men were primarily motivated to engage in DA programmes because of their children, typically to gain or regain access to their children and to be better role models.   This is consistent with wider research on fatherhood as a source of men's motivation to change (Stover and Kahn, 2013).

> "I did it for two reasons and pretty much two reasons only. One was for me to increase the chances of getting my children back in my care, and secondly, just to genuinely become a better dad, or a more caring dad really (Will, Dad)." (Youansamouth et al., 2022: 53).

> "I knew I had to change, and I wanted to change, you know, I want to be a good parent, and I don't want my kids to see me as you know, a bad person or anything… I was an angry kid [but now] I wanted to stop being an idiot all of the time."
> (Schrader McMillan and Rayns, 2021: 26)

Consequently, practitioners focused on men's roles as fathers as a motivation to change maladaptive patterns of communication and aggressive or unhealthy interactions in relationships.   In Fathers for Change, the practitioner, therefore

> "employs motivational strategies early by discussing the father's conceptualization of fatherhood and how he hopes his relationships with his children and coparent will change."
> (Stover, 2022: 450).

The strategies used in interventions for fathers focus on strengthening the therapeutic alliance, reducing shame, and, as the next section shows, encouraging motivation to change by focusing on what matters most to the man in question.

The intervention objectives align with felt priorities and goals

People are more likely to engage with support and therapeutic services if they are deemed credible – that is, if the service can help them solve a problem that matters to them (Constantino et al., 2018). Consequently, all information about projects and interventions needs to be very clear in their aims and approach, and how they can help, to gain early buy-in from potential participants.

If it safe and practicable, parents could be put in contact with other parents who have completed and benefited from the service (for an example, see Schrader McMillan and Rayns, 2021). It is important to let people know that social care workers actually care about them and their families as well as being tasked to support the family.

Helping individuals or families identify what matters to them and to set goals, not just in relation to domestic abuse but also other aspects of life, can motivate engagement. It is vital for participants

to agree with the goals of the programme. The authors of the MOVE evaluation suggest that "discomfort with program goals may have motivated some parents to actively resist their children's inclusion" in the group (Ermentrout et al., 2014: 471). Enabling participants to identify personalised goals across different aspects of life can increase motivation, especially as initial, perhaps modest, goals are achieved. Goals can also change as an individual or family gains greater insight:

> "At the beginning [of work with SafeCORE) you were not sure what you were expecting, or what you want, so we just aimed for something small to start with and went from there... The adaptability of SafeCORE is what made the difference." (Schrader McMillan, 2022: 42)

Maintaining engagement

The option of a whole family approach

Some couples want to stay together, and those who do not, still want to co-parent. Studies show that this approach can be delivered safely, although this requires careful assessment, screening and case formulation. Each intervention has explicit inclusion and exclusion criteria, and involves screening for and monitoring the risk of escalation of domestic abuse.

The option of being able to take part in a whole family practice model was valued by those who wanted to try and stay together, as noted in the evaluations of Growing Futures and Opening Closed Doors:

> "Adults from both of the families interviewed also expressed appreciation of working with a professional who was able – following risk assessment – to support them as a family rather than requiring them to break them up. As one noted, 'I'm just grateful really, the fact that there are actually people out there who want to keep families together'."
> (McCracken et al., 2017: 37)

Being able to see change in one's partner, or indeed children, also provides impetus to continue and complete planned work:

> "The whole family offer is really important... It supports victims to know that the perpetrator is also trying to change" [Practitioner]... Case file analysis identified some cases where it was recorded that there had been a positive benefit to both parents. For example, in one case, the father had benefitted from completing the DAPP [Domestic Abuse Perpetrator] programme and the mother had noted he was calmer, and their relationship had improved. In another case, both Mum and Dad completed their respective

programmes, and both had learned that verbal abuse is abuse and has an emotional impact, hence both made changes."
(Barnardo's Cymru, 2021: 31)

Psychological safety within the programme

Across several programmes, participants consistently valued the ability of facilitators to create a psychologically safe and trauma-informed environment.

A focus on strengths

Part of the skill of facilitation was seen as being able to identify and focus on strengths, leaving the parent "with a realistic and balanced message, not one that detracts from the progress they've made or knocks them back" (Youansamouth et al., 2022: 31). An intervention that seeks to do this from the beginning can move quickly from enrolment to engagement. As one mother recalled, her confidence began to change in just three weeks:

> "And then it was within three weeks when they [PC] came in… even in that time, my confidence changed, they said, 'Right we know you're a good mum, what do you feel you can do?' and I said, 'I can do this and this', and it was the way that they asked and spoke that was totally different."
> (Heal et al, 2017: 37)

Interventions like Caring Dads or Fathers for Change can involve stepping back on the father's problem behaviour – that is, the violence they perpetrated – to build their motivation and hope. As a facilitator for Caring Dads explained:

> "I worked with a dad and he had [an] eight-month-old baby. Very young mum and dad. And when we sort of went through responses of child development, when you're engaging with them, 'They don't just smile. They're smiling because you're smiling. How does that make them feel when you're holding your baby in your arms and you're touching your baby and talking to your baby? How do you feel that baby feels?'

> "And we talk around all that, and that to him, it was like 'I just love it'. And he was saying 'I stop and think now when I hold my baby boy what I'm doing, what I'm giving him when I'm smiling at him when I'm showing him things, facial expressions'. And he said, 'It's just amazing'. So that to me was really empowering, when we can give them a glimpse… of the children, and what they mean to the children, and what they are to the children."
> (Youansamouth et al., 2022: 34)

Discussions about mentalisation for children can lead to talking about domestic abuse, by explaining that if a child is not present in a room, the child can hear, and if they cannot talk, the

child can still see when domestic abuse occurs (Youansamouth et al., 2022). This realisation adds further impetus to learning and practising emotional regulation skills.

Not being shamed

A critically important feature of successful interventions is that they avoid causing shame. Not generating shame increases the likelihood that parents will adhere to and complete the intervention, because shame is deeply internalised, and the pain or threat that comes from the feeling of being a "bad" or unworthy parent is likely to lead to attrition (Gilbert, 1998).

Some participants emphasised the importance of language that does not generate shame: "I don't ever feel that having a 'victim' or 'perpetrator' is a healthy thing to label people as" (Trevillion et al., 2020: 150). In the For Baby's Sake evaluation, some fathers struggled with the language, which was perceived to frame them as the "bad guy" who needed to change, and the mother as the person who needed to be supported and protected.

At the same time, the practitioner needs to be honest about what needs to change, and, indeed, about the probable consequences of not changing. This position balances two seemingly opposite strategies: acceptance of the person, and clarity about the need for change. It is well articulated in dialectical behavioural therapy (Linehan, 2015). It was interesting that a woman engaged with SafeCORE who had been the primary perpetrator of domestic abuse and violence towards children observed that the team were neither judgemental nor sorry for her, but encouraged her to work from her strengths: "[there]... was not a day that I was finding myself as a victim – they were really encouraging me'" (Schrader McMillan, 2022: 40).

Parents valued the encouragement and acceptance, but also the honesty, of trusted practitioners. As one mother who worked with a Growing Futures domestic abuse navigator reflected, her "streetwise" practitioner was honest about problem behaviour that had to change, but did so in a way that inspired hope:

> "She's streetwise... [she'll] pull no punches, give you no [expletive], and she will say you are doing right, good, or you are not, I wouldn't do that or do this, this is my advice... So, it's all [done] in a positive manner. It's not a negative..."
> (McCracken et al., 2017: 38)

Practitioners set the tone for group interventions in which participants help each other. For example, parents or children in group interventions may be wary of talking about their ownexperiences, but it is essential for them to hear from each other to end the sense of isolation. Therefore, practitioners need to plan activities that can help create a sense of community (Wills et al., 2007).

At the same time, safety depends on the capacity of practitioners to quickly and skillfully respond to actual danger. This was the case for the three practitioners (a social worker and two police officers) from Inner Strength who identified drug-dealing by a participating father early on in the programme and took appropriate action (Schrader McMillan and Rayns, 2021: 30). An environment that is structured, follows predictable routines, and is calm, creates the sense of safety that is essential in therapeutic work with traumatised people (Bloom, 2000).

Responsivity and flexibility

Service responsivity is the ability to modify how a service is delivered to meet the "story" that the participant brings to the intervention, as well as their needs and their learning styles (Bonta and Andrews, 2017). A responsive, flexible approach is built into many practice models. However, practitioners may test a range of activities during the pilot phase of a new intervention. The confidence to adapt an intervention without compromising core components comes with experience.

> "Practitioners commented that the initial approach to implementing the programme was to apply the sessions in the same format in which they were laid out in the manuals... They reflected that this approach proved too rigid and so a flexible approach was adopted to ensure that specific sections of the programme manuals could be selected by practitioners, depending on the presenting needs of families."
> (Trevillion et al., 2020: 89)

A responsive approach can involve adapting the structure, the times when the service is delivered, and the language, to suit the needs of participating families. In addition, this approach involves patience, given the likelihood of missed appointments and cancellations, especially during the early stages of engagement when families are uncertain about the intervention.

Parents experience flexibility in programme delivery as a form of care and respect, and those who worked with SafeCORE (which integrates compassion-focused therapy) described the demeanour of practitioners as compassionate (Gilbert, 2010). Unlike children's social care, therapeutic and psychoeducational services for families where a child has been exposed to domestic abuse are not obliged "... to visit [the family] x number of times... we are working with them as opposed to doing to them. We find a time to work that suits everyone" (Schrader McMillan, 2022: 74). The objective of this approach is to offer a plan of broad, integrated supports and services for all family members, which reflects family priorities, strengths, culture and needs. This plan is strengthened by practical, possibly material supports, which are often the family's first priority (see 'Addressing practical needs and advocacy', on page 104.

The techniques used in group interventions must also be adapted when participants have different literacy levels, language proficiency, developmental needs, or face acute crises. As one of the practitioners who led the MOVE (Mothers Overcoming Violence Through Education and Empowerment) children's groups observed:

> "I'd love to think I could go into a group prepared, but it doesn't happen like that. You get in, you meet the kids, then it's like, 'We need to add this activity; we need to leave this one off; we need to prioritise here; we need to mix it up.' So we'd love to think there was a plan you could use every time, but that's not what happens."
> (Ermentrout et al., 2014: 664)

Adaptation to group interventions included working around varying levels of literacy, as was the case with the Inner Strength programme. For example, "[a] couple of lads… had writing problems, reading, writing problems, and we worked around that all of us as a group, you know…" (Schrader McMillan and Rayns, 2021: 30).

Practitioners also adapted to the needs of participants by offering one-to-one sessions and coaching that focused on helping the father or mother who had perpetrated domestic abuse to achieve their goals.

Content that is interesting and enjoyable

One theme that emerged from many of the evaluations was how much the people who completed the programmes valued the opportunity for enjoyment, even "having fun while learning". The combination of good relationships with practitioners and, where pertinent, the group, and of interactive, dynamic experiential learning helped reduce stress levels and increase participants' interest. There is established evidence from both education and neurobiology to show that enjoyable activities increase levels of dopamine, endorphins, and oxygen in the brain, and this aids learning. Conversely, stress, boredom, confusion, low motivation and anxiety can individually and more profoundly interfere with learning (Christianson, 1992).

Families involved with Opening Closed Doors valued the range of methods and tools that had helped them to develop their understanding of domestic abuse and parenting, to open up about their experiences and to learn new skills and behaviours: "We did a lot of talking about feelings, we used graphs and poems". Parents who were interviewed said they liked active learning: "This was more us coming up with things – we did activities with post-its and white boards etc. It made me think. I learned stuff" (Barnardo's Cymru, 2021: 32). Activities that rely more on experiential learning (games, quizzes, etc.) also reduce reliance on the written word, which is important when participants have low literacy or limited English (Draxler et al., 2019; Schrader McMillan and Rayns, 2021).

Each Inner Strength session is structured around short, dynamic activities to retain participants' attention.[12] One of the themes to emerge from all interviews (mentioned in passing in other sections) was that Inner Strength was demanding but enjoyable, which was not something participants had expected. When asked why it was so important to have fun, one man interviewed observed that far from being a burden, the programme provided hope, companionship and relief from participants' many problems:

> "I think a lot of people were struggling with why they got there, like me… So, it was nice for me to get out and have a laugh with other people, which I wasn't doing before that."
> (Schrader McMillan and Rayns, 2021: 35)

The same study participant observed that "if you have fun while learning, it registers more… It makes you want to do more and gets you more involved" (ibid.).

Addressing practical needs and advocacy

The provision of practical support, alongside therapeutic or psychoeducational work, is a core component of many of the interventions included in our review (Jouriles et al., 2010; Schrader McMillan, 2022). This is because families highly value practical support, and the capacity of practitioners to help resolve urgent problems can help build trust in people who have become highly guarded, as was the case for a mother who worked with Project Crewe:

> "I'm not a very good reader and writer and I was having… rent problems with the house and they were sending letters for instance. The rent, it was like from my husband, and the debt like all landed on me… and she went through everything and… not just explained it, went through it with me and every phone call she would explain before and after."
> (Heal et al., 2017: 32)

Moreover, therapeutic and practical support can be interwoven. For example, the social and instrumental support component of Project Support:

> *"… also included training mothers in decision-making and problem-solving skills. Examples of problems to which these skills were applied include deciding whether a particular apartment was suitable for the family, evaluating a childcare provider, and identifying how to maintain adequate food in the household with very limited financial resources."*

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[12] Some participants had low literacy levels, and at least one had never been to school, so it is vital to rely on experiential learning techniques where possible. Fathers with good literacy skills could team up with others who could not read well, for example, to complete a quiz.

(Jouriles et al., 2010: 331)

Similarly, SafeCORE family workers (who are part of every unit) help address problems like debt, housing, difficulties with landlords, children's school enrolment, or immigration status. *Practitioners explained that* they *could* "talk about the practical part and then weave back the emotional part... *We can weave in self-soothing.* [We explore with the parent] which parts are in your control and which are not... We can talk about rumination or loops" (Schrader McMillan, 2022: 75).

Achieving goals during and after the intervention

Building a better relationship with children's social care

A consistent theme throughout this review is that parents whose children are or have been involved with statutory social care (or even a Child in Need Plan) often express fear and mistrust of social workers (see for example Interventions for Mothers and Children, page 37; Whole Family Interventions, page 55; and Interventions for Fathers, page 68). This mistrust, and the conflict that ensues, can lead to a downward spiral of miscommunication, false compliance and re-referrals or even escalation of the case. A better relationship is more likely to result in an agreement, by all involved, on the Child Protection Plan and a better outcome for all.

Parents in several programmes described being able to understand the perspective of social workers because the intervention had helped them regulate their emotions, understand their children better, and perhaps see their children's safety from the perspective of social care. In the words of one mother whose partner had completed the Caring Dads programme:

> "I've seen the social worker, and my first thought were, 'I'd love to say something to her. You've failed me'. That's how I felt but it's not true. Now we've realised where we went wrong... You know, we accept the responsibility. My mum and dad have never heard me say, 'I picked drugs over my kids' but unfortunately, I did. Unfortunately, I kind of did."
> (Youansamouth et al., 2020: 68)

Across several studies, parents described the role of facilitators in liaising with children's social care and helping resolve difficulties. As one mother said of the domestic abuse navigator (DAN) allocated to her family by Growing Futures:

> "[Social care] weren't believing a word we said... So [the DAN]... validated what we were saying... and she's helped them understand us... and we've found that common ground, so we can all kind of get along and get where we need to get." (McCracken et al., 2017: 36)

The positive relationships built with practitioners provided a starting point for better relationships with children's social workers, which can lead to collaboration and change that will benefit children.

Being able to contact practitioners after the intervention is over

It was evident that through enabling individuals to learn to trust themselves and the practitioners, the end of the programme was an anxiety-provoking time, as clients were worried that they would not be able to cope without the support of "their" practitioner: "That's my worry when I go. If we have a breakdown, I can wait two weeks for the social worker, which might be two weeks too late" (Trevillion et al., 2020: 148).

Therefore, practitioners must "begin with the end in mind" by reflecting with the participant or family about potential problems post-intervention, and thinking through ways of managing challenges when the service has ended. But crises can and do emerge, and as a social worker who delivered the Inner Strength programme observed, many participating fathers "do not have that many people to whom they can turn for advice" (Schrader McMillan and Rayns, 2021: 39). As a result, even after the programme had ended, participants called practitioners because "at a certain point you need to ask for help" (ibid.). Being able to talk to a practitioner at a moment of crisis, which could easily have escalated into aggression and violence, can help the parent practice self-soothing and emotional regulation techniques, step back, and deal better with the situation at hand (Schrader McMillan and Rayns, 2021). Thus, new skills become habitual, and the person is less likely to need the practitioner in future.

It is beneficial for parents to know they can contact the practitioner after the intervention ends, and this may be especially important if social services has closed the case. A practitioner who was part of Project Crewe reflected:

> "[A mother] was quite dependent after a few months of working with her, but we slowly reduced the amount of times we'd see the family. She knew I'd be at the end of the phone if she needed, but she began to manage… without my support. I guess that's how you look at maintaining changes after social services step out, which was important to identify early on."
> (Heal et al., 2017: 35)

The availability of practitioners out-of-hours and after the programme has ended communicates to parents that they are "held in mind". As a father who completed Inner Strength said of a practitioner who worked with him, "when they're not working… people have their phone turned off

and wouldn't give a damn. And for her to call me back, that means a lot to me; it shows they are worrying about people" (Schrader McMillan and Rayns, 2021: 39).

Moreover, participants did not only call facilitators when they had a problem; they also got in touch to share good news – a baby, a new house, a new job, or marriage. Sharing and celebrating achievements helps to consolidate learning "as neurochemical reserves of positive feelings increase when people are reminded of their successes, and when time is taken to celebrate them" (Willis, 2007: 63).

Children's perspectives

Two published papers (Ermentrout et al., 2014; Woollett et al., 2020) and two grey evaluations included children's perspectives (Langdon-Shreeve et al., 2020; McCracken et al., 2017). Reference is also made to interview data from children who are not necessarily above the threshold for children's social care (for example, Callaghan et al., 2019; Sharp et al., 2011).

Being part of a peer group

Children interviewed who participated in the MOVE group-based programme highlighted the importance of being part of a group with others who had similar experiences. There is evidence that peer relationships are a significant, powerful protective influence for children and, particularly, adolescents exposed to domestic abuse (Tajima et al., 2011; see also Callaghan et al., 2019).

Groups can help children and adolescents exposed to domestic abuse, who are often isolated, stop feeling that they are "different" and alone, and potentially reduce avoidance symptoms (Sharp et al., 2011; Woollett et al., 2020). Being with other children is, therefore, "vital to the development of understanding of domestic abuse; to be able to give and receive peer support enhanced learning and promoted recovery" (Sharp et al., 2011: 128).

Some children (all of primary school age) who had completed the MOVE group described missing a space where they felt wholly safe: "I would come… a lot of times. It's very kind in here, and nobody cusses, nobody hits" (Ermentrout et al., 2014: 661). Other studies, predominantly of children below the threshold for children's social care, suggest that it may be difficult for children to leave the group when the programme ends: "I wish it could have lasted a bit longer" (Sharp et al., 2011: 74). One child expressed the need for long and enduring groups because they face so many challenges: "Some children might like not feel that good… there might be other stuff going on in their families" (Ibid). Children who have found a group that offers respite, helps them make sense of their world, and provides a space for enjoyment may want to continue to meet after therapeutic group work ends.

The only intervention identified that involves structured activities throughout the year and over several years is the Camp HOPE programme. Its summer camps have been designed for children and adolescents who have been maltreated and exposed to domestic abuse and are now in out-of-home care (typically foster care or group homes). Children and young people can return to the summer camp over several years and participate in monthly activities with peers and mentors during the school year.

Liking and trusting the facilitator

Children and young people appreciated the practitioners (Ermentrout et al., 2014; McCracken et al., 2017; Sharp et al., 2011; Woollett et al., 2020). A core element of the Growing Futures model is the domestic abuse navigator (DAN) who works with each family. One child described the DAN as follows:

> "… 'she's helpful. She's a happy person. She has great things for us to do'. This child had particularly enjoyed going to the park and a fast food restaurant with the DAN. The child reported not enjoying discussing feelings, but nevertheless feeling able to do so with the DAN. The child also reported feeling safer and better able to re-establish a relationship with the perpetrator, and having improved relationships with the mother and sibling."
> (McCracken et al., 2017: 38)

A sense of safety with the key practitioner – in this case, the DAN – allows the child to open up:
> "The other child we interviewed described their DAN as 'really, very, very, very, very, very, very, nice'. One of the parents also reported that the DAN had been working well with her children: 'my [child], can be quite, you know, won't really open up, type thing. But [the DAN] even got [my child] on side. So yes, obviously, whatever [the DAN] did has obviously worked'."
> (ibid.)

A child who completed MOVE reflected on the structure and reliability of the service, and implicitly, of service providers: "… because it's [the agency] like my home. It protects me. It gives me rules I need to follow" (Ermentrout et al., 2014: 661). Receiving genuine attention and experiencing care and consideration is likely to be particularly important to children whose needs have not been met due to the effects of domestic abuse on their mother and family (Sharp et al., 2011).

Learning how to identify, understand and manage difficult emotions

The most valuable skill learned is recognising and accepting negative emotions, communicating, and positively coping with potentially destructive feelings. For example, children described learning practical skills to recognise and manage overwhelming emotions. As one 13-year-old girl who scored

high on depression observed, it was good to know "when we are angry or sad, what we can do" (Woollett et al., 2020: 7).

Similarly, a child whose mother had been court-mandated to the MOVE programme and who took part in the parallel children's group illustrated how he was using emotional regulation skills in his day-to-day life:

> "In school, it's helped me a lot 'cause some people just act like they know stuff, and then they wanna say I'm stupid, and I just get mad and take a deep breath and take it out, and then I just ignore them." (Ermentrout et al., 2014: 667)

This child's comment supports the need for interventions to take a broader relational focus, exploring the implications of domestic abuse for children's broader social network (see also Callaghan et al., 2019). As one author has concluded, "it may be necessary to focus efforts... on helping children make sense of the multiplicity of feelings that they experience due to domestic violence" (Nolas et al., 2012: 10).

The importance of enjoyment

Like adults who participated in groups, children highlighted the importance of having fun (Ermentrout et al., 2014; Sharp et al., 2011). Part of the fun was in the interaction among group members, which owes much to skilled facilitation (Callaghan et al., 2019). A varied range of activities adds to the enjoyment, and children who took part in Cedar (Children Experiencing Domestic Abuse Recovery) commented positively on playing outdoors and indoors, making badges and treasure chests, playing bingo, using playdoh, and drawing. Eating together also helped children feel relaxed and at ease, as one teenage girl observed: "Having snacks there and drinks on the go just helped to make it a nice atmosphere. And I liked how we all became friends in the end" (Sharp et al., 2011: 64).

Children exposed to domestic abuse live in a stressful and unpredictable environment, and as Gaskill and Perry (2014: 186) observe, "it is impossible for a child to have pleasure in a relational interaction if the child's brain is in an alarm state".

Enjoyment is created by the setting, atmosphere and facilitation, but also by the use of creative and expressive techniques (Callaghan et al., 2019).

Using creative and expressive techniques to communicate difficult feelings

Two interventions explored children's experiences using artwork and other expressive therapeutic techniques (Sharp et al., 2011; Woollett et al., 2020). Children valued these activities because they were enjoyable and expressive techniques that helped them communicate hard-to-articulate experiences. For example, a child who took part in the evaluation of MOVE drew a picture of the

family and explained that "Everybody in the family [in the picture] is happy because they learned how to be safe and not to fight anymore" (Ermentrout et al., 2014: 661).

Woollett et al. (2020) integrated art and play therapy with TF-CBT, which is more reliant on speaking:

> "Participants reported having fun in the group. Play therapy at its core is about having fun, learning and problem-solving creatively through this approach... The key, therefore, to being true to the 'play' in play therapy is helping the child with their own emotional regulation, and, consequently, their own safety. This reality complements more structured verbal therapies such as TF-CBT. In addition, when children play and have fun, they usually laugh, which is therapeutically beneficial, leading to improved mental health, social connection, stress reduction and acceptance."
> (Woollett et al., 2020: 8)

Children living in shelters felt validated and heard when they spoke about their highly personal, often explicit art during a final exhibition of their artwork (ibid.). Interviews confirmed that being heard is important for children, especially by their mothers (see Humphreys et al., 2006).

> "Mothers appeared present to 'listen' to their children, some being visibly moved and seemed to gain improved insight into the emotional lives of their children and the impact violence had on them. For many, the artwork represented a display of emotion that was otherwise challenging to share with their mothers.' [In the words of one eight-year-old girl] 'I wanted my mum to look at my pictures and everything that was in them.' Shelter staff also reported noticing a change in the interpersonal relationship of participating mothers and children, highlighting improved tolerance of children's negative behaviors with more peaceful parenting responses and generally happier interactions between dyads."
> (Woollett et al., 2020: 7)

> "The program offered the opportunity for growth and improvement by providing a respite and a confidential, non-judgmental, dedicated space to share thoughts and feelings. As a children's group member explained, '[we] talk about how it [our family situation] makes us feel and why'."
> (Ermentrout et al., 2014: 665)

The authors note that similar positive outcomes have been reported in other studies on creative therapies with traumatised populations (Stuckey and Nobel, 2010), as people can express conflicted and painful feelings that are hard to verbalise:

> "Many children living in contexts of IPV [intimate partner violence] blame themselves for violence and have poor self-identity... The playful facet introduced through these methods may hold the child 'emotionally receptive' so that powerful positive messages can sneak through psychological defences."
> (Woollett et al., 2020: 8)

Moreover, physical activities, including role-play, can be helpful for children who are getting restless and physically agitated and are a means of emotional catharsis and expression of experiences (Callaghan et al., 2019). As a 13-year-old boy who took part in MPOWER said, "I don't like sitting still". Embodied strategies can help children cope and feel that they have agency (Alexander et al., 2016, Callaghan and Alexander, 2015; Callaghan et al., 2019).

Further research is needed on the experience of children who take part in one-to-one, dyadic or whole family interventions.

Challenges to evaluation

During the review, we identified several challenges to evaluation quality.

Engaging service users in evaluation

First, engaging clients in all evaluation components is challenging. The requirement to provide data can prompt anxiety and fear among participants, particularly if they have low levels of literacy, and particularly at baseline when their engagement with the service is new to them and when the main interest of practitioners is enrolment into the programme, rather than enrolment into the evaluation (Bunston et al., 2016). Post-intervention, participants may not wish to provide data as the evaluation reminds them of a painful time they want to put behind them (Langdon-Shreeve et al., 2020; Smith, 2016). In addition, some families move away, cannot be contacted, and may be facing a re-emergence of the challenges that led them into the intervention and so be less inclined to participate (Schrader McMillan and Rayns, 2021).

Attrition and sample size

Linked to this is the challenge of attrition, which was a common challenge for the studies in our review. For example, in all eight qualitative non-randomised trials, the average level of attrition was 28.8%. Another limitation to sample size was reported by two evaluation teams which faced difficulties in accessing social care case data other than children's safeguarding status pre- and post-intervention (Heal et al., 2017; Langdon-Shreeve et al., 2020). This problem arose, at least in one case, because it was not possible for the team to secure a data-sharing agreement with the local authority in time to complete work as planned. The sample size of the well-designed RCT by Heal et al. (2017) was ultimately too small to draw any statistically significant conclusions.

Evaluations of 'whole family' practice models can be challenging because work with families is of varying length, and it can often take longer than planned. When this is the case, many families may not have completed enough work to take part in the evaluation (see Langdon-Shreeve et al, 2020; Schrader McMillan, 2022).

Risk of reporting bias

The reliability and validity of data sources were often questionable. For example, dependence on maternal reports of child behavioural difficulties and trauma-related symptoms are vulnerable to reporting bias, and there might have been under-reporting on account of social desirability bias or stigma, including parents' anxiety about further involvement of Child Protective Services or children's social care with their families (Timmer et al., 2010). It is also possible that there is an increase in disclosure as a function of parents' increased awareness and engagement in the intervention, which may make the intervention look less effective but is a desired treatment effect. Parents' perceptions of the intervention's potential and their experience of the intervention are likely to influence their support for the evaluation and the collection of data from their children.

Involving children on or above the threshold for CSC

The inclusion of children in research on domestic abuse presents challenges that are compounded when the child is subject to a Child Protection Plan. The evaluators of NewDAy (Langdon-Shreeve et al., 2020) could not include children in the qualitative component of the evaluation because this would have required permission from both parents, including the sometimes estranged perpetrator of domestic abuse. Moreover, one evaluation that did include children cautioned that young children may be "coached" to say the "right" thing early on in the intervention (Ermentrout et al., 2014) or that children might give the response they thought was "correct" rather than accurate (Barnardo's Cymru, 2021). However, there is a rich literature on children's lived experience of domestic abuse, which contains a wealth of strategies and approaches to involving children in ways that are appropriate to their age and stage of development (see, for example, Arai et al., 2021; Callaghan et al., 2019).

Accessing data on non-completers

Most evaluations faced difficulties in interviewing families (specifically parents) who declined the service or withdrew early. However, some were able to analyse differences between completers and non-completers by looking at baseline data or social care case files (Schrader McMillan, 2022; Stover et al., 2022).

Use of social care data

Many evaluations examined changes in children's social care status, but such changes can be due to factors other than the intervention. Several evaluations conducted in the UK and in the US noted that social care files can be of uneven quality and data may be missing. Some evaluations created a

composite measure of risk to children based on information in case files, but this is only possible if the case files data are accurate.

Evaluating complex interventions

Finally, and as noted earlier, it is particularly challenging to evaluate multi-agency/multi-component practice models (see McCracken et al., 2017). Like the system of care approach in the US, a multi-agency response to domestic abuse promotes the integration of fragmented service systems and agency collaboration at the local level and, ideally, the merging of categorical funding streams at the state level and building of professional relationships (Lowell et al., 2011). However, empirical evidence of the effectiveness of this approach is constrained because of the complexity of evaluating both outcomes at both the systems and clinical/functional levels, especially relative to a comparison group (ibid.). One way to develop the evidence base for multi-agency models is to evaluate the effectiveness and acceptability of individual components in terms of desired outcomes, and the change in children's social care status of participating families and re-referrals to children's social care.

MEDIATORS AND MODERATORS

The studies included in our review rarely reported on mediators and moderators, and it has therefore been necessary to look at the broader literature on domestic abuse interventions with children who are not necessarily above the threshold for children's social care (Graham-Bermann et al., 2011) and reviews of interventions for children and adolescents who have symptoms of trauma and PTSD.

One important study is an RCT of the Kids Club and Moms Empowerment Programme (KCMEP) by Graham-Bermann et al. (2011) that sought to identify mediators and moderators of treatment effects among 180 children aged 6-12 years, although these children were below the threshold for Child Protective Services at the point of referral. KCMEP is a psychoeducational programme with parallel groups for mothers and children, and a modified version of the intervention was described in the section "Interventions for mothers and children", on page 37. A total of 120 dyads were randomised to the KCMEP, and 60 were in a waiting list control. This study found a significant relationship between the length of a child's exposure to domestic abuse, their gender, mothers' mental health change, and changes in child adjustment. Regarding gender, boys had slightly more significant improvements in externalising behaviour problems following intervention than girls. The key mediator identified was maternal post-traumatic stress, such that when the mother had significantly reduced symptoms of traumatic stress, there was a reduction in internalising problems for the child, superseding the broader effect of the intervention on the child. The relationship between reduction in maternal mental health outcomes and improvements in the behavioural problems of children was borne out in the study by Overbeek et al. (2013). of an

intervention based on KCMEP which was delivered in the Netherlands. Overbeek et al. also identified that children who had had longer exposure to domestic abuse and who had more severe internalising behavioural problems showed more significant overall improvements the more sessions they attended.

Graham-Bermann et al. (2011) recommend that mothers' level of PTSD should be identified early on and that women should be given opportunities to learn more about PTSD, understand and normalise their distress, and teach mindfulness exercises that reduce PTSD symptoms. Improving maternal mental health influences the recovery of children and increases the likelihood of adherence, especially among those exposed to domestic abuse for longer periods. Overbeek et al. (2013, 2017) conclude that parental mental health can be improved by factors such as parent-child play, positive reinforcement, and the support of a group, and that not all parents need specific work to target their trauma symptoms. The broader review-level evidence on mediators of TF-CBT effectiveness for young people who have been exposed to trauma does not necessarily find that parental PTSD symptoms mediate the effect, but rather the parent's depression does (Danzi and La Greca, 2021). A second review on mediators of the effects of TF-CBT on adolescents recommended working with the parent to reduce the parent's trauma-related maladaptive cognitions (Martin et al., 2019).

A second moderator identified in the Graham-Bermann et al. (2011) study is the length of time children had been exposed to domestic abuse, as more prolonged exposure was associated with more severe internalising problems. The same study also found that children exposed to domestic abuse for longer and with more severe internalising problems benefit from longer participation in the intervention. Mothers with more prolonged exposure to violence, and more severe PTSD symptoms, had greater difficulties participating in planned sessions. As mothers' mental health improved, so to did their adherence to the programme. The authors, therefore, recommend that a mother's level of PTSD should be identified early in treatment and that attention should be paid to providing women with opportunities to learn more about PTSD, normalise distress, and teach mindfulness exercises that reduce PTSD symptoms.

Graham-Bermann et al. (2011) found no effects for child age or ethnicity. However, the child's age has been identified as a mediator of the effectiveness of TF-CBT for children and adolescents more generally, with some studies finding that it is more effective with older children than young children. A second review of TF-CBT with children concludes that the intervention can be effective with preschool children but that this depends on practitioners' skills and capacity to work with young children with diverse levels of language skills and cognitive ability and with the children's caregiver.

Overbeek et al. (2013) analysed mediators of engagement in an adapted version of KCMEP and identified a further moderator – children who show indiscriminate trust in unknown adults (a

behaviour associated with disorganised attachment), which makes it difficult for the child to participate in a group.

Overall, the evidence suggests that the primary mediator to treatment adherence and improvements for children under the age of 12 is the mental health of their non-offending parent. The primary message is, therefore, the paramount need to identify and support the mental health needs of both the parent and the child.

DIVERSITY, EQUITY AND INCLUSION

The term "diversity, equity and inclusion" (DEI) is used to describe policies and programmes designed to promote the representation, participation and integration of people from a range of different groups, including those of different ages, races and ethnicities, abilities or disabilities, genders, religions, cultures and sexual orientations. DEI also encompasses people of different backgrounds, experiences, perspectives, skills and expertise (see Box 3).

SafeLives (formerly Co-ordinated Action Against Domestic Abuse, CAADA) has identified reasons why some groups or individuals are not accessing or engaging with domestic abuse services. These include but are not restricted to: people with severe mental health problems; minority ethnic and cultural groups; individuals with disabilities or special needs; and LGBT+ parents.[13] This section seeks to identify gaps in services and lessons learned about increasing equity and inclusion of these under-served groups.[14]

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[13] See Spotlights: Hidden victims. SafeLives website.

[14] Please see Howarth et al. (2016) for an overview of the availability of specialised services and funding for DA in the UK. Specialised services, which tend to be smaller and often local organisations, are likely to be most deeply affected by Local Authority funding cuts.

> ## Box 3: Diversity, equity and inclusion
>
> ⁄ Diversity describes characteristics that make one person or group different from another. Aspects of diversity include but are not restricted to race and ethnicity, sexual orientation, socioeconomic status, religion, language, age, marital status, education, mental ability, and physical ability, and may also include a range of ideas, perspectives and values.
> ⁄ Equity means ensuring fair treatment, access, equality of opportunity and advancement for everyone while seeking to identify and remove barriers that can prevent some people or groups from participating.
> ⁄ Inclusion describes a culture or environment in which everyone can feel welcome, contribute and participate.

Under-served groups

Working with parents with severe mental health problems or Substance abuse

Most of the interventions included in our review cannot work with a parent who has a severe and untreated mental illness (for example, psychosis, schizophrenia or schizoaffective disorder) (see, for example, Schrader McMillan and Rayns, 2021; Smith et al., 2020; Stover, 2015; Stover et al., 2022; Trevillion et al., 2020; Youansamouth et al., 2022). Some evaluations describe successful work with families where a parent can be encouraged to adhere to medication or is otherwise stable (Schrader McMillan, 2022). One study of TF-CBT for children aged 7-14 years, which did not meet the full inclusion criteria (Cohen et al., 2011), accepted mothers with mental illness (other than severe psychosis) and substance abuse, and mothers and children who were living with the domestic abuse perpetrator – both factors that would preclude their participation in many other interventions. While mothers with these problems are more likely to drop out early, levels of attrition were not higher than average for interventions of this kind. Findings suggest that the intervention may be effective even where it involves parents with more severe mental health problems.

The severity of a parent's mental health needs may not be evident from the initial assessment. The primary focus of interventions that work with families where a parent or child needs psychiatric or specialised treatment is to ensure that the referral is made. At the same time, the practitioner or

team seek to ensure that other family members get the support they need. This may be easier for services formally embedded in a multi-agency network, such as Growing Futures, where domestic abuse navigators helped families access adult or child mental health services or substance abuse treatment as part of the package of wraparound support (McCracken et al., 2017). In addition, services that have "in-house" clinicians can provide additional support through short-term, intensive and one-on-one therapy. At the same time, the other team members work with children and families (Schrader McMillan, 2022).

Some dyadic or group-based services had to exclude parents with severe substance abuse problems as they could not engage meaningfully in treatment. However, whole family or multi-agency models such as Growing Futures can also refer parents to substance abuse treatment (McCracken et al., 2017), and Fathers for Change (Stover, 2015; Stover et al., 2022) has also been used for fathers in residential substance abuse treatment. Outcomes have shown that Fathers for Change was associated with reduced domestic abuse perpetration and drug use.

Minority ethnic and cultural groups

There are many reasons why people from minority ethnic and cultural groups are under-served by interventions designed for the majority population. First, communities that have experienced egregious discrimination are often wary of government-sponsored programmes that pledge help but ultimately disappoint and intrude into the family's private domain (Daly, 2016; McHale et al., 2022). Second, victims of domestic abuse from ethnic and cultural minority groups, and indeed LGBT+ victims of domestic abuse, may fear ostracism from their community, and sometimes have to leave the community if they report domestic abuse (Domestic Violence Intervention Project (DVIP), 2012; see also SafeLives spotlight series).[15] Third, victims of violence may also feel wary about bringing attention or "shame" to a community or ethnic group that may already be the focus of negative stereotypes (DVIP, 2012). These problems have been well documented in the experience of Traveller, Gypsy and Roma communities in the UK (Daly, 2016).[16] Finally, behaviour defined as abusive in UK law may be normalised in other cultural contexts, affecting whether people seek or accept help.

Almost all studies that recorded service users' demographic characteristics reported that these broadly reflected the local area. Most interventions appear to have successfully involved parents, children and families from minority ethnic groups. In most cases, there was no significant difference in the ethnicity and race of those who did and did not complete the intervention.

This review did not identify any interventions developed by and for a specific ethnic, linguistic or religious group that also reported on outcomes for children needing statutory social care. However,

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[15] See Spotlights: Hidden victims SafeLives website.
[16] See, for example, 'Tackling inequalities faced by Gypsy, Roma and Traveller communities', Parliament UK website. See also Daly, 2016.

services for particular ethnic and cultural groups exist in the UK and deserve further evaluation (see, for example, DVIP, 2012).[17] Qualitative findings from that evaluation highlight a number of important factors: the value of involving Arabic-speaking practitioners in assessments to identify risk and resilience factors that might not be observed; the role of music, food and art in the therapeutic process; and the value for fathers of working with male practitioners who speak the same language and share their culture. Al-Aman practitioners also contribute to child protection planning, bringing unique insights into risk and protective factors that social workers from other cultures might not observe. Another way to ensure that services are equitable and inclusive is by working alongside organisations that serve a particular community. For example, in one evaluation of Caring Dads (Scott et al., 2021), four of eight groups were run in collaboration with a not-for-profit partner community agency dedicated to supporting Black fathers. These groups were run by one facilitator from the community agency and one facilitator from Child Protective Services. Again, deep knowledge of a cultural context can help ensure that the intervention is grounded in participants' lived experiences. Illustrations from an antenatal parenting intervention developed for young Black partners in the US (McHale et al., 2022), which was primarily preventive and did not report on child outcomes, highlight some of the granular ways in which services can be more (or less) inclusive. This intervention was adapted and developed by a group of community leaders:

> *"A group of 12 community elders, mentors, advocates, clergy members, and healthcare professionals reviewed a dyadic intervention model called Focused Coparenting Consultation (FCC; McHale and Carter, 2012; McHale and Irace, 2010). The community elders and leaders who helped shape the service advised recommended adaptations to FCC: a 1-on-1 mentor-to-parent rapport-building stage in advance of dyadic meetings to promote trust; reconceptualisation of the first FCC meeting to involve a get-to-know-you meal together with the interventionists (who were called mentors); regular experiential exercises; emphasis on intergenerational legacies; and use of concrete examples, visual graphics, and explicit discussion of the status of Black children in the local community... Community leaders felt parents would not explore relationship-based programming if basic family needs were going unmet,... so relationship programming in the FIOC ["Figuring It Out for the Child" intervention] was supplemented by access to a Resource and Referral (R&R) Navigator that helped parents leverage already existing community-based services."*
> *(McHale et al., 2022: 5)*

Some studies excluded participants who did not speak the language in which the service was delivered (see, for example, Pernebo et al., 2018, 2019). Good practice identified in the Caring Dads

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[17] The evaluation by DVIP (2012) of Al-Aman, a service for Arabic-speaking families in London, provides valuable perspectives from practitioners and parents but does not include outcomes for children.

project included having the same interpreter for one participant throughout his entire engagement with the programme (Youansamouth et al., 2022). Experience elsewhere has shown the possibility of using tools like Google Translate as aids when working with clients with limited English (Schrader McMillan and Barlow, 2019). Draxler et al. (2019, 2020) describe increasing the use of non-verbal techniques in the Swedish version of Project Support to make it more accessible to families from a range of minority ethnic groups who speak some Swedish but are not fluent. The use of other family members as interpreters in work of this kind is contraindicated.[18]

Several services highlight the importance of recruiting a diverse workforce, including practitioners who reflect the demographic composition of the area. As Trevillion et al. (2020: 97) observe, regarding For Baby's Sake, "the programme approaches and the ethnic diversity within the practitioner teams facilitate engagement of families from minority ethnic backgrounds". For example, in the US, Child FIRST (Child and Family Interagency, Resource, Support, and Training) (Lowell et al., 2011) sought to match practitioners and families by ethnicity and offered the service in Spanish and English. Given the demographic composition of the location, and the US as a whole, it would not be challenging to recruit Spanish-speaking practitioners. However, it may not be feasible to "match" practitioners to families based on shared ethnicity, language or other characteristics in highly diverse areas. This draws attention again to the importance of tailoring the delivery of the intervention to the needs of individuals and families. SafeCORE clinicians highlighted the value of Burnham's "social GGRRAAACCEEESSS",[19] an approach used in systemic practice to explore dynamic factors such as Gender, gender identity, Geography and generation, Race and Religion, Age, Ability and Appearance, Culture, Class/Caste, Education, Ethnicity, Employment, Spirituality, Sexuality and Sexual orientation, and how these factors interplay and change over time (see Burnham, 2013; Schrader McMillan, 2022).

Although none of the studies included in our review referred to this, it is important to draw attention to the exclusion of people with insecure immigration status.[20]

Special needs

Few of the studies included in our review discussed work with parents who have learning difficulties. One study described how parents with learning difficulties can struggle to participate in the services offered by Opening Closed Doors, even in getting to the venue and completing homework (Barnardo's Cymru, 2021). One evaluation of Caring Dads concludes that while cognitive delays can be a barrier, men with low literacy could successfully participate in the programme with additional help (Youansamouth et al., 2022)

Disabilities

Disabled women are more than twice as likely to be victims of domestic abuse than non-disabled women (17% and 7%), and the same is true for men (8% and 4% respectively) (Dockerty et al.,

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[18] For further discussion on challenges of using interpreters in social work, see S Lucas (2020) 'Spoken language interpreters in social work'.
[19] See, for example, K Partridge (2019) 'Social GGRRAAACCEEESSS and the LUUUTT model'. Practice Supervisor Development Programme.
[20] See the Child Safeguarding Practice Review Panel (2022) Multi-agency safeguarding and domestic abuse. Panel briefing 2.

2015; see also Flatley et al., 2010; Khalifeh et al., 2013). McCracken et al. (2017) found that in Doncaster, where the Growing Futures evaluation was conducted, MARAC referrals for domestic abuse victims with a disability remained well below the 16% or above recommended by SafeLives.[21]

Although it involved children primarily below the threshold for children's social care, one evaluation provides insights into how groups can be adapted to ensure that children with disabilities, or their mothers, could participate fully:

> *"Coordinators needed to strengthen the focus of the assessment process to consider children's and mothers' ability to function within a group context. In addition, a sensitive appraisal of the additional needs of some disabled children, such as hearing loss and impaired speech or language delay, was needed to ensure that appropriate support or adaptations would allow children to participate. One approach was to ask schools for their view about a child's ability to participate in groups."*
> (Sharp et al., 2011: 98)

LGBT+ parents

Review-level evidence shows that levels of domestic abuse among same sex-couples are comparable to those in heterosexual relationships. However, domestic abuse is overwhelmingly framed as male-to-female, and the challenges faced by LGBT+ victims of domestic abuse are often not considered. Like people in minority groups, LGBT+ individuals who have experienced DA might also be reluctant to talk about it or seek help, to avoid rejection and denial from their peers and keep their ties with a community where they feel safe (SafeLives spotlight series).[22]

Only two studies included in our review referenced LGBT+ parents or children, whether or not children were above the threshold for a Child Protection Plan. However, the evaluation of Opening Closed Doors reported that:

> *"One of the Service Managers described being very pleased and impressed that the Programme was able to work with and provide 'support outside of the norm' for individuals in a same sex relationship and in a case of abuse by a young person to their*
>
> (Barnardo's Cymru, 2021: 32)

The evaluation of Growing Futures (McCracken et al., 2017) provided a demographic breakdown of

MARAC referrals for LGBT+ victims of domestic abuse was well below the 5% to 7% or above

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[21] See website. https://safelives.org.uk/sites/default/files/resources/Guidance%20for%20MARACs%20-%20Disabled%20people%20FINAL_0.pdf

[22] See Spotlights: Hidden victims SafeLives website.

recommended by SafeLives. These low numbers reflect a broader trend at the national level, although SafeLives suggests this may be partly due to barriers in reporting. The need to ensure equity and inclusiveness for LGBT+ mothers and children and other "hidden" groups requires "explicit, deliberate attention… to be paid to reaching different communities of place and interest" (Sharp et al., 2011: 131).

Male victims of domestic abuse

Conservative estimates suggest that 10% of victims of DA are male (see for example, Wright, 2016), but this is likely to be an underestimate.   Figures from the Crime Survey for England and Wales (CSEW) for the year ending March 2020 present a much higher figure which suggests that around 33% of victims of DA are men (Office for National Statistics (2020).[23] Male victim-survivors of DA face considerable barriers in seeking and accessing help (see Huntley et al., 2019).   Thus, the evaluation of Growing Futures (McCracken et al., 2017) found that only 4.7% of MARAC referrals were for male victims.

'Whole family' interventions designed for situational couple violence (such as SafeCORE and NewDAy) can be adapted to work with couples in which fathers are the primary victim of violence. The same is true of 'whole family, multicomponent' services such as Opening Closed Doors. Opening Closed Doors was open to working with male victim survivors and one of 12 men who completed planned work at the time of the evaluation was in this category.   There is a gap in services for fathers who have been victimised, especially victims of more severe violence and coercive control.   No dyadic interventions were identified for fathers who are victim-survivors of DA and their children post-separation.

Women who have perpetrated domestic abuse

Two evaluations of services designed for children exposed to DA and their mothers noted that several mothers had perpetrated violence towards their partner that was not necessarily in self-defence (Bunston et al., 2016; Sharp et al., 2011). Bunston et al. explain the need to identify and provide appropriate services for mothers who perpetrate domestic abuse:

> "13.3% of mothers acknowledged that they also used violence. Whilst this violence may be understood as reciprocal, we suspect this rate is much higher and not always reciprocal. Our belief is that the shame associated with women using violence and the social debate associated with the prevalence of men's violence silences this discussion. We concur with Cho and Wilke (2010) that 'attempts at understanding the nature of female perpetrated IPV [intimate partner violence] should not be influenced by fears of a backlash from a male

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[23] Office for National Statistics (ONS) 2020. *Domestic Abuse in England and Wales Overview: November 2020. (*https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020) (accessed 22/04/2023)

dominant social structure. Instead, it should lead to a better understanding of the dynamics of IPV that is critical to better serve victims'.
In this instance, the ones most silenced and less served are the infants."
Bunston et al. (2016: 128)

Only two of the interventions included in our review – MOVE and Inner Strength – were designed to work with women who have perpetrated domestic abuse. MOVE (Ermentrout et al., 2014) involves court-mandated women who are not the primary perpetrators of domestic abuse, suggesting that the service is designed for situational couple violence or when women use violence in self-defence only. Only 3 of the 34 Inner Strength participants were women, and the sample is too small to draw meaningful conclusions.

There is limited information on how interventions that were not specifically designed for situational couple violence (that is, NewDAy and SafeCORE) have been adapted for couples who resort to violence in the context of escalating fights, and there is no clearly identifiable victim or perpetrator. For instance, one evaluation of Caring Dads (Scott et al., 2021) reports that "Fathers were primarily the alleged perpetrators in the intervention and comparison groups... jointly with the mother, 32% or 23% of the time, respectively". However, although bidirectional coercive control is rare (Johnson, 2008), social workers need to be trained to identify it if children are to be kept safe.

The studies included in our review do not report in detail about specific "hidden" populations, but they do provide guidance on adapting and working flexibly with families from diverse backgrounds and circumstances (see "Barriers and facilitators" on page 76). It was therefore interesting to note that stakeholders interviewed for a service (Al-Aman) that is embedded in a particular population – Arabic speakers in London – identified four factors to explain its acceptability and success: (1) highly professional, competent and dedicated staff; (2) a highly flexible delivery model, with extensive tailored support for individuals; (3) the combination of expertise in language, culture, domestic violence issues, law and policy; and (4) involvement by community organisations (DVIP, 2012). As Howarth et al. (2016: 5) noted some years ago, cuts to domestic abuse services nationally have led to the closure of many local services, including those for specific Black and minority ethnic groups.

The first two factors identified in the Al-Aman evaluation – the quality of staff (who build the therapeutic bond), and flexible service delivery with tailored support (including advocacy) – have been identified in the previous section, 'Barriers and facilitators' of engagement. The other two factors – experience and cultural sensitivity, and the capacity to explain the context of law and policy in the UK to service users who do not understand it – are more specific attributes of the organisation. SafeLives offers practical guidance on developing skills in working with diverse and

often excluded groups, sometimes in partnership with community organisations and advocacy groups.[24]

Given the co-existence of many factors that affect access to high-quality domestic abuse services, the Child Safeguarding Practice Review Panel (2022) stresses the need for practitioners to develop an intersectional approach when planning work with children or families. Intersectionality has been defined by SafeLives (2016) as

> *"..a way of understanding the interconnected nature of the social categories of gender, race, class, age, and dis/ability, which create unique and complex experiences of oppression and discrimination and of power and privilege. This intersection is key to understanding both the positioning of groups in society as well as individual experiences, which are complex and contradictory."[25]*

An intersectional approach can also be used to identify actual or potential strengths and resources. Finally, it is important to mention the need for equity for practitioners – for example, those who have impaired mobility. The move towards hybrid working on online platforms, and on WhatsApp, proved more popular with families who took part in For Baby's Sake, SafeCORE and NewDAy than many practitioners had anticipated (see Rees and Evans, 2020; Schrader McMillan, 2022). Skilled and experienced practitioners who are or have become physically disabled are benefiting from hybrid forms of service delivery.

DISCUSSION

Summary of findings

What is the state of the evidence on the effectiveness of different types of domestic abuse interventions delivered by children's social care alone or children's social care in conjunction with other agencies that report on outcomes for children?

While there is growing literature on interventions with children who have been exposed to domestic abuse (BCCEWH, 2013; Howarth et al., 2016), there is limited evidence on interventions for those on or above the threshold for children's social care. Most studies published in peer-reviewed journals were conducted in the US or Sweden. While a range of innovative methods of

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[24] See: Spotlights: Hidden victims SafeLives website.

[25] See: https://safelives.org.uk/practice_blog/understanding-disabled-womens-experiences-domestic-abuse

working have been developed in the UK that provide lessons on process, there is a need for robust trials to assess effectiveness both in the short and longer term.[26]

What works

Although the proportion of children on a Child Protection Plan varied, all studies included children on or above the threshold for statutory social care (for example, Child Protective Services in the US). Interventions for mothers and children, or children alone, who were on or above the threshold for children's social care or Child Protective Services were delivered by specialist agencies as part of a Child Protection Plan. Whole family interventions were led by teams within children's social care or other agencies in partnership with social care. Interventions for fathers were delivered by external agencies alongside social care or by social care practitioners.

Findings from the BCCEWH review (2013) concluded that evidence was strongest for psychotherapeutic interventions (for example, child-parent psychotherapy, parent-child interaction therapy) delivered to mothers and children. The more recent IMPROVE review (Howarth et al., 2016) found that psychoeducational interventions for children alone were more effective in improving mental health outcomes than other types of intervention, and that psychoeducational interventions delivered to (non-abusive) parents and children were most effective in improving child behavioural outcomes.

Neither of these reviews focused explicitly on children in receipt of children's social care services. The findings from the current review – which focuses explicitly on children exposed to domestic abuse who are at or above the threshold for children's social care services and have trauma symptoms – suggest that the most effective interventions target both mother and child (parent-child psychotherapy) or target children (TF-CBT) with some parental involvement. One RCT (Jouriles et al., 2010) involved Project Support, a six-month, home-based and trauma-informed psychoeducational intervention with advocacy. Adapted for children with severe behavioural problems above the threshold for Child Protective Services, Project Support does show intervention effects in terms of parenting, management of child behaviour, and significantly reduced need for Child Protective Services post-intervention, although the trial did not measure any other outcomes for children.[27]

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[26] It is possible that research on domestic abuse in the UK has been oriented towards feminist research methods (Oakley, 1981), which rejected the biomedical model of "hierarchies of evidence" in favour of qualitative work and action research. However, Oakley (2000) later modified this position and advocated the integration of quantitative methods alongside qualitative studies.

[27] Another psychoeducative intervention with a strong evidence base, included in the IMPROVE review, is the Kids Club and Moms Empowerment Programme (KCMEP) (Graham-Bermann, 2009, 2011). Although KCMEP has been used with children above the threshold for Child Protective Services, there has not yet been a study that reports on work with these children and their parents. (Communication with Sandra Graham-Bermann, 22/09/22).

Comparison of results between the most robustly evaluated psychoeducational and psychotherapeutically oriented interventions suggest that psychotherapeutic models with advocacy and practical support are needed for children with more severe behavioural and trauma-related symptoms. Such interventions need to focus on the mental health needs of the parent – typically the child's mother – because of the relationship between maternal mental health and child outcomes.

There is also evidence that one model of trauma-informed therapeutic work with fathers effectively reduces harmful behaviours associated with domestic abuse perpetration, reduces child exposure to violence and improves the father-child relationship. Further research is needed to evaluate other direct effects on child emotional and behavioural outcomes. It is important to note that the included interventions are designed for parents who meet defined inclusion criteria so that the safety of children, partners, practitioners and other participants in group-based interventions is assured.

Despite improvements in a proportion of included children, a theme across all studies that measured child outcomes other than children's social care or Child Protective Services involvement is that a proportion of children continue to have behavioural problems above the clinical cut-off post-intervention, and studies have drawn attention to the effect of parents' mental health problems on child outcomes. The authors of one study (Pernebo et al., 2018, 2019) recommend screening and routine follow-up assessments of both children's and mothers' symptoms and needs.

Limitations of the studies included in our review

The quality of the evidence reviewed was, on the whole, poor. Only three studies adopted the most rigorous design (RCTs, EIF=3), and only one study (Heal et al., 2017) conducted an RCT which met all five of the MMAT criteria. Moreover, Heal et al. (2017) were unable to conduct statistical analysis because the final sample was smaller than anticipated. The two other RCTs (Jouriles et al., 2010; Stover, 2015) had some risk of bias. It was impossible to determine whether the assessors were blinded in one case (Stover, 2015), and the RCT by Jouriles et al. was impacted by data attrition at follow-up.

The grey literature comprised mainly one-group pre- and post-designs, some of which included qualitative components. Other weaknesses noted are small sample sizes (often because of high levels of attrition), or parents' unwillingness to revisit the past by completing measures when they have completed a reportedly successful intervention. The challenges include securing consent to involve children in the evaluation and accessing case file data. Moreover, social care/ Child Protective Services case file data are sometimes incomplete and unreliable.

There were several weaknesses in the measures used to evaluate outcomes. A source of bias identified in several studies was the reliance on parental self-report and parental report of child

outcomes. Parents with a child on or above the threshold of a Child Protection Plan may want to present themselves and the child in a good light. This can lead to under-reporting the magnitude of effects, as parents may not describe the difficulties that their child is experiencing at baseline. Second, they may overestimate improvements post-intervention or at follow-up. There are also challenges in relying on changes in children's need for statutory social care, as case closure depends on a variety of factors other than the intervention.

Taken together, these findings highlight the need for better-quality studies and reporting of studies that evaluate the effect of interventions on children and young people who have been exposed to domestic abuse, and their parents. A key message is to embed evaluation design within the commissioning of programmes to ensure that appropriate data are collected, and that evaluation is used not only to inform outcomes but also to support a continuous improvement in service development and implementation.

As such, there is a need for interventions to have a robust theoretical foundation and theory of change, and for programme sites to be supported to collect good-quality and complete data that are directly aligned with the hypothesised outcomes. The IMPROVE review recommends the development of partnerships between service providers and researchers that may support the high-quality pragmatic trials that are so obviously needed in the UK (Howarth et al., 2016).

Implications for practice

Services for children exposed to domestic abuse who have a social worker

The quality of evidence on psychotherapeutic interventions, or which compares psychoeducative and psychotherapeutic interventions, is poor. However, there is some evidence to support TF-CBT, which is the best-evidenced form of treatment for children and young people with trauma symptoms and behavioural problems related to domestic abuse exposure, and PCIT. Only one study involved infant-parent psychotherapy, and it showed no treatment effect. However, it is possible that the lack of intervention effect was linked to the short duration and group format of the intervention.

There is limited high-quality research on psychoeducational interventions for mothers and children above the threshold for children's social care/ Child Protective Services. One intensive parenting intervention, Project Support, which combines psychoeducation with advocacy/practical support, reports a significant reduction in children with Child Protective Services involvement. The trial did not include any other direct outcomes for children.

The evidence to support whole family systemic approaches is, at present, only indicative. However, these models – all of which have been developed in the UK – show promise and need to be further evaluated.

There is also currently limited evidence on effective interventions for adolescents with a Child Protection Plan or with children who are looked after.

All interventions focused on children need to pay close attention to the non-offending parent's mental health, especially trauma symptoms and depression, given the relationship between the mental health of parents and children.

The past two decades have seen the emergence of trauma-informed services for fathers and, in rare cases, for mothers who have perpetrated domestic abuse. This approach draws on the evidence with regard to the impact of adverse childhood experiences and trauma on the risk of reactive aggression and violence and, therefore, on the need for work that helps build capacity for emotional regulation and mentalisation (Stover, 2015; Stover et al., 2022).

Facilitators of service delivery

Qualitative data draws attention to the relationship between the organisation and structure of the team that delivers the services, the resilience of staff, and outcomes for families. Small multi-disciplinary teams that share responsibility for work with a specific case or family were reported to experience greater safety and confidence than when a single practitioner manages work with a family with only line management supervision. Close collaboration with colleagues in multi-agency practice models strengthens practitioners' resilience.

Irrespective of the focus of the intervention, the therapeutic orientation should be strengths-based and client-centred. In addition, interventions and services must be designed to adhere to trauma-informed service and practice principles. This is the case regardless of who the participant is, given the widely documented rates of childhood trauma and adverse childhood experiences among the populations of interest. Finally, the fact that hostility towards children's social care is a barrier to engagement and enrolment suggests the need to further skill social work practitioners in trauma-informed and systemic approaches.

The inclusion of clinical expertise *within or alongside the team* strengthens the resilience of practitioners and enhances work with families. There are considerable benefits for services for families in which a child is exposed to domestic abuse to have access to one or more staff members who are professional family therapists or psychologists with other relevant areas of expertise.

The relationship between families and their practitioners/ therapists/ social workers is fundamental to the success of the intervention. This aligns with the wider literature, identifying the therapeutic relationship as the most influential pan-therapeutic factor in improving individual outcomes.

Commissioned services should therefore adopt a therapeutic and relational lens for their work, which appreciates how trust can be created and maintained. It also emphasises the management of expectations around the ending of interventions and what comes next. This holds regardless of whether the participants are perpetrators or victim-survivors fathers, mothers or children.

A multi-agency context is acknowledged to be the best practice when supporting victims of domestic abuse. Consequently, it is also recommended that any service commissioned is part of a formal coordinated multi-agency approach whereby data-sharing and risk management of all parties is prioritised. Like the system of care approach in the US, a multi-agency response to domestic abuse promotes the integration of fragmented service systems and agency collaboration at the local level and, ideally, the merging of funding streams [in the US, at the state level] and building of professional relationships (Lowell et al., 2011: 194). However, empirical evidence of the effectiveness of this approach has been constrained partially due to the complexity of evaluating outcomes both at the systems and child/ family and clinician levels, especially relative to a comparison group (ibid.).

Further attention needs to be given to making services equitably accessible and inclusive, reaching those that SaferLives describes as "hidden" populations. This includes: people from minority ethnic groups, especially those who need a translator; people with physical disabilities; people with learning difficulties or special needs; and LGBT+ parents. In addition, further work is needed with men who are primary victims of domestic abuse, women who perpetrate domestic abuse, and families in which children are exposed to situational couple violence.

The findings also suggest that for new services to be accepted within a local region, a needs analysis should be undertaken, and all stakeholders should be involved to determine the fit of the new model of working. This will reduce the likelihood of conflict with existing services and increase referrals to the new service.

Implications for research

There has been significant investment in the UK over the past few years in a range of innovative multi-disciplinary and multi-agency service models that work with the whole family, which now require further, more rigorous evaluation to assess their effectiveness. Many of these services are underpinned by good practice in terms of being strengths-based and client-centred, trauma-informed, and working with the whole family. They are provided by inter-disciplinary or multi-agency teams and focus on establishing a safe psychological environment for the parent and the child.

Previous reviews have called for RCTs to be commissioned as the evaluation methodology of choice (Howarth et al., 2016). This would need to be preceded by the use of evaluation designs that can

provide more understanding about how interventions should be targeted and that can identify the optimal implementation processes. Our review has identified a range of barriers and facilitators to programme implementation, referral, engagement and adherence, and these should also be addressed in future programme development and evaluation. Further research is also needed on mediators and moderators of the effectiveness of these programmes.

There is also an urgent need for rigorous studies to evaluate the effectiveness of interventions for adolescents exposed to domestic abuse and for these studies to include a qualitative component to better understand the intervention from the perspective of young people.

The Medical Research Council framework on the development of complex interventions (Skivington et al., 2021) can help evaluate and refine domestic abuse interventions with a focus on mitigating the impact of domestic abuse on children's outcomes. Complex intervention research goes beyond asking whether an intervention works in the sense of achieving its intended outcome to asking a broader range of questions. These include: identifying what other impacts the intervention has; assessing its value relative to the resources required to deliver it; theorising how it works; taking account of how it interacts with the context in which it is implemented; how it contributes to system change; and how the evidence can be used to support real-world decision-making.

Complex intervention research can be considered in terms of phases, although these phases are not necessarily sequential: development or identification of an intervention; assessment of the feasibility of the intervention and evaluation design; evaluation of the intervention; and impacts of its implementation.

At each phase, six core elements should be considered to answer the following questions:
- How does the intervention interact with its context?
- What is the underpinning programme theory?
- How can diverse stakeholder perspectives be included in the research?
- What are the key uncertainties?
- How can the intervention be refined?
- What are the comparative resource and outcome consequences of the intervention?

The answers to these questions should be used to decide whether the research should proceed to the next phase, return to a previous phase, repeat a phase, or stop (adapted from Skivington et al., 2021).

Finally, the IMPROVE review also drew attention to the need to develop a set of core measures to evaluate the impact of interventions of all kinds.[28] One of the recommendations to emerge from a large-scale study on outcome measures is to include a simple measure of child and parent health and emotional wellbeing pre- and post-intervention, the Warwick-Edinburgh Mental Wellbeing Scale (Powell et al., 2022).[29] This can be used across a range of intervention types and services.

Limitations

This review was limited as it comprised a rapid review of the literature, the focus being on "the state of the evidence" in terms of effectiveness for this particular group of children, the barriers and facilitators of service provision, and mediators and moderators of outcome. The findings were constrained by the limited time and funding available for the synthesis of data on these three outcomes. Despite this, the review has contributed new findings that have added to what is known from existing reviews, particularly regarding the UK evidence base. While the overall quality of the studies included in this review is low, qualitative findings significantly contributed to our understanding of the facilitators and barriers to programme uptake, implementation and evaluation.

Conclusion

Children who have been exposed to domestic abuse and are on or above the threshold for child protection services require significant support. Many interventions in this report (particularly those that involve mothers and children or children alone) focus on improvements in children's trauma symptoms, and externalising and internalising behavioural problems. While there is some evidence to support trauma-informed treatments that target parent and child (such as PCIT) or the child directly (such as TF-CBT with expressive therapies), other approaches designed for children on or above the threshold for children's social care need to be more rigorously evaluated. There is some evidence that an intensive psychoeducational parenting intervention, combined with advocacy, can result in reduced use of Child Protective Services, but this does not report on child mental health or trauma symptoms. There is also evidence to suggest that attachment and trauma-informed interventions with fathers (such as Fathers for Change) can reduce the need for children's social care/ Child Protective Services involvement.

Many of the whole family and multi-agency approaches developed in the UK over the past decade also require further rigorous evaluation. The available evidence about barriers and facilitators provides a rich source of evidence on promising methods of working, but these also need further evaluation.

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[28] Core outcome sets for family and child-focused interventions. Children and Families Policy Research Unit, UCL (University College London).

[29] The Warwick-Edinburgh Mental Wellbeing Scale.

APPENDIX 1:SAMPLE SEARCH STRATEGY AND PRISMA CHART

Sample search strategy

OVID PsycINFO 1806 to present
Date: May 16th 2022

Question 1

Search terms	Results
(mental health or behavi* or externali?ing or internali?ing or aggress* or anxiety or anxious* or depress* or PTSD or trauma* or cogniti).af.	3134328
(quality or effectiveness or evaluat* or efficacy or success* or improv* or enabl* or chang*).af	3116267
((Social adj1 (service* or work* or care or welfare)) or (child* protection service* or child welfare service*)).ab.	62624
(((((domestic adj1 (violence or abuse or cruelty)) or partner*) adj1 (violence or abuse or cruelty)) or battered or battery or violence against women or VAW).ab	60515
limit 5 to yr="2013 -Current"	23888
1 and 2 and 3 and 4 and 5 and 6	452

af. - All fields ab. – Abstract

Questions 2 and 3

	Search terms	Results
1.	(mental health or behavi* or externali?ing or internali?ing or aggress* or anxiety or anxious* or depress* or PTSD or trauma* or cogniti).af.	3134328
2.	(quality or effectiveness or evaluat* or efficacy or success* or improv* or enabl* or chang*).af	3116267
3.	(adolesc* or preadolesc* or pre-adolesc* or boy* or girl* or child* or baby or infant* or preschool* or juvenil* or minors or school* or pediatri* or paediatri* or pubescen* or pre-pubescen* or puberty or student* or teen* or young or youth).af.	3240623
4.	((Social adj1 (service* or work* or care or welfare)) or (child* protection service* or child welfare service*)).ab.	62624
5.	((((domestic adj1 (violence or abuse or cruelty)) or partner*) adj1 (violence or abuse or cruelty)) or battered or battery or violence against women or VAW).ab	60515
6.	limit 5 to yr="2013 -Current"	23888
7.	1 and 2 and 3 and 4 and 5 and 6	452
8.	(train* or fund* or supervis* or management* or (staff or worker or professional or clinic* or practitioner or facilitator)).af.	2936598
9.	barrier*.ab.	80001
10	9 and 10	61324
11.	3 and 4 and 5 and 6 and 11	49

Prisma chart

Identification of studies via databases and registers

Identification of new studies via other

Records identified from
Academic Databases (n
=2474)

Records removed *before
screening*:
    Duplicate records removed
    (n =1107)

Records identified from:
    Websites, authors and NGOs (n
    = 58)
13 systematic reviews
published 2013 to 2022 (n=19)

Records screened
(n = 1367)

Records excluded
(n =1328)

Reports sought
for retrieval
(n=40)

Reports not
retrieved
(n = 0)

Reports sought for retrieval
(n =39)

Identification

Screening

Included

Reports assessed for eligibility
(n =39)

Reports included in review
(n = 9)

Total included studies
(n =21)

Records excluded: (n=30)

No child outcomes: (n=11)
Below threshold for statutory
social care; no record of social
care status (n=13)
Rationale for service and
description: (4)
Preventive: (n=1)
No detail about intervention(s):
(n=1)

Reports assessed
for eligibility
(= 40)

Additional
studies included:
(n= 12)

Records excluded:
(n=28)

No child outcomes:
(n=4)
Below threshold for
statutory social care; no
record of social care
status (n=22)
Rationale for service
and description: (n=1)
No detail about
intervention(s): (n=1)

APPENDIX 2:DATA EXTRACTION TABLES

Table A1.1 Psychotherapeutic interventions for mothers and children: population, intervention and setting

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to domestic abuse (DA)	Objectives	Content and duration Setting	Who delivers the intervention
Peek-A-Boo Club (PABC) Infant-led psychotherapy Bunston et al. (2016) Australia	Mothers and children exposed to DA Child age 0-4	48% had no Child Protective Services (CPS) involvement, 43% had CPS involvement with a lack of clarity about the status of a further 9%. 7% of children had been in foster care.	All	To positively rework relational ruptures and attachment difficulties resulting from exposure to family violence.	11 sessions in all (8 weekly 2-hr groups, 1 reunion group and individual pre- and post-group sessions). Two pre-group sessions to assess and get to know mother and infant. Group-based, hospital setting.	Two infant mental health-trained clinicians. Two facilitators from the Mental Health service were not clinicians but trained in the PABC model in situ or in workshops.
PCIT Timmer et al. (2010) USA	Mothers and children with trauma histories All children in the intervention group exposed to DA, control group ACEs but not DA. Children aged 2-7	77% referred by CPS, 40% court mandated.	All children in the intervention group..	To meet the mental health needs of mother-child dyads by reducing children's behaviour problems and mothers' stress and psychological symptoms.	14-20 weeks Dyadic. Outpatient mental health setting.	Therapists, training not specified.

*Risk of bias as assessed on the Mixed Methods Appraisal Tool (Hong et al., 2018). For full details see Appendix 3.

Table A1.2 Psychotherapeutic interventions for mothers and children: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Peek-A-Boo Club (PABC) Infant-led psychotherapy Bunston et al. (2016) Australia	3* Quantitative non-randomised Pre-post study 30 groups over 5 years (2007-11). No comparator EIF = 2	133 dyads, data for 128	Outcome data is based on only a third to half of this number (BITSEA (n =38), MPAS (n = 62) and PIR-GAS (n = 50). During the final session of the PABC, mothers also completed a qualitative participant feedback form.	**Infants social and emotional functioning**: Brief Infant-Toddler Social and Emotional Assessment (BITSEA) (Briggs-Gowan & Carter, 2002) **The Maternal Postnatal Attachment Scale (MPAS)** (Condon et al., 2008) **Parent-Infant Relationship Global Assessment Scale** (PIR-GAS; Zero-To-Three, 2005) (Clinician completed)	**Infant functioning (mother reported)** Infants significantly more **socially competent** post-intervention (M = 17.42, SD = 3.49) infants displayed **significantly fewer problematic behaviours** post-intervention (M= 15.55, SD = 6.59) than at pre-intervention (M = 20.68, SD = 8.97), t(37) = 4.18, p< .001 **Maternal-infant attachment** The score on **overall global attachment** post-intervention (M = 76.72, SD = 9.68) was significantly higher than at pre-intervention (M = 73.55, SD = 13.13), t(61) = 2.30, p< .025. At a subscale level, results showed **significant improvements post-intervention for Pleasure in Interaction** (pre-intervention M = 17.98, SD = 5.21 versus post-intervention M = 21.42, SD = 3.37), t(61) = 4.71, p< .001, **Quality of Attachment** (pre-intervention M = 36.37, SD = 5.68 versus post-intervention M = 37.03, SD = 5.56), t(61) = 7.65, p< .001 and **Absence of Hostility** (pre-intervention M = 17.11, SD = 4.73, versus post-intervention M = 17.60, SD = 4.97), t(61) = 7.65, p< .001) **Clinician rating of parent-infant functioning** Better adaptive functioning post-intervention (M= 53.25, SD 13.88) than at pre-intervention (M = 49.62, SD 16.60), t(49) = 2.05, p< .046. **Reliable change index results** Analysis of the reliable change index (RCI \Jacobson & Truax, 1991) showed that around 10% of participants had significant improvement post-intervention in their scores on MPAS Global functioning and MPAS Pleasure in Interaction, with 90% having no significant change. Only 3% of participants reported significant improvements post-intervention in their scores on MPAS Quality of Attachment (94% showed no change, and 3% had significant deterioration). Participants demonstrated no change (92%) or significant deterioration (7%) in the Absence of Hostility based on their RCI score. Based on their reliability change scores, 8% of participants demonstrated significant improvement post-intervention in their clinician ratings (86% showed no change and 6% had significant deterioration). While no significant improvements were found for problem behaviours, 16% of infants showed significant improvement in the social competence scores (79% showed no change, and 5% had significant deterioration).

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
PCIT Timmer et al. (2010) USA	2.5* Quasi-experimental design (QED), non-randomised controlled trial of PCIT for: children exposed to DA; children without exposure to DA. Pre-post measures. EIF = 2.	342 enrolled, 178 dyads had exposure to DA, 159 no exposure. 129 dyads completed, 62 dyads had been exposed to DA and 67 had not.	Data completed at both time points for 111 dyads.	**Child trauma symptoms and problem behaviour**: Eyberg Child Behaviour Inventory (ECBI) (Eyberg & Pincus, 1999) **Child Behaviour Checklist (CBCL)** (Achenbach & Rescorla, 2001) **Parenting Stress**: Parenting Stress Inventory–Short Form (PSI-SF). (Abidin, 1995) **Parent mental health**: Symptom Checklist 90-R (SCL-90-R) and Brief Symptom Inventory (BSI) (Derogatis, 1993; Derogatis & Lazarus, 1994)	**Child problem behaviour:** Results of analyses of the ECBI intensity and problem scores showed strong treatment effects, overall $F (2, 110) = 22.16$, $p< .001$, $\eta 2 = .29$, observed power = 1.0. However, neither the reductions in intensity nor number of child behaviour problems varied significantly by DA exposure, overall $F (2, 110) = 1.86$, $p< .16$, $\eta 2 = .03$, observed power = 0.38. **Externalising behaviour:** Results of analyses of the three CBCL broadband scales also showed significant treatment effects, overall $F (3, 114) = 10.96$, $p< .001$, $\eta 2 = .22$, observed power = 1.0. Treatment effects did not vary significantly by DA exposure, $F (3, 114) = 0.56$, $p< .64$, $\eta 2 = .01$, observed power = 0.16. **Mother:** Statistically significant, but less powerful treatment effects were reported for mother's stress and psychological symptoms. **Parental stress**: Results on the PSI-SF showed a significant interaction between treatment and parents' Defensive Responding $F (3, 75) = 4.79$, $p< .004$, $\eta = .16$, observed power = .89. **Mother's psychological symptoms:** Global Severity Index (GSI) showed a significant treatment effect on mother's endorsement of psychological symptoms Tx: $F (1, 91) = 4.65$, $p< .03$, $\eta 2 = .05$, power = 0.57, but no further variation by DA exposure, Tx × DA : $F (1, 91) = 0.12$, $p< .75$, $\eta 2 = .001$, observed power = .06.

Table A1.3 Psychoeducational interventions for mothers and children: population, intervention and setting

Name of intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
Project Support Jouriles et al. (2010) USA	Mothers and children exposed to DA and direct maltreatment or neglect. Child age 3-8. (1) non-English speakers; (2) parental severe substance abuse, or severe mental health problems that require alternative treatment; (3) child or adult serious learning difficulties.	All children in this cohort were referred by CPS because of physical abuse/neglect. Children were allowed to remain in the home with the maltreating parent while on Project Support.	Referrals for child maltreatment in this sample.	*Children:* Reduce behavioural problems and improve the mental health of children. *Mothers:* Reduction of maternal mental health problems and distress, improved maternal parenting.	90-mins weekly Project Support has no fixed duration but averages 20 sessions over 8 months. Home-based.	Therapist and clinical psychology graduate students
Mothers Overcoming Violence Through Education and Empowerment (MOVE) Ermentrout et al. (2014) USA	Mothers who are involved with the courts because they have perpetrated a level of DA , but not as primary perpetrators, and their children.	All court-mandated. Some (number unclear) participating children were in foster or kinship care placements.	All	Children: Not clearly stated, but the implication is to mitigate and improve the consequences of DA exposure on children's functioning by increasing mothers' positive parenting. Mothers: To improve women's parenting, mental health, wellbeing, and their families' safety through reductions in DA.	2.5 hours weekly, 12 weeks. Group based, community setting	A clinician and a social work student intern or volunteer with DA and group facilitation training.

Table A1.4 Psychoeducational interventions for mothers and children: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Project Support Jouriles et al. (2010) USA	4* RCT with 16-month follow-up. (17 in intervention and 18 usual care). Assessment at baseline, 4, 8, 12 and 16 months involved quantitative data and direct observation. EIF = 3	35 mother-child dyads began and completed.	35 families	**CPS re referrals for child maltreatment:** CPS case files. **Parenting measures** **Parent capacity to manage children:** Parenting Locus of Control Scale (PLOC; Campis et al., 1986). **Harsh parenting:** Corporal Punishment subscales from the Revised Conflict Tactics Scales (CTS–R; Straus et al., 1996). **Quality of mother's effective parenting:** **Clinician observed:** Mother's parenting was videotaped during two 45-min home observation sessions, conducted within a 2-week time span. Data collected and coded at the baseline, 8-month and 16-month assessments. **Maternal psychological distress**. General Severity Index - Symptom Checklist–90 – Revised (SCL–90 –R; Derogatis et al., 1976)	**Re-Referral to CPS** 5.9% (1/17) of families in the Project Support condition had a subsequent referral to CPS for child maltreatment, compared with 27.7% (5/18) of families in the comparison condition. This difference did not reach statistical significance, $X2(1) = 2.95$, $p < .086$, $cp < .29$. **Parenting:** Decreases over time in scores for the outcome variables reflect improvements in parenting. The Project Support and comparison conditions differed on rates of change over time for each of the three parenting variables. Scores for the Project Support group decreased more rapidly on (1) reports of perceived inability to manage childrearing responsibilities, $bdiff = 1.09$, $t(32) = 2.58$, $p < .05$, ES = 1.02, 95% CI [0.29, 1.70]; (2) reports of harsh parenting, $bdiff = 0.14$, $t(32) = 2.26$, $p < .05$, ES = 0.86, 95% CI [0.15, 1.53]; and (3) observed ineffective parenting, $bdiff = 0.38$, $t(32) = 2.22$, $p < .05$, ES = 0.96, 95% CI [0.24, 1.64]. Within the Project Support group, mothers' perceived inability to manage childrearing responsibilities, $b = -0.97$, $t(32) = 3.66$, $p = .001$, reports of harsh parenting, $b = -0.13$, $t(32) = 2.67$, $p = .01$, all decreased over time; observed ineffective parenting did not, $b = -0.12$, $t(32) = 1.29$, $p = .21$. **Psychological distress:** In the Project Support group, mothers' psychological distress, $b = -2.08$, $t(128) = 2.84$, $p < .01$ also decreased over time None of the problematic parenting variables declined over time in the comparison group, nor did mothers' psychological distress: perceived inability to manage childrearing responsibilities, $b = 0.12$, $t(32) = 0.36$, $p = .72$, reports of harsh parenting, $b = 0.02$, $t(32) = 0.36$, $p = .72$, observed ineffective parenting, $b = 0.26$, $t(32) = 1.83$, $p = .08$, and mothers' psychological distress, $b = -0.96$, $t(32) = 1.82$, $p = .07$. *Change in the rates of change over time (curvilinear effects)* The estimates for the curvilinear term in the models indicated that the rate of change over time declined over the course of the study for three of the outcome variables: perceived inability to manage childrearing responsibilities, $b = 0.70$, $t(32) = 2.69$, $p < .01$, reports of harsh parenting, $b = 0.15$, $t(31) = 3.80$, $p = .001$, and mothers' psychological distress $b = 1.79$, $t(25) = 2.99$, $p < .01$. The rate of decline on each of these was greater during the treatment phase than during the follow-up period. The Project Support and comparison groups did not differ in the degree to which the rate of change diminished over the course of the study period.

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size	Outcomes of interest Measures used	Results
Mothers Overcoming Violence Through Education and Empowerment (MOVE) Ermentrout et al. (2014) USA	5* Qualitative (a) focus groups, interviews and optional questionnaires on demographic or work history data. Post-intervention. EIF = 0	31 mothers and 34 children. Completed: 18 mothers and 26 children. 58% completion.	18 mothers and 8 children	Experience of mothers, children and service providers. Qualitative data only.	The MOVE children's programme was acceptable and suitable to children, who expressed excitement about the programme and satisfaction with their families' outcomes. a) the importance of attention to attendance; (b) the need for a flexible, child-driven curriculum; (c) participant improvement and growth through the opportunity for expression and peer bonding; and (d) the value of certain aspects of programme content. Indispensable elements include (a) a flexible, child-driven curriculum; (b) the opportunity for expression; (c) peer bonding and support; (d) a balance between content, processing, and play; and (e) content on domestic violence, coping, goal-setting, anger management, and processing and expressing of emotions.

Table A1.5 Comparing a psychotherapeutic with a psychoeducational intervention: population, intervention and setting

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
Trauma-informed psychotherapeutic intervention (CAMHSI) and **Children are People Too (CAP)** psychoeducational mode, Pernebo et al. (2018, 2019) Sweden	Mothers and children aged 4-13.	*Psychosocial intervention Children:* 46.7% had had contact with CPS (35.5% only for investigation; 9.7% for investigation *and* intervention/support). *Mothers:* 67.7% had had contact with CPS (25.7% only for investigation; 42% for investigation *and* intervention/support). *Psychotherapeutic intervention:* *Children:* 94.7% had had contact with CPS (63.2% only for investigation; 31.5% for investigation *and* intervention/support). *Mothers:* 100% had had contact with CPS (63.2% only for investigation; 36.9% for investigation *and* intervention/support. Additionally, 42.6% had stayed at a refuge/protected living).	All	**Children: Psychotherapeutic intervention:** To decrease the children's psychiatric symptoms. **Psychoeducational intervention:** Strengthen children's capacity to cope with their experiences and to reduce risk of being negatively affected by future experiences. **Both interventions** – other goals: to help children express and understand their feelings, thoughts and experiences, and to reduce their feelings of alienation and shame. **Parallel parents' group:** Psychoeducational intervention: increase parental knowledge and skills, reduce parental feelings of shame and alienation. **Psychotherapeutic intervention**: To increase parents' knowledge and skills, reduce shame and alienation, strengthen the parent–child relationship.	12-15 weekly 90-min sessions. Group-based Psychotherapy. In outpatient child and adolescent mental health unit. Psychoeducation in a community setting, run by specialist DA service.	Psychotherapeutic: psychologists or social workers with substantial prior experience of delivering the specific intervention. Psychoeducation: social workers with substantial prior experience of delivering the specific intervention.

Table A1.6 Comparing a psychotherapeutic with a psychoeducational intervention: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size	Outcomes of interest Measures used	Results
Children are People Too and **trauma-informed psychotherapeutic intervention** Pernebo et al. (2018, 2019) **Sweden**	2.5* QED with 2 interventions, (CAP) and CAMHSI. Data collection at 4 time points, pre- and post-intervention, and 12-month follow-up. EIF = 2	50 mother-child dyads, 19 randomised to psychoeducation and 31 to psychotherapy groups. 43 dyads completed the evaluation. 18 completed psychoeducation, 25 psychotherapy.	43 dyads	*All maternal report:* **Child/parent exposure to violence:** Revised Conflict Tactics Scale (CTS2) (Straus, 1996) **Child mental health: SDQ-P** (Goodman et al., 2000) **Child post-traumatic stress symptoms:** Trauma Symptom Checklist for Young Children (TSCYC) (Briere et al., 2001) **Child emotionality and emotional regulation:** Emotion Questionnaire for Parents (EQ-P) (Rydell et al., 2003) **Maternal mental health:** The Brief Symptom Inventory (BSI) Global Severity Index (GSI) (Derogatis, 1993) **Maternal post-traumatic stress symptoms:** The Impact of Event Scale-Revised (IES-R). (Weiss, 2004) **Exposure to violence:** as per child (CTS2) (Straus et al., 1996)	**Post-intervention: CAMHSI:** Significant reductions in child's symptoms including overall mental health symptoms (SDQ-P; $d = 0.67$), emotional symptoms (SDQ-P; $d = 0.73$), hyperactive symptoms (SDQ-P; $d = 0.46$), impact score (SDQ-P; $d = 0.68$), emotionality (EQ-P; $d = 0.57$), and (TSCYC) symptoms of anger ($d = 0.65$), arousal ($d = 0.66$), and dissociation ($d = 0.76$). Large effects were for a decrease in depressive symptoms (TSCYC; $d = 0.99$) and an increased capacity for emotion regulation (EQ-P; $d = 0.85$) **CAP:** significant reduction in their child's emotional symptoms (SDQ-P; $d = 0.34$), in total post-traumatic stress (TSCYC; $d = 0.35$), and in intrusive symptoms (TSCYC; $d = 0.40$). Mothers in the CAP additionally reported a significant decrease in impact scores (SDQ-P; $d = 0.62$). **6- and 12-month follow-up: CAMHSI:** Significant improvements between post-assessment and 6-month follow-up in children's scores on the TSCYC on total PTSD ($p < 0.031$, $d = 0.33$), intrusion ($p < .033$, $d = 0.29$), avoidance ($p < .005$, $d = 0.64$), and dissociation ($p < .020$, $d = 0.64$). No significant changes were reported between the 6- and 12-month follow-up. Between the post-treatment assessment and the 12-month follow-up, significant decreases in child scores on the SDQ scale on emotional symptoms ($p < .004$, $d = 0.67$), the TSCYC scale on total post-traumatic stress ($p < .015$, $d = 0.44$), and avoidance ($p < .014$, $d = 0.55$) **CAP:** Between the post-treatment assessment and the 6-month follow-up, significant decrease on the SDQ scale on children's anger ($p < .038$, $d = 0.42$). Between the 6- and 12-month follow-ups, there was a significant improvement in the TSCYC scale on anxiety ($p < .023$, $d = 0.29$) and SDQ scale on prosocial behaviour ($p < .044$, $d = 0.49$). No significant changes reported between the post-treatment assessment and the 12-month follow-up. No significant increase in symptoms in either group on any measure at any time. High levels of **post-traumatic stress** (TSCYC) in children pre-treatment were associated with larger improvements from pre- to post-assessment on several measures: the emotional symptoms [$B = 0.047$ (SE = 0.02); $\beta = 0.349$; $p < .025$, adjusted $R^2 = 0.099$] and prosocial behaviour [$B = 1.056$ (SE = 0.517); $\beta = 0.311$; $p < .048$, adjusted $R^2 = 0.048$] subscales of the SDQ, the subscale of emotional regulation in the EQ-P [$B = 0.026$ (SE = 0.007); $\beta = −0.493$; $p < .001$, adjusted $R^2 = 0.223$], and four subscales of the TSCYC: anxiety [$B = 0.104$ (SE = 0.050); $\beta = 0.317$; $p < .043$, adjusted $R^2 = 0.078$], depression [$B = 0.174$ (SE = 0.046); $\beta = 0.515$; $p < .001$, adjusted $R^2 = 0.246$] A high level of ongoing **maternal mental health problems**, as measured by the BSI GSI at 12-month follow-up, was associated with a smaller decrease in maternal report of child symptoms on the SDQ-P emotional symptoms subscale [$B = −1.345$ (SE = −.631); $\beta = −.348$; $p = .040$, adjusted $R^2 = .095$], and on the TSCYC total post-traumatic stress subscale [$B = −6.286$ (SE = 2.838); $\beta = −.312$; $p = .034$]. A model including maternal report of **children's pre-treatment post-traumatic stress** as well as **maternal ongoing mental health problems** (BSI GSI) at 12-month follow-up explained 33% of the variance in the changes in the children's symptoms of post-traumatic stress during the interventions (adjusted $R^2 = .326$).

Table A2.1 Trauma-focused CBT for children: population, intervention and setting

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
Trauma Recovery Programme Dauber et al. (2015) TF-CBT + art therapy USA	Children aged 5-15. Included children exposed to multiple forms of trauma, 29% witnessing DA, 39% other family violence.	52% of children referred from the foster care system or the city child protective agency (10%).	68% witnessing DA or other form of family violence (29% DA, 39% other).	To overcome the symptoms of complex trauma that are specific to each child, focusing both on symptom reduction and promotion of resilience.	Duration varied by need but lasted a minimum of 12 sessions over 3 months. One to one with child, with some adjunctive work with mothers. Urban child welfare treatment clinic.	9 therapists with master's or doctoral degrees.
TF-CBT with art and play therapy Woollett et al. (2020) USA + South Africa	Children and adolescents in refuges aged 5-14.	High-risk shelters/refuges. CPS status confirmed by the author.	All	Reduction in children's depression and PTSD. Increase in parent's awareness of children's experience of DA, contributing to communication.	12 weeks, 1- 2 hours per session. Group based, domestic violence shelter/refuges.	Therapists with training in TF-CBT and art or play therapy,

Table A2.2 Trauma-focused cognitive behavioural therapy for children: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Trauma Recovery Programme Dauber et al. (2015) TF-CBT + art therapy USA	3* One-group pre-post-test. The study involved secondary data analysis of existing case file data collected as part of routine programme administration. **EIF = 2**	184 children enrolled. 122 children completed 3 months or 12 sessions (minimum for post-intervention assessment). 66% completion	31 children with completed measures pre- and post-intervention.	**Child trauma symptoms** Trauma Symptom Checklist for Children [TSCC] (Briere, 1996)	Significant declines following treatment were found in **anxiety** (t (30) = 3.33, p < .002, d = 0.60), depression (t (30) = 3.54, p < .001, d = 0.64), anger (t (30) = 3.56, p <.001, d = 0.64), dissociation (t (30) = 3.64, p < .001, d = 0.65), and sexual concerns (t (30) = 3.00, p < .005, d = 0.54). **Post-traumatic stress** symptoms also declined but did not reach statistical significance.

A significant correlation was found between the number of sessions attended and client change in post-traumatic stress symptoms (r = .37, p .05), with children who attended more sessions showing greater improvement in post-traumatic stress symptoms.

No significant correlations were found between children who completed and did not complete the intervention, suggesting that the symptom improvement demonstrated from pre- to post-treatment was largely consistent across clients regardless of age, sex, race, foster care status, therapists, and the number of sessions attended. The one exception was a significant correlation between the number of sessions attended and client change in posttraumatic stress symptoms (r = .37, p\.05), with clients who attended more sessions showing greater improvement in posttraumatic stress symptoms. |
| **TF-CBT with art and play therapy** Woollett et al. (2020) | 4* Mixed methods. Single intervention in two sites, pre-post data collection. with pre-post measures and a qualitative phase. EIF = 2 | 21 children in 2 sites. All completed. | 21 child reports, 16 mothers' reports. | **Depression:** The Children's Depression Inventory (CDI) (Kovacs, 1985) **PTSD:** Post Traumatic Stress Disorder Reaction Index (PTSD-RI) (short version) (Pynoos et al., 1998) Semi-structured interview guide. | **Depression** At baseline, children showed high rates of symptoms of probable depression (33 %). Post-intervention (CDI) depressive symptoms significantly reduced (mean of 13.7–8.3, p < 0.01)

PTSD: At baseline, children showed high rates of symptoms of probable PTSD (66 % respectively) (PTSD-RI), a non-significant trend towards improvement (40.0–34.4, p < 0.21).

Qualitative findings. Post-intervention, children valued. 1. Expressing and managing overwhelming feelings. 2. Drawing as a bridge to communicating difficult emotions. 3. The intrinsic therapeutic value of relaxation and fun. 4. Recognising changes in behaviour in self and others. 5. Desire for emotional communication with mothers and validation of their hardships and experience. 6. They felt validated as they shared their art products with others, including others in the refuge, in a final exhibition of their artwork. **Mothers:** Increased understanding of children (through group work and viewing children's art exhibition) and gained tools to enhance their parenting. |

Table A2.3 Looked after children and adolescents: evaluation design and outcomes

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
Write On writing therapy Parker et al. (2006) USA	Adolescents aged 12-17, mean 14.3. All participants were girls.	All children in foster care and group homes.	All	To increase the coping strategies, self-esteem and relationship skills of participating adolescents.	**Intervention:** Write On plus Positive Points **Content of comparator group:** Write On without Positive Points. **Intervention frequency and duration** Individual sessions x 90 minutes Group-based, community setting	Not specified.
Camp HOPE Hellman & Gwinn (2017) USA	Children and adolescents aged 7-17, divided in two groups: 7-11 and 11-17. Mean age 10.8yrs.	All children receiving services from existing family justice centres, child welfare system-involved children in group homes or foster care, and others identified from local social service organisations	All	To break the intergenerational cycle of violence by increasing children's sense of hope along with a sense of belonging	6-day intensive summer camp with regular mentoring during the year. Group based, outdoor setting	Trained therapists and children's standard summer camp leaders.

Table A2.4 Looked after children and adolescents: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Write On writing therapy Parker et al. (2006) USA	**4*** **QED**, pre-post with control. First group of participants served as a control and remaining 3 groups as experimental **Data collection:** Pre- and post-intervention. EIF = 1	15; 9 in intervention, 6 in comparator groups. No attrition.	Total 15; 9 in intervention, 6 in comparator groups.	**Anger** Adolescent Anger Rating Scale (AARS) (Burney, 2001) **Depression** Reynolds Adolescent Depression Scale 2nd ed. (Reynolds, 1987) **Self-concept** Multidimensional Self-Concept Scale (MSCS) (Bracken, 1992) **Dating attitudes (grey)** (Parker, 2003). **Capacity to express emotion: in writing** Linguistic Inquiry and Word Count (LIWC, Pennebaker et al., 2001).	**Anger, self-concept and dating attitudes**: No significant pre-post differences. **Depression**: Reduction in mean t scores for dysphoric mood, negative affect, negative self-evaluation, somatic complaints, and total depression in interventions compared to the control group. **Positive emotion words:** An overall positive change was noted in both groups, with a 67% increase in positive emotions for the experimental and the control conditions. Results indicate a significant increase in the number of words related to self in the experimental group $F(1,13) = 13.46$, $p < .003$. The experimental group also indicated less sadness. Though not significant, these differences approached significance $F(1,13) = 3.27$, $p < .09$.
Camp HOPE Hellman & Gwinn (2017) USA	**3.5*** One group pre-post. **Data collection:** Pre and post-intervention. **Precision of results:** EIF = 2	**234** children. No attrition recorded.	229 completed pre- and post-surveys, resulting in a 96.2% match rate.	**Sense of hope: Children's Hope Scale** (Snyder, 1997) (Children and counsellors separately): **Character strengths:** Counsellors only: **KIPP Character Counts Growth Card** (available: https://characterlab.org/character-growth-card/).	**Children's sense of hope:** Repeated measures Analysis of Variance (ANOVA) showed that the increase in children's hope scores from pre-test (M = 25.40; SD = 5.38) to post-test (M = 26.75; SD = 6.19) was statistically significant $[F(1228) = 15.15; p .001; g2 = .06]$. Partial eta square indicates that the estimated rate of change was small. **Counsellor report on children:** Repeated measures ANOVA showed the increase in hope pre-test scores (M = 23.23; SD = 5.92) compared to the post-test scores (M = 25.13; SD = 5.64) were also statistically significant $[F(1219) = 30.95; p<.001; g2 = .12]$ and of moderate strength. **Counsellor assessment of children's character strength:** Post-test observations showed a moderate and significant increase for zest $[F(1229) = 46.63; p<.001; g2 = .17]$, grit $[F(1228) = 30.86; p<.001; g2 = .12]$, gratitude $[F(1229) = 44.36; \.001; g2 = .16]$, and curiosity $[F(1229) = 46.51; p<.001; g2 = .17]$. Small yet statistically significant increases in mean scores were observed for self-control $[F(1229) = 9.50; p<.001; g2 = .04]$, optimism $[F(1229) = 20.16; p<.001; g2 = .08]$, and social intelligence $[F(1229) = 18.13; p<.001; g2 = .07]$ respectively. **Relationship between hope and character outcomes:** Correlational analysis showed that increase in children's self-reported hope was associated with increased scores in observed character strengths. Additionally, child self-reported hope was positively associated with counsellor observation of the child's hope.

Table A3.1 Whole family interventions: population, intervention and setting

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
SafeCORE Schrader McMillan (2022) England	Families in which a child or children of any age are exposed to situational couple violence and family violence. Piloted with families below the threshold for statutory services at the time of referral. From year 3 piloted work with families above threshold.	Years 1 and 2: Families referred who were below the threshold for Child Protection Plan at the time of referral. In Year 3: Included 14 families on Child Protection Plans for DA and other concerns. 4 families completed intervention included in the evaluation.	All year 3 children on Child Protection Plans exposed to DV and other family violence.	Intermediate aims are to create a compassionate stance among staff and to give family members skills to help them improve emotion regulation and interpersonal communication. Longer-term aims: Reduction of re-referrals of families to children's social care for incidents of DA and family violence by ending cycle of shame and emotional dysregulation.	Designed to involve 24-26 sessions weekly over 6 months. Length of intervention varied as a result of initial case formulation on the needs of the family. Home-based. Delivered on electronic platforms and telephone during Covid-19 pandemic.	A multi-disciplinary unit including a unit lead, social workers, family workers, coordinator and clinician. Different unit members (minimum 2) allocated to each family, but the whole team involved in (e.g.) case formulation.
For Baby's Sake Trevillion et al. (2020) England	Expectant co-parents (whether separated /co-parenting or together) – both joining in the antenatal period and may be supported to child age 2. Designed for parents with complex needs and unresolved childhood trauma	70% of included families had input from social care at baseline.	All cases involved pregnant women with child at risk of DA exposure.	**Children:** Birth outcomes (gestation and birth weight); ensure good functioning, emotions and behaviour from the beginning of life. **Parents:** End violence in the relationship, overcome the impact of trauma of DA, processing trauma from their own childhood. Secure attachment with infants, support to infants' social and emotional development.	One-to-one sessions with the practitioner (usually weekly), starting antenatally and may continue up until the baby's second birthday (duration of participation and frequency of sessions varies to meet individual needs). Area-based teams operate hybrid model of face-to-face sessions and video and audio calls.	Practitioners embedded in multi-disciplinary teams. Different practitioners allocated to each parent with teamwork to achieve whole family response. Strong emphasis on multi-agency safeguarding partnership working.

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Intervention Author Country	Target group	Social Care status of children	Proportion of DA exposed children	Objectives	Content and duration Setting	Who delivers the intervention?
NewDAy Langdon-Shreeve et al. (2020) England	Children age 4-17. Couples experiencing situational violence without coercive control.	69% on a Child in Need Plan and 31% on a Child Protection Plan at baseline.	All	Improved levels of children's and young people's wellbeing - witness less DA at home; improve educational engagement and attainment; children and young people experience reduced levels of risk.	Four components including short-term interventions providing support to all family members. Components of varying length. Interventions delivered in one to one, dyadically or in groups, home and school settings.	Components led by different people. 15 people involved in delivering the service: programme manager, lead advisory teacher, 2 x advisory teachers, schools liaison officer, social work practice lead, 4 x senior DA pathfinders, 2 x domestic abuse pathfinders, 2 x systemic family psychotherapists, co-production and programme officer. Social workers kept their own cases – not transferred to NewDAy workers. Overseen by a partnership board.

Intervention Author Country	Risk of bias, strength of evidence and study design	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention
Opening Closed Doors Barnardo's Cymru (2021) Wales	**3*** **Mixed-methods design.** Structured interviews with service/team managers in children's social care; interviews with families; case files reviewed for families who had completed the interventions. EIF = 2	Children aged 3-9 who have been exposed to DA with behavioural problems, and their families.	received a service (n=266) 35% (n=92) were on a Care and Support Plan other than for Child Protection, 39% (n=105) were on the Child Protection Register and 12% (n=33) were Looked After Children. Only 14% (n=36) of children were not receiving a statutory service.	All	**Children:** Safe and stable home environment; improved parent-child relationships; reduction in emotional stress; increase in positive peer relationships; improved school attendance. *Children's programme:* Increase awareness and understanding of DA; help children manage their emotions. **Both parents: Cessation of DA,** safe and stable home environment; improved parent-child relationships; recovery from DA. Families stay together safely following a reduction in violence/abuse. **Women:** Improve risk management, safety planning, identifying abuse, parenting, awareness of the effect of DA on families and children, reducing anxiety, increasing emotional wellbeing, parenting and social support.	Multi-agency, multi-system approach. Key worker approach, combined delivered in groups or one-to-one delivery to suit individual family needs. Individual interventions: *Fathers:* Domestic Abuse Perpetrator Programme (DAPP) 20-week group-based. *Mothers:* Women's support service. 10 weeks concurrent with DAPP, combines one-to-one with group work. *Children:* Safety, Trust and Respect (STAR) programme, over 10 weeks either group or one-to-one. Community group, or home-based according to family needs.	Model involves a key worker based at one of five children's centres or Multi-Agency Safeguarding Hub. Key worker liaises with and refers families to DAPP, women's service or STAR programme for children. Specialist services deliver separate interventions, but no further detail.
Growing Futures McCracken et al. (2017) England	**3*** **Mixed methods** process and impact evaluation, pre-post case file data, survey and qualitative components. EIF = 2	Children aged 5-9 years and 10-13 years who have been exposed to DA, and their families.	Of 232 children 12% (n=27) needed Early Help, 33% (n=76) were on a CiN plan, 41% (n=94) were on a CPP, 3% (n=6) were Children Looked After (in Local Authority care, 9% (n=21) in an open referral and 3% (n=8) in cases that had been closed.	All	**Children:** Reduce emotional harm; directly support recovery from DA exposure; significantly reduce repeat victimisation; challenge acceptance of DA by families and community; break the pattern of abuse as it re-presents itself in children and adolescents. **Specific targets**: Reduce repeat MARAC referrals by 25%; reduce repeat referrals to social care where DA is a factor by 30%; reduce Child in Need Plans where DA is a factor by 10%.	A multi-agency approach that works with several "intervention" components. Duration varies. Home based with referrals. A core component is the Domestic Abuse Navigator (DAN), a key worker who undertakes direct play therapy with children, provides advocacy and practical support and referrals to interventions.	12 DANs from non-statutory and social work backgrounds; 2 non-statutory senior DANs provided line management and service development. DANs train and mentor workers in other services and work with Early Help to provide individual packages of support. Line management supervision.

Intervention Author Country	Risk of bias, strength of evidence and study design	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention?
Project Crewe (now FACT) Heal et al. (2017) England	5* RCT with qualitative phase. Analysis of case file data and exploratory qualitative design. Comparator: Usual care (standard social care). EIF = 3	Families on Child in Need Plan. Presenting problems typically included DA.	All on a Child in Need Plan.	46.7% of the sample.	Improvement for children on Child in Need Plan in; social care outcomes; reduced risk factors; and better academic and behavioural outcomes. To reduce re-referrals to social care and escalations to child protection and Looked After status.	On average, family practitioners visited Child in Need family 11 times a month in autumn and 9 in spring – 3 x more often than the comparator group, families s receiving standard social care. Home-based. Multi-strand model of work with families on Child in Need Plan. Direct work with family practitioners using solutions-focused brief therapy, and work with families intensively to achieve the goals of the Child in Need Plan and sustain change after closure.	Social work consultants hold statutory responsibility for cases and manage a team of family practitioners; family practitioners are non-social work trained and are responsible for delivering the Child in Need Plan. Volunteer peer mentors and family role models work with children and parents to sustain change after case closure.

Table A3.2 Whole family systemic interventions: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
For Baby's Sake Trevillion et al. (2020) England	4* Mixed-methods quasi-experimental using case file data, with qualitative components. Data collection points: Baseline (T1), 12 and 24 months from baseline (T2, T3) **Comparator:** Families who did not complete the intervention. EIF = 2	101 families referred. 58 families signed up. At the time of the evaluation, 4 families had completed planned work and a further 31 families were engaged.	Baseline interviews were completed with 40 individuals representing 28 families, 27 were mothers and 13 fathers. 26 mothers completed the composite abuse scale post-intervention.	**Success in engaging parents with complex needs and childhood trauma** **Social care status of children:** Social care files. **Perpetration of abuse:** A composite measure of abuse. **Gestation, weight,** APGAR scores **Child development:** Birth outcomes; Ages & Stages Questionnaire (ASQ) (Squires & Bricker, 2009) **Child behaviour** Child Behavior Checklist (Achenbach & Rescorla, 2001)	**Various indicators** including PTSD for women and men respectively in line or above expected rates for high risk samples; over 70% of the sample scored above the cut-off for disordered personality traits (Standard Assessment of Personality - Abbreviated Scale). **Baseline:** 3 children in children's social care Unborn Baby Assessment, 10 on Child in Need Plan, 5 on Child Protection Plan, 1 care proceedings/interim care plan and 0 in local authority care. **T2:** 4 on Child in Need Plan, 4 on Child Protection Plan, 1 care proceedings/interim care plan 0 in local authority care. **T3:** 2 on Child in Need Plan, 2 on Child Protection Plan, 1 care proceedings/interim care plan, 1 in local authority care. **Composite Abuse Scale Scores:** *Baseline:* Mean score 16.42 (out of 150) Time 1 (T1), 12 months post-intervention: 14.31 Time 2 (T2), 24 months post-intervention 14.92. Percentage of mothers reporting abuse at levels above the cut-off reduced from 59% at baseline to 33% at two-years post sign-up to the programme. Among the women reporting ongoing abuse, however, the level of abuse remained the same (i.e., mean scores of 14.92). **Birth outcomes (gestation, weight, APGAR scores)** in line with low-risk groups, e.g. 2 out of 23 mothers gave birth prematurely. **ASQ:** Completed with 19 mothers at one-year follow-up interview: 15 babies scored within normal range across all domains; 4 babies' scores below cut-off for age group in one or two domains, suggesting possible delay; no baby scored low across all domains. **Child Behavior Checklist**: Completed with sample of 11 parents; scores below 67 are in normal range; mean scores were 40.7 for internalising problems and 45.4 for externalising scores and all scores were below clinical cut-offs. **Parenting**: 9 individuals provided data at baseline and 12 months that could be coded. 5 showed improvement, 1 no change, 3 deteriorated. **Parenting stress** was completed at T2 and T3. No formal statistical analysis of within-participant change. Comparison to normative data provided instead.

					Outcomes of interest Measures used	Results
					Parenting: Observations of parenting using CARE Index (Crittenden, 2003) **Parenting stress:** Parenting Stress Index (PSI - Short Form) (Abidin, 1995)	*Mothers' parenting stress:* At 12 months, mothers' mean percentile rank was 34.12 (SD 24.8) with a range from 1-74. Five mothers scored below the 16th percentile. By 24-month follow-up, the mothers' mean percentile rank was .30.92 (29.4) with a range from 1-84 and 6 mothers scored below the 16th percentile. *Fathers' parenting stress:* At 12 months, fathers' mean percentile was 28.4 (SD 27.5) with a range from 1-58. Two fathers scored below the 16th percentile. At 24 months, fathers' mean percentile rank was 26(10.8) with a range from 2-52. One father scored below the 16th percentile. At 12 months, 3 mothers and 2 fathers scored for "defensive responding". By 24 months, 4 mothers and no fathers scored for "defensive responding". **Mental health:** Changes in % above clinical cut-off. Depression (mothers) Baseline 45%; T2: 37% T3: 17%; (fathers) T1: 38%, T2: 38%; T3: 50%. Anxiety (mothers): T1: 7%; T2: 21%; T3: 8% (fathers) T1: 23%, T2: 13%, T3: 50%; PTSD (mothers)T1: 5%, T2: 1%,T3: 2% (fathers) T1: 4%, T2: 0% T3: 0%. The sample was too small for statistical analysis but evaluation data indicates that For Baby's Sake sustains engagement with families with complex needs, including multiple mental health needs/high levels of symptoms.
					Mental health: Anxiety and Depression - Edinburgh Postnatal Depression Scale (Cox et al., 1987) **Post-traumatic stress**: Generalised Anxiety Disorder, 7 item, GAD-7 (Spitzer, 2006) **Alcohol use** – The Alcohol Use Disorders Identification Test (AUDIT) (World Health Organization, n.d.) **Drug use** – The Drug Use Disorders Identification Test (DUDIT) (Berman et al., 2005)	

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size		Outcomes of interest Measures used	Results

| NewDAy

Langdon-Shreeve et al. (2020)

England | 3*

Quasi-experimental matched counterfactual comparison group, with qualitative components.

Evaluation focuses on three components: **Caring Dads** 17-week group programme for fathers (see above); **Inter-Parental Relationships** sessions with both members of the couple informed by systematic practice – 6 months; **school-based support** for children and young people– 3 terms.

EIF = 2 | 254 began a component of the intervention. 157 completed either Caring Dads (n=20), parental relationships (n=51) or school learning interventions (n=86) | **Social care:** Social care status data for 139 young people. Reviewed social care files for 20. **Education outcome data:** 79 children involved in schools prog. **SDQ:** 51 children in schools programme. **Score 15:** 31 families involved in parenting programme.

Social care files - 20

Interviews: Strategic leads (n=8); adult victim-survivors (n=6); adult users of abuse (n=5); children and adolescents involved in schools programme (n=4); and parents who were not themselves involved in Interparental Relationships sessions or Caring Dads (n=3), but whose children were in the schools programme Focus group with Caring Dads cohort (n=4). | **Child behavioural outcomes** – SDQ (Goodman et al., 2000)

Social care status of children and families; wellbeing and safety of children: Social care case file data.

Family functioning – Score 15 measure (Stratton et al., 2010)

Educational outcomes: Teacher rating | **Child behavioural outcomes**: Hyperactivity (-.78) prosociality (+.75), emotional symptoms (-.14), peer problems (-.20).

Social care outcomes: 81% of children and young people whose families received support had a reduced level of social service risk 6 months post-intervention relative to 57% of the comparison group. 59% of the cohort closed to social services.

Case file analysis: 60% of cases high/medium improvement in anxiety; 74% wellbeing; 80% health of family relationships; 77% education engagement and achievement; 65% impact on reducing the child/young person's witnessing of DA, and 60% feelings of safety.

Family functioning: Score 15 scores improved over time based on 32 individuals (14 couples and 4 single parents) average change score -6.07. "Overwhelmed by difficulties" -2.96; disrupted communication -2.29; strengths and adaptability -1.0.

Educational outcomes: 58% of children's engagement at school improved as rated by teachers (n=45). 4% deteriorated. 38% no change. 58% improvement in English, 55% improvement in writing, 60% improvement in maths. 61% no change in attendance. |

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size	Outcomes of interest Measures used	Results
SafeCORE Schrader McMillan (2022) England	3* Mixed methods; pre-post single sample quantitative study; interviews and focus groups. EIF = 2	**Whole intervention** (3 years) 298 enrolled. 110 families did not begin the service or ended early. 139 completed most or all of planned work and 49 cases ongoing when the evaluation was conducted. Eight families on a Child Protection Plan enrolled on the "bolt-on service" alongside a statutory social care plan in the intervention in year 3 at the time the evaluation was conducted.	Interviews with 4 families above threshold who had completed SafeCORE in year 3.	**Social care status of children:** Social care files. Participants' experience of service	**Families above threshold for Child Protection Plan:** All families completing intervention at the point of evaluation were scheduled for case closure. Participants who were interviewed highlighted improvements in self-compassion and self-care; improved capacity to manage emotions; improvements in their relationship with their partner; improvements in parenting; improved child happiness, increased confidence, and reduced anxiety.

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size	Outcomes of interest Measures used	Results
Project Crewe Heal et al. (2017) England	5* RCT with qualitative phase. Analysis of pre-post case file Data and exploratory qualitative design. **Comparator:** Usual care (standard social care). EIF = 3	132 families, 93 in intervention and 39 in the control group.	Social care data available for 126 cases. Other data for 30 families (20% of sample). The sample size was 50% smaller than expected so quantitative results were statistically significant.	**Education outcomes:** National pupil database. **Social Care case closure outcomes:** Social care case files. **Child risk ratings:** Social care case file data. **Child behavioural outcomes:** SDQ (Goodman et al., 2000) Focus groups and individual interviews.	**Education:** No statistically significant difference in children's school attendance. **Social care:** No significant differences in the closure of social care cases between intervention and control groups. However, case closure was faster in intervention families. **Child risk factors:** Project Crewe increased protective factors around the Child in Need families more than the control. These factors, when present, correlate with a decreased likelihood of reoccurrence of harm. This may indicate that future re-referral and escalation to child protection is less likely. Sample too small for statistical analysis. SDQ completed at baseline only. Solution-focused brief therapy may be less effective with families in acutely stressful or chaotic situations.
Opening Closed Doors Barnardo's Cymru (2021) Wales	3* **Mixed-methods design, pre-post data collection.** Structured interviews with service/team managers in children's social care; interviews with t case files reviewed for families who had completed the interventions. EIF = 2	426 people received a service. 102 individuals had completed a service at the point of the evaluation (11 men in Domestic Abuse Perpetrator Programmes (DAPP); 38 women and 1 man victim support service; 52	SDQ completed by 30 children and 75 parents; Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) completed by 154 parents/carers participating in interventions. 49 individuals (23 children; 17 women; 9 men) included in file review for outcomes.	**Child behavioural outcomes:** SDQ (parent report) (Goodman et al., 2000) **Social care status of children:** Social care case file data. **Parent/carer mental wellbeing:** WEMWBS (Tennant et al, 2007).	**Child behaviour - SDQ:** Significant change on Emotional Problems scale:(z=-2.858, p<.01, r =.3); Conduct problems scale: (z = -2.648, p <.01, r =-.3) and Total Difficulties scale (z = -2.462, p <.05, r =-.3) on 75 parents/carers reports. **Social care status.** 76% of children's case files provided evidence that children were living in a safer and more stable home environment. 48% of children had been de-escalated from Child Protection Plan to Care and Support Plan or from Care and Support Plan to case closure. **Parents wellbeing:** Parent/carer mean WEBWMS scores were significantly higher post-intervention M = 53.25 (SD = 8.04) vs. M = 45.72 (SD = 11.55) t (31) = -5.02, p <.001, r = .67.

		children completed STAR).	Interviews with 9 fathers, 17 mothers and 23 children. Interviews with practitioners.	**Cessation of DA:** Social services case files, DAPP files.	**DA:** 70.5% of women's service case files highlighted reduction or cessation of DA and 80% of DAPP files.

Intervention Author Country	Risk of bias Study design EIF strength of evidence	Number to enrol and complete intervention	Sample size	Outcomes of interest Measures used	Results
Growing Futures McCracken et al. (2017) England	**Mixed-methods** process and impact evaluation, pre-post case file data, survey and qualitative components. The focus of this evaluation is the impact of a new model of working with families, enacted by Growing Futures DANs.	Domestic Abuse Navigators (DANs) supported 102 families. This equates to a total of 440 family members, including 232 children and young people, 102 victims, 90 perpetrators, and 16 other family members. Of these, DANs conducted direct therapeutic work with 277 family members, including 153 children and young people, 72 victims, 49 perpetrators and 3 other family members.	Data analysed: social care files (n=34) analysed; DAN learning logs (n=87). Observation of MARACs: 64 cases MARAC case files: Interviews x 2 families (2 mothers, 2 fathers and 2 children), and 3 additional mothers.	**Reduction of repeat MARAC referrals:** MARAC files. **Social care status of children:** Social care files. **Child risk and vulnerability:** DAN casework logs. **User experience:** Quantitative data reported as percentages. Stakeholder experiences: Additional interviews with DANs, social workers, board members and perpetrator engagement worker.	**MARAC files:** Data set ambiguity suggests that a 15%-25% reduction in repeat MARAC referrals was achieved. **Social care files:** At baseline, DA featured in 38.9% of cases of Children Looked After, and 44% of Children in Need. 12 months later, these figures were reduced to 29.7% of Children Looked after and 36.4% of Children in Need. **DAN casework logs**: 68 children had a decrease in vulnerability; 3 increased; 79 no change. **Qualitative data:** Parents interviewed valued focus on the whole family, and effort to help the family stay together safely if possible. No comparison or control group; unclear how representative sample is of whole population that has taken up services.

Table A4.1 Interventions for fathers: population, intervention and setting

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention Required training
Caring Dads Scott et al. (2021) **Canada**	Inclusion criteria: fathers who have perpetrated DA. Fathers were eligible if they had an open file at Child Protective Services (CPS) and children were deemed at risk of significant harm. Age range of children: fathers of children aged 0-16 but 51% of children under age 6. M - 5.9 (intervention)	All families CPS involved.	All	Objectives: *Child*: Reduced risk from abusive fathering behaviours, improved parent-child relationships, safety and wellbeing. *Father*: Improvement in child-centred fathering and willingness to take responsibility for previous abusive fathering behaviour. *Partner outcomes*: Reduced risk of exposure to abusive behaviours, feelings of safety and wellbeing.	15 sessions, 2 individual sessions midway to focus on behavioural goals. Adjunctive work with partner and child(ren), practical support and advocacy. Group based, community settings.	Child protection social workers, with external facilitators from partner agencies.
Caring Dads Youansamouth et al. (2022) **England**	Inclusion and: As above. Child age: Fathers of children aged 0-17.	Social care: All referrals from children's social care. 61% of fathers had a child on a Child Protection Plan, 37% on a Child in Need Plan at baseline.	All	Objectives: Improve father's recognition and prioritisation of children's needs, identify and counter the distortions underlying men's previous (and potentially ongoing) abuse of their children and/or children's mothers, improve child-centred fathering.	As above, but with one-to-one work pre-intervention using motivational interviewing. Group-based, community settings.	Two facilitators, one male and one female, background not specified.

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention

Fathers for Change Stover et al. (2022) USA	**Inclusion:** Fathers. Some sessions with child's mother, or with child, if safe and mother consents. **Child age:** Child age range: 0-12.	Fathers referred by CPS after CPS determines that children do not immediately need to be placed in out-of-home care.	All	**Objectives:** *Child:* Cessation of child exposure to violence. Decreased symptoms of emotional and behavioural difficulties in children. *Father:* Cessation of family violence, improvement in father's mental health.	Individual sessions with the option of conjoint work with mother or child, 90 mins, weekly over 18-24 weeks. Home based.	Clinicians with a master's degree or above, attached to each of 6 services chosen to deliver the intervention.
Fathers for Change Stover (2015) USA	**Fathers as above.** **Child age:** 0-10.	Fathers referred by the courts or Department of Children and Families (DCF) following arrest for DA or drug use or both, being mandated by DCF or CPS.	All	**Objectives:** *Child:* Cessation of child exposure to DA. Decreased symptoms of emotional and behavioural difficulties. *Father:* Cessation of DA, cessation/reduction drug use (in this sample, predominantly cannabis), improved co-parenting.	Individual sessions with the option of conjoint work with mother or child, 90 mins, weekly over 18-24 weeks. Home based.	Child protection social workers, sometimes in conjunction with a facilitator from a community agency dedicated to supporting Black fathers. At least 1 facilitator was accredited by professional bodies of social workers/counsellors/psychologists.

Intervention Author Country	Target group	Social care status of children	Proportion of children exposed to DA	Objectives	Content and duration Setting	Who delivers the intervention Required training
Inner Strength Schrader McMillan (2022)	**Inclusion:** Fathers or mothers who had perpetrated DA on the mid-range on the Holtzworth-Munroe & Stuart Scale (1994) with and without record of general offending. Exclusion: no history of sexual offending or use of weapons. Age range of children: 0-18.	82% had a child above the threshold for Child Protection Plan. 66 children on Child Protection Plans and 19 in local authority care at baseline. 3 participants referred by probation following incarceration, and 2 self-referred.	All	*Child:* Improved child safety and wellbeing, reflected in cessation of need for statutory children's social care. *Parent:* Improved emotional regulation, resilience, coping skills and conflict-resolution skills to reduce risk of repeat DA and general offending.	2-3 one-to-one sessions, and 24 group sessions (90-120 minutes) twice a week over approximately 16 weeks. Home-based (3 sessions) and group based in community setting. Men and women in separate groups.	Social worker (Families in Need team) and police. This intervention led by a social worker and two part-time police officers seconded part-time to the programme Facilitators trained by psychologist trained in Dialectical Behavior Therapy (DBT).

Table A4.2 Interventions for fathers: evaluation design and outcomes

Intervention Author Country	Risk of bias Study design Strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Caring Dads Scott et al. (2021) Canada	3.5* QED, using retrospective using anonymised case file data. **Data collection:** 2 time points: pre-intervention and x2-year follow-up. **Comparator:** Fathers who completed Caring Dads treated as experimental and non-completers as a comparator group. EIF = 2	185 fathers enrolled, 85 completed. 100 non-completers. 45% completion.	**Data collected:** **T2 post-intervention,** 185 fathers, 85 completers, 100 non-completers. **T3: 2 years post-intervention.** Data available for 181 fathers, 82 completers, 99 non-completers.	**Social care status of children:** Social care case file data.	**Two years post-intervention:** **Child CPS status:** 3.6% of children in intervention group and 8.1% in comparison group placed in permanent out-of-home care by two-year follow-up. Completing intervention associated verified re-referral to CPS due to fathers' maltreatment in 20.5% of cases, as compared to 36.0% in the comparison group, a difference that was statistically significant [$\chi2$ (1, 169) = 5.061, p < .024] and between small and medium in size (Cramer's V = 0.17). Initial comparison (waitlist) found no significant differences in intervention and comparison (waitlist) group fathers in demographic characteristics, child protection concerns, and all but one area of risk and needs.
Caring Dads Youansamouth et al. (2022)	3* Mixed methods, pre-post study, using retrospective anonymised case file data. Qualitative phase. EIF = 2	181 fathers enrolled, 91 completed the programme (14/17 sessions). 51% completion.	Data on 118 fathers, 311 children and 145 mothers included in case file data analysis. 9 fathers and 3 partners interviewed.	**Social care status of children:** Social care case file data. **Overall changes in father-child relationship, reduction of professional concerns about the family:** Focus group discussions with practitioners.	**CPS status:** A 66% reduction in children's social care involvement was reported post-intervention for children of fathers who completed the intervention. The most common worsened outcomes for children whose father did not complete the programme were: a deterioration in their relationship with their father (26%); an increase in professional concerns (26%); and escalation in the status of their children's social care case (25%). **Interviews with professionals**: Most common improvements noted were improved father-child relationship (73%) and reduced professional concerns (68%) about the family. In fathers, increased and improved contact with a child (n=45, 75%), improved co-parenting (n=43, 72%), improved couple relationships (n=41, 69%) and better engagement with professionals.

Intervention Author Country	Risk of bias Study design Strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used Measurement Precision of result	Results
Fathers for Change Stover et al. (2022) USA	**3*** Pre-post, using anonymised file data from all families enrolled in the state-wide Fathers for Change Jan 2016 to Feb 2020. EIF = 2	373 fathers enrolled, 272 completed. 73% completion.	272	**Child: Child exposure to conflict:** Children's Exposure to Conflict subscale of the Co-parenting Relationship Scale (CPRS; Feinberg et al., 2012) (mother completed) Abusive behaviour by father. **Father: Abusive behaviour: Abusive Behavior Inventory (**ABI; Shepard & Campbell, 1992). **Depression and anxiety:** The Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995). **Emotional regulation**: Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). The Multidimensional Anger Inventory (MAI; Siegel, 1986). **Mentalisation:** Pre-mentalising subscale of the Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017). **Alcohol:** The Alcohol Use Disorders Identification Test (AUDIT) (World Health Organization, 2001) **Drug use:** The Drug Abuse Screening Test (DAST-10; Skinner, 1982)	**Child: Child exposure to conflict**: Statistically significant decreases in mother's reports of children's exposure to conflict on the CPRS from pre- to post-treatment for completers and non-completers with small-to-medium effect sizes. **Father: Abusive behaviour:** Statistically significant decreases in maternal report of fathers' intimate partner violence on the ABI from pre- to post-treatment for completers and non-completers with small-to-medium effect sizes. Mean ABI scores post-treatment for completers were below and for completers above the abusive score of 9. **Emotional regulation:** Significant pre- to post¬treatment change for completers in emotion dysregulation on the DERS, anger arousal, responses to anger eliciting situations, hostile outlook on the MAI. **Depression, Anxiety and Stress:** Significant pre- to post¬treatment change in negative emotionality on the DASS, **Mentalisation:** Significant pre- to post-treatment change in pre-mentalising on the PRFQ. Effect sizes ranged from 0.10–0.45 indicating small-to-moderate effects. **Reductions for non-completers were statistically significant**. It was not possible to ensure that men who dropped out would complete other measures post-intervention.

Intervention Author Country	Risk of bias Study design Strength of evidence	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used Measurement Precision of result	Results
Fathers for Change Stover (2015) USA	4.5* RCT: fathers randomly assigned to 1 of 2 interventions. EIF = 3	18 fathers, in intervention (n=9) and control group (n=9).	18	**Child: Quality of parent-child interaction** (video recorded) The Child Interactive Behavior Rating (Feldman, 1998). **Father: Addiction:** Addiction Severity Index 5th Edition (ASI; McLellan, 1992). **Abusive behaviour:** Revised Conflict Tactics Scale (CTS2; Straus et al., 1996). **Coparenting: The Coparenting Relationship Scale** (CRS; Feinberg, 2003).	**Quality of parent-child interaction:** Analyses of videotaped interactions of father-child play revealed that men in Fathers for Change were significantly less intrusiveness during free-play interactions. There was also a trend approaching significance in greater consistency of style, allowing for child-led activities by less frequently disrupting or redirecting the child's activities or attention following the intervention. Fathers in the control condition did not improve in this area. **Addiction:** Both groups reduced their substance use during treatment, with 90% of the sample maintaining abstinence throughout. There were no significant differences between groups, $F(1, 18)$ = .32, p = .58. **Violence:** Repeated-measures model examining reports of physical violence revealed that men in both groups reported less violence during and following intervention. Both intervention groups had significantly less violence over time. There was a trend toward greater reductions in violence in the Fathers for Change group. **Co-parenting:** Analyses did not reveal any significant differences in men's self-reported co-parenting experiences/behaviours, either over time or as a result of the intervention. **Overall satisfaction**: Analysis of variance revealed that Fathers for Change participants had higher mean scores than the IDC on all satisfaction items, with significantly higher scores on the following items: "met my treatment needs"; and "helped me deal more effectively with my problems".

Intervention Author Country	Risk of bias Study design EIF rating	Number to enrol and complete intervention	Sample size of study	Outcomes of interest Measures used	Results
Inner Strength Schrader McMillan (2022) England	3* Mixed methods; analysis of pre-post case file and police data and semi-structured interviews post-intervention. Data collected post-intervention, but involved 7 cohorts who had completed at different time points (38 months to 6 months post-intervention). No comparator. EIF = 2	34 (31 men and 3 women) completed the intervention in 7 cohorts over 3 years. No records held on attrition.	Social care data for 32 participants, police data for 22 participants with police records for offending 2 years pre-intervention. Interviews with 8 men and 2 women.	**Child protection status of children:** Social care files. **Perpetration of DA by parent:** Social care and police records.	**Child Protection status:** The number of *children subject to Child Protection Plans* was reduced from 66 at baseline to 24 post-intervention. *Children in local authority care*: 19 at baseline, 9 post-intervention. All children who returned to parental care were placed with the parent (in all cases the father) who had completed Inner Strength. Some cases remained open for reasons other than DA , including risk from another parent. *Cases escalated:* 2 children who had been on Child Protection Plans when their parent began the intervention were taken into care in the months that followed the programme and 2 children already in foster care were adopted. **DA perpetration and general offending:** DA: At the point of referral, 32 of 34 participants had social care file records for DA (two men had self-referred and no social care record). Post-intervention, 4 people (3 men and 1 woman) had had a further police sanction for assault or battery, and 2 other cases of harassment were investigated.

APPENDIX 3: RISK OF BIAS ASSESSMENT SUMMARY

Risk of bias assessment

The Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) is designed to help standardise the critical appraisal of the methodologies used across different study designs, including quantitative randomised, quantitative non-randomised studies (that is, quasi-experimental designs, QEDs), quantitative descriptive studies, qualitative and mixed-methods studies. Five quality criteria are specified for each study design type.

For the purpose of the current review the following scoring conventions were used:

- 1* If a criterion was fully met (green in the tables that follow).
- 0.5* If a criterion was partially met OR it was not possible to score through omitted information (amber in the tables that follow).
- 0* If a criterion was not met and this was discernible from the details provided (red in the tables that follow).

Studies were then scored across all criteria by summing the number of stars given (0-5* ratings were possible, with 5* meeting all criteria and with the lowest risk of bias). None of the studies included in this review adopted a quantitative descriptive design. Consequently, the remainder of this appendix summarises the MMAT ratings for the included studies and discusses the principal risks of bias observed.

The majority of academic studies (n=9, 43%) were described as quantitative non-randomised (EIF=2). The remaining academic studies comprised qualitative (n=1, 5%; EIF=0 and quantitative randomised (n=3, 14% EIF=1). All eight of the grey studies (38%) were mixed methods (EIF=2).

Quantitative randomised controlled trials

Table A5.1 MMAT ratings for quantitative randomised controlled trials

Study	Appropriate randomisation	Comparable baseline groups	Complete outcome data	Assessors blinded	Intervention fidelity	MMAT rating
Jouriles et al. (2010)	🟩	🟩	🟥	🟩	🟩	4*
Stover (2015)	🟩	🟩	🟩	🟪	🟩	4.5*
Heal et al. (2017) (grey)	🟩	🟩	🟩	🟩	🟩	5*

Bias in randomisation

All of the studies adopted appropriate procedures for randomising participants to conditions.

Bias in baseline groups

Across all studies, efforts were made to ensure that the baseline groups were comparable, and systematic efforts were made to examine the groups to check that this was the case.

Bias in outcome data

Jouriles et al. (2010) lost 11% of their baseline sample at follow-up.

Bias in assessors

Stover (2015) did not specify whether assessors were blinded or not.

Bias in compliance

All studies reported that the interventions were monitored and implemented as required.

Quantitative non-randomised studies

Table A5.2 MMAT ratings for quantitative non-randomised studies

Study	Sample	Appropriate measure	Complete outcome data	Confounders accounted for	Intervention fidelity	MMAT rating
Bunston et al. (2016)	🟩	🟩	🟥	🟥	🟩	3*
Dauber et al. (2015)	🟩	🟩	🟥	🟥	🟩	3*
Hellman & Gwinn (2017)	🟩	🟩	🟩	🟥	🟪	3.5*
Pernebo et al. (2018)	🟩	🟩	🟩	🟥	🟩	4*
Pernebo et al. (2019)	🟩	🟩	🟥	🟥	🟪	2.5*
Scott et al. (2021)	🟩	🟩	🟥	🟥	🟪	2.5*
Stover et al.(2022)	🟩	🟩	🟥	🟩	🟪	3.5*
Timmer et al. (2010)	🟩	🟩	🟥	🟥	🟩	3*

					2.5*

Bias in sample

All samples reported were representative of the context from which they were drawn.

Bias in measures

All studies adopted appropriate measures – that is, they measured constructs that were appropriate as outcome measures given the research questions and the intention of the interventions under examination.

Bias in completion data

The majority of quantitative non-randomised studies reported attrition between baseline and follow-up data. This ranged from 2% (Scott et al., 2021) to 79% dropout over time (Dauber et al., 2015). The average across studies was 28.8% attrition.

Bias in confounders

The majority of studies did not discuss or statistically control for potential confounding variables that might influence the outcomes observed.

Bias in intervention fidelity

Intervention fidelity is the extent to which the intervention is delivered as expected. Four studies specified that the intervention had been delivered as intended. The remaining failed to specify whether this was the case.

Table A5.3 MMAT ratings for qualitative studies

Study	Appropriate approach	Adequate methods	Findings derived from data	Interpretation backed by data	Coherence	MMAT rating
Ermentrout et al. (2014)						5*

Bias in approach

The study selected appropriate methodologies to address the research questions of interest.

Bias in methods

The study selected appropriate methods of data collection relative to the research questions of interest.

Bias in findings

The findings were derived from the qualitative data collected, and the authors provide details of the analytic process.

Bias in interpretation

The study supported their interpretation of the data with direct quotes from participants.

Bias in coherence

The authors present a coherent account of the study, data sources, data collection analysis and interpretation.

Mixed-methods studies

Table A5.4 MMAT ratings for mixed-methods studies

Study	Rationale	Integration	Interpretation	Inconsistencies	Quality	MMAT rating
Woollett et al. (2020)	Red	Green	Green	Green	Green	4*
Youansamouth et al. (2022)	Green	Red	Pink	Green	Red	2.5*
Trevillion et al. (2020)	Green	Green	Green	Green	Red	4*
McCracken et	Green	Red	Pink	Green	Red	2.5*

al. (2017)	Green	Red	Pink	Green	Red	
Schrader McMillan (2022)	Red	Green	Green	Green	Red	3*
Langdon-Shreeve et al. (2020)	Red	Green	Green	Green	Red	3*
Barnardo's Cymru (2020)	Red	Green	Green	Green	Red	3*
Schrader McMillan & Rayns (2021)	Green	Green	Green	Green	Red	4*

Bias in rationale

Five studies did not provide a clear rationale for the study, and it seemed that the approach was governed largely by available data rather than a priori decision-making. The remaining studies provided a clear rationale as to why a mixed-methods approach was appropriate for the research questions. Grey literature was all of mixed methods.

Bias in integration of components

Two studies did not clearly integrate the components, instead reporting the qualitative and quantitative components separately, and drawing conclusions from them in parallel, rather than conducting a complete synthesis. Again, this largely reflects the use of service-level data, which are not routinely collected for research purposes.

Bias in interpretation

The majority of studies reported appropriate interpretation of the qualitative and quantitative components. However, those studies that did not clearly integrate the qualitative and quantitative components only partially fulfilled this criterion.

Bias in inconsistencies

Across studies, divergence between qualitative and quantitative findings was adequately explored and discussed.

Bias in quality of components

Most studies did not meet this criterion, usually because of the quality of the quantitative component of the mixed methodology. Only Heal et al. (2017) reported on an RCT design quantitative study that met EIF level 3 rigour criteria. Due to the reliance on service data, most often single sample pre-post test designs were adopted with no non-intervention comparison group, and with little consideration of how confounding variables may have influenced outcomes where more than one group was involved.

APPENDIX 4: OUTCOMES MEASURED

The following section outlines specific outcomes for each type of service identified in the review.

Interventions for mothers and children

Psychotherapeutic interventions

Two studies involved dyadic interventions involving mothers exposed to domestic abuse and young children who showed behavioural challenges, trauma symptoms, or both. These interventions are a form of infant-parent psychotherapy (Bunston et al., 2016) and parent-child psychotherapy (Timmer et al., 2010).

Child behavioural outcomes

Infant-parent psychotherapy

One study of infant-parent psychotherapy (Peek-a-Boo Club) (Bunston et al., 2016) found that infants displayed significantly fewer problematic behaviours post-intervention relative to pre-intervention and were reported to be significantly more socially competent post-intervention. When analysed using the Reliable Change Index, 16% of infants showed significant improvement in their social competence scores, 79% showed no change, and 5% had significant deterioration.

Parent-child interaction therapy

One study of PCIT (Timmer et al., 2010), analysis of the ECBI intensity and problem scores showed strong treatment effects. However, neither the reductions in intensity nor the number of child behaviour problems varied significantly by intimate partner violence exposure. The three Child Behavior Checklist (CBCL) broadband scales also showed significant treatment effects on child externalising behaviour. Treatment effects did not vary significantly by intimate partner violence exposure.

Child and Adult Mental Health Service Intervention – Sweden and Children are People Too. Pernebo et al. (2018, 2019) compared CAMHSI and CAP psychoeducational programmes, and measured behavioural outcomes using the Strength and Difficulties Questionnaire (SDQ-P) (Goodman et al., 2000). Intervention effects were stronger for children in the psychotherapeutic intervention than in the psychoeducational programme, with largest effects in prosocial behaviour.

Child trauma symptoms

Parent-child interaction therapy

The study of PCIT (Timmer et al., 2010) measured trauma-related behaviours in children aged 2-7 years using the Eyberg Child Behaviour Inventory (ECBI) (Eyberg and Pincus, 1999). Analysis of the ECBI intensity and problem scores showed large treatment effects.

Neither the reductions in intensity nor the number of child behaviour problems varied significantly by severity of exposure to domestic abuse.

Child and Adult Mental Health Service Intervention – Sweden and Children are People Too.

Pernebo et al. (2018, 2019) compared results from a trauma-informed psychotherapy (CAMHSI) with a psychoeducational intervention (Children are People Too, CAP). Child trauma-related outcomes were measured using the Emotion Questionnaire for parents (EQ-P) and the Trauma Symptom Checklist for Young Children (TSCYC). Intervention effects were stronger for children in the psychotherapeutic intervention than in the CAP psychoeducational programme, with large effects on emotional regulation, depression, anger and dissociation for mothers in the CAMHSI compared with mothers of children in the psychoeducational intervention.

Results also showed a trajectory of continued symptom reduction for children in the CAMHSI, with the main reduction during the first six months post-intervention and sustained treatment gains at the 12-month follow-up. The path was a little different for the children in the CAP psychoeducational intervention as the effects of the treatment appear to have been consolidated and sustained, but with little continuing improvement after the intervention ended.

The Pernebo study also showed that children with initially high trauma symptoms benefited the most from both interventions. Children who were reported by their mothers to have been physically maltreated before they began treatment improved more than non-abused children from pre-treatment to the 12-month follow-up in measures of depression. High levels of post-traumatic

stress in children at baseline were associated with greater improvements on symptoms of post-traumatic stress, intrusion, avoidance and arousal at 12-month follow-up.

Despite these improvements, a proportion of children in both interventions continued to have trauma symptoms at clinical levels post-treatment, particularly in symptoms of post-traumatic stress, although these symptoms had been reduced for both intervention and control group children six months post-intervention (Pernebo et al., 2018, 2019).

Mother-infant relationship

Infant-child psychotherapy

The evaluation of the Peek-a-Boo Club (Bunston et al., 2016) measured treatment effects on maternal attachment behaviours using the Maternal Postnatal Attachment Scale (MPAS) (Condon et al., 2008) and the Parent-Infant Relationship Global Assessment Scale (PIR-GAS; Zero-To-Three, 2005) (clinician completed). The score on overall global attachment post-intervention was significantly higher than at pre-intervention. Results showed significant post-intervention improvements in in the subscales for Pleasure in Interaction, Quality of Attachment and Absence of Hostility.

Clinician rating of parent-infant functioning reported better adaptive functioning post-intervention than at pre-intervention.

Maternal stress

Parent-child interaction therapy

Using the Parenting Stress Inventory–Short Form (PSI-SF) (Abidin, 1995), Timmer et al. (2010) reported statistically significant changes in the stress symptoms of mothers who completed the intervention (P 4.79, p< .004, η = .16, observed power = .89.).

Maternal mental health

Parent-child interaction therapy (PCIT)

Using the Brief Symptom Inventory (BSI) and the Global Severity Index (GSI) (Derogatis, 1993), Timmer et al. (2010) reported statistically significant effects on mother's endorsement of psychological symptoms, but no further variation by intimate partner violence exposure. Results on the PSI-SF showed a significant interaction between treatment and parents' defensive responding.

Psychoeducational interventions

One paper reports on outcomes for a psychoeducational intervention (Jouriles et al., 2010).

Parenting

The Project Support evaluation (Jouriles et al., 2010) measured changes in parenting using the Parenting Locus of Control Scale (PLOC) (Campis et al., 1986). Mothers' harsh parenting was measured using the Revised Conflict Tactics Scales (CTS–R) (Straus et al., 1996). Within the Project Support intervention group, mothers' perceived inability to manage childrearing responsibilities and reports of harsh parenting and psychological distress all decreased over time.

No change was observed in ineffective parenting. None of the problematic parenting variables declined over time in the comparison group.

Children's social care status of children
Project Support (Jouriles et al., 2010) measured change in social care status of children. At 16 months post-intervention, the rate of family re-referral to Child Protective Services was 5.9% (1/17) for families in the Project Support condition and 27.7% (5/18) for families in the comparison condition. This difference did not reach statistical significance.

Comparing psychoeducational and psychotherapeutic interventions

The study by Pernebo et al. (2018, 2019) compared CAP with a psychotherapeutic intervention of comparable length and complexity.

Child behavioural problems
This study reported positive treatment effects for child behavioural problems in the psychotherapeutic and the psychoeducational CAP group post-intervention and at 12-month follow-up. Children in the therapeutic intervention sustained treatment gains at 12-month follow-up, whereas there was little continuing improvement post-intervention for children in the CAP group.

The SDQ impact scale indicated that the effect of the children's behavioural problems on their daily activities also decreased. However, there was no change from the pre-intervention to the 1-year follow-up assessment. Pre- to post-assessment effect sizes were small. No changes were found in children's prosocial behaviour in either analysis. Mothers' initial trauma symptoms accounted significantly for the variance in the children's change scores from pre to 1-year follow-up assessment (20.0% of the variance): the higher the mother's initial trauma symptoms, the more significant the reduction in SDQ total. Children's violence exposure did not explain changes in SDQ over and above mothers' initial trauma scores. No association was found between the mother's self-reported changes in trauma symptoms following her participation in the conjoint group for mothers, with her rating of her child's change in symptom level on SDQ.

Results were also analysed at the individual level using the Reliable Change Index (RCI), which showed that most children were unchanged after treatment. While it produced some improvements in outcomes for children post-intervention, these were not sustained at 12-month follow-up.

Interventions for children

Trauma-focused interventions

Two papers evaluate trauma-focused cognitive behavioural therapy (TF-CBT) for children who have been exposed to domestic abuse, with some parallel sessions with their mother or other non-

offending caregivers. Both studies combined standard TF-CBT with expressive therapies (Dauber et al., 2015; Woollett et al., 2020).

Child PTSD symptoms

Woollett et al. (2020) reported a non-significant trend towards improvement in PTSD symptoms on the PTSD-RI among 21 children and adolescents aged 5-14 years in a domestic abuse refuge who engaged in a 12-week combination of TF-CBT with art therapy and play therapy. A non-significant trend in PTSD symptoms was also reported by Dauber et al. (2015), using the Trauma Symptom Checklist for Children (TSCC) among 5-15-year-olds. As noted above, Dauber et al. observed that children and adolescents who attended more treatment sessions showed more significant improvement in PTSD symptoms.

Child mental health and trauma symptoms

Dauber et al. (2015) analysed change across trauma symptoms for the 31 children and adolescents who completed measures pre- and post-intervention. The 31 children and adolescents in this sample reported statistically significant reductions, on the TSCC, in trauma-related dissociation and sexual concerns, with moderate effect sizes across measures. However, this study reported no significant differences in the reduction of trauma symptoms between treatment completers and non-completers. Despite this, a significant correlation between the number of sessions attended and client change in post-traumatic stress symptoms was found, with children and adolescents who attended more sessions showing greater improvement in PTSD symptoms (see below).

Child anxiety

Dauber et al. (2015) measured change in child anxiety, using the Screen for Child Anxiety Related Disorders (SCARED) and a subscale on the TSCC-A (Briere, 1996) and reported statistically significant reductions in child anxiety post-intervention on the TSCC scale.

Child depressive symptoms

Two studies reported changes in children's depressive symptoms, using the Children's Depression Inventory (CDI) (Kovacs, 1985) or the TSCC-A (Briere, 1996).

Woollett et al. (2020) observed statistically significant post-intervention improvements in child depression (using the CDI) (Kovacs, 1985). Dauber et al. (2015) also reported statistically significant post-intervention reductions, on the TSCC, for children's trauma-related symptoms of depression. Both of these interventions involved TF-CBT with expressive therapies.

Children's experience of the service

The evaluation of TF-CBT with art and play therapy (Woollett et al., 2020) included qualitative data on children's experiences and the views of mothers and other stakeholders. Parent and stakeholder experiences are discussed in the section, 'Barriers and facilitators'.

Looked-after children or adolescents

Only two interventions were identified for adolescents or children in out-of-home care (typically in foster care or group homes): Camp HOPE (Hellman and Gwinn, 2017) and Write On writing therapy (Parker et al., 2006).

Children's sense of hope

Hellman and Gwinn (2017) used the Children's Hope Scale (CHS) (Snyder et al., 1997) to measure children's sense of hope and both children and counsellors completed this. Repeated measures ANOVA showed a statistically significant increase in children's self-reported sense of hope scores from pre-test to post-test, although partial eta square indicates that the estimated rate of change was small.

Counsellor reports on the CHS analysed using repeat measures ANOVA showed the increase in hope scores post-intervention was statistically significant and of moderate strength.

Children's character traits/resilience

In the evaluation of Camp HOPE, counsellors' observations of children's character strength were recorded pre- and post-intervention using the KIPP Character Counts Growth Card (available: https://characterlab.org/character-growth-card/). This scale reported a moderate and significant increase for zest, gratitude and curiosity. Small yet statistically significant increases in mean scores were observed for self-control, optimism and social intelligence. Correlational analysis showed that increases in children's self-reported hope were associated with clinician-measured scores in children's character strengths.

Capacity to identify and express emotions

For the evaluation of Expressive Writing therapy, Parker et al. (2006) found a 67% increase in positive emotions for both the experimental and the control conditions at the end of the programme on the Linguistic Inquiry and Word Count (LIWC) (Pennebaker et al., 2001). In addition, there was a significant increase in the number of words related to self in the experimental group.

Child depressive symptoms

The enhanced version of Expressive Writing – Write On – was associated with a reduction in mean t scores for dysphoric mood, negative affect, negative self-evaluation, somatic complaints, and total depression in interventions compared to the control group on the Reynolds Adolescent Depression Scale (Reynolds, 1987). There was a more significant reduction in measures of depression among the treatment group, and the post-test indicated less sadness among the treatment group but this was not statistically significant.

Other outcomes

The evaluation of Expressive Writing found no significant pre-post **or** between-group differences identified on the Adolescent Anger Rating Scale (AARS) (Burney, 2001), in adolescents' self-

concept on the Multidimensional Self-Concept Scale (MSCS) (Bracken, 1992), or in dating attitudes as measured on an unpublished grey scale (Parker, 2003).

Whole family interventions

This section includes six grey evaluations of interventions designed for all family members. Three interventions are described as "family systemic" because they are informed by family systems theory and are delivered by a single team. Three further studies are described as "multi-agency/multi-component" because coordinated services are provided by multiple agencies.

Children's social care status

Social care involvement with the family is measured using social care/Child Protective Services case file data.

NewDAy

Eighty-one per cent of children in intervention families had a reduced level of social service risk 6-months post-intervention, relative to 57% in the counterfactual control group. Fifty-nine per cent of families on a Child in Need Plan were closed to social services 6 months post-intervention. NewDAy case files reported significant improvements in other outcomes, including 74% improvement in child wellbeing; 80% of cases indicate improved family relationship and 60% in increased feelings of safety, a 65% reduction in the number of children witnessing domestic abuse.

For Baby's Sake

Sixty-three per cent (17 out of 27) families who completed For Baby's Sake were involved with social care at baseline. Of these, 5 children were on Child Protection Plans, 1 in an interim care plan, and the remaining 11 were on a Child in Need Plan. Twenty-four months post-intervention, 2 children were on Child Protection Plans and 1 was in local authority care, a 50% reduction in the number of children above the threshold for social care. In addition, 10 children were on a Child in Need Plan at baseline, and 2 were on a Child in Need Plan 24 months post-intervention.

SafeCORE

In year 3, four families had Child Protection Plans at baseline and completed the intervention at the point of the final evaluation, and all four cases were de-escalated from Child Protection to Care and Support Plan, or closed altogether. Other families were at an early stage of intervention and were not included in the evaluation.

Opening Closed Doors

The majority of the 60 children in this study were involved with social care at baseline. Forty per cent of children were on a Child Protection Plan and 15% in local authority care. A further 32% were on a Care and Support Plan. Social care case file data showed that 48% of children whose families had engaged in services provided by the project had been de-escalated from a Child Protection Plan to a Care and Support Plan or from a Care and Support Plan to universal services or case closure. Case file data indicated that 76% of families who completed the intervention lived in a safer and more stable home environment.

Project Crewe

Social care closed cases with 8.5% more Project Crewe families than cases in the comparator group. Social care also closed 12% more cases involving Project Crewe families with a history of social care involvement than social care-involved families in the comparator group. These differences did not reach statistical significance. Project Crewe families tended to stay longer on Child in Need Plans than those in the comparator group. However, Project Crewe cases (particularly those involving families with more severe needs at baseline) also experienced a more significant increase in protective factors.

Growing Futures

An analysis of social care data shows that domestic abuse featured in 38.9% of Children Looked After cases at baseline and 28.7% after 12 months. Of Children in Need cases, 44.8% included domestic abuse as a factor at baseline, reduced to 36.4% after 12 months.

Child risk and vulnerability

Two studies used qualitative case file data to create risk ratings for children.

Growing Futures

Sixty-eight included children had decreased vulnerability, 3 increased, and 79 remained at the same level of vulnerability based on domestic abuse navigator (DAN) casework books. Parents interviewed valued focus on the whole family and effort to help the family stay together safely if possible.

Project Crewe

Case file data showed that post-intervention, risk factors were reduced for children in Project Crewe and control (usual care) groups, but the samples were too small for statistical analysis.

Child behavioural outcomes

Two interventions, NewDAy and Opening Closed Doors, measured change in child behavioural outcomes using the SDQ parent or child report and, in the case of NewDAy, case file analysis.

NewDAy

Statistically significant change was reported on the SDQ scale in children's hyperactivity, prosociality, emotional symptoms and peer problems.

Opening Closed Doors

Statistically significant change was reported in children's emotional problems and total difficulties based on 75 parents/carers' reports using the SDQ.

School attendance and educational outcomes

NewDAy, Project Crewe and Opening Closed Doors assessed changes in children's school attendance and educational outcomes. However, Opening Closed Doors reported difficulties obtaining reliable data on school attendance or educational outcomes and could not include it in the evaluation. NewDAy included a school based strand of work, and staff allocated to this work collected the data they needed.

NewDAy

Positive changes based on teacher reports on 45 children, with 56% of children improving school engagement, 4% deteriorating, and no change in the remainder. Teachers reported improved educational outcomes, with 58% of children improving English, 55% writing, and 60% maths.

Project Crewe

No differences were identified in school attendance pre- and post-intervention or between intervention and control groups. Samples were, in any case, too small for statistical analysis.

Family functioning

Two interventions, NewDAy and SafeCORE, used the Score 15 to measure change in family functioning.

NewDAy

Score 15 scores improved over time with significant improvements in subscales for disrupted communication, strengths and adaptability, and being overwhelmed by difficulties. Measures were completed by 28 individuals (14 families).

Parenting stress

For Baby's Sake

Data on parenting stress was completed 12 and 24 months from baseline. No formal statistical analysis of within-participant change. Comparison to normative data is provided instead.

Mothers' parenting stress: At 12 months, mothers' mean percentile rank was 34.12 (SD 24.8), ranging from 1-74. Five mothers scored below the 16th percentile. By the 24-month follow-up, the mothers' mean percentile rank was .30.92 (29.4) with a range from 1-84 and six mothers scored below the 16th percentile. Three mothers scored as engaging in "defensive responding" at 12 months, and four at 24 months.

Fathers' parenting stress: At 12 months, fathers' mean percentile was 28.4 (SD 27.5), with a range from 1-58. Two fathers scored below the 16th percentile. At 24 months, fathers' mean percentile rank was 26 (10.8), with a range from 2-52. Again, one father scored below the 16th percentile. Two fathers scored for "defensive responding" at 12 months and none at 24 months.

Domestic abuse perpetration

Three studies measured the prevalence of abuse pre- and post-intervention. Growing Futures used MARAC case files to identify repeat referrals. For Baby's Sake created a composite abuse scale to assess the prevalence of violence towards women, and Opening Closed Doors used social care files and DAPP files. The SafeCORE study examined social care files.

Growing Futures

Analysis of 64 MARAC case files indicates a 15%-25% reduction in the number of referrals to MARAC.

For Baby's Sake

The percentage of mothers in the sample reporting abuse at levels above the cut-off reduced from 59% at baseline to 33% at two-years post sign-up to the programme. Among the women reporting ongoing abuse, however, the level of abuse remained the same (i.e., mean scores of 14.92). 88%of

women reported a lifetime exposure to DA, but relatively low numbers at baseline (i.e. of abuse in the current relationship) may have been due to their unwillingness to recognise explicitly or to disclosure experiencing domestic abuse by their co-parent, perhaps because of minimisation, fear or shame (Trevillion, 2020: 130).

Opening Closed Doors

A total of 70.5% of women's social care service case files highlighted reduction or cessation of domestic abuse.

SafeCORE

Of four families with a child above the threshold for a Child Protection Plan, there was no further reoccurrence of domestic abuse, although two couples had separated.

Parental mental health

For Baby's Sake measured parental anxiety and depression at three time points. Anxiety was measured using the Generalised Anxiety Disorder (GAD-7) measure, and depression using the Edinburgh Postnatal Depression Scale (EPDS). In both cases, changes are reported as a percentage above the clinical cut-off at baseline, at 12 months and 24 months. The sample was too small for statistical analysis

Mothers depression: Baseline 45%; T2: 37% T3: 17% Mothers anxiety: Baseline: 7%; T2: 21%; T3: 8%
Fathers depression: Baseline 38%, T2: 38%; T3: 50%. Father's anxiety: T1: 4%, T2: 0% T3: 0%.

Results indicate a reduction in maternal depression and paternal anxiety. Findings for mothers' anxiety are equivocal, with an increase at 12 months followed by a return to baseline levels at 24 months. Men's depression levels did not change between baseline and 12 months but had increased by 24 months, with 50% of the men in the sample showing symptoms above the clinical cut-off point.

Parental subjective wellbeing

Opening Closed Doors used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to evaluate the subjective wellbeing of parents and carers. Mean WEMWBS scores were significantly higher post-intervention.

Interventions for fathers

Five studies evaluated interventions for parents who had perpetrated domestic abuse. Two interventions (Fathers for Change and Caring Dads) were designed for fathers only, and one (Inner Strength) for fathers or mothers who have perpetrated domestic abuse or general violence outside the home.

Children's social care status

Social care involvement with the family is measured using social care/ Child Protective Services (CPS) case file data.

Caring Dads

In Scott et al.'s (2021) evaluation of Caring Dads, in Canada, 3.6% of children in the intervention group and 8.1% in the comparison group had been placed in permanent out-of-home (that is, adoption) care by two-year follow-up. In addition, children of 20.5% of fathers who had completed the intervention were re-referred to CPS because of their father's behaviour, compared to 36.0% in the comparison group, a statistically significant difference and with a small-to-medium effect size (Cramer's V = 0.17).

The evaluation by Youansamouth et al. (2022) involved fathers in north-east England. At baseline, 61% of children were on a Child Protection Plan and 37% on a Child in Need Plan. A 66% reduction in children's social care involvement with children was reported post-intervention for children of fathers who had completed the intervention. Conversely, the proportion of children of fathers who did not complete the programme had much worse outcomes than children of fathers who completed Caring Dads. The most common worsened outcomes for children whose father withdrew from the programme were: a deterioration in their relationship with their father (26%), an increase in professional concerns (26%); and escalation in children's social care status. However, there was no inferential analysis of these changes, so their statistical significance is not known, despite their evident practical importance.

Inner Strength

A total of 31 men and 3 women completed the Inner Strength programme (Schrader McMillan and Rayns, 2021). Between baseline (at the point of their parent's referral to the programme) and follow-up (between 6 and 38 months post-completion), the number of children looked after decreased from 19 to 9. All the children who had been in local authority care and returned to parental care went back to the parent who had completed Inner Strength. Of the 66 children subject to Child Protection Plans when their parent was referred to Inner Strength, 44 were closed or scaled down to universal services post-intervention. Again, these data were not analysed statistically.

Quality of father-child interaction

Fathers for Change

Analyses of videotaped interactions of father-child play revealed that men in the Fathers for Change group were significantly less intrusive during free-play interactions than fathers in the individual drug counselling (IDC) comparator group (Stover, 2015). The same RCT found a trend approaching significance in greater consistency of style in that in father-child interaction, the Fathers for Change fathers were involved in more child-led activities and were less likely to interrupt or deflect the children than fathers in the control condition post-intervention.

Domestic abuse perpetration and child exposure to violence

Fathers for Change

Both included evaluations of Fathers for Change reported decreases in measures of fathers' perpetration of violence. Statistically significant pre- to post-treatment change in abusive behaviours by Fathers for Change completers were recorded, by children's mothers, on the Abusive Behavior Inventory (ABI) (Stover, 2015). Changes pre-post intervention were of small-to-medium effect sizes. Fathers for Change completers had ABI scores that were below the score of 9, which indicates abusive behaviour.

Inner Strength

Two years pre-intervention, all participants in the Inner Strength programme had perpetrated domestic abuse; of these, 22 received a police sanction. Post-intervention, four men received a further police sanction for assault or battery, while one case of harassment was being investigated at the time of the evaluation (Schrader McMillan and Rayns, 2021).

Parent emotional regulation

Fathers for Change

Statistically significant pre- to post-treatment change in emotion dysregulation on the Emotion Regulation Scale (DERS) (Gratz and Roemer, 2004), anger arousal, responses to anger-eliciting situations, and hostile outlook on the Multidimensional Anger Inventory (MAI) (Siegel, 1986) were reported for Fathers for Change completers in Stover et al. (2022).

Child exposure to conflict

Fathers for Change

Completers and non-completers reported statistically significant reductions of small-to-medium effect sizes in children's exposure to conflict on the Conflict Tactics Scales from pre- to post-intervention (Stover et al., 2022).

Mentalisation

Fathers for Change

Fathers for Change completion was also associated with of small-to-moderate effect size changes in fathers' capacity for mentalisation on the Parental Reflective Functioning Questionnaire (PRFQ) (Luyten et al., 2017) (Stover et al., 2022).

Depression, anxiety and stress

Fathers for Change

Fathers for Change completion was also associated with statistically significant changes in fathers' negative emotionality on the Depression and Anxiety Scale (DASS) (Stover et al., 2022).

APPENDIX 5: REVIEWS SEARCHED

Reviews searched

First author	Date	Review title and focus
Anderson	2018	Mothers and Children Exposed to Intimate Partner Violence: A Review of Treatment Interventions
Austin	2019	A Systematic Review of Interventions for Women Parenting in the Context of Intimate Partner Violence
BCCEWH	2013	Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence
Chamberlain	2014	Comprehensive Review of Interventions for Children Exposed to Domestic Violence
Chung	2020	Fathering programs in the context of domestic and family violence
Hackett	2016	The Therapeutic Efficacy of Domestic Violence Victim Interventions
Howarth	2015	IMPRoving Outcomes for children exposed to domestic ViolencE (IMPROVE): an evidence synthesis
Mitchell	2019	A Systematic Review of Trials to Improve Child Outcomes Associated With Adverse Childhood Experiences
Romano	2021	Meta-Analysis on Interventions for Children Exposed to Intimate Partner Violence
Rydström	2019	Young witnesses of intimate partner violence: screening and intervention
Stith	2021	Using systemic interventions to reduce intimate partner violence or child maltreatment: A systematic review of publications between 2010 and 2019
Turner	2017	Interventions to Improve the Response of Professionals to Children Exposed to Domestic Violence and Abuse: A Systematic Review

APPENDIX 6:ADDITIONAL STUDIES

The following studies were excluded because the proportion of children on or above the threshold for children's social care was below 49% or because the study had not recorded children's social care status at baseline.

The primary reason for exclusion across these studies was the lack of information on social care status of children at baseline. Authors who were contacted confirmed in all cases that the sample included children above the threshold for children's social care. The study by Lowell et al. (2011) was designed for children at a high level of risk; under 50% had Child Protective Services involvement or had been exposed to domestic abuse.

Psychotherapeutic interventions: mothers and children

Author	Target	Intervention	Objectives	Children's social care/ CPS involvement
Lowell et al. 2011 RCT	Children exposed to domestic abuse (DA) who screened positive for social-emotional/behavioural problems. Mothers screened high for psychosocial risk. Child aged 6 months to 3 years.	**Child FIRST** The Child FIRST model combines systems of care, home visitation programmes, and a dyadic psychotherapeutic intervention (infant-child psychotherapy) into an integrated intervention that (a) provided comprehensive, coordinated services and supports to the child and family to decrease environmental stressors and address family needs; and (b) utilised the power of early relationships to enhance social-emotional and cognitive development. The dyadic psychotherapeutic component is grounded in infant-child parent psychotherapy based on work by Fraiberg (1980) and Lieberman et al. (2005, 2006).	Improve maternal mental health, reduce parenting stress, increase family access to social supports and resources in the community. Reduce child emotional and behavioural problems, improve language development. Reduce Child Protective Services (CPS) involvement with children.	28.2% of the intervention families and 39.2% of families in usual care had a history of CPS involvement. 39% of children exposed to DA in a multiple trauma sample.

Psychoeducation interventions: mothers and children

Name of intervention, author, country Design	Group	Intervention	Objectives	Children's social care/ CPS involvement
Draxler et al. (2019) Quantitative non-randomised (QED) Draxler et al. (2020) Qualitative	Children aged 3-9 and their mothers.	**Project Support adaptation** Project Support, adapted for Swedish context (Jouriles et al., 1998), is a multi-component, dyadic home-based family intervention for mothers and children who have left domestic violence shelters. It was designed to address conduct problems in children exposed to domestic violence and child maltreatment. It helps mothers with problem-solving skills, and teaches mothers to use child management and nurturing skills designed to improve the parent-child relationship and reduce children's conduct problems. It also includes practical support such as housing, financial and legal assistance, and liaison with the police.	To reduce conduct problems in children exposed to domestic violence and child maltreatment. Mothers to manage childrearing responsibilities, reduce harsh parenting, and enhance parenting effectiveness.	Draxler et al. (2019) Quantitative non-randomised (QED) Draxler et al. (2020) Qualitative
Grip et al. (2012) Quantitative non-randomised (QED)	Children aged 5-15 and their mothers.	**Children are People Too,** Psychoeducation group intervention with parallel sessions for mothers and children, based on Children are People Too. Originally developed to prevent substance abuse among youth; was revised for young people exposed to intimate partner violence. Core focus is education about violence, safety planning, feelings, defences, risks and choices and parent-child communication. Work with mothers and children included a range of modalities (play, drawing, discussions and	To improve the general behavioural problems, degree of social impairment and increase prosocial ability of children exposed to domestic violence and abuse.	Grip et al. (2012) Quantitative non-randomised (QED)

lessons). Six to eight children of a similar age.

Smith (2016), Smith et al. (2020) Mixed methods	Children aged 7-14 and their mothers.	**Domestic Abuse Recovering Together (DART)** A group programme developed by the NSPCC to address some of the harm caused by domestic abuse, focusing on supporting the mother-child relationship. The intervention was strongly influenced by the work of Humphreys et al. (2006) who produced a resource, Talking to Mum, on the basis of their research with mothers and children who experienced domestic abuse. This resource included activities to help children share their experiences of the abuse with their mother. DART aims to improve the mother-child relationship and to reduce the impact of the domestic abuse experienced, helping them recover from the adverse effects.	To address the immediate and long-term negative effects that children are likely to experience in order to improve their educational attainment. To increase the self-esteem of mothers and children, and increase mothers' confidence in their parenting abilities.	Smith (2016), Smith et al. (2020) Mixed methods
Overbeek et al. (2013) RCT	Child age 6-12.	**"It's my turn now", adaptation of Kids Club/Moms Empowerment Programme (KCMEP) vs "You belong" play therapy** Parallel group interventions (1) "It's my turn now": Adaptation of KCMEP for Dutch context. Kids Club and Moms Empowerment are two group-based programmes designed to run in tandem. They are most effective when both mother and child participate. Each child or parent group had a maximum of 8 participants. Moms Empowerment is a parenting programme aimed at improving victimised parents' repertoire of parenting and disciplinary skills, and enhancing social and emotional adjustment, thereby reducing children's behavioural and adjustment difficulties.	To enhance the child's sense of safety, create a therapeutic alliance, and create a common vocabulary of emotions for making sense of violence experiences, managing emotions, and understanding conflict and its resolution. To increase victimised parents' repertoire of parenting and disciplinary skills, and enhancing social and emotional adjustment, thereby reducing the children's behavioural and	Overbeek et al. (2013) RCT

	(2) Control group: "You belong", an intervention that is not specific to intimate partner violence.	adjustment difficulties.		

Psychotherapeutic interventions: children

	Target	Intervention	Objectives	Children's social care / CPS involvement
Cohen et al. (2011) **RCT**	Children aged 7-14.	**TF-CBT** Group-based TF-CBT for children. Components combined psychoeducation about trauma, relaxation skills and stress management, managing distress, cognitive coping skills. Joint child-parent sessions to enhance communication and increase child safety. Developmentally appropriate strategies were used across a range of ages and clinical presentations.	Cohen et al. (2011) **RCT**	Children aged 7-14.
Puccia et al. (2012) Quantitative non-randomised (QED)	Children aged 4-19.	**TF-CBT** Intervention combining individual work with child or parent alone, and combined sessions for parent and child. The intervention combines 8 modules: psychoeducation and parenting skills; relaxation; affective expression and regulation; cognitive coping and processing; trauma narrative; in vivo exposure; conjoint parent-child sessions; and enhanced safety skills. This modular treatment aims to help children talk about their traumatic experiences in an open and supportive environment. It also allows parents and children to communicate about these traumatic events**.**	Puccia et al. (2012) Quantitative non-randomised (QED)	Children aged 4-19.

Interventions for fathers

c	Target	Intervention	Objectives	Children's social care/ CPS involvement

| McConnell et al. (2016) Mixed methods | Fathers of children 0-18, but most children preschool age. | **Caring Dads** is a group-based intervention that combines motivational interviewing, psychoeducation, CBT and trauma theory. | To leverage men's role as fathers to motivate behavioural change. | No detailed breakdown. 2 in 3 (66%) referrals from children's social care, remainder from Children and Family Court Advisory and Support Service (CAFCASS), probation and health services. (Communication with author). |

Additional studies excluded

First author	Date	Intervention	Primary reason for exclusion
An	2017	Teenagers groups	Social care status unclear
Banting	2017	Solution-focused brief therapy	Lack of child outcomes
Berry	2019	Parent Life Coaching	Below threshold for CSC
Bunston	2006	Peek-a-Boo Club	Lack of child outcomes
Callaghan	2019	MPOWER	Social care status unclear
Caron	2016	Attachment and Biobehavioral Catch-up (ABC)	Lack of child outcomes
Clark	2021	Preschool Kid's club	Below threshold for CPS
Domoney	2020	For Baby's Sake	Descriptive
Emerson	2013	Child Protective Services Casework	Case study
Fainsilber Katz	2020	Emotion coaching	Social care status unclear
Fellin	2018	MPOWER	Rationale and description of service
Ghosh Ippen	2011	Child Parent Psychotherapy	Only 3% above threshold
Graham-Bermann	2011	KC/MEP	Below threshold for CPS
Graham-Bermann	2013	KC/MEP	Below threshold for CPS
Gutwich	2016	Child–Adult Relationship Enhancement (CARE)	Descriptive
Harwin	2018	Family Drug and Alcohol Courts	No detail about interventions
Heyman	2019	Couple CARE for Parents of Newborns Program	Lack of child outcomes
Huebner	2021	Sobriety Treatment and Recovery Teams (START) program	Primarily substance abuse
Humphreys	2006	Talking to my Mum	Social care status unclear
Jacobs	2016	Home visiting for at-risk young parents	Primarily preventive
Kan	2015	Family Foundations	Lack of child outcomes
Kelly	2015	Project Mirabal	Social care status unclear
Lieberman	2005	Child Parent Psychotherapy	Below threshold for CPS
Lieberman	2006	Child Parent Psychotherapy	Below threshold for CPS
Lowell	2011	Child FIRST	Below threshold for CPS
Matjasko	2013	GREAT multisite violence prevention	Social care status unclear

McCarry	2021	Community based early intervention intimate partner violence	Below threshold for CP plan
McHale	2022	Focused Coparenting Consultation	Lack of child outcomes
Miller	2012	KC/MEP	Below threshold for CPS
Noether	2007	Psychoeducation for children of battered women	Social care status unclear
Pennell	2015	Restorative Justice	Lack of child outcomes
Renner	2020	Parent group for survivors of domestic abuse	Lack of child outcomes
Rizo	2018	MOVE	Lack of child outcomes
Safe and Together Institute	2018	Safe and Together Model	No detail about intervention
Safe and Together Edinburgh	n/d	Safe and Together Model	No detail about intervention
Sen	2019	Restorative Justice Family Group Conferences	Lack of child outcomes
Stein	2018	KC/MEP Latina mothers	Lack of child outcomes
Stevens	2019	Multi-agency intervention program	Lack of child outcomes
Stover	2013	Fathers for Change	Lack of child outcomes

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