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Chapter One

Introduction

SUPPORTING FAMILIES EXPERIENCING DOMESTIC VIOLENCE

Domestic violence[1] against adult partners is neither uncommon nor confined to people from particular socio-economic, educational, ethnic, religious, or cultural groups. Instead, research in Ireland and internationally has demonstrated its prevalence, suggesting that nearly one-third of men and women have experienced some form of domestic abuse incident (e.g. Watson & Parsons, 2005; WHO, 2013). Although more typically perpetrated by men against women, especially with regard to severe acts of violence, men are also victimised by women, as are partners in same-sex relationships (e.g. Black et al., 2011; Devaney & Lazenbatt, 2016). The different forms of physical, sexual, psychological and emotional threat or abuse that domestic violence encompasses result in wide-ranging immediate and long-term negative outcomes for affected individuals, their children, their families, and society in general. As such, domestic violence is a serious, complex, social, health, and human rights concern.

[1] The literature in the field of domestic violence uses a variety of terms to refer to acts of abuse between partners who are presently, or were previously, in intimate relationships. These include 'domestic abuse', 'gender-based violence', 'sexual violence', 'intimate partner violence', and 'interpersonal violence'. The present report adopts the working definition of domestic violence as outlined in the Children First Act (2015): "*The use of physical or emotional force or the threat of physical force, including sexual violence in close adult relationships. It can also involve emotional abuse; the destruction of property, isolation from friends, family & other potential sources of support; threats to others including children; stalking; & control over access to money, personal items, food, transportation & the telephone*"

The Daughters of Charity Child and Family Services (DoCCFS) provide a range of early years, therapeutic, and child protection and welfare services to children and families most in need. In 2017, the DoCCFS established 'Dublin Safer Families Service' (DSFS), which uses a systemic approach to working with families experiencing domestic violence. The current policy response to domestic violence in the Irish context is largely driven by research demonstrating prevalence and impact. It has been sensitive to the gendered dimension of abuse and conscious of the Irish Government's aim of ratification of the Istanbul Convention, which seeks to promote the protection of women. As part of the Second National Strategy on Domestic, Sexual and Gender-based Violence 2016-2021, the Domestic Violence Act 2018 has been enacted. Whilst the Act is largely concerned with what should happen in the aftermath of domestic violence occurrence, DSFS, in line with emerging research evidence that early intervention involving both partners is effective in addressing relationships where there is indication that violence and control are already features, or likely to become so, has developed a programme to respond to concerns at the earliest possible time. This programme carefully assesses the particular patterns of domestic violence in each presenting case and responds with therapeutic services that involve both partners, where this is mandated. This type of approach is largely in contrast to established models of service provision in Ireland in particular, and indeed internationally, where interventions tend to be concerned either with the provision of safe and nurturing environments for female victims (often with children), or programmes designed to reduce male violence.

This present document describes and evaluates a system for monitoring the effectiveness of intervention and therapeutic services provided by DSFS over a two-year period from June 2017 to June 2019. A key focus is on describing the families who engage with this service and changes in the objective measures used to capture and quantify their progress from the start of their involvement with the programme through to completion.

THE SERVICE

Dublin Safer Families Service has been working with families experiencing domestic violence since 2017. It offers direct intervention with individuals, children, couples and families, and consultation, training and supervision to professional colleagues and teams.

Referrals to DSFS come from Tusla (The Child and Family Agency) or the Probation Service. Family Workers [2] follow a systemically informed safety methodology involving the assessment, identification, and management of risk of future violence, helping people take responsibility for safety and for behaviour that harmed others, and collaborative practices (Cooper & Vetere, 2005; Scerri, Vetere, Abela, & Cooper, 2017). The work begins with each victim attending for individual sessions while safety for all is being assessed. When safety has been established the perpetrator is invited for individual sessions. These individual sessions continue for as long as needed to ensure safety is sustained and many issues such as intergenerational violence, triggers, and emotional regulation are addressed. If referred, the children can begin their individual work, when it is safe to do so. Part of the work can include joint sessions with victim and perpetrator, sessions with victim and child/ren, sessions with perpetrator and child/ren and, at times, entire family sessions. Family Workers adopt a variety of therapeutic tools and approaches in their sessions with clients including, but not limited to,

[2] The position of Family Worker in Dublin Safer Families Service involves working systemically with families experiencing Gender, Sexual and Domestic Violence. Family Workers are educated to at least degree level in one or more of the following disciplines: Social Care, Psychotherapy, Systemic Psychotherapy, Psychology, Social Work, Cognitive Behavioural Therapy or related areas.

Safety Plans, No-Violence Contracts, In-Room Consultant, Psycho-education, Motivational Interviewing, and Cognitive Behavioural Therapy.

Since beginning its service a total of 276 adults (victim, proxy victim[3], and perpetrator) have been referred to DSFS. Eighty percent of victims referred have attended services. Those that have not cited reasons such as homelessness, substance misuse and changed family circumstances (e.g. where victim and perpetrator no longer have any direct contact). The current engagement rate of perpetrators is 47%. However, another 32% of referred perpetrators are awaiting work to begin while the safety of the victim and children in the home is assessed. With regard to children in these families, currently 205 children have been referred directly while 243 have been identified as indirectly impacted by the violence in their homes.

While the majority of referrals received at DSFS (62%) are at Level 4, the highest level of need as categorized by the Hardiker Model (Hardiker, Exton, & Barker, 1991), some Level 2 (4%) and Level 3 (35%) referrals have also been received[4]. A pattern has emerged in DSFS whereby many Level 2 and Level 3 referrals initially increase in risk as the family engage in the work and members may disclose further abuse, or more details about the abuse, as they form a relationship with their Family Worker.

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[3] A proxy victim is a person who is substituted for the primary victim, often when the perpetrator no longer has access to the primary victim. Proxy victims are most commonly the children in the family, but can include other family members, friends, neighbours or anyone else the perpetrator can use to threaten, harass or manipulate their victim into doing what they want.

[4] Interventions at Level 4 involve intensive and long-term support and protection for children and families. Level 3 interventions are best described as therapeutic and support services for children and families with severe difficulties, while Level 2 services are aimed at families with some additional needs such as parenting support or more focused educational services. Level 1 refers to mainstream services that are available to all children and families (e.g. health care, education, and leisure) in communities.

Dublin Safer Families Service has seen an increase in the level of risk in the families that have been referred to the service. Overall, 36% of families have a 'threat of death', for the victim, in the referral.

A case study example of an anonymised family who engaged with DSFS and the intervention they received is provided in Appendix A.

SERVICE EVALUATION

"…violence prevention programmes are only worthy of implementation if they are effective in reducing the level or consequences of violence. This can only be scientifically proven if they have been evaluated rigorously"

Sethi, Marais, Seedat, Nurse & Butchart (2004, pg. 9)

A key goal in evaluating an intervention programme is to ascertain what effect, if any, it is having on the clients engaging with it, and whether it is achieving its stated objectives. By identifying areas of strengths and weaknesses, delivery of the service can be adjusted so as to better meet the needs of those who participate.

To this end, in the six months prior to DSFS meeting its first clients, management of the Service and the DoCCFS met with researchers based at Trinity Research in Childhood Centre (TRiCC) at Trinity College Dublin to discuss how the effectiveness of the proposed intervention could be assessed and evaluated. This research partnership between the DoCCFS and Trinity was already working on an evaluation of Family Centre and Early Childhood Development Services, since published as *Why Measures Matter* (Spratt, Swords & Vilda, 2018). As such, the DoCCFS had already endorsed the crucial role of evidence in directing service delivery and professional practice, and valued outcomes for service-users as much as data on service activity.

Thus, a plan for the development of outcome measures and their systematic collection and analysis was developed for DSFS. This involved reviewing and selecting a suite of standardised evaluation tools, training staff in their administration, monitoring implementation, and providing interim feedback so as to determine the effectiveness of the Service in meeting its objectives. From the outset a shared strategic approach from service provider and research parties involved agreement as to aims of the project, the measures employed, and the training necessary to inculcate and maintain a joint sense of ownership of the enterprise.

OUTCOME MEASURES

Evidence gathered for evaluation purposes can arise from qualitative or quantitative research approaches and include information from a variety of informants (e.g. programme management, staff or service users) gleaned using a variety of means (e.g. case histories, focus group discussions, interviews, or survey completion). As an initial evaluation step with the new DSFS it was decided to engage adult service users in the completion of a quantitative survey[5]. This survey was developed to elicit information on a range of child, parent, family and household characteristics along with outcome measures that aimed to evaluate parent mental health, the quality of child-parent relationships, and conflict tactics between parents and between parents and their children. If there was more than one child in the family, interviewers asked parents to answer the child-related questions with the child who they identified as being of principal concern to them in mind. The specifics of the demographic information and outcome measures are detailed below.

- Information gathered on **individual and family characteristics** included:

[5] Future evaluations are planned which will engage service staff and child/adolescent service-users using a mix of quantitative and qualitative means. Consideration and development of sensitive, age-appropriate approaches is underway and will be applied in the next phase of the evaluation process.

- Service-users' age, gender, nationality, marital status and highest level of education attained
- Number of children in the family and their biological, adoptive, step or other relationship to each parent
- Type of family accommodation
- Sources of family income and the degree of ease or difficulty with which this income meets the family's financial commitments and needs
- Exposure to **Adverse Childhood Experiences** (ACE) scale as measured by an 11-item instrument that presents service users with a list of life events and asks them to indicate if they experienced any of them prior to the age of 18 years, or if their child has experienced any of them so far in his or her life. The events include being the victim of physical or sexual abuse, or neglect, witnessing domestic violence, or having a parent with a mental illness or an alcohol or drug dependency. A final ACE score can be computed by counting the number of events experienced. As such, scores can range from zero, where the individual has experienced no adversities, to eleven, where the full range have been experienced.

- The **Conflict Tactic Scales** (Straus, 1979) were developed to measure the range of ways that family members report engaging with each other in conflict situations.

    - The 20-item **Conflict Tactics Scale-2 (CTS-2;** Straus, Hamby, McCoy, & Sugarman, 1996) is a widely used instrument for measuring negotiation as well as psychological and physical attacks on a partner in a marital, cohabiting, or dating relationship. It is one of the most widely used instruments for measuring intimate partner violence that taps into the conflict tactic behaviours of both partners, both from their own perspective and from the perspective of their

partner. The measure consists of 20 items that are divided into five categories:

- Negotiation (e.g. *"I showed my partner I cared even though we disagreed"***)**
- Psychological Aggression (e.g. *"I insulted or swore at my partner")*
- Physical Assault (e.g. *"I passed out from being hit on the head by my partner in a fight"***)**
- Sexual Coercion (e.g. *"I used threats to make my partner have sex"***)**
- Injury (e.g. *"I had a broken bone from a fight with my partner"***)**

Respondents indicate if they or their partner have used the particular tactic and, if so, how frequently it was used in the previous six months. The original scale refers to the previous year, but for practical reasons around the timing of the DSFS therapeutic sessions it was more appropriate to ask about a six-month time frame. Thus, higher scores in each subscale reflect greater experience of the tactic as a perpetrator or victim in the six months prior to survey completion.

- The **Conflict Tactics Scale Parent-Child (CTSPC;** Straus, Hamby, McCoy, & Sugarman, 1996) captures psychological and physical maltreatment and neglect of children by their primary caregiver, as well as nonviolent modes of discipline. The short-form 10-item instrument asks both parents to report on the tactics they employ when they encounter conflict with their child. Responses are divided into five discipline categories:
  - Corporal Punishment (e.g. *"Spanked child on the bottom with bare hand"***)**
  - Physical Abuse (e.g. *"Hit child on the bottom with something like a belt, hairbrush, a stick or some other hard object?"***)**

- Neglect (e.g. *"Had to leave child home alone, even when you thought some adult should be with him/her"***)**
- Nonviolence Discipline (e.g. *"Explained why something was wrong"***)**
- Psychological Aggression (e.g. *"Shouted. yelled. or screamed at child"***)**

Respondents indicate if they have used the particular tactic with their child and, if so, how frequently it was used in the previous six months. The original scale refers to the previous year, but for practical reasons around the timing of the DSFS theraputic sessions it was more appropriate to ask about a six-month time frame. Thus, higher scores in each subscale reflect greater application of the tactic in the six months prior to survey completion.

- Parents' mental health was assessed using the 10-item **Clinical Outcomes in Routine Evaluation (CORE-10**; Barkham et al., 2013**)** screening tool that assesses a person's psychological distress over the last week. Items include "I have felt tense, anxious or nervous" or "I have felt panic or terror" and respondents rate each one on a five-point scale from 'none of the time' to 'most of the time'. The minimum score that can be achieved is 0 and the maximum is 40. The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distress they are experiencing.

- Parents' perceptions of their relationships with their children were assessed by the **Child-Parent Relationship Scale** (**CPRS**; Pianta, 1992). This 15-item scale taps into both 'closeness' (e.g. *'I share an affectionate, warm relationship with my child')* and 'conflict' (*'My child and I always seem to be struggling with each other'*) experienced between parents and their sons and daughters. Statements are rated on a five-point scale from 'definitely does not apply' to 'definitely applies'. Scores for the Closeness subscale can range from 7 (low levels of closeness) to 35 (high levels of closeness) while on the Conflict

subscale scores can range from 8 (low levels of conflict) to 40 (high levels of conflict).

- The **Psychological Maltreatment Inventory** (**PMI**; Tolman, 1999) is a 14-item scale designed to assess psychological abuse experienced in a relationship. This instrument measures the conflict tactic behaviours of both partners in the previous six months and differentiates between two types of psychological maltreatment: domination/isolation and emotional/verbal abuse. Items on the dominance/isolation subscale reflect behaviours such as isolation from resources, demands for subservience, monitoring partner's time and interfering in their relationships with other family members and friends. Items on the emotional/verbal subscale depict behaviours such as verbal attacks, behaviours that disrespect and demean the partner, and withholding emotional resources. Respondents were asked to assess their own and their partner's behaviour at Time 1 and Time 2 by indicating if the tactics were used by them or used on them either 'never', 'rarely', 'occasionally', 'frequently', or 'very frequently'. Scores on the subscales can range from 0 to 28 with higher scores indicating greater exposure to the particular form of abuse.

The above measures and their administration were continually reviewed and refined throughout the implementation of the evaluation survey. This is not the final word on the best measures to use to best capture the outcomes of interest and their change over the course of treatment, but it is a significant step forward in the process of getting there. In addition, although the focus of the present report is on the objective measures noted above, the learning process within which their application and meanings are situated should be acknowledged.

IMPLEMENTATION

The surveys were administered to clients in person by DSFS Family Workers between July 2017 and June 2019. The partners of each new case were informed of the purpose of the survey and invited to participate. At Time 1 the participation rate was 52% of all adults referred to, and attending, services[6].

The objective was to collect Time 1 data upon take up of the service and then repeat the exercise close to completion of the work, Time 2. It was a matter of the Family Workers' professional judgments as to when the optimum time for data collection may be achieved. As a general rule the earlier and later the better, but these goals had to be held in tension with the realities that (i) a relationship may need to be established to facilitate full and honest participation with respect to answers given and that (ii) partners may have limited investment in such activity when it comes to their final session in the service. Thus, as a guide, it was recommended that Time 1 data would be collected within one to three sessions of the case being opened, and Time 2 data completed following the Final Review meeting.

The purpose of the survey questionnaire was to generate aggregated data that would enable a view to be formed as to pre-post service changes; the purpose was not for individual assessment. The only exception to this rule is in situations where, during the course of data collection, the person being interviewed mentions something by way of an aside that which might indicate danger to themselves or others. In such cases, in accordance with Children First: National Guidelines for the Protection and Welfare of Children (2017) and the policies and procedures of

[6] Service-users who declined to take part in the research survey did so for a number of reasons. Most commonly it is reported that they presented to the Service in a distressed state so that participating in the survey may have been beyond their capacity at a point when they were yet to build rapport with their Family Worker and disclose sensitive information about their lives.

the Daughters of Charity Child and Family Services, all disclosures of child protection concerns are reported to Tusla.

OUTLINE OF THE REPORT

Chapter Two that follows reports on the child, parent, family and household characteristics of the service users. Chapter Three focuses on responses to the measures of domestic violence so that a picture is presented of the type and frequency of conflict between parents and between parents and their children before engaging with DSFS and at the end of treatment. Analyses are also conducted to determine if families attending DSFS experienced positive changes in their mental health and their relationship with their children from Time 1 to Time 2. Finally, the last chapter, Chapter Four, provides concluding statements and some recommendations for taking forward the aim of making services ever more effective.

Chapter Two

Who are the Service Users?

This chapter describes key characteristics of the families who attend DSFS and agreed to complete our survey. Information presented here represents data collected from 63 families (38 fathers and 56 mothers) who completed Time 1 surveys as of July 2019.

CHILD CHARACTERISTICS

Parents were asked to identify which of their children they had the most concerns about. The characteristics of this child can be seen in Table 1 below. Slightly more boys (55%) than girls (45%) were recorded, with ages ranging from 9 months to 18 years. The largest proportion of children (38.2%) fell into the 1-7 years age bracket. The majority of children were Irish (73%) and spoke English as their native language (70.5%). Just two children (3.4%) were noted as living apart from their family.

Table 1. *Key characteristics of children*

		N	%
Gender	*Male*	33	55%
	Female	27	45%
Age	*<1*	1	1.8%
	1-7	21	38.2%
	8-12	18	32.7%
	13-16	13	23.6%
	17-19	2	3.6%
Nationality	*Irish*	46	73%
	Other	17	27%
Language	*English*	43	70.5%
	Other	18	29.5%
Lives with family	*Yes*	57	96.6%
	No	2	3.4%

PARENT CHARACTERISTICS

Table 2 on the following page details some key characteristics of the parents engaging with DSFS who participated in our survey. Respondents represented all age categories but the largest proportion were aged between 30-39 years and reported that they first became parents when in their twenties. A similar number of Irish and non-Irish parents participated. The majority of parents were still living with their family, though this was true of significantly fewer fathers (63.2%) than mothers (94.4%). All mothers reported that they were the biological parent of the child that they identified as having most concerns about. The majority of fathers (97%) were also biological parents or a legal guardian, with just one male participant reporting that he was unrelated or the partner of the child's mother.

Table 2. *Key characteristics of fathers and mothers*

		Fathers N= 38		Mothers N = 56	
		N	%	N	%
Age	*20-29*	8	21.6%	16	29.1%
	30-39	13	35.1%	21	38.2%
	40-49	13	35.1%	18	32.7%
	50-59	3	8.1%	-	-
Nationality	*Irish*	20	52.6%	29	51.8%
	Polish	5	13.2%	5	8.9%
	Nigerian	3	7.9%	2	3.6%
	Other	10	26.2%	20	35.6%
Native Language	*English*	21	55.3%	28	50%
	Other	16	44.7%	28	50%
Age when first became a parent	*≥ 19*	5	13.5%	17	30.9%
	20-29	21	56.8%	31	56.4%
	30-39	10	27%	7	12.7%
	40-49	1	2.7%	-	-
Lives with Family	*Yes*	24	63.2%	51	94.4%
	No	14	36.8%	3	5.6%
Relationship to Child	*Biological parent*	32	94.1%	50	100%
	Step-parent or legal guardian	1	2.9%	-	-
	Unrelated/Parent's Partner	1	2.9%	-	-

Figure 1 below illustrates the highest level of education achieved by parents. Just 5.5% of mothers had not progressed beyond primary-level education in comparison with 21.1% of fathers. At the other end of the continuum, half (50.9%) of mothers had attained third level certificates, diplomas, primary or postgraduate degrees, compared with just under one third (29%) of fathers.

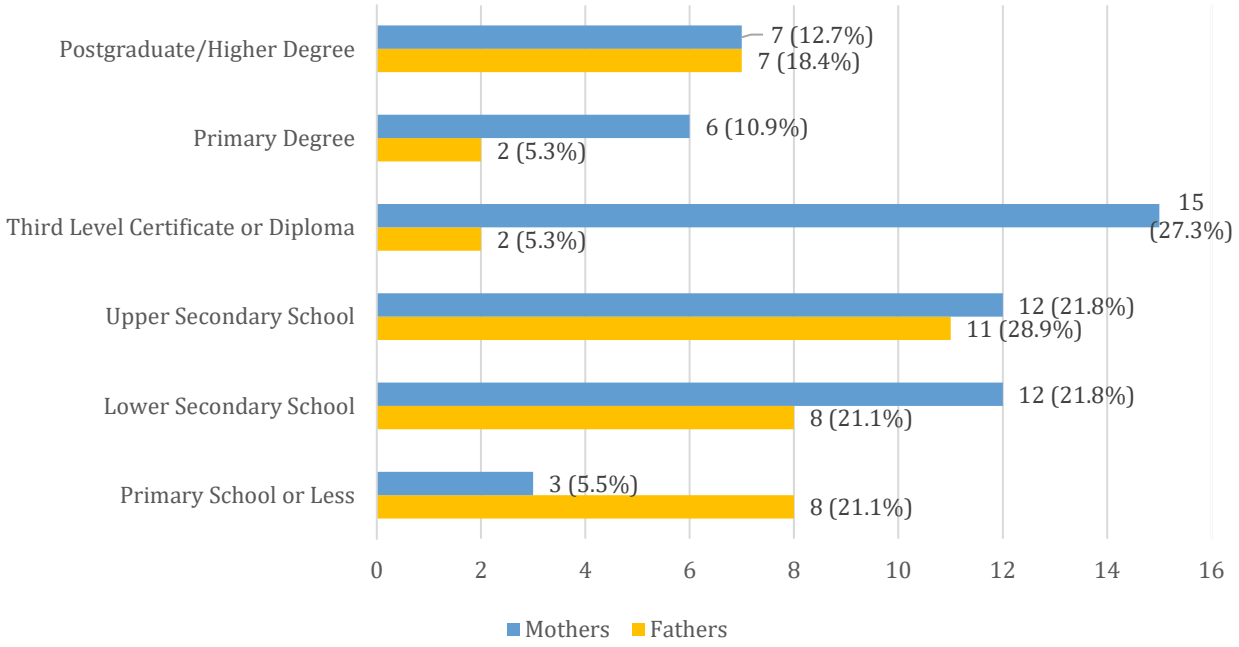

Figure 1. *Highest level of education achieved by mothers and fathers*

Parents reported the length of their relationship with their partner. Some were together less than four years while others reported that they were in a relationship with their partner twenty years or longer. The time category with the greatest number of parents (33.3%) represented those who were together between five and ten years (Figure 2).

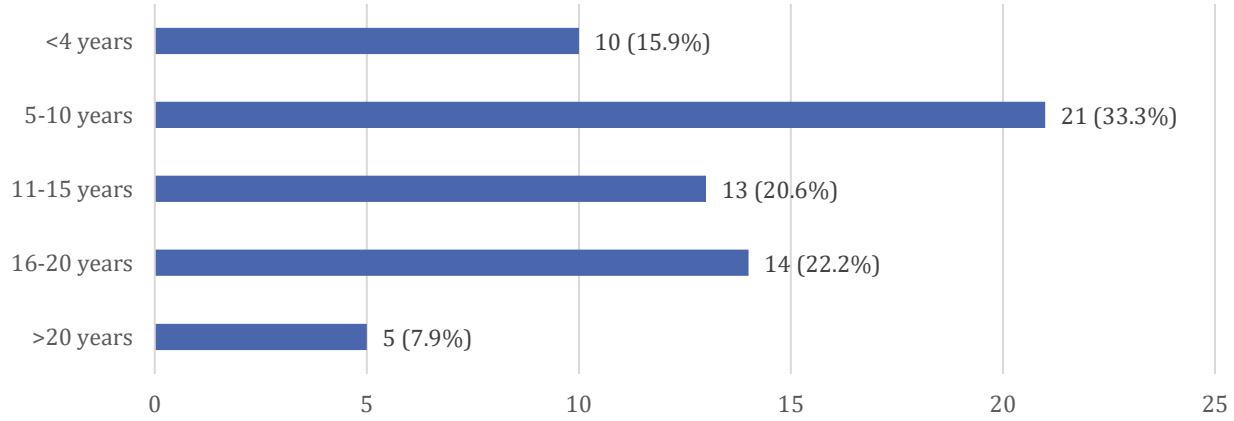

Figure 2. *Length of time parents report being in a relationship together*

At Time 1 almost half of parents were living together, either as married/civil partners (25.4%) or as unmarried partners (23.8%). Almost forty percent (39.6%) of married/civil partnered and unmarried parents were living apart. Just over ten percent of parents reported that they were separated or divorced. See Figure 3.

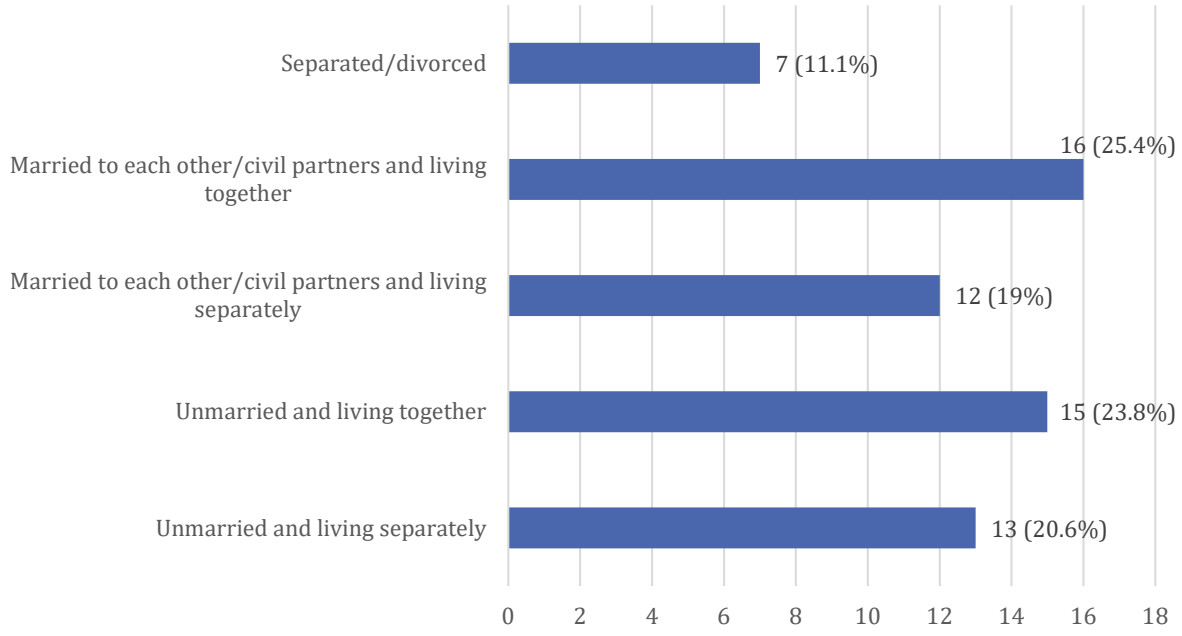

Figure 3. *Relationship of partners to each other*

FAMILY CIRCUMSTANCES

In terms of accommodation, the majority of respondents lived in a house (57.1%), followed by an apartment, flat, or bedsit (30.2%). Other forms of accommodation reported by the remaining 12.7% included homeless shelter, direct provision centres or halting site. See Figure 4.

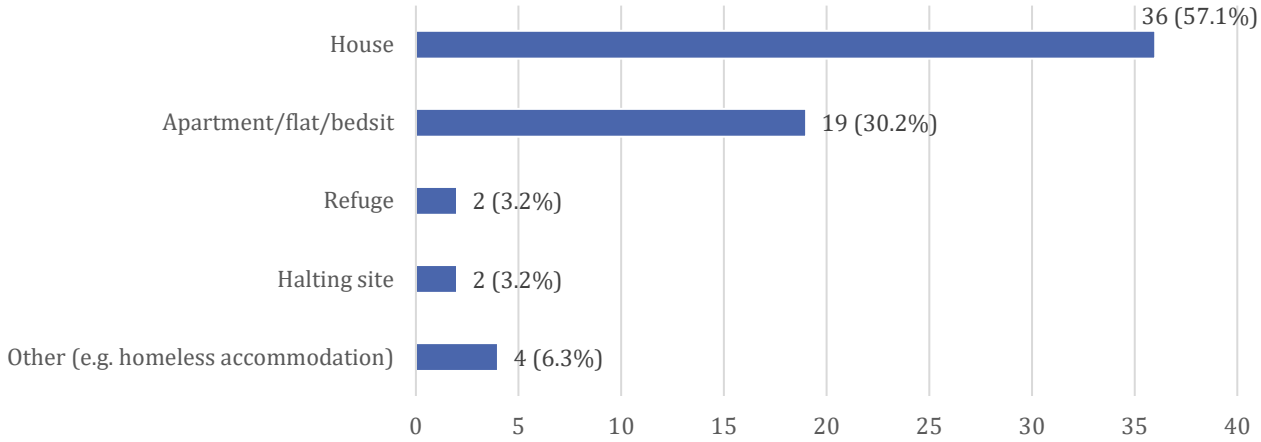

Figure 4. *Family accommodation*

Families were relatively evenly split between those whose primary household income came from wages or salaries (52.4%) and those in receipt of social welfare payments (42.9%). Other sources cited included direct provision and income from self-employment. See Figure 5.

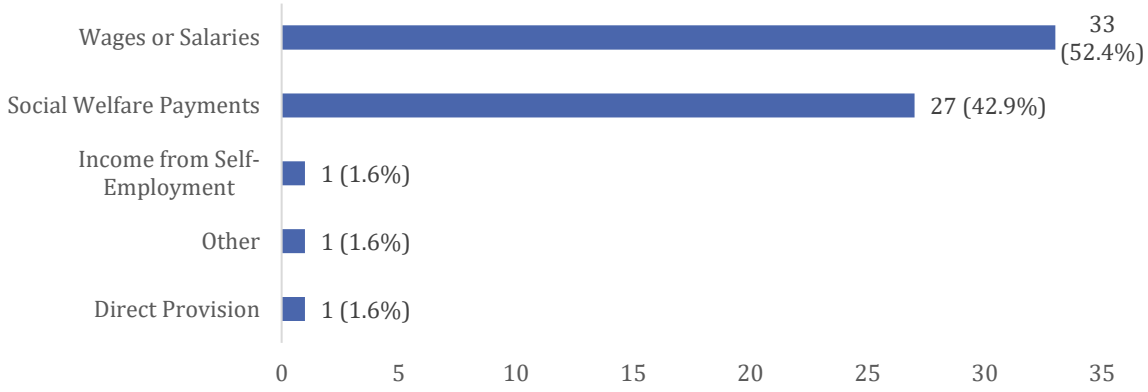

Figure 5. *Family income: Main source*

In terms of the degree of ease or difficulty parents reported being able to 'make ends meet', the majority of respondents reported that they experienced 'some level of difficulty' (50.8%) or 'great difficulty' (15.9%). Approximately one third of families stated that they had no such financial issues. See Figure 6.

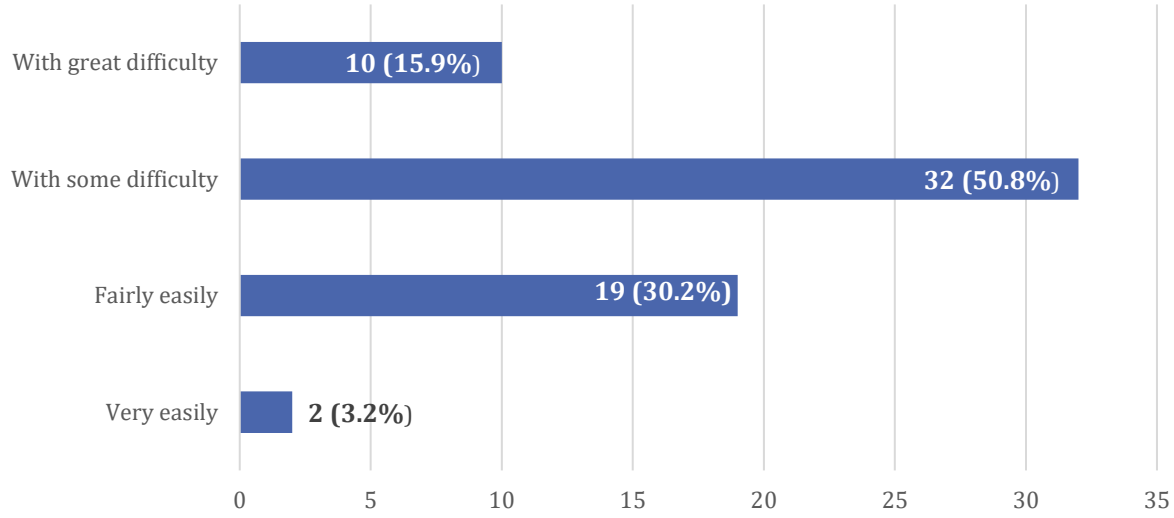

Figure 6. *Family income: Ability to 'make ends meet'*

Just over half (55.6%) of families indicated that they were receiving therapeutic and/or support services in addition to what they were receiving from DSFS. These included help from a range of services providing counselling, parenting, and homeless supports.

Out of the 63 families who were engaged with our survey at Time 1, 37 had Court issued safety orders in effect. The different types of orders are depicted in Figure 7 on the following page.

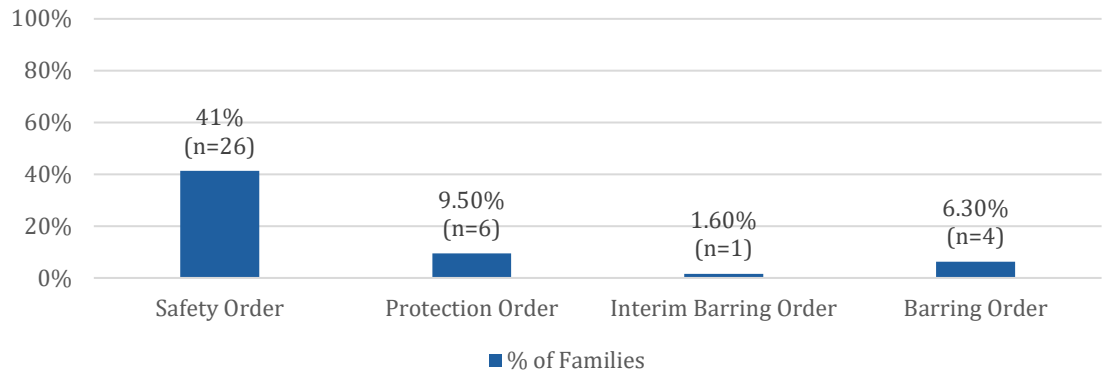

Figure 7. *Court issued safety orders in effect at time of data collection*

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

The 10-item Adverse Childhood Experiences (ACE - http://www.acestudy.org/the-ace-score.html) survey counts exposure to a range of traumatic life situations or events prior to an individual's 18th birthday. The factors in the survey include five of abuse directed against the individual (for example, *Did a parent or other adult in the household often or very often…swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?*) and five which are concerned with adverse family circumstances (for example, *Was a biological parent ever lost to you through divorce, abandonment, or other reason?*). An individual's final ACE score can range from zero (no adversities experienced) to ten (where the full range has been experienced). It is proposed that as scores increase, so too does the probability of an individual experiencing negative impacts on their wellbeing, as measured across a range of health and social circumstances across their life-course.

In the present study an additional item was added to the list of ten. The original ACE asks *"Was your mother/stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her* ***or*** *sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard* ***or*** *ever repeatedly hit over at least a few minutes or threatened with a gun or knife?"*. We extended the scale to ask the same question but in reference to the respondents' fathers or step-fathers.

Table 3 below details the number of fathers and mothers who reported experiencing each of the ACE items at any point in their childhood or adolescence. It also shows the number of parents who reported that their child had experienced each of the ACE items.

Table 3. *Number and percentage of parents reporting on ACEs for themselves and the child they have most concerns about*

	Fathers (n=38)	Fathers reporting on child	Mothers (n=56)	Mothers reporting on child
1. Did a parent…swear at you, insult you, put you down….	16 (42%)	13 (34%)	19 (34%)	24 (43%)
2. Did a parent…push, grab, slap, or throw something at you…	11 (29%)	8 (21%)	16 (29%)	13 (23%)
3. Did an adult…ever touch or fondle you…	2 (5%)	0	10 (18%)	0
4. Did you often feel…that no one in your family loved you…	12 (32%)	9 (24%)	17 (30%)	14 (25%)
5. Did you often feel…that you didn't have enough to eat…	5 (13%)	0	10 (18%)	4 (7%)
6. Was a biological parent ever lost to you through divorce, abandonment or other reason?	19 (50%)	8 (21%)	23 (41%)	20 (36%)
7. Was your mother…pushed, grabbed, slapped…	7 (18%)	14 (37%)	10 (18%)	25 (45%)
8. Was your father…pushed grabbed, slapped…	5 (13%)	10 (26%)	5 (9%)	13 (23%)
9. Did you live with anyone who was a problem drinker or alcoholic…	15 (39%)	11 (29%)	19 (34%)	23 (41%)
10. Was a household member depressed or mentally ill…	10 (26%)	15 (39%)	13 (23%)	22 (39%)
11. Did a household member go to prison?	10 (26%)	3 (8%)	8 (14%)	6 (11%)

For fathers and mothers attending DSFS approximately one fifth had experienced domestic violence as children between their own parents (17.5% of fathers and 20.6% of mothers reported witnessing physical abuse directed at either their mother or father, or both). A national representative household survey in England (Bellis, Hughes, Leckenby, Perkins, & Lowey, 2014) found this rate to be approximately 12%, though a similar rate of 21% was noted among an adult patient population in a medical general practice setting (Hardcastle & Bellis, 2018). However, many more parents in the present study also had experiences of other ACEs when compared to respondents to either the aforementioned studies. For example, 29% of DSFS parents reported physical abuse directed as children, in comparison with 14.3% in the general population sample and 17.8% in the patient sample. Childhood experiences of family members who had alcohol abuse issues were also reported by approximately three times as many parents in the present study, and reports of having family members who were incarcerated were 26% for DSFS fathers and 14% for DSFS mothers in comparison with 4% or less of respondents in the other samples. With the exception of reports of sexual abuse or neglect and a family member in prison, it is of concern that such a large proportion of parents also informed us that their children were presently experiencing the ACE items listed.

Figure 8 on the following page illustrates the number of adverse life events that fathers attending DSFS reported experiencing. Almost seventy nine percent (78.9%) of fathers encountered at least one adverse event as children or adolescents. Almost a third (31.5%) reported experiencing four or more.

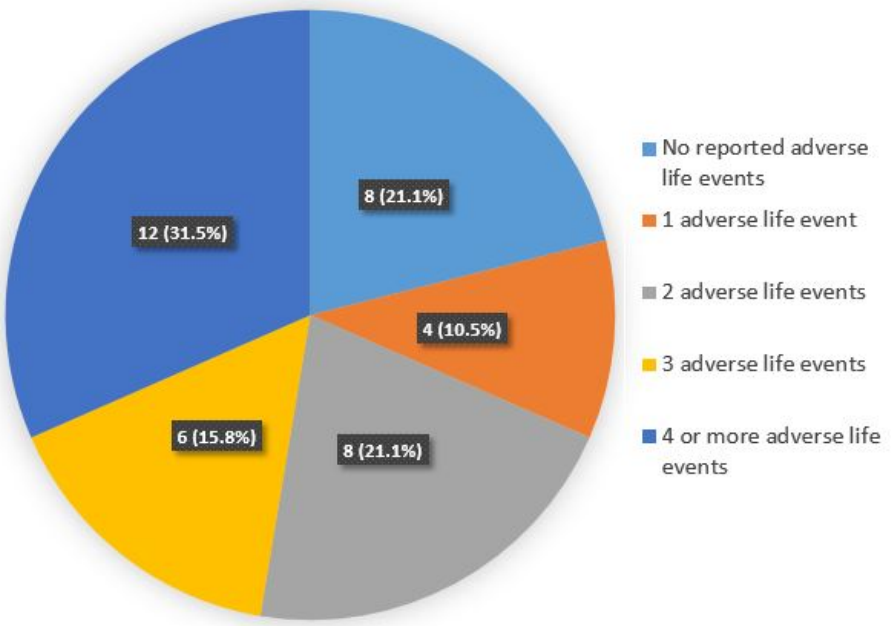

Figure 8. *Adverse Childhood Experiences: Fathers (N= 38)*

For mothers, 66.1% reported experiencing at least one adverse event in their childhood or adolescence, with 37.5% having experienced four or more such events (see Figure 9, below).

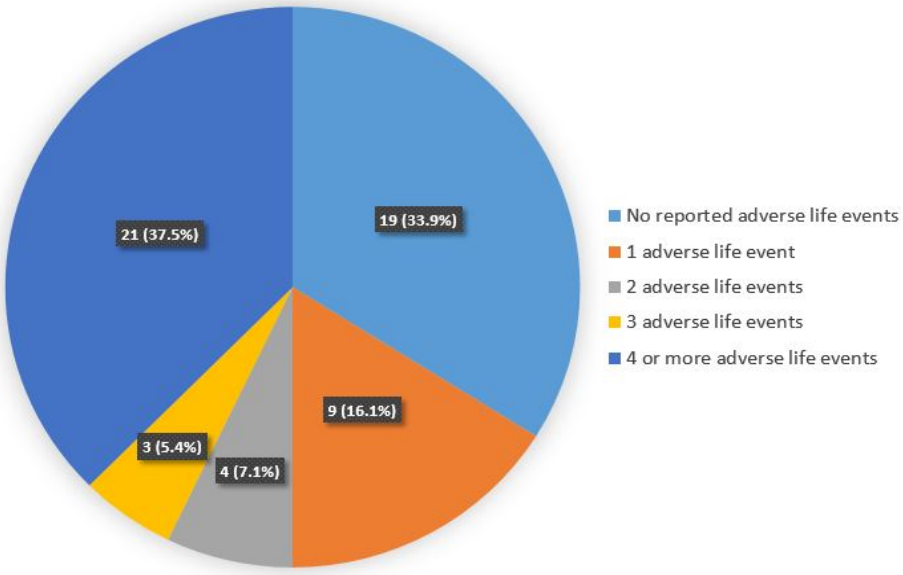

Figure 9. *Adverse Childhood Experiences: Mothers (N=56)*

Figures 10 and 11 below show the number of Adverse Childhood Experiences parents reported for the child that they are most concerned about in their family. Fathers reported fewer potentially traumatic events for their child than mothers did. For example, 26.3% of fathers reported no adverse events for their child, as opposed to 16.1% of mothers. However similar proportions of mothers and fathers reported that their child had experienced four or more stressful life events (36.8% of fathers versus 37.5% of mothers).

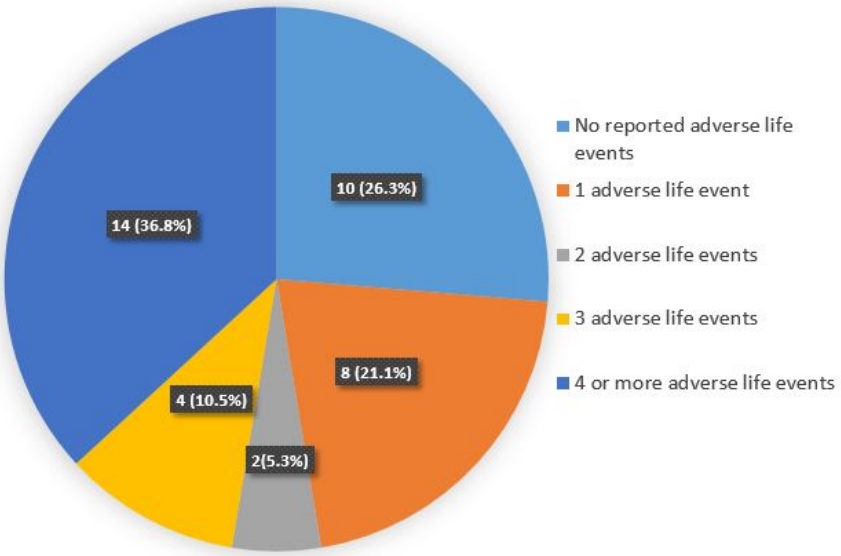

Figure 10. *Adverse Childhood Experiences: Father referring to child (N=38)*

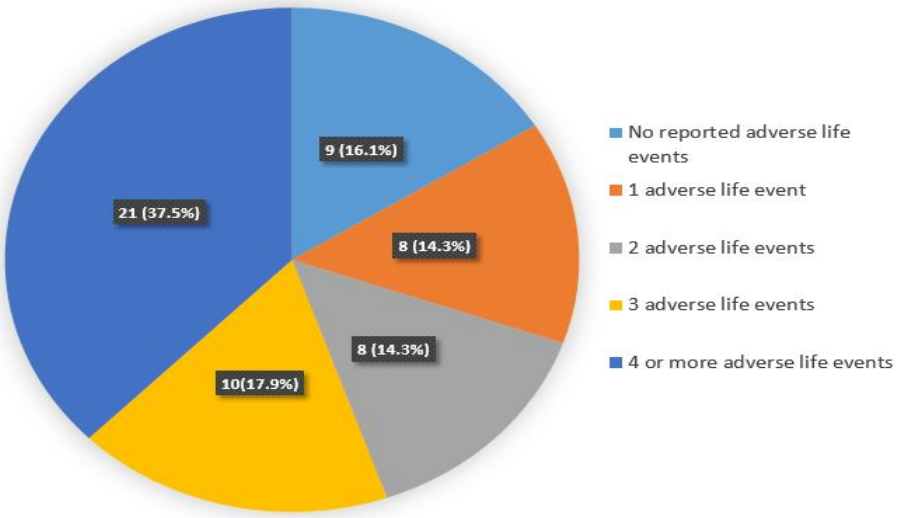

Figure 11. *Adverse Childhood Experiences: Mother referring to child (N= 56)*

A score of 'four or more' adverse experiences in childhood is often cited as the tipping point where an individual's cumulative stresses show a strong, graded association with many negative outcomes throughout the lifecourse. As points of comparison, 9% of respondents reported four or more ACES in Bellis et al. (2014) and this percentage was 14% in Hardcastle and Bellis (2018).

Chapter Three

What are the Outcomes of the Evaluation?

OVERVIEW

This chapter describes the analyses that were conducted to determine if families attending DSFS experienced positive changes as assessed using a range of outcome measures. To do this both partners were invited to complete the range of scales detailed in Chapter One prior to engaging with DSFS (pre-intervention or 'Time 1') and again after work with DSFS was complete (post-intervention or 'Time 2'). In order to assess whether the intervention had a measurable impact, average scale scores taken at Time 1 and Time 2 are statistically compared. If a significant change is observed, in the desired direction, this is an indication of positive change in pre- to post-intervention scores. Observations of the statistical effect size are then made to determine the magnitude of improvement. The diagram below provides information on how statistically significant changes and related effect sizes are determined.

Interpreting statistically significant change

- Statistical analyses inform us if any change between Time 1 and Time 2 average scores on a measure is 'significant'. The '*p*' values that analyses produce refer to the probability that the changes observed are only due to chance. Typically, *p* values must be below 5% in order to confidently say that the change in scores is statistically significant. Thus, a $p < .05$ could only have occurred by chance 5 times out of 100, or a $p < .01$ could only have occurred by chance 1 times out of 100.

Interpreting effect sizes

- Where statistically significant change is observed, the magnitude of this change is evaluated by calculating effect sizes. A Cohen's d analysis is conducted. By convention, a Cohen's *d* value of 0.2 can be considered a 'small' effect size, 0.5 represents a 'medium' effect size and 0.8 a 'large' effect size.

At Time 1, 38 fathers and 58 mothers completed the surveys and, at the time of data input and analysis, 19 fathers and 28 mothers had completed the follow-up surveys at Time 2[7]. Nineteen couples participated fully at both data collection time points. The comparative analysis of Time 1 and Time 2 data that follows applies to the sample of parents who completed the relevant scales in both surveys.

CONFLICT BETWEEN PARTNERS

The **Conflict Tactics Scale**-2 (CTS-2) is a widely used instrument for measuring negotiation as well as psychological and physical attacks on a partner in a marital, cohabiting, or dating relationship. It is one of the most widely used instruments for measuring intimate partner violence that taps into the conflict tactic behaviour of both partners, both from their own perspective and from the perspective of their partner. The measure consists of 20 items that are divided into five categories; "Negotiation", "Psychological Aggression", "Physical Assault", "Sexual Coercion" and "Injury". Higher scores in each category reflect greater application of the tactic in the six months prior to survey completion.

Figures 12-15 show changes in prevalence rates of each behaviour by partners' sex. That is, the number of respondents, male and female, who reported either being a victim or perpetrating a behaviour at least once over the previous 6 months, as reported at Time 1 and Time 2. As can be seen, the prevalence rates of aversive conflict tactics decreased from Time 1 to Time 2 for both partners.

[7] Additional analyses were performed to compare parents who completed Time 1 and Time 2 surveys with parents who disengaged with the service and only completed the survey at Time 1. The results of these analyses are available in Appendix B.

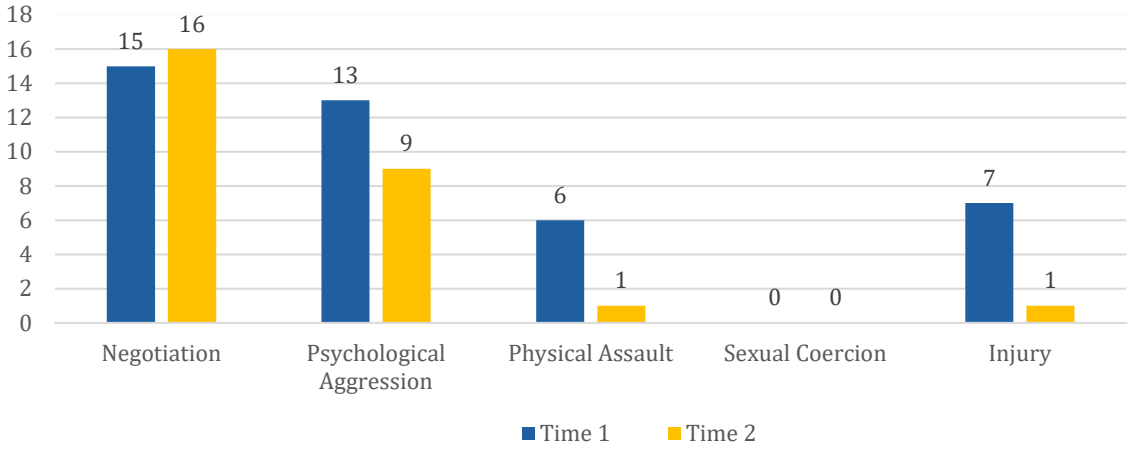

Figure 12. *Prevalence of psychological and physical attacks reported by fathers (n=18): Being a victim.*

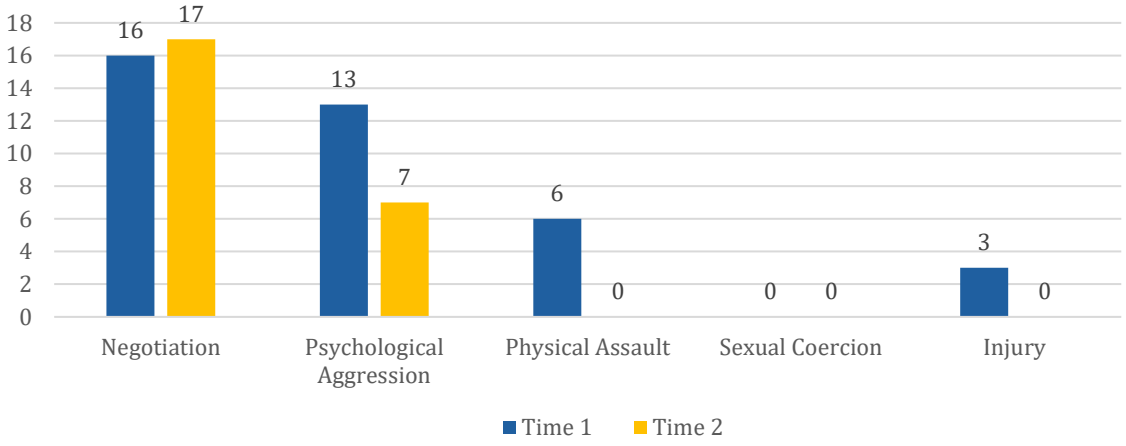

Figure 13. *Prevalence of psychological and physical attacks reported by fathers (n=18): Being a perpetrator.*

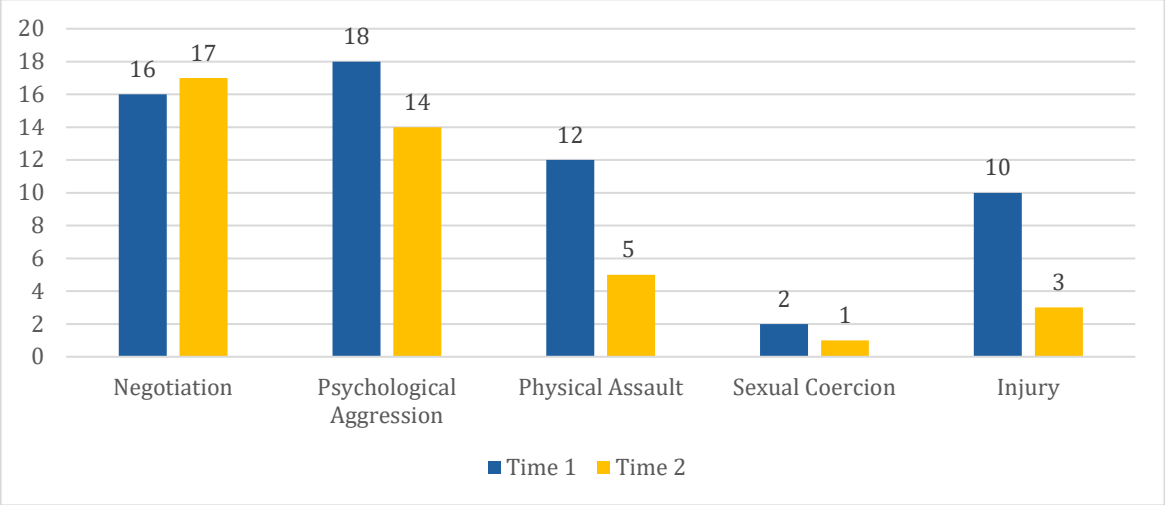

Figure 14. *Prevalence of psychological and physical attacks reported by mothers (n=27): Being a victim.*

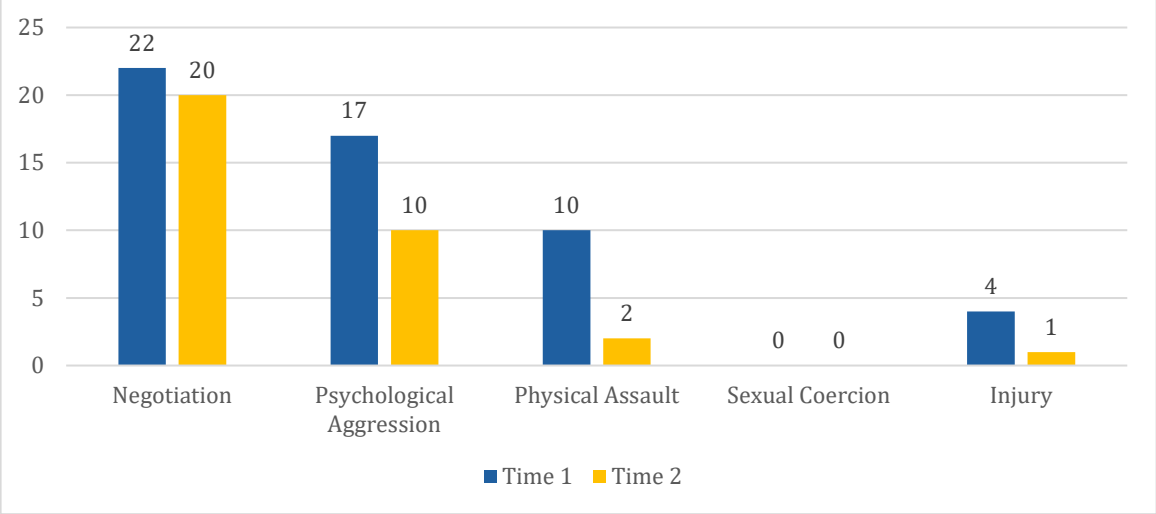

Figure 15. *Prevalence of psychological and physical attacks reported by mothers (n=27): Being a perpetrator.*

Figure 16 below shows the average frequency for all domestic violence attacks (i.e. the sum of all psychological and physical attacks, excluding "negotiation" behaviours) as experienced by parents as either victims or perpetrators in the six months prior to Time 1 and then between Time 1 and Time 2. The decline in domestic violence at Time 2 was statistically significant with regard to fathers as both victims ($t(13)= 3.09$, $p<0.00$, effect size=0.96) and perpetrators ($t(16)= 2.93$, $p<0.05$, effect size=0.68), and mothers as both victims ($t(24) = 3.16$, $p<0.05$, effect size=0.66) and perpetrators ($t(24)= 2.48$, $p<0.05$, effect size=0.05). These significant findings hold true even when analysis is conducted just with parents who are still cohabiting at Time 2. Thus, the reduction in conflict cannot be attributed to partners no longer being in contact with each other.

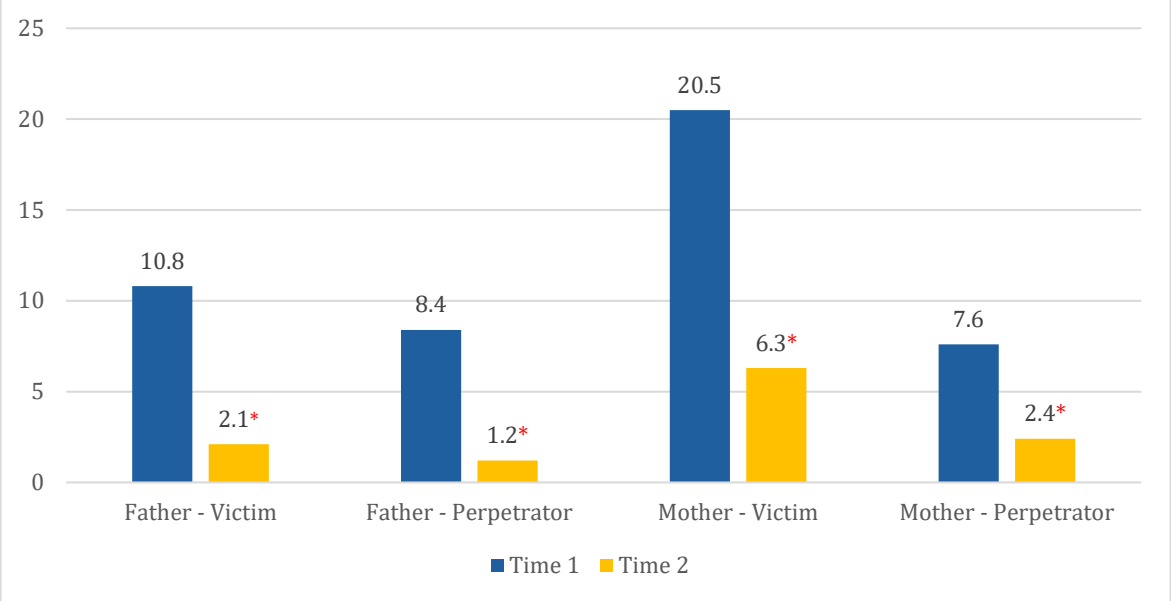

Figure 16. *The average frequency of all psychological and physical attacks at Time 1 and Time 2.*

* *highlights statistically significant change*

Figure 17 shows the average frequency of using and/or experiencing minor conflict tactics among the respondents in the last six months, as reported at Time 1 and Time 2. Minor conflict tactics include "*I insulted, swore, or shouted or yelled at my partner*" or "*I pushed, shoved, or slapped my partner*". Average frequencies

decreased significantly over time for fathers and mothers, as both victims (Fathers: $t(16) = 3.36$, $p<0.00$, effect size=1.01; Mothers: $t(25) = 3.43$, $p<0.05$, effect size=0.68) and perpetrators (Fathers: $t(16) = 2.96$, $p<0.5$, effect size=0.7; Mothers: $t(25) = 2.46$, $p<0.05$, effect size= 0.5).

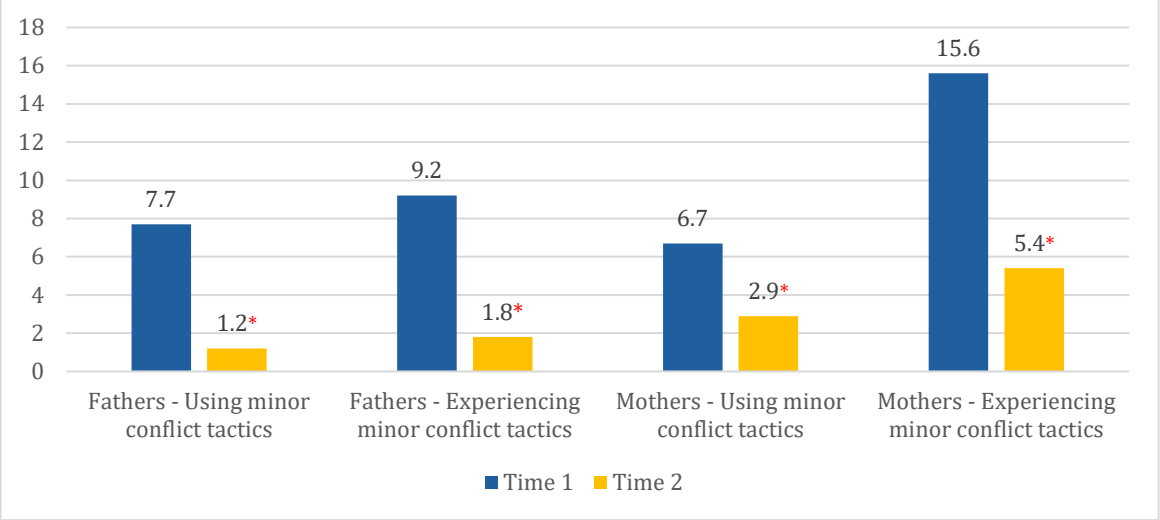

Figure 17. *The average frequency of using and/or experiencing minor conflict tactics in the last 6 months as reported at Time 1 and Time 2*

* *highlights statistically significant change*

Finally, Figure 18 shows the average frequency of using and/or experiencing severe conflict tactics among the respondents in the last six months, as reported at Time 1 and Time 2. Severe conflict tactics included psychological and physical acts such as "*I punched, kicked or beat up my partner*" or "*I used force (like hitting, holding down or using a weapon) to make my partner have sex*". The average frequency of using and/or experiencing severe conflict tactics was low at Time 1 and, although decreased further by Time 2, these changes are marginally above the statistically significant cut-off point of $p<.05$ (p values ranged from 0.055 to 0.067).

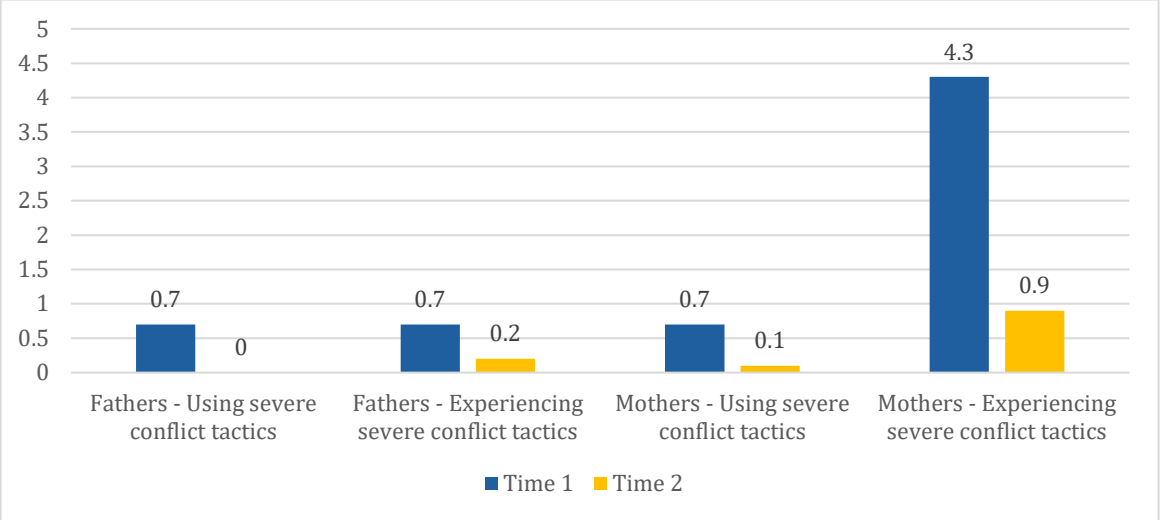

Figure 18. *The average frequency of using and/or experiencing major conflict tactics in the last 6 months as reported at Time 1 and Time 2*

* *highlights statistically significant change*

In order to capture the various presentations of psychological aggression in relationships the 14-item **Psychological Maltreatment Inventory** (PMI) was administered. This instrument measures the conflict tactic behaviors of both partners in the previous six months and differentiates between two types of psychological maltreatment: domination/isolation and emotional/verbal abuse. Items on the dominance/isolation subscale reflect behaviours such as isolation from resources, demands for subservience, monitoring partner's time and interfering in their relationships with other family members and friends. Items on the emotional/verbal subscale depict behaviours such as verbal attacks, behaviors that disrespect and demean the partner and withholding emotional resources. Respondents indicate if the behaviour occurs, and if so, if it occurs *rarely*, *occasionally*, *frequently* or *very frequently*. Scores for each subscale can range from 0 (behaviour never occurs) to 28 (behaviour occurs very frequently).

Respondents were asked to assess their own and their partners' behavior at Time 1 and Time 2. With regard to emotional or verbal abuse at Time 1, 88.2% of fathers reported some degree of perpetration and 90% reported some degree of victimisation. This decreased to 55.6% being perpetrators and 64.7% being victims

by Time 2. With regard to dominance or isolation at Time 1, 48.4% of fathers reported some degree of perpetration and 75.9% reported some degree of victimisation. This decreased to 31.2% being perpetrators and 33.3% being victims by Time 2. For mothers at Time 1, 88% reported some degree of emotional abuse perpetration and 94% reported some degree of victimisation. This decreased to 73.9% being perpetrators and 64.7% being victims by Time 2. With regard to dominance or isolation at Time 1, 60% of mothers reported some degree of perpetration and 85.1% reported some degree of victimisation. This decreased to 40.9% being perpetrators and 63.6% being victims by Time 2. Thus, the percentages of parents who report using or experiencing psychological abuse tactics are dropping, but remain high.

Figure 19 shows changes in the average frequency with which fathers and mothers used or experienced psychological abuse in their relationship in the last six months. As can be seen, the average frequency scores of both being a victim and a perpetrator of psychological abuse decreased over time among male and female respondents. These changes were statistically significant with regard to being both a victim and perpetrator of emotional abuse for fathers (Victim: $t(17)=2.91$, $p<.01$, effect size=0.57; Perpetrator: $t(16)=4.49$, $p=.000$, effect size=1.23) and mothers (Victim: $t(25)=2.46$, $p<.05$, effect size=0.48; Perpetrator: $t(24)=3.20$, $p<.01$, effect size=0.72). Though a reduction was noted for both parents in all Time 2 total scores for behaviours meant to dominant or isolate, these observed changes were not statistically significant.

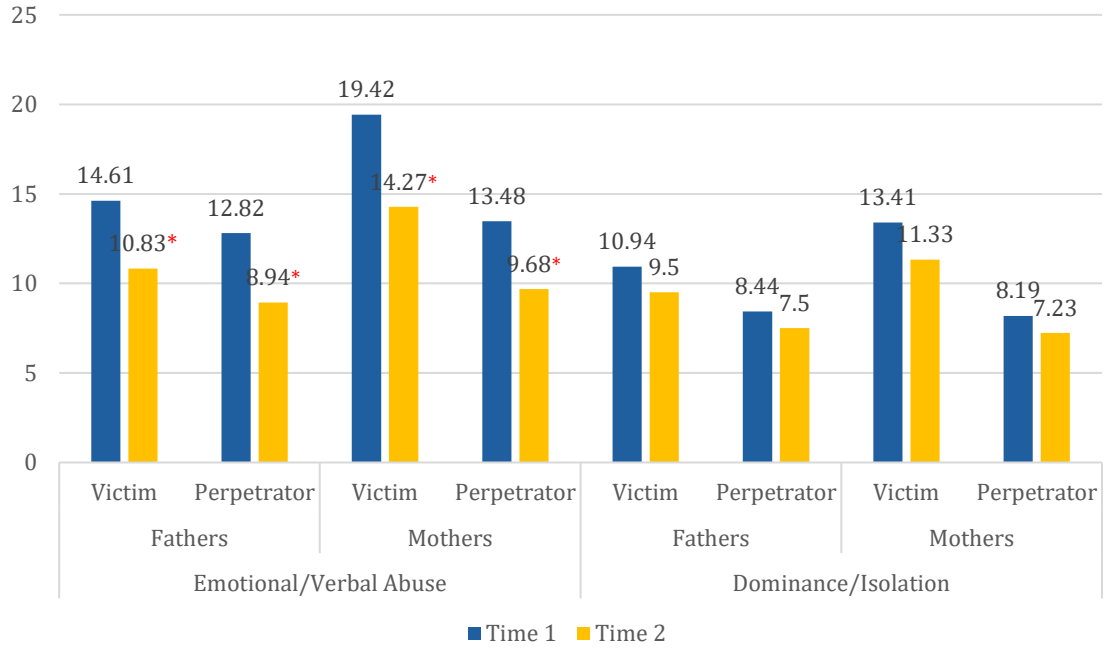

Figure 19. *The average frequency of psychological abuse reported by fathers and mothers*

* *highlights statistically significant change*

PARENTS' PSYCHOLOGICAL DISTRESS

The **Core-10** is a 10-item brief screening tool that taps into person's psychological distress over the last week. Items include "I have felt tense, anxious or nervous" or "I have felt panic or terror" and respondents rate each one on a five-point scale from 'none of the time' to 'most of the time'. The minimum score that can be achieved is 0 and the maximum is 40. The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distress they are experiencing.

Within the clinical range, the scores 0-10 signify 'healthy' or 'low level' of psychological distress; 11-15 marks the 'mild' level; 16-20 marks the 'moderate' level; and the 21-25 range signifies the 'moderate-to-severe' level of psychological distress. A score over 25 marks the 'severe' level of psychological distress.

At Time 1 53.8% of parents were in the 'low level' of psychological distress category, 26.4% reported mild issues, 9.9% reported moderate issues, and 4.4% could be categorized as having severe mental health difficulties. Overall for fathers the average clinical score was 10.7 (*SD*=7.524; score range from 0 to 27) and for mothers the average clinical score was 10.0 (*SD*=6.44; score range from 0 to 29). Although these scores are just on the threshold of mild psychological distress, they are still more than twice the norm reported by scale developers for the general population (4.7). A comparison of Time 1 with Time 2 scores for both parents show statistically significant improvements in psychological wellbeing for both mothers ($t(26)=2.317$, $p<.029$, effect size=0.36) and fathers ($t(17)=2.465$, $p<.025$, effect size=0.58) from pre-intervention to post-intervention.

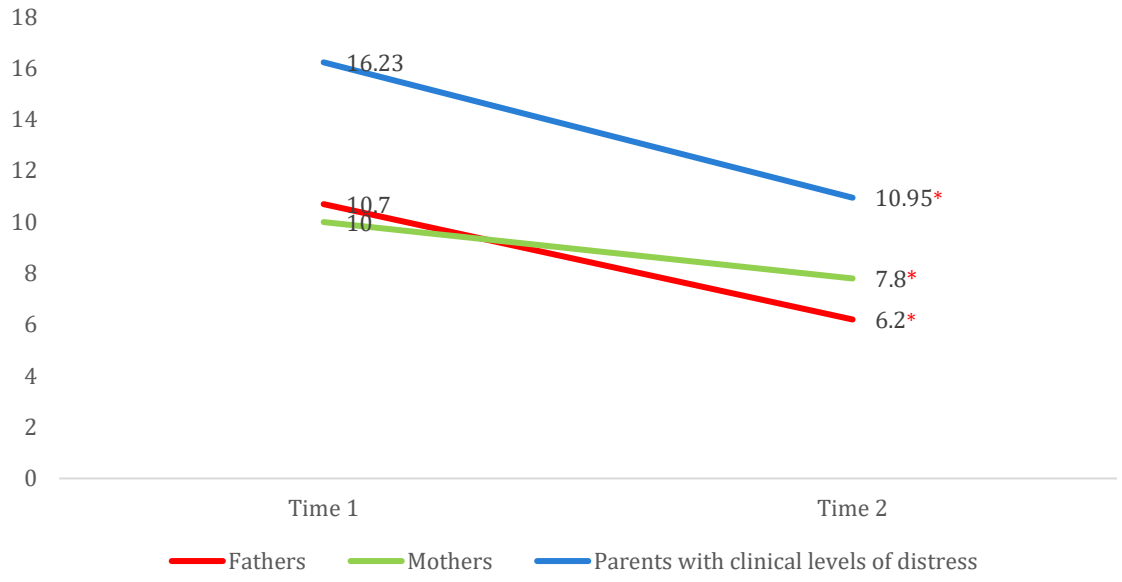

Figure 20. *Scores on psychological wellbeing (Core-10) for fathers (n=18), mothers (n=27), and parents reporting clinical levels of distress (n=21) from Time 1 to Time 2*

* *highlights statistically significant change*

Taking just those parents (46.2% of respondents) who reported mild to severe levels of psychological distress at Time 1 and comparing their scores before and after the intervention showed a statistically significant decrease in distress from a mean score of 16.23 (*SD*=5.26) at Time 1 to 10.95 (*SD*=8.13) at Time 2 ($t(18)=3.176$,

p<.005, effect size=0.77). Furthermore, this sizeable reduction in average distress scores from Time 1 to Time 2 is indicative of clinically significant change as well as statistically significant change.

PARENT-CHILD RELATIONSHIP

The **Child-Parent Relationship Scale** (CPRS) is a self-report instrument completed by both parents separately to assess parents' perceptions of their relationships with their children. The 15 items used in this present study were rated on a 5-point Likert scale ranging from 'completely agree' to 'completely disagree' and the ratings were summed into groups of items corresponding to *Closeness* and *Conflict* subscales which represent two distinct domains of parent-child relationships:

- The 7-item *Closeness* scale assesses the extent to which a parent feels that the relationship with a child is characterized by warmth, affection, and open communication. Scores on the CPRS Closeness scale can range from 7-35 with higher scores indicating closer relationships between a parent and their child.
- The 8-item *Conflict* subscale measures the degree to which a parent feels that his or her relationship with a particular child is characterized by negativity. Scores on the CPRS *Conflict* scale can range from 8-40 with higher scores indicating more tense or conflictual relationships between a parent and their child.

Figures 21 and 22 illustrate changes in CPRS *Closeness* and *Conflict* average scores over time for parents who completed Time 1 and Time 2 surveys. For fathers a decline was noted in reported closeness and conflict with their children, while for mothers closeness increased and conflict decreased. However, these changes were generally slight and not found to be statistically significant.

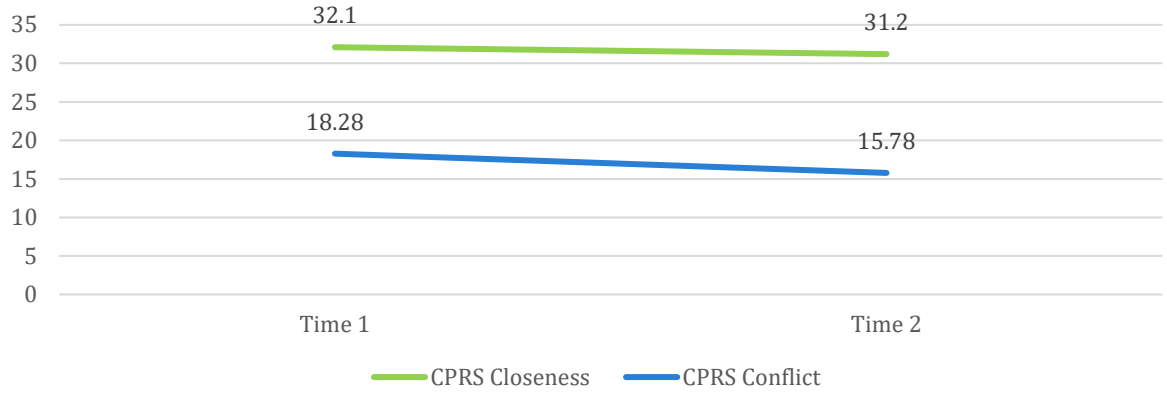

Figure 21. *Changes in CPRS Closeness and Conflict scores from Time 1 to Time 2 for fathers (n=18)*

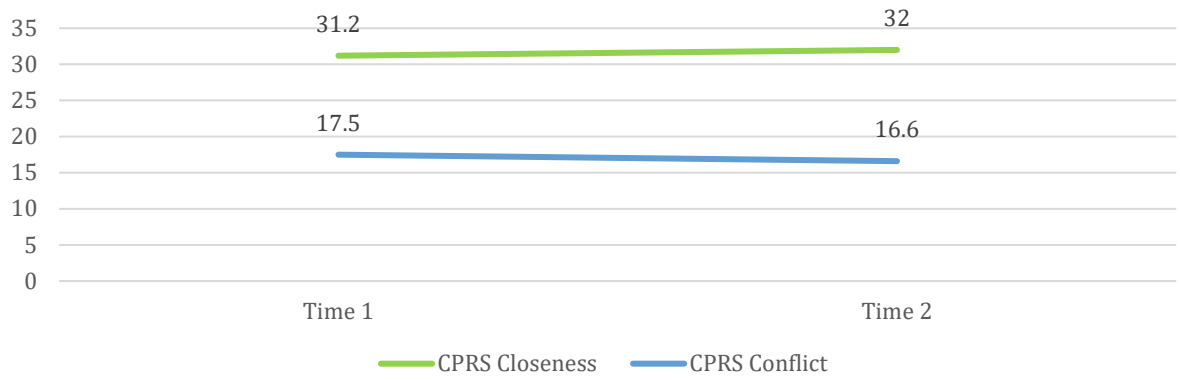

Figure 22. *Changes in CPRS Closeness and Conflict scores from Time 1 to Time 2 for mothers (n=27)*

It should be noted that the average closeness scores observed for both parents are similar to that found in the general population. For example, data from Growing Up in Ireland (GUI) shows that parents of 5 year-olds have an average closeness score of 33.7 for mothers and 32.9 for fathers (Murray, McNamara, Williams, & Smyth, 2019). At age 13 fathers report an average closeness score of 31 and mothers' average score is 32 (Williams et al., 2018). Thus, closeness scores on this scale tend to have a skewed distribution, with the majority of parents reporting positively on their relationship with their children.

With regard to conflict, parents here report relationships that are more conflictual than that reported by the national sample in GUI. For example, for children at age 13, GUI parents report an average score of 15 out of a possible 35. In the present sample parents' scores are getting closer to this national average by Time 2, but are still a little higher.

PARENT-CHILD CONFLICT TACTICS

The short-form **Conflict Tactics Scale Parent-Child** (CTSPC) instrument captures psychological and physical maltreatment and neglect of children by their primary caregiver, as well as non-violent modes of discipline. The 10-item measure asks both parents to report on the tactics they employ when they encounter conflict with their child and their responses are divided into five discipline categories; "Corporal Punishment", "Physical Abuse", "Neglect", "Nonviolence Discipline", and "Psychological Aggression". Higher scores in each category reflect greater application of the tactic in the six months prior to survey completion.

Figures 23 and 24 show the prevalence of specific maltreatment and non-violent discipline occurring at least once in the past six months, as reported at both Time 1 and Time 2 by both fathers and mothers. Among fathers, the prevalence of child maltreatment decreased over time, while non-violent disciplining remained the same.

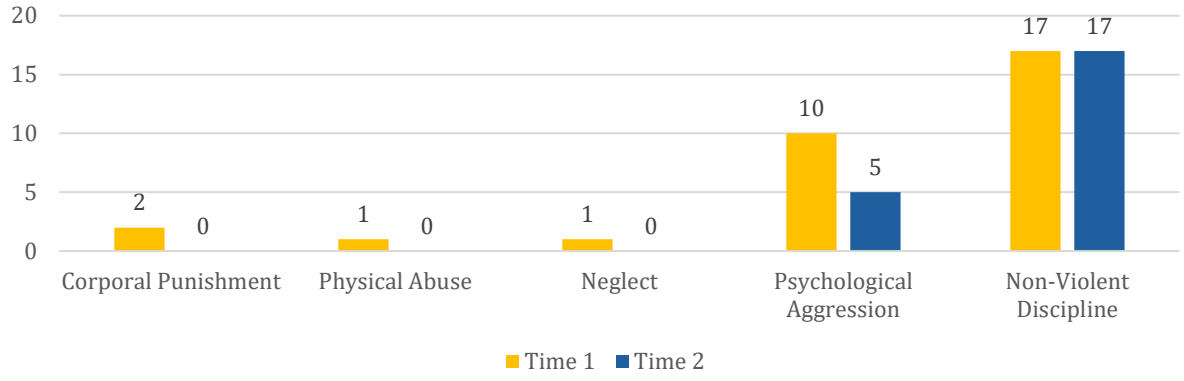

Figure 23. *Prevalence of fathers (n=18) use of psychological and physical maltreatment and neglect of children*

For mothers, prevalence of corporal punishment, physical abuse and neglect decreased over time, but psychological aggression remained the same from Time 1 to Time 2. Their use of non-violent forms of discipline increased Time 1 to Time 2.

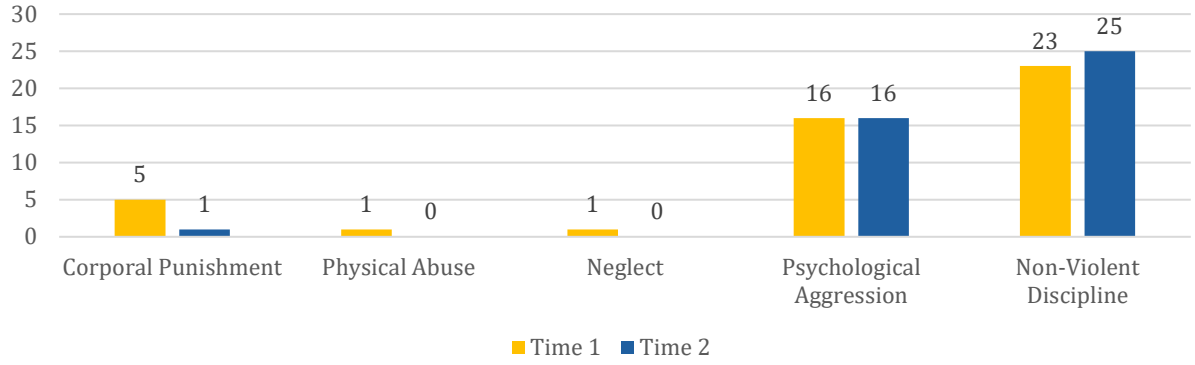

Figure 24. *Prevalence of mothers (n=27) use of psychological and physical maltreatment and neglect of children*

Figures 25 and 26 present the average frequency with which each disciplining behaviour occurred in the last six months as reported by both parents at Time 1 and Time 2. As seen in these graphs, for both mothers and fathers, the average frequency of psychological aggression reduced slightly from Time 1 to Time 2, with the use of non-violent discipline tactics increasing over time. The average frequency of corporal punishment, physical abuse and neglect dropped to zero at Time 2 for both parents, however the average reported frequency was very low at Time 1. These changes were not found to be statistically significant.

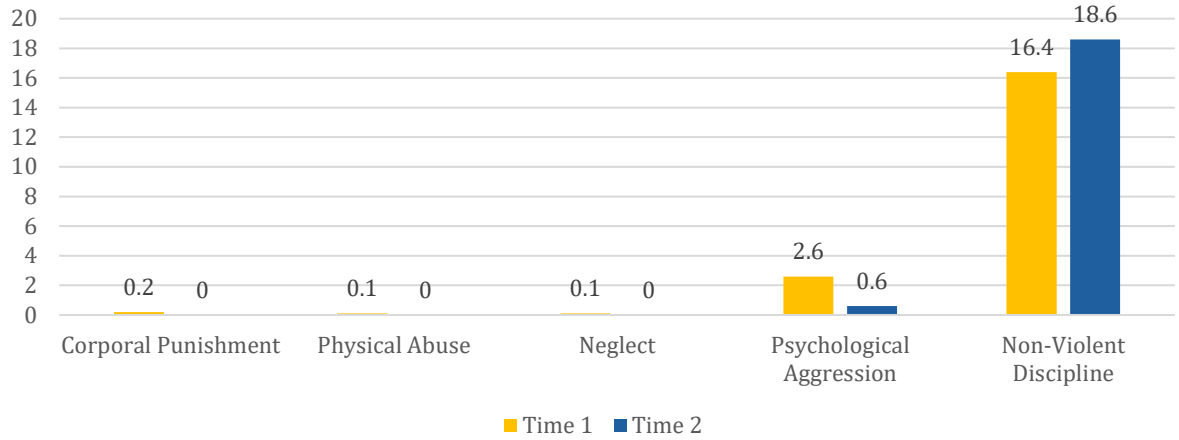

Figure 25. *The average frequency of psychological and physical maltreatment and neglect of children: CTS-PC subscales for fathers (n=18)*

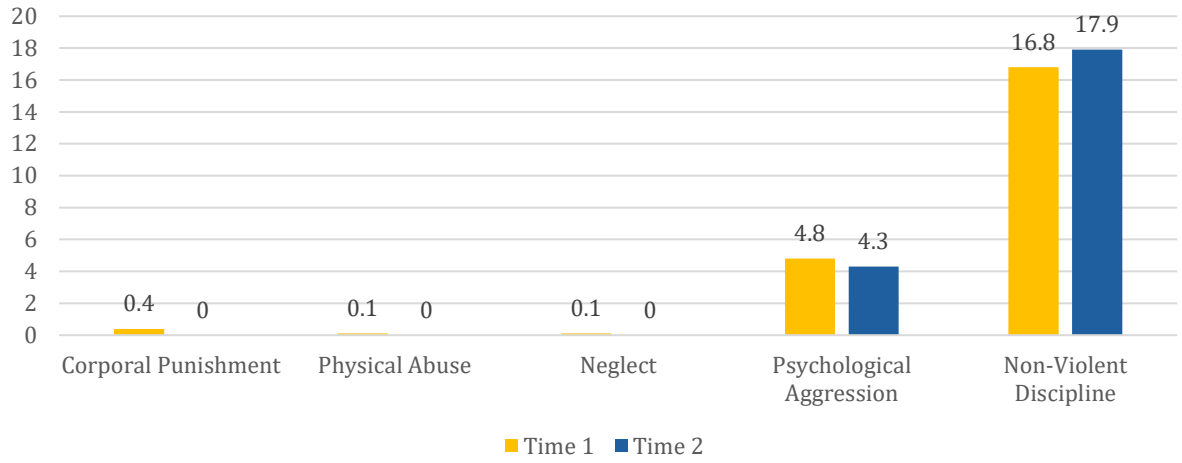

Figure 26. *The average frequency of psychological and physical maltreatment and neglect of children: CTS-PC subscales for mothers (n=27)*

SUMMARY & DISCUSSION

The present study is concerned with tracking a sample of mothers and fathers attending DSFS from their initial sessions through to service completion. This is with a view to exploring and describing their experiences and outcomes, and to compare these outcomes to service objectives. Data collection via survey administered to DSFS clients via their Family Worker took place between July 2017 and June 2019 and resulted in one or both partners from 63 families participating.

Results reported here indicate positive trends in parents' mental health functioning and conflict tactics in their interactions with their partners, with many of the findings reported reaching statistical significance, despite the modest sample size. Thus, from comparing data collected at the start of service uptake with data collected by Time 2, we can see that parents' psychological wellbeing is improving, and the prevalence and frequency of various forms of physical and psychological aggression in their interactions is declining. Findings relating to parents' interactions with their children also show positive trends, though changes in reported interactions from Time 1 to Time 2 did not reach statistical significance. So, as examples, parents' reports of conflict with their children (as measured by

the CPRS) are decreasing from Time 1 to Time 2, but this reduction is slight. Frequency rates of harsh or aversive parenting (as measured by the CTS-PC) in the form of corporal punishment, physical abuse or neglect drop to zero by Time 2. However, Time 1 prevalence reports of these conflict tactics are extremely low to begin with. Psychological aggression also reduced from Time 1 to Time 2 and the use of non-violent discipline is more frequently used by mothers and fathers by the end of their engagement with DSFS, but these changes were not found to be statistically significant.

Judgments about the effectiveness of an intervention depend on how it is evaluated. It should be noted that if we are to fully attribute positive changes in our outcome measures to the effect of the DSFS intervention, a more methodologically rigid research design would need to be employed. This could take the form of a randomized control trial, with a comparison group of families. However, non-experimental evaluation designs, as applied in the present study, have practical and ethical advantages when working with certain samples experiencing crisis situations. For example, assigning a family in need of services to a non-intervention comparison group for the sake of research design would not serve any real-world purpose. The evaluation approach also warrants attention. In the present report we have focused on effect evaluation, with limited attention of the mechanisms and process issues driving or underpinning the change process. A future process evaluation focusing on evaluating the mechanisms of change, rather than the outcome of change, could be considered so that changes following intervention can be better understood.

A related point is that judgments about the effectiveness of an intervention also depend on the quality of the outcome measures used to measure change. It is recommended that the process of monitoring outcomes is continued and measures reviewed to ensure they are meeting evaluation needs. For example, findings that parents' engagement in dominance or isolation as a conflict tactic is reducing by Time 2, but not significantly so, could suggest that this particular form of

psychological aggression is more difficult to modify or needs particular addressing during therapeutic sessions. However, it could also be that our measure to assess coercive control and pre-post intervention changes in its expression needs to be more sensitive.

Over the coming months a larger sample of Time 2 completers will increase statistical power so that it will be possible to conduct tests of significance within sub-groups of the participant sample. From scanning the output of demographic analyses it could be cautiously suggested that there may be clusters of families that share similar circumstances, be that the experience of adversity in their early years, present socio-economic status, level of education and so on. By identifying these clusters who may also share distinct therapeutic needs, it may be possible to tailor services accordingly. Furthermore, with more families engaged in services and completing the surveys at both time points it may be possible to characterise different types of individuals who engage in domestic violence. For example, our present sample contains only families referred for services where fathers were the primary perpetrator of domestic violence[8]. As such, we presently know little about women who perpetrate violence and the men who are victimised.

Finally, a qualitative piece of evaluation research to compliment and support the quantitative assessments needs to be developed and implemented with both those delivering services and those in receipt of them, over the coming months. It is anticipated that the deeper understanding of families' experiences[9] when engaged

with DSFS will assist the DoCCFS in progressing a key aim of making services ever more effective in meeting users' needs.

[8] DSFS have to date worked with three families where mothers perpetrated violence and fathers were victimised. These families were invited to participate in the present study but declined to do so.

[9] Appendix C contains some samples of written feedback given to DSFS upon service completion by the men and women attending their services.

Chapter Four

Conclusions & Recommendations

The term 'domestic violence' may be regarded as a general concept covering a range of phenomena wherein physical and psychological acts, which are harmful to one or more persons, take place within a familial environment. Within this broad categorisation there are a great number of sub-types reflective of gender, age, severity, ethnicity, and a myriad of social contexts. This creates difficulties in nuancing service response to 'fit' the particular expression of domestic violence in each presenting case. In the popular imagination the stereotypical case of domestic violence is often represented in female victim and male perpetrator terms. Indeed, most services reflect this dichotomy with support of a protective nature being largely provided for female victims and services designed to challenge aggression being provided for male perpetrators. The services provided by DSFS, however, are reflective of evidence emanating from a large body of epidemiological research. This demonstrates that whilst the great majority of severe acts of violence are perpetrated by men against women (sometimes referred to as intimate terrorism), the most frequent expressions of domestic violence are not at this high level and appear to be bi-directional in nature (sometimes referred to as situated couple violence). As such, DSFS-provided interventions carefully assess the particular patterns of domestic violence experienced within each family, with therapeutic service designed to address these in ways which involve both partners.

To gauge the efficacy of this approach the measures used in this study are reflective of the range of instrumentation used across the world in both epidemiological research and in evaluation of therapeutic services. While the resulting data is very helpful in establishing prevalence of domestic violence, tracking diminunition of such, along with associated perceptual and behavioural benefits associated with the provision of therapy, it cannot shed further light upon the complexity of contexts within which domestic violence occurs, nor address the

more general critiques of epidemiological research which question the validity of using quantitative methodologies where qualitative investigation might add meaning to measure. As an example, the authors of the present report are aware that one of our main outcome measures that gathers information on perpetrators' and victims' experiences of intimate partner violence, the Conflict Tactics Scale, is not without criticism. Although it offers insight into the prevalence, frequency, type, and severity of acts of domestic abuse, it has caused some controversy for using a 'one size fits all' approach to assessing violence between male and female partners. Specifically its gender-neutral approach to assessing violence is faulted for not considering, or accounting for, the context within which violence occurs. So, while not intending to downplay violence perpetrated by women against men, critics of this and similar other measures state that it may lead to over-reporting of women's acts of violence as it does not account for violent actions used in self-defence. The scale also does not account for varying motivations or consequences for engaging in violent acts. So one person who endorses "I pushed, shoved, or slapped my partner" with the intention of placing them in front of a moving car will receive the same 'score' as the partner who pushes or shoves back in self-defence. In sum, it is important to note that while the Conflict Tactics Scale is one of the most widely used measures in this field of research, it is not without its limitations and issues.

One innovative aspect of this study, however, has been to record ACE measures at initial assessment. The results reveal a pattern that is evident in the literature for individuals and families using therapeutic services in general. That is, they tend to have higher mean ACE scores than the general population. So, while we might expect approximately 14% of adults in the general population to have an ACE score of four or more, amongst families referred to DSFS, 31.5% of fathers and 37.5% of mothers had this score. This provides an important clue to the antecedents of expressed domestic violence to lie beyond the immediate and situational. The ACE thesis identifies two ways in which a high ACE score may make domestic violence more likely to occur. The first of these is the presence of 'toxic' stress, sometimes referred to as symptomatically similar to PTSD, where the

individual has limited capacity to cope with additional stress generated by family life and expresses this in acts of violence. The second is the process of intergenerational transmission. In the present study we do not have the ACE scores of the parents' parents, but we do have the scores of their own children. These reveal that 37% of children had already experienced four or more ACEs. This is particularly concerning for two reasons, the first is that the children are well short of their 18thbirthdays (the age up to which is the reference period for recording ACEs), and therefore this percentage, which currently replicates the higher ACE scores of their parents, in time, will likely exceed them. Secondly, the presence of the domestic violence ACE indicates increased probability that the other ACEs will contain maltreatment and neglect experiences. Higher ACE scores indicate greatly increased probability of a range of poor outcomes across the life course, including physical and mental health problems and early death. The findings of this study that interpersonal conflict is decreasing and may be having an associated positive effect on parents' mental health, is to be welcomed as a proxy indicator that tackling one ACE may have positive contagious effect in reducing the incidence of other ACEs and/or diminishing their effects.

As noted above, there is great debate in the domestic violence literature on the nature and meanings attached to domestic violence, especially in relation to gender differentiated power dynamics, motivations and effects. These issues are beyond the scope of the present study. Some of the questions raised by such debates, however, do lend themselves to empirical investigation and therefore potential resolution. We might view the work of DSFS as an intervention which seeks to reduce conflict and improve the mental health and wellbeing of all those adults who are using the service, irrespective of 'victim/perpetrator' labels, with a consequent positive impact on their children, therefore reducing the probability of intergenerational transmission of adverse childhood experiences. What we can say with some certainty is that, in terms of the central research question "what impact, if any, does DSFS have on reducing conflict and improving the mental health and wellbeing of all those adults who are using the service?", the data establishes positive results. That is, whatever the motivations for violence and its

consequences (the questions of meaning that this study cannot answer), there is demonstrable evidence for reduction in the propensity to violence for both men and women with consequent indication of improved mental health and of increasingly positive relationships with their children.

To summate, there are clear and compelling signs that DSFS is providing families with the types of help that enable them to reduce expressions of conflict. Such preventative approaches to family violence enable reduction of adversities in the lives of all those affected, so greatly enhancing their chances of going on to lead healthy, productive and conflict-free lives. This is consequential for policy makers and practitioners within the domestic violence sector nationally and internationally, who work with these most vulnerable families.

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Appendix A

A Case Study Example of a Family Engaging with Dublin Safer Families Service

The Murphy Family* were referred to DSFS in relation to concerns that Ms Murphy and her children had experienced physical and emotional domestic violence perpetrated by Mr Murphy. Referral indicated that Ms Murphy had spent a number of weeks in a Woman's Refuge. As the work progressed it was discovered that Ms Murphy was the victim of severe coercive control, as a camera had been installed in the house as a method of monitoring Ms Murphy's time.

Ms Murphy attended 26 individual sessions and worked towards safely separating from Mr Murphy. As part of the work Ms Murphy developed a safety plan with the practitioner for how to keep her family safe whilst transitioning from their family home. This included identifying triggers in relation to domestic violence and coping strategies to aid Ms Murphy manage volatile situations. Ms Murphy worked on safe communication with Mr Murphy to keep their children safe from violent interactions. Safety strategies were also developed by Ms Murphy in the form of a Time Out Strategy for when she became aware that the safety of her and her children were at risk. The practitioner provided emotional support following violent incidents that occurred during the course of the work, and 6 Child Protection and Welfare Notifications were submitted to TUSLA. Ms Murphy engaged in psychoeducational work on topics such as; the impact of domestic violence on children and self-esteem. She explored her family history through genogram work to identify behavioural patterns and social supports that were available to her. Over the course of the work Ms Murphy was supported to leave her family home with her children, and move into her own house assisted by the HAP scheme. Following this work was done with Ms Murphy on how to co-parent effectively. Weeks after Ms Murphy had separated from Mr Murphy she

commented that her youngest son appeared to be less hyperactive and she felt that he had the ability to concentrate more.

Mr Murphy attended 16 individual sessions in total. He was resistant at the initial stages of the work, however as he began to build a therapeutic relationship with the practitioner he became open about his perpetration of domestic violence and reflected on how this impacted his children. He explored his family history during systemic genogram work, which highlighted behavioural patterns within the family and ideas around his own values. From this he identified social supports. It became apparent that the couples values and ideas on parenting were core to causing conflict. Psychoeducational work was done with Mr Murphy about the impact this violent behaviour had on his children. During the work it came to light that a camera had been installed as a method of monitoring Ms Murphy's behaviour. Mr Murphy was challenged on his beliefs around this and this was removed over the course of the sessions. Mr Murphy engaged in work around managing his emotions in reaction to his triggers. He became more reflective about the effect of his behaviour on his children. He implemented safety strategies to manage this so that he could keep his children safe from further violence. As the family began to separate Mr Murphy engaged in work around supporting his children through separation. He reflected that he was happy that his children were no longer living in an abusive environment. Mr Murphy was supported to organise access with his children, which was reportedly a positive experience. This was confirmed by Ms Murphy and their children.

Elaine Murphy (8) daughter attended 8 individual sessions. Elaine engaged in CBT work around her experience of domestic violence. Her assumptions regarding violence were challenged during the course of the work. She appeared to have distorted views on gender roles and also normalized the violent behaviour that she was experiencing. Work was conducted with Elaine on safety planning and also strategies for how to keep safe in the future. A change was observed in the way Elaine presented over the course of the work, and she explained to the

practitioner that she felt less annoyed. She also stated that she was happy that her parents were separated, as she did not have to see them fighting anymore. Case closed following 14 months of intervention work with family.

*All identifying details have been removed.

Appendix B

Analysis of Engaged vs. Disengaged Families Attending Family Centres

Analyses were performed to compare a random selection of parents who completed Time 1 and Time 2 surveys (i.e. engaged cases or 'completers') with parents who completed Time 1 surveys but then decided not to complete Time 2 surveys (i.e. disengaged cases or 'dropouts'). The table on the following page details differences between the groups for fathers and mothers with regard to demographic variables and Time 1 scores on the various measures administered. The only statistically significant difference noted related to if fathers were still living in the family home or not. Thus, fathers who dropped out were significantly less likely than those who completed Time 2 surveys to have been living with the family at Time 1 (X^2 (1) = 7.5, p<0.01.)

Table x: Demographic characteristic and outcome measures at Time 1 between engaged and dropout families.

Variable		Fathers (n=20)		Mothers (n=18)	
		Completers (n=10)	Dropouts (n=10)	Completers (n=9)	Dropouts (n=9)
Gender of child of concern	Male	7 (70%)	5 (50%)	5 (55%)	5 (55%)
	Female	2 (20%) 1 missing	5 (50%)	3 (33%) 1 missing	4 (44%)
Age of child of concern	Mean	8.7	6.5	7.8	7.1
	SD	5.5	5.5	4.9	4.7
Parent age	Mean	38.4	36.6	36	30.1
	SD	8.8	9	10.3	7.5
Age of becoming a parent	Mean	27.2	26.6	21.3	21.8
	SD	6.1	5.9	6	4.1
Adult living with family	Yes	9 (90%)*	3 (30%)*	9 (100%)	8 (89%)
	No	1 (10%)*	7 (70%)*	0 (0%)	1 (11%)
Main source of income	Wages/salaries	3 (30%)	4 (40%)	3 (33%)	4 (44%)
	Social welfare	6 (60%)	5 (50%)	6 (67%)	5 (55%)
	Other	1 (10%)	1 (10%)	0 (0%)	0 (0%)
Parents' mean number of ACEs	Mean	2.3	3.1	3.2	3
	SD	2.7	3.1	2.9	3.5
Children's mean number of ACEs	Mean	1.2	2.5	3.6	3
	SD	1.4	2.7	2.5	2.2
Parent Core-10 (psychological distress)	Mean	10.1	7.8	12.9	13
	SD	6.6	6.7	6.6	5.6
Parent-child closeness	Mean	32.3	28	29.6	32.9
	SD	2.7	6	5.8	1.5

Parent-child conflict	Mean	18.6	15.6	17.3	19
	SD	8.8	9.7	5.6	8.8
Total CTS score as perpetrator	Mean	8.2	3.1	5.3	5.2
	SD	9.1	3.8	6.5	5.1
Total CTS score as victim	Mean	10.8	6.3	21.4	15.8
	SD	9.6	9.6	13.4	11.5

Appendix C

Feedback to Dublin Safer Families Service by Service-Users

The following is a sample of the feedback received between March 2017 and July 2019 by DSFS from their service-users by way of 'comment cards':

Comments from Victims:

"A very important service that supported and guided me through a very difficult time in my life"

"The Family Worker was an incredible support/guide and help to my family. I see more stability/safety and happiness in mine and the children's lives"

"I hope the service will be always available should I need it in the future"

"I think this service helped us from all the troubles we had initially to understand how we can better work as a team so that our children will have little or no negative impact"

"'Every meeting I had with counsellor was like light to my path…"

Comments from Perpetrators:

"Joint session was very good, we found out a few things about each other and it helped us to deal in difficult or stressful situations"

"Helped me change completely the way I manage my family life-in a good way"

"I learned myself how to deal with my family and people in a calm way, I learned how to have the healthy relationship, how to solve the problems, how to find compromise in any situation"

"It gave me confidence to talk openly about my life, it was very non-judgemental"

"It was brilliant and would recommend it to anyone, I didn't think we needed it but we did"

Comments from Children:

"This service is great, the person who worked with me is amazing, she really helped me a lot"

"Me and my Da talk a lot more and he is a lot happier…"

"I liked coming because she [Family Worker] is kind and I feel better now"