



STEPS TO SAFETY: REPORT ON THE FEASIBILITY STUDY

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NSPCC

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Impact and Evidence series

This report is part of the NSPCC's Impact and Evidence series, which presents the findings of the society's research into its services and interventions. Many of the reports are produced by the NSPCC's Evidence (formerly Evaluation) department, but some are written by other organisations commissioned by the society to carry out research on its behalf. The aim of the series is to contribute to the evidence base of what works in preventing cruelty to children and in reducing the harm it causes when abuse does happen.

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DEFINITIONS

For brevity, ‘parents and carers’ will be referred to as ‘parents’ in this document.

The term ‘domestic abuse’ will be used instead of ‘intimate partner violence’ or ‘domestic violence’.

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EXECUTIVE SUMMARY

Background

Safeguarding children from exposure to domestic violence and abuse is a priority for the NSPCC¹ and is underpinned by the steadily growing body of evidence highlighting the impact of domestic abuse on children’s emotional, social and cognitive development, as well as their physical health. This research highlights the importance of intervening as early as possible because domestic abuse can compromise the parent’s capacity to provide the sensitive and attuned care necessary to enable young children to develop optimally.

In conjunction with the University of Oxford and the University of South Florida, the NSPCC developed Steps to Safety (S2S), a practice model designed to end the perpetration of reactive violence in both heterosexual and same-sex couples who are expecting a baby or have a child under the age of five. It was delivered by the NSPCC’s frontline practitioners, who are trained social workers.

The Steps to Safety model has been designed for couples where violence is perpetrated by one or both partners in the context of escalating conflict, and there is no evidence that one partner is engaging in coercive control. Additionally, it is for couples where abusive behaviour has not crossed a critical threshold. Finally, it is for those who are motivated to change. Because it is critical to ensure that couples-based interventions can be delivered safely, this approach requires careful screening and assessment.

Steps to Safety

Steps to Safety was developed after extensive reviews of the literature on the risk factors associated with domestic abuse perpetration. The model focuses on three key domains: increasing parents’ capacity for mentalisation/reflective functioning; increasing parents’ capacity for emotional regulation and interpersonal functioning; and providing an introduction to early parenting. Following safety planning, screening

1 For the sake of consistency, the term ‘domestic abuse’ is used throughout. Domestic violence and abuse is defined by the UK government 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: psychological, physical, sexual, financial and emotional abuse.” See www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf. The term ‘intimate partner violence’ (and other terms like ‘partner abuse’, ‘spousal violence’ or ‘partner aggression’) is more widely used in the US literature. The focus of this paper is on domestic violence and abuse within heterosexual couple relationships, as research on the impact of domestic abuse on parenting of same-sex couples is nascent (see for example, Donovan et al, 2006).

and assessment, this first version of Steps to Safety begins with some core activities focused on goal-setting and emotional regulation. Video Interaction Guidance (VIG) and in-depth work on affect regulation takes place on concurrent weeks. The programme ends with parenting and closing sessions. The programme was designed to be delivered in the home in approximately 44 sessions, over a period of six months.

The feasibility study, 2017–2018

Implementation

The feasibility study for Steps to Safety took place in three different cities in England, Wales and Northern Ireland, and was in each case implemented by a local NSPCC team². Specific sites were selected because the team in each place included staff members who were trained in Video Interaction Guidance, and there were staff with some experience of work on domestic abuse.

Steps to Safety was delivered by NSPCC staff who are all qualified social workers. Nine practitioners were trained to deliver it with support from their respective line managers. Training took place over two three-day periods in November 2016, and the first couples were introduced to the NSPCC team in the spring of 2017.

This feasibility study – originally scheduled to end in October 2017 – was extended until May 2018, with final data collected in October 2018. The study was designed to identify what aspects of Steps to Safety needed to be changed before a pilot of it could take place.

The objectives of the feasibility study were therefore to assess:

1. The effectiveness of the referral routes into the new service, and the potential for recruitment to a trial;
2. The acceptability of its implementation within the participating local authorities to enable refinement of the intervention and delivery model; and
3. The acceptability of the outcome measures utilised, additional tools that could be included as part of large-scale testing, and an assessment of the formative impact of the intervention on the participating families using service level data.

² Details have been anonymised to protect the identity of service users and local partners.

Methodology

This is a mixed-methods study that involves the use of data from a range of sources:

- Case record data (all referrals), standardised measures pre-intervention, and results of an online survey completed by practitioners after each session. The survey requested information about the parents' views on the content of each session.
- Qualitative interviews with practitioners and project managers.
- Qualitative interviews with parents.

Data was organised using a Framework Analysis, which is a method of analysing interviews and identifying the themes that emerge in response to questions. The original interview guides – semi-structured questionnaires – provided the initial framework. This was expanded as further themes emerged from the data.

Limitations

Because of difficulties and delays in recruiting families and attrition during the assessment, detailed findings are presented on only 10 service users (five couples) who had completed more than six months of the programme, although reference is made to other couples in the section on assessment and screening. It was only possible to conduct one-to-one interviews with three parents who had completed the programme as of October 2018. Therefore, as a result, most of the information for this report was obtained from secondary data, such as case file reports and interviews with practitioners. This means that the report draws strongly on the experiences and views of frontline practitioners who delivered the services.

It has consequently only been possible to assess the acceptability and feasibility of Steps to Safety with a very small group of people, thereby limiting the validity of the findings. Furthermore, the difficulties encountered resulted in a significant number of modifications to the programme, and further research is now needed to assess to what extent the revised programme is feasible and acceptable with a wider group of stakeholders.

Findings

The effectiveness of referral pathways

Although a total of 70 people (35 families) were referred to Steps to Safety, this included only a small number of couples who met the inclusion criteria and who were motivated to engage in this intervention and able to do so.

This suggests that to engage more families, referral pathways would need to include organisations and services that routinely reach families where the level of violence may not yet have escalated beyond a critical point. It points first to the need for practice sites to have time to construct referral networks from General Practitioners (GPs), midwifery, health visitors, housing associations, Family Nurse Partnership and children's centres, as well as Social Care. Second, the creation of steering groups for Steps to Safety could ensure greater consistency in referral and safeguarding processes. Finally, couples who are aware of their problems but are not involved with Social Care need to be motivated to change before problems escalate.

Acceptability of screening and assessment measures

Eight measures were used to screen for intensity and direction of violence, to guide work with the family, and to assess the impact of the programme. After a first home visit with the couple together, the practitioner met with each parent separately, at the NSPCC office, in order to complete the screening and assessment.

The PARTNR Scale (Wilks-Riley & Graham-Kevan, 2011) and the Abusive Behavior Inventory (ABI) (Shepard & Campbell, 1992) were used to screen for violence. One of the results of screening was that risks to children were quickly identified, leading to swifter action to ensure the safeguarding of young children. In one site, almost all cases became child protection referrals. The Audit C (Babor and Grant, 1989) was used to screen for alcohol abuse and the brief version of the Depression, Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995) for these common mental health problems.

While the combination of the ABI, PARTNR scale, Audit C and (DASS-21 was acceptable and effective, there is a need to reduce the number of measures and to simplify the assessment process, as the length and complexity deterred potential participants.

Towards the end of the feasibility study, the decision was made to use the dynamic assessment model developed by VIG. Further work is needed to develop this model. However, practitioners in the one site that introduced dynamic assessment concluded that it can be an effective way of building a relationship with parents and motivating

them to engage. The use of VIG in dynamic assessment was also reported to be an effective way of quickly identifying difficulties and gauging the couple's readiness to change.

Working with the couple in the home

The findings suggest considerable advantages to working with the couple together, including the fact that it can enable the couple to reflect together, practice new skills and communicate more effectively. However, practitioners need to have flexibility in this respect as there are times when it may be necessary to work one on one, particularly on aspects of emotional regulation.

Programme components

(i) Foundational components

Foundational components are designed to help the participant set goals, identify strengths, start practising emotional regulation were reported to work well, and their use provided a structure for each session. Although it took some time for staff to use the Functional Assessment confidently, it was reported to be a useful way of helping people gain insight into their motivation and actions. This, in turn, helped establish and achieve goals. A second delivery of training helped to embed the model for practitioners.

(ii) Video interaction guidance (VIG) to increase reflective functioning

Although some couples were initially anxious about VIG, once engaged, they were reported to be motivated to build on the strengths identified using the feedback. The purpose of Couples VIG (i.e. in which the couple watch themselves interacting) was also reported to be immediately useful in helping couples understand and change the way they communicated. Watching the video helped at least one parent in the sample decide to end a relationship with a partner who was unable or unwilling to engage fully in Steps to Safety, as the parent became more aware of the impact of domestic abuse exposure on children.

(iii) Affect regulation (AR) grounded in dialectical behavioural therapy

Not all participants needed the affect regulation component or needed it to the same degree, and practitioners identified the need for the flexible use of programme components. Further work is needed to determine 'what works best for whom'.

As they reached the end of the programme, practitioners recommended that the emotional regulation components of Steps to Safety could be used as part of early intervention in other NSPCC programmes and services, to help strengthen parents whose distress is expressed in their emotional dysregulation.

(iv) Introduction to early parenting

Steps to Safety includes five sessions on early parenting, including work on praise and reinforcement, creating routines, and emotion-coaching for children. Guidance on coaching children about emotions and emotional regulation was found to be original and useful, and practitioners recommended that these materials be circulated more widely within the NSPCC as a stand-alone resource.

(v) Strengthening social support around the family

The degree of social support developed by each participating family varied, although it was generally improved following the intervention – except in the case of couples who separated. It is possible that people can engage more readily in social networks as the relationship quality improves.

What motivated people to engage and change

Parents who were interviewed confirmed that their initial motivation to engage was to do better for their children and that their motivation increased as they successfully applied new affect regulation techniques in their relationship with their partner, children and beyond their family. Success in one area motivated further learning. This was reported both from what was observed through VIG and the use of affect regulation techniques. Two couples separated halfway through Steps to Safety. In both cases, the decision to leave was made by the victim/survivors.

Recommendations

The components of the Steps to Safety practice model appear to confirm the value of applying an approach grounded in attachment and emotional regulation to work with people whose emotional distress is expressed in emotional dysregulation. However, this is based on a small sample and there is a need for further revisions to Steps to Safety, and a further feasibility study involving a revised version before a pilot is possible.

Interview data suggests that: a) the Steps to Safety approach requires further adjustment to address the issues raised as part of the feasibility study; and b) that components of Steps to Safety could be used as part of a range of programmes being delivered by the NSPCC to parents and families who struggle with emotional regulation.

1. Improve Referral pathways

- i. Widen referral networks to include universal services including General Practitioners (GPs), midwifery, health visitors, housing associations and Family Nurse Partnership, children's centres, as well as Social Care.
- ii. Ensure that practice sites have time to assess need and to construct a referral network.
- iii. Creation of steering groups for Steps to Safety to ensure greater consistency in referral and safeguarding processes.

2. Adjusting and restructuring the Steps to Safety programme

- i. **Screening and assessment measures:** The ABI and the PARTNR scale were sensitive to the detection of both severe violence and instrumental violence and should continue to be used together. The routine use of the DASS and Audit C is recommended. After screening, practitioners should move to a dynamic assessment using video feedback, and this should enable participants to take an active role in planning their work.
- ii. **Tailoring the programme to the couple:** Following the assessment, practitioners work with parents to plan an approach that best meets the needs of the family. Components of the programme should be selected accordingly.
- iii. **Further integration of programme components:** The programme components should be further integrated. For example, it would be possible to make further use of short video clips in the affect regulation sessions and incorporate some affect regulation themes, particularly on interpersonal skills and

communication, within the couples VIG. Parenting interventions like the importance of structure, validation, praise and emotional coaching can and should be introduced earlier and could be integrated within VIG.

- iv. **Changing the structure of the programme would then lead to a new form of evaluation.** If it involves dynamic assessment using VIG, then the methods used for evaluating it will need to be adapted for Steps to Safety.
- v. **Management, training, and support to staff:** Managers and staff needed ongoing booster training and supervision by professionals with experience in applying this or comparable programmes. When the programme is introduced, this training and supervision may need to be contracted in. Once enough practitioners have gained experience, as is the case in this feasibility study, they are in a position to provide support and guidance to others within the organisation.

3. Integrating a Steps to Safety approach to early intervention

Steps to Safety comprises a set of intervention modules, many of which are suitable for work with individuals and families whose emotional distress is expressed in dysregulation (i.e. where the presenting problem is not domestic abuse as such). These modules, and in particular those focusing on emotional regulation, could be turned into 'stand-alone' resources for practitioners who are trained and supervised in their application. This would require a further implementation evaluation.

NSPCC response to the feasibility study

The Steps to Safety Study has given us important information about how this service was experienced by service users, practitioners and other local stakeholders. It has assisted in helping understand which aspects of the innovative approach have been useful including information about content and intensity, how it has been received and for whom it may be most applicable. Some parents clearly benefitted from tools within Steps to Safety that helped them with emotional regulation. Learning from Steps to Safety is helping us design a new service for families with young children living with adversity who will benefit from support to manage and express their feelings.

1. Steps to Safety Feasibility Study

1.1 Introduction

The need to safeguard children from exposure to domestic abuse (DA) as early as possible is a significant priority for the NSPCC.³ This is due to a steadily growing body of evidence outlining the impact of exposure to domestic abuse in infancy on children’s emotional, social and cognitive development, and on physical health (Chan & Yeung, 2009; MacDonnell, 2013; Levendosky et al, 2003; Stanley, 2011). Exposure to domestic abuse is harmful to children at whatever age, but there is a significant concern that at an early age, and particularly the first five years, children’s cognitive and emotional development can be severely impacted (Levendosky et al, *ibid*). There is, therefore, awareness of the importance of preventing exposure of very young children to domestic abuse, which in any case usually co-occurs with other adverse childhood experiences (ACEs) (Anda et al, 2006; Felletti et al, 1998).

NICE has found inconsistent evidence to support cognitive behavioural therapy or batterer intervention programmes (BIPs) for perpetrators of domestic abuse, and recommended commissioning *and evaluating* tailored interventions while making the safety and wellbeing of victims and children the primary consideration (NICE 2014; British Columbia Centre of Excellence for Women’s Health 2013).

This is because, as Crane and Easton (2017: 33) observe, domestic abuse is perpetrated by a heterogeneous population and requires a range of different, “... integrated treatment options to achieve ... reductions in violent behaviour”.

The NSPCC worked with the University of Oxford and the University of South Florida to develop Steps to Safety. This is a practice model designed to end the perpetration of reactive violence in both heterosexual and same-sex couples who are expecting a baby or have a child under the age of five. Numerous studies suggest that parenthood, and specifically fatherhood, can be a motivation for change among men who perpetrate violence (Rothman et al, 2007; Stanley

³ The terms ‘domestic abuse (DA)’, ‘domestic violence (DV)’ and ‘interpersonal or intimate partner violence (IPV)’ are used interchangeably, but for the sake of simplicity, the term ‘domestic abuse’ (DA) is used throughout this paper. The UK Government defines domestic abuse 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: psychological, physical, sexual, financial and emotional abuse.’ See www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf. The focus of Steps to Safety is on domestic abuse between adults in heterosexual or same-sex relationships.

et al, 2012). Many couples want to stay together and often want help to improve their relationship. Because of high levels of attrition from group-based programmes in community settings, the decision was made to test a model that can be delivered in the home.

However, it is critical to ensure that conjoint, i.e. couples-based, interventions can be delivered safely. Steps to Safety has been designed for couples where violence is perpetrated by one or both partners in the context of escalating conflict, and there is no evidence that one partner (often but not invariably the man in heterosexual relationships) is engaging in coercive control. Second, it is for couples where abusive behaviour has not crossed a critical threshold. Finally, it is for those who are motivated to change. Because of this, work with couples requires careful preparatory work, including screening and assessment.

1.2 Development of Steps to Safety

The NSPCC in partnership with the University of Oxford and the University of South Florida developed Steps to Safety by building on existing research. An Expert Advisory Group (EAG) of practice leaders in the field gave critical feedback and contributed expertise to the development of the model. This EAG included a Service Manager and Team Manager from the NSPCC to represent the NSPCC's practice perspective. Service users were consulted in one-to-one interviews; these were men who had completed the Caring Dads programme (McConnell et al, 2016) and women who had completed or were engaged in Domestic Abuse Recovering Together (DART) work (Smith, 2016). Frontline practitioners and managers were also interviewed. Rapid reviews of the evidence were also undertaken (Schrader McMillan et al, 2016; Gardner, 2015).

Step 1: Identifying the focus of Steps to Safety

The first step involved identifying what the evidence showed were consistent risk factors, or clusters of risk factors, associated with domestic abuse perpetration, through a comprehensive review of evidence published between 2000 and 2014 (Schrader McMillan et al, 2016). We examined the strength of association between different factors and domestic abuse perpetration: this included (for example) the relationship between perpetration and childhood exposure to violence, mental health, poverty, emotional regulation, marital and relationship quality, demographic factors including socioeconomic status, beliefs and attitudes about masculinity and a range of other factors. Findings are summarised in Appendix 1 and, more briefly, Table 1 below. A further review looked at the impact of domestic abuse on parenting. A third review was conducted on risk factors for perpetration in same-sex relationships (Gardner, 2015; this been superseded by Longobardi & Badenes-Ribera, 2017).

Although there are some differences in the stressors experienced by people in sexual minority groups, risk factors predictive of both perpetration and victimisation are largely the same for people in heterosexual and same-sex relationships.

Findings from these reviews support the theoretical framework developed by Dutton (2006) and Siegel (2000; 2013). This focuses on the relationship between trauma, difficulties with affect regulation and perpetration of domestic abuse.

Steps to Safety focuses on the following domains:

- **Reflective functioning:** the capacity to give direction to one's behaviour (metacognition) and empathy/mentalisation – in particular, the ability to read and understand the emotional states of partner and child/ren.
- **Interpersonal skills:** the ability to develop positive, healthy communication and conflict resolutions skills.
- **Affect (emotional) regulation:** the capacity of adults to regulate stress and process emotions. This involves learning to recognise maladaptive responses including rumination, 'splitting', avoidance and dissociative tendencies; improving one's capacity to recognise and manage feelings of shame and to manage anger; questioning and changing irrational beliefs and cognitive distortions that increase the risk of violence (i.e. hostile cognitive biases, expectations of aggression, negative attributions of the intentions of others); improving the *response* to jealousy, the desire to exercise control, exact retribution, etc.; improving capacity to process social information, which includes addressing problems in decoding threatening or ambivalent situations.

Other key elements relating to parenting and the prevention of child maltreatment were:

- **Parenting practices:** this includes the preparation for parenthood in the antenatal period; development of parents' capacity for attuned and sensitive interaction with babies postnatal, in conjunction with nurturing and authoritative parenting.
- **Access to social support.**

Emotional regulation, reflective functioning and attuned, sensitive parenting are closely linked, and the intervention is designed to address all three domains.

Several quantitative measures were also identified to ensure that couples were screened for safety. It was essential to screen out instrumental abuse/coercive control (see Kelly & Johnson, 2008; Ross & Babcock, 2009) and any form of violence that had crossed a critical threshold, where there was a high risk of escalation, or where a parent’s severe mental health problems or addictions meant they were not ready to engage in a programme of this kind. How the risk of escalation was assessed, and what was determined to be a ‘critical threshold’ is discussed below.

Step 2: Identification of evidence-based approaches to mentalisation, emotional regulation and early parenting in the context of domestic abuse

The second step involved a review of the evidence on the therapeutic or psychoeducational strategies (see Table 1 below) that would be most effective in addressing the above key domains. In every case, it was possible to identify a response that had already been tested safely with perpetrators in a group, couple or family settings.

Table 1: Key domains and evidence-based approaches

Focus of Steps to Safety	What is supported by the evidence?
Emotional regulation	Dialectical Behavioural Therapy (DBT) (Linehan, 2015) further developed by Wilks-Riley and Graham-Kevan (2011). Additional exercises from other sources. Dialectical Behavioural Therapy is also used in couples therapy with highly conflictive partners (Fruzzetti 2006).
Interpersonal skills	Interpersonal skills section of Dialectical Behavioural Therapy (DBT) (Linehan, 2015; further developed by Wilks-Riley and Graham-Kevan, 2011). Additional exercises from other sources.
Mentalisation/reflective functioning	Mentalisation-based therapy (MBT) (Allen & Fonagy, 2006). Evidence also supports Video Interaction Guidance (Kennedy & Underdown, 2017).
Introduction to parenting	Antenatal period: Video Interaction Guidance for the prenatal period. Toddlers and young children: Fathers for Change (Stover, 2013; 2015) is one of the few parenting programmes for male perpetrators of domestic abuse.
Access to social support	The couple’s social supports were drawn on an ecomap at the beginning of the programme. This exercise identified the number and quality of the family’s social, family and community networks. These goals were revisited at intervals in the course of Steps to Safety.

Step 3: Integration of the programme components

The programme incorporates dialectical behavioural therapy as developed by the authors of the Inner Strength programme (Graham-Kevan and Wilks-Riley, 2011), Video Interaction Guidance (VIG) (Kennedy & Underdown, 2017; Celebi, 2013; 2014) and Fathers for Change (Stover, 2013). Additional components are drawn from work by the *Junto con los Niños* (JUCONI) Foundation (see Schrader McMillan & Herrera, 2016) and the Brighter Futures programme (Bowen et al, 2018). This is the first time that these components have been used together.

The Steps to Safety manual is divided into five modules that comprise a total of 44 sessions designed to be delivered through twice-weekly home visits over the course of six months (Rayns et al, 2016). Module 1 contains core activities for parents to set goals, identify strengths and introduce foundational tools for emotional regulation. Module 2 provides instructions for VIG that complement the training that practitioners are undertaking or have already completed. It begins with VIG for the individual parent with their youngest child, or in the case of expectant parents, using techniques for antenatal VIG (this includes the use of the scan, and resources about child development in the womb – see Celebi, 2014). Parent-child VIG has been designed to increase a parent's sensitivity and attunement to their child. This is followed by couples VIG, in which the couple are filmed, and finally VIG with the family.

Module 2 (VIG) was designed to run concurrently with Module 3 – Affect Regulation (AR). The affect regulation module integrates components of Dialectical Behavioural Therapy⁴ and the Inner Strength programme. It has four main strands: emotional strength and skill, distress tolerance, crisis management and interpersonal skills (communication). The practitioner is expected to adapt these activities for the family in question. A range of optional materials on mindfulness and emotional skills development have been included later in the Appendices.

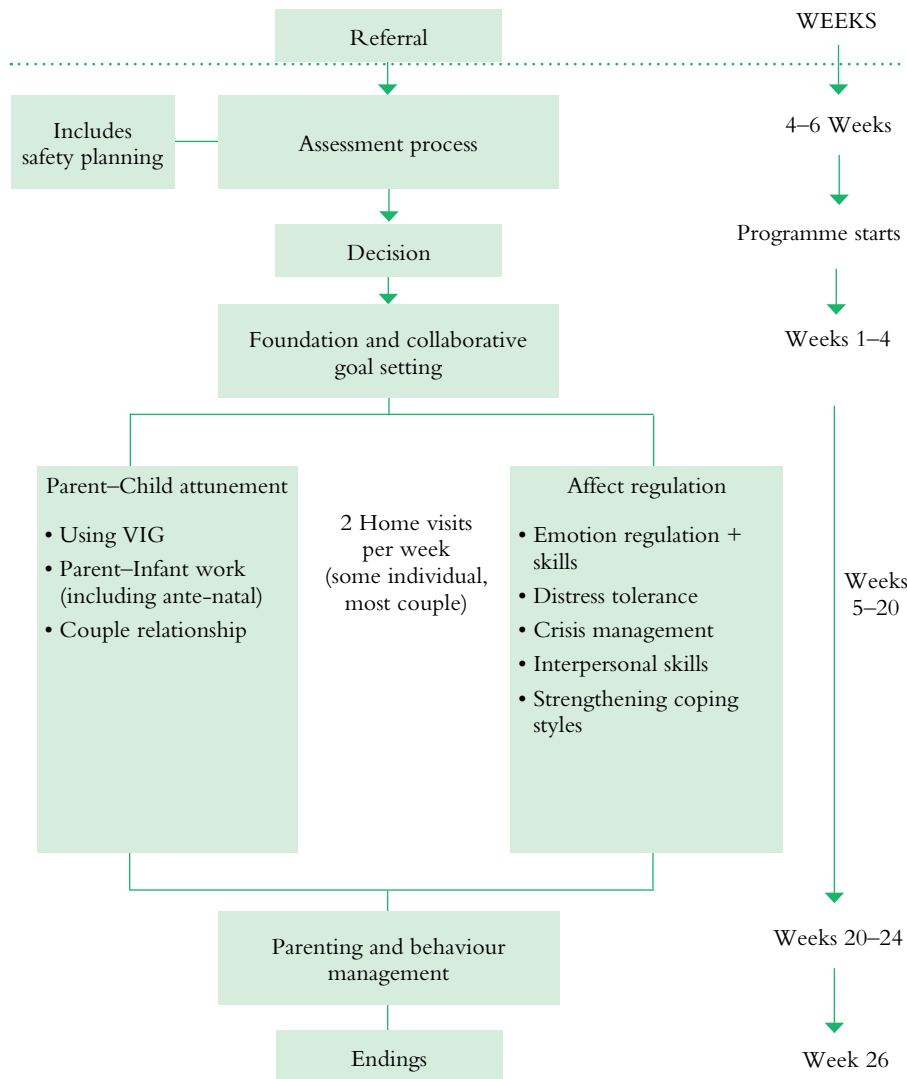
Module 4 consists of five sessions on early parenting that include applying many lessons learned earlier on positive reinforcement, creating structure and coaching children on their emotions. Steps to Safety is not a parenting programme as such; therefore, parents may be encouraged to take part in an appropriate programme.

4 A manual of DBT resources is available online (see <http://clearwalksoft.com/medical/48888-dbt-skills-training-manual.html>)

Module 5 contains guidelines on the closing sessions, which should involve the application of Time 2 measures (i.e. the Abusive Behavior Inventory and other assessment tools used at the outset) and a review with the family. Parents completed a sessions rating scale after each visit.

The structure and timing of the programme are outlined in Chart 1 below.

Chart 1: Steps to Safety programme structure



1.3 The feasibility study

The feasibility study for Steps to Safety was undertaken by NSPCC practitioners in three cities in England, Wales and Northern Ireland. These sites were selected because each team included staff who had been trained in VIG and or had some background in domestic abuse or both. Nine practitioners were trained alongside their respective line managers over two three-day periods in November 2016. The first couples were referred to Steps to Safety in the spring of 2017.

i. Objectives of the study

The objectives of this feasibility study are to assess:

- The effectiveness of the leading referral routes into the new service;
- The potential for recruiting couples to a trial;
- The acceptability of the way Steps to Safety was implemented within the participating local authorities;
- The acceptability of the outcome measures utilised, additional tools that could be included as part of large-scale testing;
- An assessment of the formative impact of the intervention on the participating families using service level data; and
- Identification of what needed to change before a revised version could be piloted in a trial.

ii. Ethics approval

Ethics clearance was received from both the University of Oxford's Central University Research Ethics Committee (CUREC) (R49261/RE002) and the NSPCC's Ethics Board (NSPCC R-16-87).

iii. Methods

This is a mixed-methods study that involves the use of data from the following sources:

- **Case record data (all referrals)** – including who is being referred to the service and where; who provided the referral; main perpetrator if named and direction of violence; what occurs between referral and assessment; why families drop out; whether referrals were appropriate; and what other actions (e.g. referrals, safety planning) were taken to safeguard families who did not continue.

- **Standardised measures were used to screen for intensity and direction of violence, pre-intervention using two measures – the Abusive Behavior Inventory (ABI) and the PARTNR scale.** Further measures were used to screen for alcohol abuse and for depression and anxiety, which have implications for people’s capacity to adhere to the programme. An additional four measures were incorporated to assess co-parenting, emotional regulation, adult attachment, and child outcomes. These measures were applied separately to each parent.
- **Practitioners completed an online survey after each session.** The survey provided information about the parents’ views on the session content and also the specific focus for each session held with parents. The survey also enabled practitioners to comment on what worked well during the session, what might need to be changed or what they would like to do differently, any suggestions for amending the manual and any additional materials that they used during the session. The final survey was completed in May 2018.
- **Qualitative interviews with practitioners and team managers.** A total of six practitioners and three team managers were interviewed one to one (by telephone) or in focus groups between July and October 2018. In three cases, follow-up interviews were conducted with practitioners.
- **Qualitative interviews with families.** The intention had been to interview a purposive sample of 12–18 couples/families. Using this approach, practitioners would have selected a heterogeneous group in order to explore the impact of the intervention across a range of different people. When the number of participants is small, practitioners can save time and money by using their judgement to create a representative sample.

Because so many referrals did not progress past assessment, delays in starting and completing the programme, and because some parents were not ready to be interviewed, it was only possible to directly interview three parents (two men and one woman). Insight into a further four couples was provided by interviews with practitioners and case file data. Of these, two were close to completion, and two couples had separated in the course of engagement.

All names and identifying details have been changed throughout. This applies to sites, practitioners and partner agencies as well as to the participating couples.

Table 2: Interviews and case record data

	Interviews	Case record data (couples with six months or more of engagement)	Case record data (all referrals)
Practitioners	6		
Team managers	4		
Individual service users	3	7	70

Data analysis

Data was analysed using a Framework approach. A Framework Analysis is primarily based on observation and accounts of participants; it allows for change or amendment of conclusions throughout the process; it provides for a systematic treatment of data; and access to original textual data enables transparency (Srivastava & Thomson, 2009).

Semi-structured interview guides were designed to learn what was most and least effective about Steps to Safety from the perspective of parents and practitioners, in order to make further adjustments before the programme. This included what motivated parents, whether desired changes had been achieved, what aspects of the programme content and delivery were most and least helpful, and for their recommendations on how Steps to Safety could be adjusted. Practitioners were asked further questions about the referral pathways, training, supervision, application and data collection.

The interview guides provided an initial structure and the first themes to populate the framework. This was expanded as further themes emerged from the data. Interviews were undertaken by an experienced researcher with no links to the project.

Data was manually coded and entered into the framework, organised into data sets, mapped and interpreted. Emerging findings were shared with colleagues and practitioners, revised and redrafted. The final paper was sent for peer review, and recommendations were incorporated.

Note: Quotations from the data have been used to support the description of the themes. It should be noted that the following nomenclature has been used: [...] indicates the removal of text that complicates the clarity of the quotation but without affecting its meaning; [TEXT] indicates the insertion of one or more word to the quotation to enhance clarity.

iv. Limitations

Because of challenges with referrals and assessment, and delays in completing the programme, detailed data is presented for only 10 service users (five couples). This is because practitioners were reluctant to arrange interviews with couples who had not completed the programme in case it affected their engagement. Issues of timing meant that it was only possible to conduct face-to-face interviews with one couple and one telephone interview. Thus, most of the findings are based on the reports of practitioners, survey data and mid-term reviews rather than families themselves. It was not possible to collect quantitative data post-intervention.

2. Findings

2.1 The effectiveness of the leading referral routes

In this section, we begin by outlining how Steps to Safety was introduced to local partners, including Local Authorities and public services, and other agencies that work on domestic abuse. Section 2.1.1 describes referral pathways, section 2.1.2 discusses the acceptability of Steps to Safety to local partners and their recommendations, while section 2.1.3 introduces the couples who were referred to the service and had come close to completion of Steps to Safety at the time of writing, as well as those who decided to separate in the course of the programme.

Key messages

Engagement of participating agencies

- The team managers and staff presented Steps to Safety to a wide range of public and voluntary sector agencies. However, they had relatively little time to do this or to consult agencies before training began, as the sites were selected at relatively short notice.
- The level of support for the new service from Social Care varied to some extent across sites, as did involvement of local domestic abuse networks. Local Authorities expressed some interest in all areas, although their primary concern is for more effective work with ‘high end’ perpetrators.
- The primary source of referrals in all areas was Social Care, with a smaller number from health-related services and the Family Nurse Partnership.
- A key lesson learned is the need to conduct a scoping study to examine existing levels of provision in each area.

The effectiveness of referral routes

- Reliance on referrals from Social Care led to two difficulties. Because of the high threshold needed for Social Care to become involved in the first place, a high proportion of families had severe and compounded difficulties that Steps to Safety could not be offered. The second challenge involved families who met the inclusion criteria but whose problems were not severe enough to justify continued involvement of Social Care. In the latter case, most families did not want further involvement from the NSPCC either. Some couples split up in the early stages of assessment. This points to the need for referral pathways from a broader range of universal services.

- Practitioners believed that where conflict had not reached a critical threshold, couples may have lacked the motivation to continue because they did not understand the impact of chronic conflict and risk of violence on their children.
- The intention at the outset had been to create a multi-agency steering group at each site, which could enable a more consistent flow of referrals. However, it was not possible for teams to do this because of the short lead-in time before the feasibility study began.

2.1.1 Referrals pathways and local support

From the outset, practitioners faced a considerable challenge: identifying the agencies in the area that were working around domestic abuse and who could, therefore, identify and link families who met the project's inclusion criteria. The teams had relatively short notice that they had been selected for the feasibility study and limited time to introduce the project and to create a referral pathway. This was problematic as sites were told they had been chosen to run the feasibility study with limited time – in one case, a few weeks before training was due to start in November:

“We were told we were doing Steps to Safety on the 16th September!”

(Practitioner)

Across all sites, the first referrals started to come in several months after the service went live:

“It was very difficult to get it set up.”

(Team Manager)

Considerable effort was spent by the teams in developing relationships with local agencies at the outset.

During the development phase, the authors of Steps to Safety proposed that local multi-agency steering groups be established as the conduit through which referrals to Steps to Safety NSPCC teams would be made. Risk would then be managed through multi-agency processes and progress through the programme (including that agreements on case closure would be overseen by the group). The decision was made not to form these groups as it would duplicate existing procedures for multi-agency work and safeguarding procedures that were already in place. In hindsight, it may have been valuable to have steering groups for Steps to Safety to ensure greater

consistency in referral and safeguarding processes. This might have been possible with a longer lead-in to the programme.

2.1.2 Acceptability to external agencies

Practitioners were given support on how to explain the service to local partners. They had practice meetings and rehearsed information regarding the service, enabling them to feel confident with their presentation skills.

Stakeholder engagement meetings were organised, beginning in December 2016 and continuing until the end of 2017. These stakeholders included Service Managers at the Local Authority, Team Managers in the Early Help Teams, Child in Need Teams, Family Nurse Partnership, Children's centres, police, midwives, Home Start, Victim Support, Women's Aid and other voluntary sector agencies. All three cities had an inter-agency domestic abuse network, although these did not necessarily include every organisation working on the issue in the area. In all sites, team managers reported learning about organisations that were starting new services in the area.

Stakeholders interested in referring families were asked to complete a structured form and five items (Part 1) of the PARTNR scale (Wilks-Riley & Graham-Kevan, 2011). Couples needed to be living together, although it was recognised that this could change after the intervention began. The Steps to Safety practitioner then visited the family at home and introduced the service.

2.1.3 Couples referred for assessment

A total of 70 individuals (35 families) were referred to Steps to Safety as of May 2018. In all three sites, the majority of families (80 per cent) were referred by Social Care, with a further 11 per cent from health services and the remainder from other sources, including the Family Nurse Partnership. Of these, demographic data was collected on all couples. As noted earlier, cases involving ten families (20 parents) were active, of which five (10 parents) were close to completion as of October 2018.

The majority of families referred by Social Care had problems that were too severe (because of the level of violence or child safety concerns or both) for conjoint work to be feasible. Many of these couples were in fact interested in Steps to Safety but it was not possible to go further:

“Families that did engage were cases where either Social Care were involved and stayed engaged – but that meant that we got high level, child protection cases and we did not get the opportunity to work with the family because they were at the point of an escalating crisis.”

(Team Manager)

In some cases, victims of instrumental violence may not have acknowledged the severity of harm until the assessment:

“I started work with a same-sex couple but identified coercive control. They have separated and are not co-parenting. So they have exited out, and we signposted [the victimised partner] to an assertiveness skills course.”

(Practitioner)

One site, which had delivered the Caring Dads and DART programme, checked to see whether Steps to Safety might be an option for couples on waiting lists for these programmes, but the level of violence was deemed too high for conjoint work. This again indicates the high threshold of violence that is present before people are referred to domestic abuse services, especially those referred by Social Care.

A smaller number of families were referred by Social Care with problems that were not severe enough to justify the continued involvement of statutory services. Some of these families began assessment but withdrew after Social Care involvement ended:

“[These couples were told] ‘We think you could do with some domestic abuse work, and we will refer you to the NSPCC programme, but we will close the case.’ After that there was nothing to make them engage with the programme.”

(Team Manager)

At the other end of the spectrum were families who felt that the level of violence and abuse in their relationship was a problem “*like [that] of any other couple*” (Practitioner). Although they wanted to stay together, the couple appeared to lack motivation to change. As one manager explained:

“We are looking for families who have internalised that there is something wrong. [But if they] hadn't understood it for themselves so you would not get them engaging at a meaningful level.”

(Team Manager)

Some couples dropped out during or just after assessment because the length of the programme is challenging for people who are working or going to college:

“When the programme was explained, the family realised they could not commit to it. They had two young children, and both worked full-time.”

(Practitioner)

One manager concluded that to reach people at an earlier stage required close work with community organisations and universal services:

“Couples do not seek help early because if they ask for help for domestic abuse that they would bring down the wrath of Social Care ... however, I also think it may be because they do not have insight into the actual impact of domestic abuse on children and unborn babies. Therefore, it is necessary to work with professionals not associated with Social Care.”

(Team Manager)

Widening the range of referrals would mean “*educating the professionals* [such as] *Sure Start, Health visitors, midwives etc*” (Team Manager) on the importance of early intervention.

The relationship ended during the assessment

Several couples broke up in the course of the assessment and two after several months of work on Steps to Safety (this is discussed in section 2.3.4 below). One practitioner observed that many couples were contacted at a point where they were not sure whether they wanted to stay together or not; they broke up, then came back together, which of course made it difficult to continue: “*moving from enquiries to referrals ... [couples] physically split up but then get back together.*”

Cultural and language barriers

Although most couples were open to working with VIG, one couple “could not do VIG, for religious reasons” connected to being filmed (Practitioner). Another couple would not accept working with a male practitioner – again for cultural and religious reasons – at a point when only two male practitioners were available.

On several occasions, families were of minority ethnic groups who are still learning English. Working through skilled professional interpreters is problematic because “it takes so much time, and [people] make eye contact with the interpreter!” (Practitioner). Even with families who are highly motivated, it was difficult to find interpreters in the area who spoke uncommon minority languages. Nonetheless, the first couple to complete the service spoke basic English as a second language but worked well on the programmes with a skilled, flexible practitioner who made good use of online translation programmes on her iPad.

2.1.4 Child protection as a result of early assessment

Although it was disappointing to have to screen out so many families, assessment did have the swift action of ensuring that children were safe:

“In most of our cases, we had to escalate to Child Protection once we did our assessments. There were too many concerns – there was a lot of disguised compliance.”

(Team Manager)

As a practitioner in another site noted in relation to the risk to which children were not necessarily known to Social Care:

“I guess that that was a positive change for those families, for those children – they got additional support [that] may have been missed if we hadn’t intervened [the parents].”

(Practitioner)

Summary: referral pathways and acceptability of Steps to Safety

There were considerable delays and difficulties in recruiting families to the feasibility study. The three NSPCC teams were asked to implement Steps to Safety at relatively short notice and in hindsight they needed more time to do a scoping study and to create referral pathways.

The main lesson learned is the need to conduct a scoping study to examine existing levels of provision in each area before the project was introduced. Over 16 months, greater coordination of domestic abuse services in all three areas revealed some organisations offering individual and group services, some of which were shorter (and possibly more accessible in terms of time and childcare) than Steps to Safety. These were not known to the NSPCC at the outset.

Most families who came through Social Care had had several police callouts, and assessment showed higher levels of abuse and instrumental violence than Social Care knew. In other instances, Social Care closed cases because the problems did not justify their continued intervention. Practitioners believed that where conflict had not reached a critical threshold, couples lacked the motivation to continue, possibly because they did not understand the impact of escalating domestic abuse on their children and the assessment process did not increase their motivation (this is discussed in the next section).

There are three lessons to be drawn from this. First, referral pathways need to include organisations and services that routinely reach families where the level of violence may not yet have escalated beyond a critical point. This suggests the need to work, where possible, with antenatal and perinatal health services including General Practitioners (GPs), midwifery, health visitors, housing associations and Family Nurse Partnerships, and with children's centres as well as Social Care. Second, steering groups for Steps to Safety could ensure greater consistency in referral and safeguarding processes. Finally, couples who are aware of their problems but are not involved with Social Care need to be motivated before problems escalate. This is the subject of the following sections.

2.2 The acceptability of screening and assessment measures used

This section introduces screening and assessment measures used. We begin by introducing the tools used to screen for violence and the risk of violence escalating. Six further tools were used for assessment and planning. We assess lessons learned about the effectiveness of the individual tools and the assessment process as a whole. We explain why we introduced a new approach to assessment in the second half of the feasibility study.

Key messages

- Experience to date suggests that the value of combining an expanded version of the Abusive Behavior Inventory (ABI) with the PARTNR scale.
- The 3-item AUDIT C and the Depression, Anxiety and Stress Scale (DASS-21) are also recommended, as people with severe alcohol abuse, severe depression or anxiety may need other programmes before engagement in a programme of this kind is possible.
- It is otherwise necessary to change the assessment process, as the length and number of measures discouraged participants.
- Towards the end of the feasibility study, a decision was made to use the dynamic assessment model developed by VIG. Further work is needed to develop this model – reports from practitioners indicate multiple advantages, including the capacity to build a relationship with parents, motivate engagement and gauge participants' readiness to change.
- Even where a family had had substantial engagement with Social Care, severe mental illness (SMI) had not always been identified. Workers may need to refer the parent to specialist support to ensure that they have the correct support and diagnosis. Latent mental health problems sometimes emerge after the initial assessment, for instance after a baby is born.

Screening and assessment

After a couple were referred to the NSPCC, the practitioner visited them in their home. The objective of this first visit was to get to know the couple, clarify their hopes and introduce the programme. This stage included a demographic survey (summarised later in Appendix 3). Couples who were interested were then invited to take part, separately, in screening and assessment at the NSPCC offices. Women were provided with guidance on personal safety using a

leaflet produced by Women’s Aid, together with a list of local support services and shelters. Practitioners soon asked for guidance for men at risk of violence, and this too was designed.

Table 3 below lists the screening and assessment tools used (for further details see Appendix 2).

Except for part 1 of the PARTNR scale, which was filled in by the agency providing the referral, all measures were completed by the individual parent with guidance from the practitioner. Paper versions were used for all measures.

Screening and assessment data were collated only for the 18 people (nine couples) who were screened into the programme, as it was only at that point that consent was sought from participants to use measures data. Appendix 3 summarises the main findings from all measures except the Relationship Scale, as there are some inconsistencies in the way this was applied

Table 3: Screening and assessment measures used during the Steps to Safety feasibility study⁵

Assessment Stage	Measure and number of items	Authors
Initial Screening	PARTNR Scale (Partner Abuse Risk, Treatment Need and Responsivity Scale) T1 only	Wilks-Riley & Graham-Kevan, 2016
	Abusive Behavior Inventory (Enhanced) – 58 items (29 per partner)	Steps to Safety used the enhanced version of the ABI. Zink et al, 2007, with further adaptations
Further assessment	Audit C T1: 10 items T2: 3 items	Babor & Grant, 1989
	Depression Anxiety and Stress Scale T1 & T2 21 items	Lovibond & Lovibond, 1995
	Co-parenting relationship T1 & T2 35 items	Feinberg, 2003
	Emotional Regulation T1 only 10 items	Gross & John, 2003
	Relationship Questionnaire T1 only 4 items	Bartholomew & Horowitz, 1991
	Strengths and Difficulties Questionnaire T1 & T2 25 items	Goodman, 2001

⁵ All measures other than the PARTNR scale are currently available free of charge.

2.2.1 Acceptability of screening measures

The decision was made to use both the **Partner Abuse Risk, Treatment and Responsivity (PARTNR) Scale** (Wilks-Riley & Graham-Kevan, 2011) and an expanded version of the Abusive Behavior Inventory (ABI) (Shepard & Campbell, 1992).

The **Abusive Behavior Inventory (ABI)** is a 29-item self-report questionnaire that measures incidence and frequency of both psychological and physical abuse – in this case over the previous two months. Although it was originally designed for use with women victims of domestic abuse, it has been adapted for use for both partners in heterosexual and same-sex relationships and the version used in Steps to Safety therefore contains 58 items.

Positive scores on specific items (e.g. perpetration of sexual violence, use of weapons by one or both partners) indicate a level of danger that is too high for conjoint work to be feasible, irrespective of the overall score. However, the fact that both partners complete the measure separately means that the results can be checked for consistency; discrepant accounts may be a sign of instrumental violence because information is being concealed or minimised by one partner. (For further information on contents, scoring and reliability of this and other measures see Appendix 2, and for main findings see Appendix 3).

The PARTNR scale is grounded in Dutton's theoretical work on the relationship between trauma, difficulties with affect regulation and domestic abuse perpetration (Dutton, 2006; Dutton & White, 2012; Henderson et al, 1997). The scale is designed to identify treatment need and responsivity of people who have perpetrated violence. An innovative feature of the PARTNR is the inclusion of items on emotionally unstable personality traits that are predictive of violence escalation.

The PARTNR is divided into three sections that are completed by (1) the referral agency, who needs to have access to police records (five items) and the individual being referred (three items); (2) the practitioner (12 items); and (3) the individual being referred (45 items) plus demographic/diversity questions (five items). Positive scores on specific items (e.g., use of weapons by one or both partners) indicate a level of danger that is too high for conjoint work to be feasible, irrespective of the overall score.

Practitioners found the PARTNR scale acceptable. However, there is some repetition of questions in the ABI and PARTNR scales. If both are used for screening, the PARTNR scale may need to be further adapted.

2.2.2 Acceptability of assessment measures

Two measures were selected to identify patterns of alcohol abuse and the intensity of a parents' depression and anxiety, since this can affect adherence to the programme. In some cases, parents might need to be referred first to other services. A further brief measure was used to identify adults' attachment patterns.

The **Alcohol Use Disorders Identification – Audit C** (Babor & Grant, 1989) is a brief self-report tool to test for heavy drinking and/or active alcohol abuse or dependence that exists in both a 3-item and 10-item version. (Appendix 3 reports on findings from the short version). Audit C was found to be acceptable and useful to practitioners and parents alike.

The **Depression, Anxiety and Stress Scale (DASS-21) Short Form Version** (Lovibond & Lovibond, 1995) contains 21 items that measure three related negative emotional states: depression, anxiety and tension/stress. The DASS-21 was reported to be generally acceptable, although some parents assessed for Steps to Safety struggled with understanding some of the terms contained in this measure.

The **Relationship Questionnaire (RQ)** (Bartholomew & Horowitz, 1991) is made up of four short paragraphs, each describing a prototypical attachment pattern as it applies in close adult peer relationships. Although the RQ was designed to obtain *continuous* ratings along a 7-point scale, of each of four attachment patterns, in Steps to Safety it was used only to identify the attachment pattern that best fits the respondent. Here again, practitioners needed to provide parents with examples to clarify the questions, so the scale cannot be standardised.

Other measures were used to gain a better understanding of the couple and to help measure change on co-parenting, emotional regulation and child outcomes.

The **Co-parenting Relationship (CPR) scale** (Feinberg, 2003) is a 35-item self-report tool with seven subscales that measure aspects of co-parenting. These are the level of parents' agreement, closeness, conflict, support, undermining, endorsement of each other and division of labour. The CPR was used to help practitioners plan their work, but also to measure change post-intervention. Practitioners found that the scale as a whole took a long time to administrate. They recommended using subscales on *Exposure to conflict* and *Endorse partner parenting*. Further investigation is needed to know if the validity of the measure is affected if these two subscales alone are used.

The **Emotion Regulation Questionnaire (ERQ)** (Gross & John, 2003) is a 10-item measure that assesses the individual's use of two emotion regulation strategies: cognitive reappraisal (thinking about a situation and deciding how to respond to it) and expressive suppression (hiding the expression of emotions once an emotional response has arisen). The habitual use of expressive suppression appears to be negatively associated with wellbeing (Ibid). The ERQ was used as a guide to planning and to measure change in parents' emotional regulation strategies post-intervention, since one of the objectives of Steps to Safety is to increase parents' capacity for cognitive reappraisal. Some practitioners found that the ERQ was too abstract for participating couples, and as one practitioner concluded, *"If the language is complicated, the parent will feel overwhelmed and just give you any answer."*

Finally, the **Strengths and Difficulties Questionnaire (SDQ)** (Goodman, 2001) is a 25-item screening and assessment tool that describes children's behaviours, emotions and relationships. The SDQ has five subscales: Emotional symptoms; Conduct problems; Hyperactivity-inattention; Peer problems; and Prosocial behaviours. The SDQ was used because it can identify child outcomes. In this context, the SDQ for children aged 3 to 4 was used. The SDQ is well established, and no complications were reported regarding language and application.

However, these screening tools are insufficient to identify more severe mental health illness (SMI), which is not necessarily known to the agencies making the referral. Also, latent mental health problems can emerge during the programme (for example, after a baby is born). A referral option for psychiatric assessment may be necessary if a practitioner is in doubt.

2.2.3 How parents experienced assessment

People who have experienced trauma may find it hard to engage in assessment at all

Practitioners observed the number of painful, often traumatic, events that parents had experienced in childhood, including, *"... domestic abuse ... neglect, [parental] substance abuse, and being looked after children."* (Practitioner). For example, 7 per cent of parents referred to Steps to Safety had been 'looked after children', a figure substantially higher than the average for the UK as a whole.⁶ Although they did not use the Adverse Childhood Experiences (ACE) measure (Anda et al, 2006), practitioners were familiar with the ACE literature and

⁶ The percentage of children in care differs over time and across the UK but was 64/10,000 (0.16%) of children in England in 2016. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664995/SFR50_2017-Children_looked_after_in_England.pdf.

concluded that in many cases parents' histories of trauma made it difficult to engage in assessment at all. The question for the teams was *"how to reach people in [abusive] relationships where they're not even going to manage to be there for the assessment visits"* (Team Manager). Again, this points to the need for assessment that is not experienced as a threat.

Length of assessment

A consistent theme from the survey was that the screening and assessment process was too lengthy and demanding. There were several reasons for this:

- The assumption that practitioners could meet with families twice a week was not possible with some families, which meant the process stretched over several weeks.
- The collection of information took longer than anticipated as time was needed in working with parents who had experienced traumatic events.
- Because of this, practitioners described needing to debrief parents and ensure that a self-care and safety plan was in place following emotionally demanding sessions.
- Other forms of social work activity were often necessary during the early stages, in order to help the family address problems that needed to be resolved before they could start Steps to Safety.
- The number of measures used and the challenge of explaining some of the underpinning concepts meant that practitioners had to decide whether to hold long sessions or include additional sessions to complete the assessment. Crossover and repetition of some questions, the complexity of language, and the use of different scaling methods led to delays in scoring and interpretation of measures. Then practitioners needed to explain scores in a way that was meaningful to parents. This was more difficult if the practitioner was unfamiliar or less confident with using the measure. All these factors posed questions and significant barriers to timely completion, parental engagement and ultimately the utility of the measures to the programme.

2.2.4 Moving to Dynamic Assessment

One of the lessons learned from these difficulties is that assessment needs to motivate people to engage. This means having enough preliminary screening to ensure participants' safety without putting them off taking part at all. As problems in recruitment emerged, the decision was made to shift to a form of dynamic assessment that

incorporates VIG, during the second half of the feasibility study. Dynamic assessment was introduced and used after screening (i.e. after the ABI and PARTNR scales).

In a dynamic assessment, the individual – in this case, the parent – is directly involved in an activity that they observe and discuss with the practitioner. The practitioner can note and record the parent’s response and readiness to participate and engage. Although there are several models of dynamic assessment with varying degrees of structure and content, all are grounded in the idea that, with guidance and reflection, people can change (Cotrus & Stanciu, 2014). Dynamic assessment consequently fits well with the strengths-based approach of Steps to Safety.

AVIGuk has tested dynamic assessment with families engaged in the Family Drug and Alcohol Courts (FDACs) (Kennedy et al, 2018). VIG usually involves the practitioner taking a video of around 10 minutes’ interaction, editing it to capture the moments of greatest attunement and positive engagement, and showing the clip at the next session. External advisors who have developed the VIG programme recommended that a much quicker process can be used in the context of assessment. Rather than producing a compilation of the most positive interactions, the practitioner can tape and replay the unedited video to prompt discussion. At the end of the session, the practitioner asks the parent what their strengths are and what they want to develop, because if a parent thinks there is something they need to change, then they are much more likely to engage. In the next videoed session, the practitioner can observe whether there has indeed been some change.

This form of assessment was introduced in one site in early 2018 by a practitioner who used it with three couples. It was reported to be a fast and effective way of building rapport with the one couple who were screened into Steps to Safety and completed the programme. In two other cases, video screening quickly revealed issues that would have otherwise taken much longer to detect:

“We used the VIG assessment ... took some video of mum and baby, and it was quite frightening what we were seeing. The baby seemed terrified. [...] We now know that when the child cried, mum got distressed and could not cope with her, would be hurting herself, banging her head.”

(Practitioner)

When the dynamic assessment was tried with another couple, and the man refused to engage:

“... even at that stage, it was showing up that Dad was not acknowledging the problem, so work did not progress with them.”

(Practitioner)

Dynamic assessment therefore appears to help the relationship between the couple and practitioner to build naturally. At the same time, it quickly reveals problems or whether a parent is willing to engage.

Summary: screening and assessment

However, the number and nature of measures could overwhelm parents, particularly those who were finding it most challenging to engage in the first place. This was, in turn, demoralising for practitioners. This led quickly to realisation that a simpler, strengths-based assessment was needed, and the decision was made to move towards dynamic assessment.

The combination of the ABI and PARTNR scales show promise in terms of identifying the severity of abuse and risk of violence escalation. Although further adjustments are recommended to avoid duplication of questions, the measures are recommended, together with the short versions of the AUDIT C and the DASS-21, both of which have sound psychometric properties (see Appendix 2). However, there is some overlap between the PARTNR, DASS and ABI and further adjustment is needed to avoid repetition of the same questions.

2.3 Practitioners' and parents' views on the impact of Steps to Safety

This section reports on what practitioners, team managers and families thought of Steps to Safety. We begin in section 2.3.1 by examining what was learned from working conjointly with the couple, and of working in the home. In section 2.3.2, we then turn to what practitioners felt about the manual, which includes written guidance on structure and how the programme should be delivered. This is followed by section 2.3.3 on the content of Steps to Safety; core foundational tools, emotional regulation techniques, video interaction guidance, and introduction to early parenting. Finally, section 2.3.4 concludes with the perspective of service users on other aspects of the programme, and in particular their relationship with their practitioner.

2.3.1 Working with the couple and working in the home

Key messages

Working with the couple

- Practitioners find conjoint work satisfying because changes in the relationship are happening in real time.
- Couples begin to support each other's learning and practice new skills together.
- There is a potential for conflict to arise during sessions. The couple may have had arguments between sessions, meaning that the practitioner has to spend time doing some mediation and preparation before work begins.
- The practitioner, therefore, needs to have the option of working one to one if they need to.

Working in the home

- Couples felt comfortable working in the home.
- Practitioners felt that working in the home gave them greater insight and understanding into the family.
- Practitioners believed that practising new skills in their 'real life setting' can help a couple continue to practice and develop these skills.
- The most significant consideration when working in the home is the wellbeing of children.
- Working in the home involves the potential for interruption.
- There are advantages to working in the home, but practitioners need to have the option of working in a more neutral therapeutic space if necessary.

Working with the couple

Despite the challenges involved in getting couples through assessment, once work had begun, it was reported to be immensely satisfying for practitioners. Although "*embracing the couple, together*" and working dialectically is extremely demanding, as one practitioner put it:

"I am working hard, and they are working hard – to doing work with the couple and feel that we have achieved something."

(Practitioner)

Another practitioner echoed this:

“We’ve come away from a house after doing a session with a couple and feeling like we’ve worked hard and that we’ve seen cogs turning, we’re effecting some change.”

(Practitioner)

This was the case with Franco and Maria. Maria believed that their conflicts had escalated because they could not understand each other. *“I did not speak much, with my husband, I do not know how he feels, what he thinks.”* As they worked through the sessions, they were able to talk more openly. One of the things that emerged was their constant sense of stress and tiredness, something that had been exacerbated by the condition of their middle child. As Franco said, *“My life is always just running, always.”* Maria believed that she had not just become more attuned to her husband, but that she had developed an *“awareness of the people around me”* that extends beyond her family: *“But, now, after this programme, I started to ... understand the people. I started to understand the couples.”*

Because of this, Franco and Maria decided on something that would work for them: to spend half an hour every day just talking: *“We had a plan ... to speak a minimum of 30 minutes or something a day, and we did it. [We] sit down and talk with each other, not just rush, rush ... Yeah, we did [and] it was good.”*

As with Franco and Maria, Monhad and Katie were able to help each other. For example, Katie reached out when Monhad was having problems: *“Dad was experiencing a bit of trauma reaction to things. Mum would hold his hand and help him calm.”* (Practitioner)

Practitioners helped couples see what each of them needed to change. Katie became agitated not knowing what Monhad’s plans were and sometimes tracked his movements on her mobile: *“There were times [when] his plans changed – his friends had made new plans. If her hubby went out [and didn’t go where he said, he would] it was a significant problem.”* (Practitioner). Monhad came to understand Katie’s anxiety and committed to letting her know when his plans changed: *“But Dad was able to think ‘it freaks her out not knowing what I am doing’. And he asked what he could do to be helpful.”* (Practitioner). At the same time, Katie worked on her tendency to ruminate.

Another couple reported the same patterns. Joshua (24) described how working together he and his partner had become much less conflictive: *“I have a quick temper, it has helped with that, and [my partner] would ruminate with ideas and thoughts. So both [of us] got different elements [from Steps to Safety] and it ... has calmed the waters now.”* Working

together can help the couple change maladaptive communications and patterns of interaction in a way that would be more difficult if each was engaged, for example, in group work.

Conflict can arise between sessions

In the online survey, practitioners noted the times when arguments had probably occurred during the week, leading to a 'heavy atmosphere in the room' on the day of the session. The practitioner needed first to do some preparatory work before they could engage in the session:

"In sessions where there is tension between the couple, some mediatory work is needed before they reach a point where a shared activity can be undertaken. The manual assumes couples will be in a place to commence work from the onset of the session and I am finding this is not always the case."

(Practitioner report in online survey)

It may be necessary to work separately with each person at the beginning to help them develop some skills to de-escalate conflict before starting work with the couple. This was recommended in particular for couples with a pattern of splitting up and getting back together:

"So, maybe [at the] beginning, give some thought [...] to separate visits until they get to a period where they can be together."

(Practitioner report in online survey)

Even when the couple is working well, it is sometimes necessary to meet with one or other of the parents alone:

"[There are moments] where you might need to do a wee extra session with Mum or Dad, maybe as a check in on how you are. What made you feel like that? In terms of safety and risk?" [Although it would be labour-intensive,] "I just think it needs to be [...] thought about."

(Practitioner)

Working in the home

Working with a couple in their home suits some families but not others, and practitioners need to decide with the family what works best for them. For professionals, seeing the family at home can help to understand them: *“It can be good to see them and see how they interact”* (Practitioner) or as another practitioner concluded: *“You get to know people in their homes.”* This was also echoed by a parent, who was happy that the practitioner felt at ease. *“I always made coffee for her [laughing], and, eh, yeah, she was okay in my house.”* This sense of security and ease may help build a relationship and, as one practitioner observed, when people feel at ease work can progress more quickly:

“As a social worker, I’ve done a lot of work with families in their homes. In one respect, I think it’s beneficial because they’re in their surroundings, they feel safe, they feel comfortable, and with that in mind, they could maybe concentrate better or learn more effectively.”

(Practitioner)

However, potential disadvantages were noted. Practitioners reported being concerned that they might be unable to contain a fight if one broke out during the session:

“There was thought amongst us about some of the ... stuff that we’d be raising ... and how we would be managing the dynamics between the couple, with just us in the family home.”

(Practitioner)

An experienced practitioner recommended having the option of another, more neutral, space:

“[Working in] the home may not allow [...] detachment.”

(Practitioner)

Childcare

The biggest challenge related to childcare. Even when social practitioners or the family themselves organised childcare, this could fall through:

“And while the social worker has supported with day-care, there’s been times when I haven’t been able to do the sessions that I needed to do because the children have been present.”

(Practitioner)

The presence of children in the house limited what practitioners could do:

“[I had] concern that there was no childcare to support families because some of the sessions about emotional regulation can’t really take place when the children are in the house, even if they’re in a different room.”

(Practitioner)

One practitioner working with two couples who could only take part in Steps to Safety in the evenings was aware that both children and adults would be more tired. Although Steps to Safety sessions are designed to begin with a check-in using the ‘thermometer’ activity, and end with a mindfulness or relaxation activity, this is challenging in the evenings when sessions are timed to last no more than an hour:

“You know that that child is going to be returning to that house later ... there’s always that sort of worry ... [you have to] make sure ... that the home is safe and secure for [children] to come back into.”

(Practitioner)

In some cases, grandparents or friends looked after children, but this was not always viable. In others, social care could not always supply childcare meaning that sessions sometimes needed to be postponed with a loss of continuity in learning:

“The NSPCC needs to think about childcare. That was a real issue. Because a lot of the families are so isolated! ... Some of the families were not open to [help with childcare from] social services – [in other cases] the social worker bent over backwards to provide the family with childcare so they could access the services. However, she was running out of resources.”

(Practitioner)

The need to work out of hours

A practitioner who committed to work with two couples in the evenings noted that the programme assumes that people are available during the day, but this is not true for the majority of people who work. Families lives are complex, and practitioners needed to be flexible in the way the programme was delivered:

“The other thing as well the organisation needs to take on board – the NSPCC is big on [working with] ‘hidden men’ – but we can't embrace everyone by doing a nine to five service. You have to be flexible around when people are available.”

(Practitioner)

Strengthening technical support and training in work with couples

Staff training and supervision are discussed in greater detail in Appendix 1 (Workforce preparation and Training). NSPCC practitioners receive supervision from their team managers and this was essential, among other things, to help practitioners retain objectivity:

“Steps to Safety is so involved – [you are] in people's homes, all sorts of stuff are coming up you have to deal with – with the nature of the work you don't see the wood for the trees.”

(Practitioner)

However, as will be seen in Appendix 1, this was challenging for managers who were themselves new to Steps to Safety or indeed to work with couples. Further external support to managers is recommended.

2.3.2 The programme components

i. Foundational and core activities

This section focuses on Module 1, the foundational activities that aim to build insight, set goals, and introduce some simple tools and techniques for emotional regulation. These activities are also intended to create a predictable structure within Steps to Safety and to provide the family with a shared language for emotional regulation.

Key messages

1. Although it took some time for staff to confidently use the version of the Functional Assessment used in Steps to Safety, it did help people identify what they needed to change and to set goals.
2. The core activities ('thermometer', personal calmness plan, mentalisation exercises) were reported to work well, although there is not enough time to use them at the end of a session.
3. Participants practised and developed personalised calmness plans that incorporate self-soothing activities that work for them. Some activities are introduced by the practitioner, but people seek out strategies that work for them.
4. Practitioners recommended the strengths-based collaborative exercises (ecomap; family shield; goal setting exercises). The ecomap does seem to provide couples with insight into the range and quality of their social networks. While this can motivate people to create immediate and positive change (i.e. become more involved in groups), the exercise can also trigger conflict – (for example, about the impact of extended family on the relationship.)
5. Practitioners need to tailor the session, even these 'core skills' sessions, to parents' needs and emotional states at any one time.
6. Practitioners' confidence in the techniques and materials increases when they apply them in their own lives.
7. The manual could contain a section on learning styles, along with the lines of work developed by Honey and Mumford (1982). This could help practitioners become more aware of, and respond to, people's learning styles.

The core activities: setting goals and creating structure

A small set of activities is introduced early to build the foundations for emotional regulation and goal setting.

Functional Assessment

The Functional Behaviour Assessment (FA) is used to identify the immediate and more distal factors that led up to a recent incident of violence perpetration. This helps the person who has perpetrated it to identify the purpose of the behaviour, i.e. the circumstances, thoughts and feelings at different stages that led up to the incident. One of the objectives of this exercise is to help the person understand what they fundamentally sought to gain from the violent act: “through a functional [assessment] ... we can begin to uncover some of the motives for violence [...] with the goal of designing specific treatments to address these motives.” (Ross & Babcock, 2009: pp.615).

A flaw in the manual and the gap between training and application meant that some teams were using the Functional Assessment only as part of the screening, not as a therapeutic tool (i.e. before couples had necessarily been accepted onto Steps to Safety ; this is both intrusive and time-consuming). The mistake and other uncertainties about application were resolved and further training provided by an external advisor:

“A lot of practitioners were used to doing something like that but in a different framework – looking at it as a way of what would have stopped you from going there rather than to reflect about thoughts, memories and feelings. And for a while, we were struggling to work out. But the [follow-on training] was really good and guiding us with that.”

(Practitioner)

There are widely varying opinions on the use of the FA. One practitioner described disagreements among the teams:

“Some practitioners felt that going back into childhood became too in-depth, but for me, ... there was a lot of learning that did support the rest of the programme.”

(Practitioner)

Some practitioners found that it helped some couples make a breakthrough, even at an early stage:

“In one [couple] ... the functional assessment was illuminating for them. It was a lightbulb moment!”

(Practitioner)

But another practitioner asked if briefer exercises could achieve the same end as the FA. Further work is needed to determine whether this is the case, or whether when it is properly applied, the FA can indeed provide ‘lightbulb moments’ by helping people understand the function of problem behaviour:

“The Functional Assessments have led us to think about some of the issues in the relationship, so it does help ... But I don’t know if we could have got some of that in other ways.”

(Practitioner)

The thermometer, personal calmness plan and mindfulness exercises⁷

Every session begins and ends in the same way: with the application of the ‘emotions thermometer’ (to help parents identify the intensity of any emotions they are feeling) and personal calmness plan. This is a list of five or possibly more activities that each person does to help them become calmer. Activities are on a scale to match to the intensity of the emotion, so, for example, some form of breathing exercise can help a person who is mildly agitated, while more extreme measures can help to prevent a crisis. Each is encouraged to update their calmness plan until they find the activities that work best for them. The emphasis is of course on identifying and soothing emotions before they escalate. As one of the brakes to violence is understanding what the other person is thinking and feeling, it is theorised that the motivation to apply these strategies is increased by mentalisation.

Each session was designed to begin with a brief check-in: where is each person on their ‘emotion thermometer’, and close with a mindfulness or relaxation exercise. Parents are helped to use these tools on a routine basis and identify the relaxation, calmness and stress management strategies that work best for them.

Practitioners agreed that the core components were useful “*because it was about trying to get some predictability about the session and [having a] structure.*” (Practitioner). This is intentional as structure helps to generate an experience of safety, something that is essential in work with people who have experienced trauma (Bloom, 1997).

7 These activities were developed in their present form by Sylvia Reyes, Martha Espinoza and colleagues at JUCONI Ecuador and by the late Alison Lane of JUCONI Mexico. We gratefully acknowledge permission to adapt them to Steps To Safety.

These core tools can help people become aware of their level of emotional arousal and rehearse strategies that will work for them when their emotions threaten to get out of hand (or ‘turn red’ on the thermometer scale). Practitioners stressed the importance of encouraging people to practice these strategies until they become habitual:

“It is about getting them to practice, properly practice, every week, or every fortnight, things that when the programme finishes, that they’ll hopefully embed and practise, so I thought it was really useful.”

(Practitioner)

Mindfulness

The intention behind mindfulness exercises – and indeed calming, self-soothing exercises as a whole – is to help parents identify techniques that work for them. To do this, practitioners tested a range of different activities, some in the manual and some from online resources. Participants are encouraged to test different, often very simple, mindfulness techniques. Eating cream cakes during a mindfulness exercise helped one couple to understand mindfulness and made the exercise fun for them. One father described how he had discovered that ‘mindfully drinking coffee’ worked for him when he started to feel overwhelmed at work: *“I just watched the coffee powder dissolve, and stir it ...”* (Parent)

Practitioners were advised to end each session with a short mindfulness or relaxation technique. In reality, this is not always possible. As one practitioner observed: *“We’ve got to allow the couple to talk and engage with them and that all takes time. So, I think the expectations of what can be packed into a session need to be re-thought.”* This has been especially true when the session needs to be completed in just over an hour – as was the case for this practitioner who was working with two families after they returned from work.

Practitioners stressed that it was important to allow parents to decide whether they wanted to do a mindfulness exercise at any point in a session, either because “calm and quiet doesn’t work” for them or because of tensions within their relationship that particular week (Practitioner). One of the guidelines in the manual was to avoid exercises that involve people closing their eyes, as this may be frightening for people who have experienced trauma. But at least in the early stages, any form of mindfulness exercises can be challenging, as this practitioner observed:

“Mum told me that she found the art of letting her mind relax stressful, as when her mind wasn’t busy, she tended always to think she was a ‘bad mum’ – I was a bit thrown by this. I told her to notice where her thoughts were going, and then to gently try to bring it back on what we were doing. She was pleased that she could do this a little bit, but it [...] is not something she is going to find easy to do, and this is possibly due to her traumatic past.”

(Practitioner)

A practitioner who worked with three couples for more than six months each at the time of writing, had experienced differences in the way that men and women responded to the idea of mindfulness:

“It was much easier to explain mindfulness to men than to women. Men, even when they get babies and families, tend to retain their hobbies and interests. Women pour themselves into children, but the men [I worked with] keep up with other interests too. If you can say to the man, what interests do you have? When you are taking that shot in golf, what are you thinking about? Unless a woman does something like that. It was harder to reach women.”

(Practitioner)

This led to a discussion with the couple about the need for women to take time for themselves and engage in absorbing activities to strengthen their self-care.

Calmness plan

Practitioners recommended that once a person has found what works for them, they practice until it becomes habitual: “*Maybe some families need to practise the same thing for a few weeks.*” (Practitioner).

Practitioners found that parents gradually developed and amended their own ‘personal calmness plan’.

One practitioner concluded that when people started working on their calmness strategies in their own home, they were more likely to continue because what they practice must fit into their everyday life, including their childcare responsibilities and physical environment:

“It takes place in their home, a very personal space to that family, and it’s real.”

(Practitioner)

For one father, the calmness plan provided a kind of inventory of self-soothing and distraction techniques that enabled him to create space “before I start shouting [at] the kids or my wife”. He explained:

“Calming plans worked for me. [...] I just learn how to cool myself down. I learned something very important, to be quiet and don’t sometimes say anything.”

(Parent)

Franco identified a series of distraction and self-soothing strategies that work for him. In the past, he would try to calm down by having ‘time out’ with a cigarette. “*It used to be I would smoke, but I’m not smoking now for over a year*”. He has switched from smoking to nibbling pumpkin seeds (which the practitioner who works with him describes as “*so fiddly, I don’t know how he does it!*”) – an alternative that distracts and calms him perhaps precisely because it is ‘fiddly’. Franco does other things to create some calmness between feeling emotionally aroused and doing anything: “*deep breath or something ... it’s helped a lot. It’s changed a lot in our life, so, yeah, it’s good.*” His partner Maria finds that listening to classical music diffuses her irritation and lifts her mood and she deliberately switches it on whenever she needs to feel better.

Ecomaps, Family Shield, and goal setting

A key theme in feedback on core activities, as with everything else, is that “*some [activities] are [suitable] for some families, others not.*” (Practitioner). Because core activities take place early on, practitioners need to be particularly alert to the potential for conflict. For example, the ecomap activity helps couples identify their social networks. In one case, this exercise quickly revealed to one couple the extent to which some friends and family had been the source of conflict. In other cases, the exercise was immediately helpful. In one example, a couple realised how very isolated they were and set goals to expand their networks. While they focused on this, they ceased – for a time – to take part in the programme:

“This was a family where we nearly scuppered ourselves when we did the ecomap and goal setting. One of the things that stood out was that they had a limited social network – then they were no longer available to do sessions on the programme!”

(Practitioner)

In other cases, couples thought about ways they could help each other make new friends or have more time to relax:

“Mum has friends and social outlets that support her while Dad has very little. [The] parents worked together to identify things he could do to strengthen his social relationships.”

(Practitioner)

Although (as has been seen) the ecomap can trigger arguments, on the whole practitioners felt that exercises that involved the couple collaborating and setting goals together “*were good ... they enjoy it all the time*” (Practitioner). Other exercises included activities like the creation of a family coat of arms or ‘family shield’, which identifies their strengths, values and positive qualities. Practitioners encourage the family to put the picture of their shield (as well as stills from VIG, and other positive images) in a place where they will be visible.

Practitioners’ personal experience: application of techniques in everyday life

In order to effectively share emotional regulation techniques, practitioners need to have tested these techniques. Practitioners often mentioned that they were applying the techniques in Steps to Safety in their daily lives and had shared techniques with their own partners and children. For example, one of the strategies recommended for people who are in an extremely high level of emotional arousal is to change their body temperature – for example, splashing one’s face and hands in very cold water. One practitioner described trying something like this to help his toddler calm down:

“Some of the Dialectical Behavioural Therapy [ideas], like using cold water, got me thinking about helping my daughter through tantrums, [offering her] a cold flannel to bring her out of her emotional state, quite quickly. So, there was good stuff like that that I enjoyed.”

(Practitioner)

Practitioners reported that experiences like those increased their confidence in coaching families:

“I have explained radical acceptance – I know there are boundaries – with my examples. I am practising it!”

(Practitioner)

The need for flexibility

For a variety of reasons, the couple is sometimes not ready to start a session, possibly because of an argument in the last few days. When this happens, *“the thermometer has the potential of taking the session in a completely different direction.”* (Practitioner). As noted earlier, if there is a *“heavy atmosphere in the room”* on the day of the session, *“some mediatory work is needed before they reach a point where a shared activity can be undertaken.”* (Practitioner). This may take longer during the early stages when couples are just starting to work on emotional regulation. In this respect, the manual offers guidance because every session has a learning goal, and at times the practitioner needs to work on whatever is happening in the ‘here and now’ while focusing on what needs to be learned.⁸

With Monhad and Katie, the practitioner observed that there was no need to deliberately use the thermometer and personal calmness plan in the mid and later stages of work:

“We did the thermometer, but after they got into VIG, we didn’t use it. Personal calmness plan, I think it was effective at the beginning, but as strategies become more embedded, they were doing the stuff.”

(Practitioner)

In another case, *“Calming strategies, like the ‘5, 4, 3, 2, 1’ activity helped Mum.”*⁹ The couple began to practice this activity together but, *“as Dad’s distress was diminishing they used these things less and less.”* (Practitioner).

8 Many thanks to Professor Sharon Dawe and Professor Paul Harnett, creators of the ‘Parents under Pressure’ (PUP) programme, for recommending this approach.

9 The 5,4,3,2,1 exercise is a coping technique sometimes used in DBT (see Linehan, 2015). This was not included in the Steps to Safety manual. Adaptations to materials used in the manual were recorded in the online survey and shared in team meetings.

ii. Mentalisation and reflective functioning: acceptability of VIG

Key messages

Acceptability of VIG

- With only one exception, couples were willing in principle to engage in VIG. People's increasing familiarity with social media is probably leading to greater acceptance of being filmed.
- VIG may not be acceptable to couples of some religious backgrounds.
- It may take a little while for some parents to get the 'hang' of VIG, and in part because parents are not used to the programme's strengths-focus.

VIG with infants and young children

- Parents were motivated by seeing what they were doing well.
- Positive reinforcement encouraged people to repeat what they have successfully done.

Couples VIG

- Couples VIG was reported to be immediately useful in helping couples understand how they communicated.
- Only three practitioners had reached the stage of using couples VIG, so it is not clear with whom and in what circumstances couples VIG is most effective.

Increasing attunement and developing the capacity for mentalisation

Video Interaction Guidance¹⁰ (Module 2) involves a practitioner videotaping up to 10 minutes of interaction between two individuals (for example, a parent and infant), returning subsequently to examine the tape with the adult parent(s) (whose session is also filmed) and using little episodes caught in the videotape to encourage the parent to identify examples of positive interaction. In VIG, attunement is understood as: (i) being attentive to the other person; (ii) encouraging and receiving initiatives from the other person; (iii) developing attuned interactions; (iv) guiding the other person; and (v) deepening communication. Attunement is modelled in the relationship between practitioner and parent(s) (and between the practitioner and their supervisor) – the facilitator encourages parent(s) to develop these skills with the child, and with each other. This process demonstrates and

¹⁰ For further information, see www.videointeractionguidance.net/

thus reinforces what the person or couple is doing well, increasing their confidence and sense of agency.

VIG was organised in the following sequence: (i) beginning with work with the individual parent and their youngest child (with adaptation if for the antenatal period), before (ii) progressing to work with the couple and finally (iii) VIG with the couple and child. In Steps to Safety, VIG was delivered concurrently with sessions on Affect Regulation (Module 3), with the intention that the two strands mutually reinforce each other. In the case of expectant parents, antenatal VIG involves the use of a scan (where possible a 3D scan), and resources about child development in the womb (see Celebi, 2014).

At the outset of the programme, six of the nine practitioners had completed VIG training, and of these one was preparing to be an accredited trainer in the course of the feasibility study. Three other practitioners began VIG, training just before starting Steps to Safety. They were expected to achieve accreditation – which requires supervision for over two years – while working with Steps to Safety families. The level of skill and experience in delivering VIG, therefore, varied within the team.

Acceptability of VIG

Although some people were a little hesitant about doing VIG, only one couple refused to do it:

“Some people might be hesitant to see themselves on video at first, but eventually, they get used to it.”

(Practitioner)

There were no differences reported between the willingness to engage by men and by women: “*I found no difference in uptake.*” (Team Manager). Only one man “... *didn't want to do the VIG at first, but afterwards, he softened up.*” (Practitioner). As noted in section 2.1.3, the one exception to this was a couple from a conservative religious background who felt uncomfortable with the idea of being filmed.

Practitioners observed that people are increasingly used to filming themselves and seeing video clips of others on their mobile phones: “*They are used to filming their kids, it's ... becoming more common in their everyday lives, filming and photographs, so ... they were really up for it* (Practitioner). Greater familiarity with social media means that people appear to get over their concerns about how they look and sound on video. As one practitioner recalls, “*Just looking back, you [can] initially think, oh my gosh, the way I talk, the way I look! But you get over that.*”

It may take a little while for some parents to get the ‘hang’ of VIG and this may be in part because parents are not used to the programme’s strengths-focus.

“There has been an occasion where one of the dads struggled initially to name what he was seeing, what he was doing well, but I think that was because he’d been so used to maybe having a deficit approach to his parenting. Once he got into ... the concept of VIG ... he took it on board then.”

(Practitioner)

VIG with infants and young children

Positive reinforcement motivates people to repeat what they are doing well.

The early stages of VIG for couples who already have a child involve filming each parent and their youngest child, separately. Practitioners observed how motivated parents were, when reminded, when watching themselves on video and reflecting on what they are doing right:

“I think for someone to watch themselves back on a video [...] it’s that positive affirmation over and over which motivates them.”

(Practitioner)

This was the experience of one father, who said that *“the way [our practitioner] said we interact with Kim [toddler] gave me a lot of confidence.”* Experienced VIG practitioners (outside the NSPCC) have observed that at least in the early stages, parents’ relationship with children provides stronger motivation to change than the relationship with their partner. The expectation is therefore that positive changes in relation to the child should encourage further efforts in relation to their partner.¹¹

Images from VIG serve as reminders of achievement

Although not entirely comfortable with being videoed, Franco enjoyed having laminated stills from VIG of himself or Maria playing with little Ben:

“... and then we have some photos ... outside in the hallway and upstairs when Maria with Ben or me, so yeah, that is good.”

(Parent)

It is worth noting that Franco finds playing with his children so relaxing that he has added this to his personal calmness plan.

¹¹ Personal communication, Hilary Kennedy. See also Stanley et al, 2012.

VIG with couples

Couples VIG can quickly help partners understand how they communicate

The application of VIG in couples work is relatively new and more so in the context of domestic abuse.¹² Again, practitioners reported that couples VIG worked well in Steps to Safety:

In one case, a couple who were already reasonably attuned to their children found *“the useful thing for them was couples VIG ... When they came to do the couple work, they got into it straight away. They got straight into each other’s interactions – and looked at what would make them more attuned.”* (Practitioner).

Another practitioner had observed the same thing in a couple with whom he was working: *“VIG will show them the times that they communicate better, in terms ... tone of voice, the way that they cut each other off and things like that.”* But because of VIG’s focus on positive interactions *“... show them when they’re doing stuff that helps that communication, and I think they’ll learn a lot from that.”* (Practitioner).

In one case, a couple was receiving another form of trauma therapy. As a practitioner observed:

“This was a dad with PTSD, so his trauma experiences were not rooted in childhood trauma and only came out in aggression in the years after he was traumatised but still in the [uniformed services.] When he reduced alcohol and did the EMDT that helped regulate – but they found the VIG very helpful.”

(Practitioner)

When asked if insights gained in VIG had helped couples make any sustained changes, one practitioner observed that it was too soon to say. But her years of experience with VIG had shown that it: *“has been a motivating factor in the parent making significant changes in their life that can increase protection around the child, such as removing certain people from their home.”* Provided people were willing to engage in VIG, *“I would recommend VIG to anybody.”* (Practitioner)

Adapting VIG

One experienced practitioner (who was training as a VIG trainer) began to integrate components from the parenting module (Module 4) within VIG. This points the possibility of integrating emotional regulation activities within couples VIG, which can, in turn, reduce the number of sessions. Further thought needs to be given to practical

¹² VIG is being used in work with families in extreme poverty and with histories of violence and domestic abuse in Central and South America and Sub-Saharan Africa, but not in the UK. See: www.videointeractionguidance.net/Sys/PublicProfile/12323400/4150678

issues, such as the gap between filming a session and providing feedback. It may be possible to make short video clips during the sessions on affect regulation, and without editing them, select and discuss moments of positive interaction.¹³

iii. Emotional regulation and communication skills: perceptions regarding the acceptability and impact of Steps to Safety components

Key messages

- Although limited, this data suggests that the combination of several different strategies (learning words for emotions, recognising the physical states associated with specific feelings, identifying signs of escalating conflict, having a calmness plan in place) can translate into better coping skills and reduced risk of perpetration of reactive violence.
- Nonetheless, not all participants needed the Affect Regulation component or needed it to the same degree. This indicates the need for flexibility in terms of delivery of the program components, in addition to further work to identify what works best for whom.
- AR techniques were seen as potentially valuable across a range of NSPCC programmes because of the high level of emotional dysregulation in clients and families.
- The writing and case studies are too complicated for some couples although they work well with others. Practitioners have collected materials from other sources that can be used with people with different language skills and learning styles.

Emotional regulation and communication skills

Module 3, on Affect regulation, contains a series of exercises to help develop an adaptive response to strong emotions, to increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and use coping skills to avoid undesired reactions.¹⁴

This is the first time that Dialectical Behavioural Therapy is being used in conjunction with VIG. As noted above, there is a growing body of evidence to show that VIG and other video-based interventions strengthen sensitivity and reflective functioning, which in turn contribute to greater emotional regulation.

¹³ Personal communication, Hilary Kennedy.

¹⁴ These materials incorporate work by Marsha Linehan (2015) and from work by Professor Nicola Graham-Kevan and Dr Fiona Wilks-Riley, whose permission to draw on the Inner Strength programme is gratefully acknowledged.

Materials give people ‘time out to just think about their emotions’

The section begins by explaining what emotions are, what they are for, and aims among other things at helping parents develop a vocabulary to accurately describe not only the emotion they feel but also its intensity:

“For the very first time, some of the couples are thinking about [the fact] that ... they feel an emotion, and that there can be an intensity of that emotion. About what emotions were, what the meaning was of different emotions, what level [of emotion] they are feeling and ... that was a novel concept.”

(Practitioner)

Franco discussed what he learned from the sessions on crisis management, which in this context involved strategies to step back from an already bad situation to prevent things from getting worse, such as to stop an argument escalating into a fight. Franco has learned to (literally) walk away before he ‘explodes’: *“I turn around, leave them alone, and ... when we can normally talk again, yeah, come back”*. Not only with Maria but also, on a recent holiday, on the brink of an escalating argument with a male relative, Franco *“just walked away, what I’ve never done before ...”*. In the society where he grew up, men are expected not to back down from confrontation: Franco believes that his strength lies not in escalating confrontation but in exercising his agency. This may indicate a point stressed by VIG practitioners, that cognitions that increase the risk of violence are more likely to change when people are already calm¹⁵, something which is echoed in section vii (below) from a woman who left her partner in the course of Steps to Safety.

Different activities should reinforce each other

Emerging findings illustrate the way that the different activities build on each other. Thus, one of the first activities – the thermometer core exercise – is designed to increase awareness of the intensity of emotion – any emotion. Then an early session on affect regulation explores the physical sensations that are associated with different emotions, like grief, irritation, or joy. This, again, provides an ‘early warning system’ that it is time to take action to self-soothe and become calmer. Couples also learn about primary and secondary emotions, or ‘surface’ and ‘deep down’ emotions. In many contexts, it is socially acceptable to express anger, but not fear, hurt or shame; or conversely, anger is expressed as sadness. Naming the emotion that is the real source of distress is the first step to managing it:

15 Personal communication, Hilary Kennedy 02/2018.

“[They] were able to learn about the difference between primary and secondary emotions and how their physical feelings link to their emotions, so they’re starting to become more aware of how they feel, what physical sensations they feel ... They are then looking at their calmness strategies, what do they do to calm themselves, to soothe, to regulate. And sometimes it is the first time they’ve even ever thought about those concepts.”

(Practitioner)

Linked to this is a series of exercises to develop and expand an ‘emotional vocabulary’ – the range of words for a range of feelings of different intensity (for example, the distinction between annoyance and anger, or affection and love, contentment and joy).

Once the concept of primary and secondary emotions is understood, it is possible to focus on whatever that person needs. For one couple, *“the sessions they really benefited from are the managing rejection, assertiveness, jealousy and fear of abandonment.”* (Team Manager). This then moves on to work on rumination, to help participants distract themselves from dwelling on perceived grievances and threats. Not everybody needed to spend much time on rumination, but it made a difference to some couples:

“[In one family] mum, who ruminated a lot, found it really useful. [...] When she ruminates, she imagines that [a woman with whom her partner had flirted] has wormed her way back into her partner’s attention. It is not happening! [So] she would model working on rumination in a session: ‘This is not happening, and I can’t combat it.’”

(Practitioner)

Practitioners felt that the affect regulation tools empowered people to *“become the agents of their own change, developing skills and awareness ...”* (Practitioner). Watching families take on and practise new skills was also rewarding: *“It’s a privilege for me, working with families, [to] see couples and individuals have lightbulb moments, particularly around primary and secondary emotions.”* (Practitioner). This practitioner found that couples began to work together *“to help each other develop the learning.”*

Work on affect regulation needs to be adapted to the needs and learning styles of different people

As noted, the content of some case studies was not suitable for all couples, and it needs to be adapted. In one case, most of exercises on affect regulation were actually unnecessary:

“[The] dad with PTSD from a [uniformed services] background, so his trauma experiences were not rooted in childhood trauma and only came out in aggression in the years after he was traumatised but still in the [uniformed services]. We checked with his psychiatrist who thought the affect regulation work would be up his street. But he was doing Eye Movement Desensitisation Therapy alongside Steps to Safety – so we didn’t have to get into the affect regulation sessions ... When he reduced alcohol and did the EMDT that helped regulate – but the [...] the most useful thing for them was VIG.”

(Practitioner)

One of the practitioners described the range of ways in which different couples prefer to work on emotional regulation, something which again illustrates the need for flexibility in the way the programme is delivered:

“[One] couple is motivated by science! They like theory. The [work] on rumination was going down the pan because mum was ruminating on the go. And I knew that they would take on board mindfulness. I had read a book on mindfulness in action, I photocopied a chapter on a book, and we are going to read this chapter together ... I would doubt that [would work] with [other couples I’m working with] – they do not have the skills- but with this couple, theory works!”

(Practitioner)

While the strategy of getting the couple to reflect about theory was unusual, it appeared to have motivated the father in question to seek out further opportunities for personal growth in future. In the closing interview, the father said that he was: “*now reading [more], things about the body ...*” (Parent). This, in turn, may help consolidate the changes and gains this father has made.

Language and case studies are too complicated for some users

The manual contains activities and case studies derived from Dialectical Behavioural Therapy and the Inner Strength programme. Although practitioners were advised to adapt activities, this was challenging for those who had not done that before.

As one practitioner noted, some of the examples used in the manual related to people in full-time work and were therefore “quite ‘middle-class’ and not always relatable for the service users. [Although] we can reframe case studies to fit the service user, it takes a lot of thought before you go out to meet the couple.” (Practitioner).

Case studies did not work well for everyone and in some instances needed to be substantially adapted, “Whereas, another family that I work with, it’s right up their street, and they love doing the case studies.” (Practitioner).

Practitioners began not only to adapt the activities but to draw on other resources with which they were familiar or which they found online. For example, one practitioner found materials on rumination, and on mindfulness, that were aligned with Steps to Safety but which involved more straightforward language:

“It takes a genius to make things simple: I try and steer away from too many words. And the material from Activate Your Life does help with that. ... It was from the Living Well Service and Wellbeing Service [and] aimed at ordinary people [in the UK].” (Practitioner)

Adapting activities to a person’s learning style

One practitioner recommended adapting activities to people’s learning styles:

“I suggest adding the Honey and Mumford¹⁶ approach [...] Some people respond better to metaphors and pictures, and other people need two pages of spoken word. Perhaps if the manual could embrace that concept, I think it would meet most needs.” (Practitioner)

Practitioners reported that the manual was a rich source of activities that aid person-centred learning but that these need to be adapted to different people, and that this requires care and experimentation:

16 Peter Honey and Alan Mumford (1986a) argue that people have different approaches to learning, or preferred learning styles, so different learning activities are better suited to some people than others. Knowing a person’s preferred style means that activities can be adapted to enable optimum learning. Honey, P. & Mumford, A. (1992). *The manual of learning styles*. Berkshire: Peter Honey Publications.

“Some of the thermometer stuff didn't work for one family. Some of the mindfulness ... they struggled with it, and it was [about] finding an alternative way to engage them. I guess it's about practitioners having the skills and ability to adapt and be flexible with the sessions and not to follow some of the activities in the manual if they're not going to work for that family.”

(Practitioner)

Emotional regulation and reflection about gendered roles

It is also interesting to note that greater emotional regulation appears to have helped some participants become aware of the cultural and social influences on their lives that increased the risk of violence. In this particular instance, it appears to have helped one man calmly walk away from potential fights with another man, and a woman to recognise that she had the power to walk away from a sometimes-frightening relationship. In both cases, these changes were attributed to the person's increased capacity for emotional regulation and the sense of agency this inspired. This suggests that people may be more willing to reflect critically on cultural norms around gender that may increase risk of violence perpetration or victimisation if they have the confidence that comes from emotional strength and skill.

iv. Guidance for early parenting and closing sessions

Key messages

- Practitioners were already familiar with the content of the guidance for early parenting, but further insights were gained from training.
- Work on parenting needs to be introduced early and could be integrated within VIG sessions.
- Sessions on emotional coaching for children are valuable in themselves and are recommended as a standalone tool for practitioners in many contexts.

Early parenting

Module 4, Supporting Early Parenting, is meant to be underpinned by the work that the parents have done together to improve their mentalisation skills, emotion regulation, communication and attunement with their children. This module includes activities to build children's sense of security (e.g. creation of routines and structure, non-violent limit-setting), regulate affect (through emotion coaching), and develop confidence and communication skills (child-

led play).¹⁷ The practitioner may pick and choose sessions based on the family and children's age.

At the time of writing, only two families were completing the parenting sessions. Rather than use the parenting sessions as indicated in the manual, one practitioner and couple used video work around an issue that deeply concerned the couple: their child's anxiety about going to school. The practitioner also drew on a session in the parenting module on how parents can coach children to understand their emotions. Each parent was filmed separately, interacting with the child, but the shared review was done together. Precisely because of the fact that by then they had had several sessions of experience with VIG, the parents quickly observed what they needed to do:

"... and I think that because [the couple] were so embedded [in VIG]. It [follows from] that principle – what you learn with one child can apply to another ... It was surprising how quickly they grasped things."

(Practitioner)

The couple became aware that they approached the child in different ways:

"Mum is more vocal, and Dad more laid back, he gives the child a lot more space. Mum could see where Dads space was good, and Dad saw where Mum was engaging emotionally with the child. ... They recognised [...] when it was best for Mum to deal with the little boy and when it was Dad because of [their] communication styles."

(Practitioner)

The couple also began to identify situations in which they could work with the child to help him understand how he was feeling: "*The best time to do that was not when [the child] was aroused and anxious [but when] he could have a bit of space, when they could talk about what he was feeling and what might help.*" (Practitioner). This practitioner proposed treating the 'emotional coaching' sessions in Steps to Safety as a stand-alone resource that would be useful to practitioners in many other contexts.

The practitioner also used these sessions to help parents reflect again on how dealing with their child's problems affected them:

17 This section of the programme was created by Professor Carla Stover and derives from her work on 'Fathers for Change'.

“Mum said, ‘it makes me feel anxious’, and Dad, ‘it makes me feel angry’ – and these were the two emotions that brought them into [Steps to Safety] in the first place. [So] they then thought about [...] using mindfulness [that they had already practised] to deal with their own emotions before jumping in and trying to deal with the child.”

(Practitioner)

Although this had not been the practitioner’s intention, the parenting sessions enabled the couple to reflect on their journey over the last year:

“It was a nice ending to Steps to Safety as well – there was a real agreement around we have reached the end here. They felt they were leaving the work in a place where they were equipped; they had skills.”

(Practitioner)

Module 5 consists of **closing sessions**.¹⁸ These two sessions should be about: (i) identifying progress to date regarding violence cessation and improved parenting and affect regulation; and (ii) identification of goals for the future. Steps to Safety should also involve a celebration, marked with some small ritual (a party, a gift of laminated photographs or an album and certification that they have completed Steps to Safety). Parents are encouraged to reflect on change, internalise these changes, take ownership of them, and begin to describe themselves differently. At the time of writing, practitioners were planning to do this but anticipated a simple closure since couples had already reflected on what they were learning:

“The end of the video work [involved] going over what they had achieved. Recapping on their journey. I am writing up a summary of all they have done and let them see that, and that will be officially the closing. Social services aren’t involved anymore, so there are no other professionals involved ... It is more of a formal closure in terms of what the NSPCC needs”.

(Practitioner)

18 Elements of this section draw on work by Professor Erica Bowen, and permission to use them is gratefully acknowledged. See Bowen et al (2018).

Although both Franco and Maria were already experiencing this loss, they were also glad to have completed Steps to Safety and indeed Triple P. As Franco said, *“I have mixed feelings – first I lost Sandra [from Triple P], and now Rosie [from Steps to Safety]. But [Rosie] will be in my mind and everything that I learned, and Sandra too. So, it’s up to me now.”* Franco’s reflection shows that while the couple have developed a close relationship with Rosie, they have together prepared for the conclusion of Steps to Safety. This is essential to avoid evoking a sense of loss – in this case in the individual parents or couple – which could cause them further distress.

v. Strengthening support around the family

Key messages

- Identification of the nature and strength of social networks around the family begins with the use of the ecomap early in Steps to Safety.
- Couples who identify the need for stronger and better sources of social support are more easily able to set goals.
- The development of social networks takes time, and because Steps to Safety is delivered over a number of months, the family can work on this with encouragement and at times, suggestions from the practitioner.

Developing strong and positive social networks

One of the objectives of Steps to Safety is to help more isolated families increase their supportive social networks. This begins from the very outset of the programme with the application of the ecomap (discussed in 2.3.3, above). As noted, the ecomap is a visual tool that helps people stand back and look at the existence or absence of relationships with helpful groups – including friends, families, or organisations in their community.

Couples who stayed together reported expanded social support at the end of Steps to Safety, although they did not necessarily attribute this to Steps to Safety: *“[social life] has changed, but not because of the programme.”* (Parent). Having said that, the practitioner helped this particular family access specialised support. This includes a local group for parents with children who have diabetes: *“We just met with the coordinator twice. So many families have children with diabetes. [The coordinator] knows two families with the same [condition] as my son.”* (Franco). Such help in getting families access to other networks is standard practice within the NSPCC.

In contrast, the ecomap exercise provided Monhad and Katie with a powerful visual picture of their networks – and specifically, Katie’s isolation. The exercises revealed that while Monhad went out with groups of former colleagues, even though Katie had family in the area, she had few friends. According to their practitioner: “... *on the back of the ecomap [Katie] got herself up and out and signed up for a course and took the initiative ... and built up a network for herself.*”

In spite of the efforts made by their practitioner, the two couples who split up in the course of Steps to Safety did not really increase the quality of social support:

“I would suggest simple things ... I would do a community audit and find out what it is about. But to be honest [the parent] could have done a bit more to help themselves.”

(Practitioner)

Whether social isolation exacerbated couples’ problems or was a consequence of their underlying difficulties is not clear. However, the contrast between these parents and those who stayed together suggests that once positive changes are being achieved in a relationship, it may be easier for people to expand their involvement in community life.

2.3.3 What motivated parents

This section focuses primarily on factors that couples said had caused them to engage, stay with a demanding programme, and which ultimately led to positive changes in their relationship. It relies primarily on interviews with three parents and therefore the results are clearly tentative.

Key messages

What motivated parents

The two parents who first completed Steps to Safety provided further insight into the reasons they engaged and persevered:

- They established a warm, trusting relationship with their practitioner. The practitioner and programme focused on building strengths.
- The practitioner was considerate and flexible and adapted the schedule of visits around their demanding lives.

- Both were motivated from the outset, mainly because they already wanted something better for their children. Prior participation in a parenting course may have increased their motivation.
- The couple began to apply skills, develop insight and see changes in their relationship and beyond it. Success in one area motivated further learning.

What motivated the decision to end a relationship?

- Two couples separated half-way through Steps to Safety. In both cases, the decision to leave was made by the victim/survivor because the perpetrator did not appear to be motivated to change, although physical violence had ceased.
- Practitioners felt that the affect regulation skills gained by a female victim/survivor galvanised her decision to end the relationship and had brought both her and her children to greater safety. The effects on a male survivor are less clear but suggest the benefit of VIG in terms of a closer bond with his children, and this again may have helped the decision to make a final break.

i. What motivated parents

The following section draws primarily from one-to-one interviews with three parents and is complemented by case file data.

Both partners want a change

Although Franco and Maria do have arguments, this has become much more infrequent, and physical aggression ceased when they began Steps to Safety. In the past, Maria had been physically violent and emotionally aggressive, but the precipitating incident had involved Franco's violence towards Maria. A year later, Franco observed "... *we don't have [arguments] anymore, or maybe once in the last couple of months – that is brilliant.*" As noted, the couple attributes the change in Franco's ability to step back from emotionally charged situations to his skills in emotional regulation. Maria believes that by working together with him in the sessions, she was able to gain a greater understanding of Franco and that this capacity for mentalisation has extended to other people as well, even outside the family. Interview data suggests that each was dealing alone with the stresses involved in caring for a child who is ill and that they are better able to support each other.

Franco said in an interview that he wanted "*something better for my children*". But for Maria, the most important thing is that her partner was motivated too:

“If you get a couple where one is not intelligent and refuses [to recognise] the problem, that’s the trouble. But [Franco], he thought we needed – he needs it, I thought [that too] ... so we were good. But [there’s] a problem if the mother wants it and the father is, ‘No way!’ This is the problem.”

(Maria)

It is worth noting that with encouragement from Social Care, the couple had already completed a home-based Triple P parenting programme. Their positive experience with the Triple P practitioner may have increased their willingness to engage in Steps to Safety in spite of the length of the programme – as Franco commented:

“With these [...] programmes, not just this, the previous one [as well] we always change, we try to do better – we go back a little bit, yes, but we ... we know how we can do now, and we ... we just remind each other.”

(Franco)

Focusing on strengths

Franco and Maria also emphasised that the practitioners’ (and programme’s) focus on strengths increased their motivation. Their practitioner modelled how to give praise and encouragement: “*Rosie would say said, ‘Oh, Maria, I am the same! You’re doing well, Maria!’ Of course, this increases your confidence.*” (Maria). Instead of doing a mindfulness exercise at the end of each session, she encouraged Maria and Franco to say something nice about each other and the couple did this throughout Steps to Safety: “*At the end of the session ... we always have to be positive, we talk about positivity, so it was really good.*” (Franco). Not only Rosie but also the Triple P practitioner with whom they had worked were “*... positive people, and it’s good to see that type of people.*” (Franco).

The practitioners’ warmth, capacity for containment and flexibility

Above all, parents interviewed spoke with warmth about their practitioner. As Franco said of Rosie: “*When you see her, you feel yourself better.*” Joshua said of his practitioner, Tom, that Tom was “*a great ‘professor’ and human being.*” Parents felt able to talk to practitioners openly: “*when I had a concern, and she said, [please tell me].*” (Maria). Franco and Maria were able to work together with Rosie to set personalised goals: “*I know how important it is to plan, [set] goals.*” (Maria)

Practitioners' warmth was balanced by their capacity to provide containment. As another father, Joshua, commented, his practitioner Tom *"was able to mediate"* when Joshua and Lindsay *"talked over each other."* Franco and Maria describe how Rosie stopped them when an argument began to escalate during a session: *"We were shouting – she said, 'I am not listening to this.'" (Franco).* The tone of these reflections evokes both warmth and respect for the practitioner and confirms the importance of the therapeutic alliance.

Practitioners' consideration was deeply valued by parents. As noted earlier, Franco and Maria asked for visits once a week only, because of childcare and while Rosie was always on time she understood when they needed to finish a session early: *"Rosie always came the right time ... when I said to her, 'Oh Rosie I have to go because of the time ...' oh, she said, 'Okay, okay.'" Joshua – the father of a toddler – echoed this: "... if we couldn't [have a session] because of childcare, he was flexible."* As one practitioner stressed, she and her colleagues sought to be flexible because couples were achieving goals *"and there were no further instances of physical violence."* (Practitioner).

ii. Motivation to end a relationship that was not changing

Two couples who engaged in Steps to Safety split up six months or more into the programme. This section relies primarily on interviews with one practitioner who worked with both couples and on case file data. In both cases, the decision to leave was made by the victim/survivor.

In the case of Nate (48) and Stephanie (35), Stephanie had perpetrated violence towards her family (including violence towards an older relation) in all but one occasion in which Nate made a retaliatory verbal threat. At the outset, both people expressed the desire to stay together, and Social Care was supporting this. In reality, however, the fact that Stephanie showed a tendency towards general violence should probably have precluded the couple from taking part in Steps to Safety. In hindsight, it became clear that participation was driven by Nate but that Stephanie was unable to engage.

After several months, the practitioner observed that: *"They enjoyed the content but were not taking learning on board to make a change. They weren't working well as a team so he would have a lot of the childcare. They were arguing about the fact they weren't working together. Mum was more resistant because of her mental health."* Stephanie began to take strong medication that affected her sleep. Nate had to leave his job to look after the children.

The practitioner was satisfied with this outcome in spite of spending so much time on working with a couple who might not commit to co-parenting in the future, because the children were safer: *“Now the family has split up, Social Services is supporting dad to look after the children, and she is living elsewhere. I am glad that they have split up for the sake of the two little boys.”* (Practitioner). Although Nate was struggling financially after giving up his job to care for the children, VIG and mindfulness exercises had helped him: *‘Nate got a lot out of the VIG, – that will help with his relationship with the children. And he found the mindfulness useful. Going for a walk whenever he could.’* (Practitioner) The fundamental objective of ending children’s exposure to domestic abuse has been met, and some support given to parenting.

The same practitioner worked with Debra (35) and Martin (48) intermittently for over a year, and here again the impetus to do Steps to Safety was with the victim of repeated aggression and threats of violence – in this case, Debra. Martin (who had spent part of his childhood in care) had underlying depression, which became more marked over time:

“There were lots of breaks, there were problems with the pets – I would turn up, and he would say he had to go to work – sometimes it was true – but sometimes [not]. I had a meeting, and if you want to do the best by your children, you have to do this programme. I only managed to do very few sessions — module 1, and part of module 4 and one session of VIG with each of them.”

(Practitioner)

After several months of intermittent home visits, all in the evening, Debra left and moved into a women’s shelter, not because physical violence had resurfaced but because in the short-term the shelter was the only option open for her.

In spite of this, there were positive outcomes for the children. The practitioner believes that after making an effort to work on the Steps to Safety, Debra decided to leave the relationship. It was interesting that Debra’s confidence in the application of new emotional regulation techniques increased her sense of agency; as the practitioner put it: *“It enabled her to take charge of her own power and leave.”* (Practitioner)

Here again, are signs that people can change their ideas about their roles as women or as men when they have greater confidence that comes with emotional regulation:

“I was struck by their ‘traditional values’ relationship. Martin worked; Debra was the stay at home wife. She was unhappy with her lack of status in their relationship. However, she appeared to respond to the messages of the importance of looking after herself, exercise, social life, would make her a better mum. She has been sharing techniques with women in the refuge. I observed Debra developing affect regulation techniques, such as mindfulness, and felt happy about when they worked.”

(Practitioner)

The practitioner is aware that Martin wanted to be a good father and did respond when he came to sessions – but just was not committed, for reasons that are not wholly clear. Martin responded to work on jealousy and fear of abandonment:

“Dad [went into a rage] because [she] was supporting her sister but not him during a crisis ... I worked with him on primary and secondary emotions – he understood [the primary emotion] was jealousy, not anger.”

(Practitioner)

“In spite of [this], Martin would talk about sharing skills with family members. One of the last sessions I did with him was VIG. He benefited from that one session of VIG. Didn’t have a strong bond but once he gave up work, he was able to bond with the baby. We didn’t even do it with a video, but with a picture of him holding his son in his arms. Martin was absorbed and looked at his strength. He had not had a father.”

(Practitioner)

These small positive changes in Martin do suggest the value of having access to group-based programmes grounded in attachment and trauma perspective, for men or women whose relationships end or who find couples-based work too difficult.

2.3.4 Practitioners recommendations: future applications of Steps to Safety components

Three practitioners were reaching completion of their work with three families. These and their managers balanced reflections on the difficulties in recruitment and assessment with the value of the components in achieving change.

Future applications

- Whether or not the NSPCC moves to a further pilot of an adapted form of Steps to Safety, practitioners were planning to apply Steps to Safety components in other services.
- This is because practitioners believe that the high level of adverse childhood experiences (ACEs) in the people they assessed are also present in the wider population of service users. In other words, they concluded that multiple ACEs are not only a common factor in domestic abuse perpetration and victimisation but also contribute to the emotional volatility and high levels of conflict in other families with whom they work.
- The use of emotional coaching for children was also recommended, and attention was drawn to a particularly useful session on this subject in Module 5.

The programme needed to be adapted to each couple

Practitioners were expected to use their professional judgement on how to tailor activities to the needs of each couple, but they recommended going a step further and actively involving the couple in planning from the outset:

“I think it could be [...] more bespoke to each family, to sit down with the family ... to tailor it to their needs. [One couple] didn't have any difficulties with rumination, so I discussed the concept, they didn't have an issue, so I didn't go through with that session.”

(Practitioner)

In all cases, the delivery of the whole programme has taken more than six months – much longer than anticipated within the study design. Holidays, sickness and other considerations have made it necessary to take breaks. Most importantly, families could not manage two sessions a week. As a result, two families have completed only after a year:

“We have been involved with this family for over a year. Did the full intense assessment and they stuck with that. We started VIG and affect regulation. They were quite a busy couple. He was being discharged from [services] and had a discharge plan.”

(Practitioner)

Practitioners have structured sessions so that these are shorter. This has been particularly important in the case of evening visits:

“So, you’ve got to adapt the session to meet the family. For example, I work with a family of an evening and ... the feedback that I’ve had [is] ‘Look, an hour and a half session are too long, two hours is too long – can we do it to an hour?’ I’ve got to look at how I can fit this session into an hour, chop it down ... but make sure that they [...] meet the key objectives.”

(Practitioner)

Franco and Maria recommended that Steps to Safety be spread over more than six months, but with weekly sessions that are just over an hour. In their case, the fact that English was their second language meant that sessions took longer than scheduled and some were spread over two or three weeks: “*We said, do the session over three [visits]*” (Franco). As they concluded: “*[Once a week] is enough if you have four children and also, you work.*” (Franco) They were also concerned about not overburdening the practitioner with commuting to and from their home: “*... your worker, social worker ... she’s got family.*” (Franco).

“It has been such an effective piece of work with this family, but we didn’t stick to the manual”

In spite of the great difficulties in recruitment and the loss of morale this entailed at the time, practitioners who are reaching completion have consistently reported profound changes in the families and noted that these changes could happen quite quickly:

“That’s what we’ve seen as the beauty of the programme ... I’ve come away from a house after doing a session with a couple and feeling like we’ve worked hard and that we’ve seen cogs turning, we’re effecting some change.”

(Practitioner)

One practitioner drew attention to the fact that the changes she had seen were likely to endure, hinting that on other occasions she had ended a piece of work half anticipating hearing that problems had resurfaced after a while:

“You feel that they have come such a long way and invested such a lot in it. I could come away quite confident that I don’t expect to hear something negative about this couple – I am not expecting that with them.”

(Practitioner)

This was possible because practitioners were agile in using their professional judgement on the frequency of home visits, and increasingly on what content to use with the family: “[You need to] know your couples and pitch to their strength.” (Pratitioner). Or as another practitioner said, “It has been such an effective piece of work with this family, but we didn’t stick to the manual.”

Potential for emotional regulation skills in other services

One practitioner concluded that in her experience as a frontline social worker, “almost every family with whom I work is dysregulated ...” and as a result had decided that “I will be using the affect regulation techniques with other services – with people who have ACEs [adverse childhood experiences].” At the same time, they were aware of the high number of ACEs in the wider population with which they work – who also generally tend to emotional reactivity.

Others who have come close to completing Steps to Safety were keen to apply the experience they have developed in their day-to-day work – not always for families who have been referred for Steps to Safety:

“I am sitting with the family at the minute – we are considering that we might do some Steps to Safety work with them and pick and choose from the programme. ... there has been that history of verbal [aggression] and losing it with each other. Not being able to stop arguing in front of the children [...] I will do dynamic video assessment mostly because this Dad finds it threatening to be faced with the fact that [his actions prompted referral to NSPCC]. The video work would build a relationship to go in then and look at the Functional Assessment. VIG and some affect regulation work would be good.”

(Practitioner)

A different practitioner is moving on to work on a new antenatal service for pregnant women who are vulnerable. Women are being referred to this service as a result of the routine perinatal assessment:

“I am starting with pregnant mums between the second and third trimesters and working with parents with mental health problems. I am on [this] service because of the expertise I have developed on Steps to Safety. We are going to be using calming plans, might call it something else, essential things – using the thermometer, how to communicate, listening, primary and secondary emotions, validation – I have been doing a bit of

reading up on the service, and when a new-born baby comes into a family it can have an impact on how the parents manage household tasks and that stuff.”

(Practitioner)

Summary: the programme components

Emerging findings suggest considerable advantages to working with the couple, as this can enable them to help each other reflect, learn and understand each other. However, practitioners need to have flexibility in this respect. There may be times when it is better to work separately, particularly on aspects of emotional regulation, before working together.

Working in the home has the potential for interruption and the constraints involved in working on highly charged subjects when children are in the house or are due to return from childcare. Practitioners recommend that childcare is built into this home-based intervention, although this will increase costs. It is also necessary to make adjustments, such as working in the evening as most participants had jobs.

Programme components

Steps to Safety begins with a series of foundational activities that aim to build insight, set goals, and introduce some simple tools and techniques that will aid emotional strength and regulation. Some activities are designed to be used routinely throughout Steps to Safety to help each person develop a personalised ‘calmness plan’. These activities are also intended to create a predictable structure within Steps to Safety and a shared language for emotional regulation. Practitioners reported that these tools worked well. Participants have practised and developed personalised calmness plans that incorporate activities that they find work for them.

A key message regarding the core exercises – and as will be seen, the programme as a whole – is the need to tailor sessions, even these ‘core skills’ sessions, to parents’ needs and emotional states at any one time.

Data suggests that the combination of several different strategies (learning words for emotions, recognising the physical states associated with emotions, recognising signs of escalating conflict, having a calmness plan in place) can translate into better coping skills and reduced risk of perpetration of reactive violence.

Here and elsewhere, practitioners and couples stressed the value of learning these skills together. Greater emotional regulation and the confidence that comes with it was reported to help parents reflect critically on social and cultural norms, including potentially harmful social norms around gender. The confidence that comes from acquiring these skills appear to have helped some parents make the decision to end a relationship where a partner had abused them and was not willing to change.

Work with parents on communication, validation and praise was reported to lead naturally to discussions about communication and praise with children. Practitioners' recommendations were to incorporate parenting modules earlier on. They also recommended sharing the section on coaching children on their emotions across the NSPCC as it is relevant to many services.

The application of VIG in couples work is still new, and this is the first time it has been used in the context of domestic abuse. Further work is needed to 'blend' the use of video more effectively with work on emotional regulation techniques.

The quality of the relationship with the practitioner

Interviews with parents confirm the paramount importance of a relationship with a warm, skilled and authoritative worker. The practitioner was willing to make changes and adaptations, and in some cases to work in the evenings, provided that the couple made the same commitment, and this too was appreciated. In the case of the couples who have completed Steps to Safety, and to some extent those who separated in the course of the programme, motivation stemmed from the need to offer 'something better' to their children but was sustained by the strengths-based focus of the work and the acquisition of practical skills and deeper insight. This is, of course, consistent with the literature in what works across all forms of theoretically sound therapy, a therapeutic alliance and personal motivation (Laska et al, 2014).

The need for a flexible approach: working with the family to set their agenda

From the outset, practitioners were concerned about the intensity and length of Steps to Safety. After it became clear that this was deterring some couples from taking part, practitioners began to use their professional judgement to adapt the programme in response to the family's needs, for example, by having weekly visits or shorter sessions, and by adjusting the language and in some cases the activities used. The activities required some simplification.

3. Conclusion and next steps

One of the most important learning points from the feasibility study is that ‘one size does not fit all’. This suggests the need for an approach of varying length and intensity, which may need to be broken down into shorter modules with a review. The findings from this paper will help determine which activities are always necessary and which are more flexible.

It has only been possible to test Steps to Safety with a small group of people. Albeit with a limited sample, the attachment and trauma grounded approach of Steps to Safety shows promise in helping end the perpetration of reactive violence, or in ending exposure by strengthening the resolve of one parent to remove themselves and their children from a relationship with a partner that would not change. This is important because of the growing evidence on the developmental risks to children of exposure to domestic abuse.

Practitioners have also proposed that components of Steps to Safety may be relevant to work with highly reactive parents, in families where domestic abuse as such is not the primary presenting problem.

Data suggests that:

- the Steps to Safety model requires further restructuring to address the issues raised in the feasibility study; and
- components of Steps to Safety are likely to be of interest to practitioners who are working in any NSPCC programme with families who could benefit from developing greater emotional regulation.

1. Improve referral pathways

Referral pathways need to include organisations and services that routinely reach families where the level of reactive violence has not yet escalated beyond a critical point. This involves widening the range of referrals from General Practitioners (GPs), midwifery, health visitors, housing associations, Family Nurse Partnership, children’s centres as well as Social Care.

2. Restructuring the Steps to Safety programme for work with families affected by reactive violence

Screening and assessment measures: The expanded ABI and the PARTNR scale were sensitive to the detection of both severe violence and instrumental violence and should continue to be used together. The routine use of the short version DASS (DASS-21) and 3-item Audit C are recommended, but these can be integrated within dynamic assessment.

After screening, practitioners can move to a dynamic assessment. The use of dynamic assessment involving VIG was explicitly recommended in this instance. This approach would enable parents to take part in planning the work that follows. Short self-soothing and mindfulness techniques can be built into the assessment.

Tailoring the programme to the family, using a flexible approach that may involve a succession of shorter modules followed by a review: Practitioners can plan what components they want to use based on the results of the dynamic assessment. Couples should be consulted when drawing up this plan. Shorter modules with revision and the possibility of booster sessions may be more appropriate for some couples provided certain objectives have been reached. Practitioners should use their professional judgement to determine which activities are most effective in helping individuals and the couple achieve greater emotional strength, skill and regulation. Practitioners need to use their professional judgement about when to work one-on-one with a parent, or even in a 'neutral space' outside the home. However, unless there are compelling reasons not to, the use of the core activities (such as the thermometer, calmness plan, mindfulness exercises, family shield) is recommended at the start of the programme and intervals throughout.

Further integration of programme components: This first iteration of Steps to Safety included parenting components towards the end of the programme that need to be introduced earlier. Some activities on early parenting that include coaching parents on how to create structure, and on validation, praise and emotional coaching for children can and should be introduced earlier and could be integrated within VIG.

Need for further support for practitioners who are new to this approach: Practitioners need booster training and advice from professionals with experience in comparable programmes when Steps to Safety, or an adapted version of the programme, is introduced. This guidance is particularly important for team managers.

Once enough practitioners have gained experience, as is the case with the managers and practitioners who delivered this programme, they are in a position to provide support and guidance to others within the organisation.

3. Integrating a 'Steps to Safety approach' to early intervention and other programmes

Steps to Safety comprises a series of intervention modules, many of which are suitable for work with families and individuals who struggle with emotional regulation, often a result of their exposure to ACEs and trauma. Many components of Steps to Safety could be integrated into work with families in which the presenting problem is not domestic abuse as such. This could include work in the antenatal periods and with parents of children in a wide range of other services.

Moreover, materials on coaching children on emotions are likely to be of value to practitioners across NSPCC programmes.

APPENDICES

Appendix 1: Workforce preparation and development

The following section summarises lessons learned on the training and supervision of practitioners. It indicates the need for external supervision – at least of Team Managers – when a project of this intensity is introduced. It ends with participants’ observations on the Steps to Safety manual.

Key messages

Training

- Training was delivered over two three-day periods, with follow-on training 14 months later. The quality of training was felt to be excellent, but practitioners would have preferred it to be more spread out and strongly recommended booster sessions.
- Booster sessions are recommended on the use of screening and assessment tools.
- Face-to-face training should focus on practice and developing skills for delivery. Theory can be circulated before training, and it is possible to provide distance training on the use of assessment measures.

Experience of practitioners

- Steps to Safety can be delivered by social work professionals who have no previous experience in work with couples.
- However, the model of Steps to Safety used in the feasibility study was predominantly delivered by practitioners who are already VIG accredited. The large number of cases closed during assessment meant that practitioners in training could not accrue the professional experience they needed. In the end, all Steps to Safety deliveries were managed by the six accredited practitioners.
- Practitioners had substantial experience of families where domestic abuse was a concern. Their work focused primarily on ensuring the safety of children and women. The range and quality of their prior training on domestic abuse varied but generally involved the Duluth model. This had been complemented more recently by training for the DART and Caring Dads programme.

- The practitioner with the most significant experience of VIG had the confidence to make innovations to it.

Supervision

- Managers could offer only limited support in monthly case supervision because they were new to the programme. Supervision was further complicated in one site where there were changes of managers.
- Managers, in particular, would benefit from regular external clinical supervision, especially in the early stages, so that they can better support staff.
- Forms of peer-to-peer support were developed. The Steps to Safety Pod model could also be documented as it is may of interest to practitioners in other services.

The Steps to Safety manual

- The individual sessions in the manual are detailed and offer a range of activities.
- Practitioners have collected materials from other sources that can be used with people with different language skills and learning styles.
- The manual should be made available digitally as well as in a hard copy. It needed an index and a sample schedule of visits.
- The manual also needed to provide explicit guidelines on child protection in line with NSPCC practice standards.

i. Training

All practitioners had some level of experience and training of working with families in which there was or has been domestic abuse. At one end of the spectrum was a manager who had once worked with Women's Aid; at the other, practitioners who had received some training on domestic abuse at college, perhaps with some work experience later on.

For practitioners involved in frontline child protection, domestic abuse was a constant theme:

"I have worked frontline in child protection teams, where domestic abuse was a present theme in my work, doing a lot of safety planning around keeping children safe, removing families from homes, re-housing them."

(Practitioner)

However, the quality and depth of their earlier training varied. Staff reported taking opportunities to access training on an ad-hoc basis, typically in conferences and workshops where the primary focus was on some other aspect of work with children: *“There have been bits and pieces in workshops and conferences, and as a periphery topic in other programmes.”* (Practitioner). Others had had ‘bits of training’ in prior roles: *“[I have done] bits ... of domestic abuse training, internal and external, for instance, Barnardo’s Risk assessment.”* (Practitioner). In most cases, their training was grounded in the Duluth model, which is guided by feminist and sociological theory.

Some staff had trained with Caring Dads and/or Domestic Abuse, Recovering Together (DART) programmes. Although DART is for women who have left violent partners, and for their pre-adolescent children, DART *“also offered, individual work [where the perpetrator was] female.”* (Practitioner). Other than that, practitioners’ training had focused entirely on work with male perpetrators.

For all staff, prior experience had focused almost exclusively on safeguarding children and enabling women victims/survivors to leave relationships with male perpetrators:

“It was all around the male being the perpetrator. I have never had experience of the female being the perpetrator. But it was all around safeguarding the children, and [...] empowering the women to be able to flee or break free from those abusive relationships.”

(Practitioner)

Irrespective of the nature of their training, no practitioner had prior experience of working with couples. The fact that practitioners did successfully deliver the programme suggests that the combination of their prior experience, together with training on taking a ‘dialectical’ approach, did help them to some extent. However, further supervision on couples work is recommended in future.

Of the nine practitioners initially allocated to Steps to Safety, six had experience of delivering VIG. One of these practitioners had considerable experience and was training as a trainer.

To gain the accreditation necessary to deliver VIG, three new practitioners need to work for about two years under the guidance of an external supervisor. Delays in recruiting families meant that practitioners who had planned to work on Steps to Safety had to gain accreditation by working with families on other programmes. This in turn reduced the number of staff in a position to deliver Steps to Safety.

Effectiveness of training

Training was delivered in two three-day sessions with a fortnight in between. Training also provided the opportunity for a handover between the lead author of the programme and her successor in the NSPCC.

The quality of training was felt to be “*exceptional and opportunities to get that kind of training are rare.*” (Team Manager). Training combined theory and practice, and although both were found useful, the practical sessions were particularly highly rated: “... *training was great, well-delivered.*” (Practitioner). However, even spread over two three-day sessions with a gap in between, training was felt to be too rushed: “*The training was very intense, and I would suggest pacing it differently.*” (Practitioner). Many practitioners felt exhausted by the pace and intensity, as one observed, “*A lot of people walked away feeling overwhelmed. It was rolled out very quickly.*” (Practitioner).

Practitioners very quickly began to apply what they learned about emotional regulation in their own lives, and it was common to hear practitioners refer to the application of materials with their own families: “*[Training on Dialectical Behavioural Therapy] got me thinking about helping my toddler through tantrums!*” (Practitioner).

The gap between training and first clients meant that much information was forgotten. Practitioners also recommended booster sessions, as one practitioner noted: “*In training, you are thinking, yeah, I have got it! – And then when it comes to delivering [the material], it is difficult to remember how to use them.*” It is possible that assessment would have been faster had the practitioners received further booster sessions on the application of the screening measures. The swift application of screening measures is particularly important since, as Hamel and Nicholls (2007) has noted that people are more likely to answer questions on violence perpetration and exposure more accurately if they have to give quick answers.

Feedback from practitioners in the final evaluation indicates that they would prefer training to have been more spread out, of lower intensity, and that it should include refresher sessions: “*It would have been useful to get refreshers once the programme was up and running.*” (Practitioner). Managers, in particular, recognise that ways need to be found to reduce the cost of training while maintaining quality:

“I am mindful of the costs involved in that type of training, and as a manager, I worried that the NSPCC would not be able to deliver something so costly in future.”

(Team Manager)

ii. Supervision

Each NSPCC staff member had a monthly supervision meeting with his or her manager, and this involved looking at cases. Since VIG requires supervision, each practitioner also had a monthly distance supervision session with his or her VIG trainer. A clinical psychologist who has developed Dialectical Behavioural Therapy in the context of domestic abuse was involved in around four telephone conference calls with each team during the early stages of the programme, but work was at such a first stage that it focused only on assessment. This potential source of support was discontinued.

From the perspective of practitioners, the monthly supervision sessions with their managers provided an essential opportunity to take about individual cases. However, as one practitioner observed: *“I have had different managers as well through [this] period, so some better than others, so it has been very varied.”*

A challenge for all managers was, of course, that they were new to Steps to Safety as well. As one practitioner observed:

“Our manager was getting her head around it all too. Managers and practitioners were on the same level, and that made supervision hard. Someone like a family therapist ... better placed to do that.”

(Practitioner)

As a result, one manager explained that managers' capacity to offer supervision was constrained:

“We were thinking together. The benefit is that it gave me the experience of Steps to Safety cases. To take a step back, be holistic and together think about things differently. But clinical supervision would have supported us during the early stages of the programme.”

(Team Manager)

Practitioners were therefore reliant on peer-to-peer support because *“case supervision was not enough. [...] We built up the weekly practice of meetings where our team could discuss issues.”* (Practitioner).

A practitioner in another site found the ‘Steps to Safety pods’ useful both to plan work and to discuss ongoing cases. This is a structured group meeting in which they rehearsed activities, reflected on practice and established routines (such as telephoning a colleague after a home visit):

“I found it helpful to have peer discussions about all the different complexities of the programme and about where we were all at and supporting each other.”

(Practitioner)

In addition to these group meetings, practitioners gave each other one-to-one support, sometimes immediately after a visit:

“We’ve even set up a WhatsApp group between us. So, if we [...] have been on a session in the evening, [our colleague] can message us. We wouldn’t mention names, but it would be, ‘Can I have your advice on something?’, [...] and we’d have a debrief session or something like that.”

(Practitioner)

The need for guidance and supervision is particularly critical when working with couples:

“The fact that we need to be dialectical and do not judge and take sides and things like that, has been really, really beneficial and empowering to these parents, but I don’t feel as if we’ve had anyone in, apart from our managers, to guide us.”

(Practitioner)

iii. The Steps to Safety manual

As noted in the section on programme components (see section 2.3.2 previously), the Steps to Safety manual was felt to contain a collection of interesting resources. Each session in the manual is clearly described and offers guidance and activities that can be adapted by practitioners:

“I think there are some lovely elements and there are some lovely sessions in there, which are effective and ... and can create the change that we’ve talked about, the ... the core components and ... and VIG is so powerful, that strengths-based intervention where they can look back on themselves and how they attune to their kids, yeah.”

(Practitioner)

“It does specify what each session is and what the outcomes are, and it does give different examples of activities and how to make it person-centred.”

(Practitioner)

Although practitioners found the manual to be attractive, they also found it to be impractical to use. It is large, heavy and currently laid out in landscape format within a ring binder, so *“it’s difficult to even turn the pages without them coming out!”* (Practitioner). It is also felt too hard to navigate. One of the main gaps identified is the absence of a flowchart showing when each activity should be delivered:

“There wasn’t a structure or timetable provided in the manual, so having to come up with your own schedule is hard.”

(Practitioner)

“It took some preparation to figure out how the different activities fit together. There is some flexibility to pick and choose between which exercises would be relevant to a family.”

(Practitioner)

Practitioners also felt that the manual needed more explicit alignment with the NSPCC’s practice standards. Attention was drawn in particular to the lack of a clear directive on interviewing older children, that appears only in an appendix:

“I’m not sure how much [authors] looked at the organisation’s practice standards and how they married. One example: it asks us to interview the eldest child in the family, and I think that’s like halfway through the manual – that should be in the beginning. Our bread and butter are ensuring children are safe and we speak to children anyway. But that should be at the front of the manual.”

(Practitioner)

However, the manuals were still being edited and completed right up to the point of training and there was no opportunity for participants to engage with materials prior to training. Where the NSPCC contracts a programme that has been designed and tested elsewhere, materials are likely to have gone through several iterations. This was not the case with Steps to Safety. It would therefore be more practical (and much more cost-effective) to have the manual in digital form, and from practitioners to have access to other resources their colleagues have collected over time.

Summary: training, supervision and resources

Practitioners valued training but recommended booster sessions at periodic intervals.

All practitioners had substantial experience of social work practice with families so, while prior training of working with couples would be an advantage, it was not essential to delivering Steps to Safety. Nonetheless, staff referred on numerous occasions to the constant need for self-awareness in order to avoid being drawn into alliances with one or other partner. Standard supervision from managers was felt to help them maintain objectivity.

Staff receive external supervision as they implement VIG but felt the lack of specialist supervision as they began to implement on the materials on affect regulation.

The most significant responsibility for the programme lay with team managers who are responsible for both frontline practitioners and ensuring the wellbeing of families. In this case, they were tasked to implement therapeutic approaches that were also new to them, in particular, the application of emotional regulations techniques in the context of domestic abuse. Team managers, in particular, would benefit from regular external supervision especially during the early stages of a new intervention such as this.

Practitioners valued peer-to-peer support and developed a format for structured weekly meetings, and their experience could be valuable for other programmes as well.

The Steps to Safety manual should be available in digital form, which would be easier for practitioners to use as well as being more cost-effective.

Appendix 2: Screening and assessment tools

i. Screening

Instrument and version used	Purpose and suitability for this population	Description	Scoring and cut-off point	Populations for which it has been validated and reliability
<p>Abusive Behavior Inventory (ABI) – Revised version (Zink et al, 2007, adapted by Carla Stover, author of the Fathers for Change programme and co-author of Steps to Safety).</p>	Measures frequency of psychological as well as physical abuse between the respondent and his/her partner.	<p>The ABI is a self-report questionnaire that uses 58 items to measure physical and emotional abuse on a 4-point Likert scale.</p> <p>Although initially designed for use with women victims only, it has been adapted for use for both partners in heterosexual and same-sex relationships.</p> <p>In Steps to Safety, participants are asked to record incidents two months before the interview and post-intervention.</p>	<p>A score of 10 or more indicates an abusive relationship.</p> <p>Positive scores on specific items (e.g. perpetration of sexual violence, use of weapons by one or both partners) indicate a level of danger that is too high for conjoint work to be feasible, irrespective of the overall score.</p>	<p>Although widely used, the ABI has not been extensively tested since it was developed with men and women in a substance abuse programme (in primary care settings and with female survivors of abuse (Shepard & Campbell, 1992; Zink, 2007; Postmus et al, 2016).</p> <p>Tests on the original 30-item scale (Shepard & Campbell, 1992) reported that Cronbach alpha was .92 for the entire scale, .91 for the psychological subscale and .86 for the physical subscale.</p> <p>Results indicated that the ABI had good criterion-related validity with the ABI scores accounting for 25% of the variance between the abuse and no-abuse groups. Also, the ABI had good construct validity through the correlation of the ABI to other known abuse measurements and the lack of correlation to demographic variables.</p> <p>A more recent test of the revised ABI found that the two-factor original model (i.e. physical and psychological abuse) was not a good fit. The second phase of EFA revealed that sexual violence is a separate, third factor. The third phase of the study established reliability. Together, these results suggest that these three types of abuse should be recognised and measured as separate constructs.</p> <p>Overall, the ABI was found to be a reliable and valid measure (Postmus et al, 2016).</p>

Instrument and version used	Purpose and suitability for this population	Description	Scoring and cut-off point	Populations for which it has been validated and reliability
<p>Partner Abuse Risk, Treatment and Responsivity Scale (PARTNR) (Wilks-Riley and Graham-Kevan, 2011). Copyright of Forensic Psychological Solutions.</p>	<p>The PARTNR scale is designed to identify treatment need and responsivity to the intervention. Enables assessment of the risk of violence continuation/escalation.</p>	<p>The scale is divided into three sections that are completed by (1) the police with reference to the Police National Computer (5 items) and the individual being referred (3 items); (2) the practitioner (12 items); and (3) the individual being referred (45 items) plus demographic/ diversity questions (5 items). Scoring varies, with some items on a scale of 1–3, some items requiring binary answers (true/false) and some open questions.</p>	<p>Positive scores from specific items in Section 1 (e.g. police records of violence to a previous partner) completed from police records indicate a high risk of violence escalation. A combination of several items indicates the likelihood of instrumental violence.</p>	<p>This is a relatively new tool, and psychometric properties have not yet been established.</p>

ii. Assessment and planning

Instrument and version used	Purpose and suitability for this population	Description	Scoring	Psychometric properties
Depression, Anxiety and Stress Scale (DASS-21) Short Form Version (Lovibond & Lovibond, 1995)	As a guide to planning and to measure change. Severe depression and anxiety may indicate that other forms of treatment may be needed before, or as well as, Steps to Safety.	The short form version of the DASS contains 21 items and measures three related negative emotional states: depression, anxiety and tension/stress on a 3-point Likert scale. It has been tested in psychiatric and non-clinical samples in numerous countries and languages (Henry & Crawford, 2005).	Scores of 40 indicate a normal range; 41 to 79 moderate and severe symptoms; 80+ as extremely severe symptoms.	The short form version of the DASS (DASS-21) has been shown to possess adequate construct validity and high reliabilities (Henry & Crawford, 2005) Cronbach's alphas for the DASS-21 subscales are .94 for Depression, .87 for Anxiety, and .91 for Stress (Antony et al, 1998). Results from CFA modelling indicate that although the three DASS-21 scales index a substantial common factor (i.e. general psychological distress); they also contain variance that is specific to each scale.
Alcohol Use Disorders Identification Test (AUDIT) – 3 items; Alcohol Use Disorders Identification – 10 items (Babor & Grant, 1989).	As a guide to planning and to measure change. Severe alcohol abuses by one or both partners may make adherence to Steps to Safety difficult. Other forms of treatment may be needed before Steps to Safety is possible.	The AUDIT is a brief self-report tool to test for heavy drinking and/active alcohol abuse or dependence on a 4-point Likert scale. Both the short and long versions of the measure were used.	On the 3-item measure, a score of 5+ indicates risk. On the 10-item version, a score of under 7 = low risk, 8 to 15 = increasing risk; 16 to 19 = higher risk; 20+ = possible dependence.	Both the 10- and 3-item versions of Audit C have been extensively tested in numerous countries and languages. One review of 47 original studies confirmed the validity and efficiency of the AUDIT in both the original version and modified ones and has consistently reported reliability. The results indicate that the abridged versions have satisfactory psychometric qualities, sometimes with sensitivity values higher than those of the AUDIT itself (Meneses-Gaya et al, 2009).
Co-parenting Relationship Scale (CRS) (Feinberg et al, 2012)	As a guide to planning and to measure the change in co-parenting post-intervention.	The CRS is a self-report tool that consists of 35 items organised into seven subscales: co-parenting agreement, co-parenting closeness, exposure to conflict, co-parenting support, co-parenting undermining, endorse partner parenting, and division of labour.	Responses are ranged on a 6-point Likert scale. There is no cut-off point as such.	Initial examination of the Co-parenting Relationship Scale involved parents of preschool children. This found that it has excellent psychometric properties (reliability, stability, construct validity, and inter-rater agreement) with Cronbach's alphas ranging from .91 to .94 across gender and data collection time points. The brief CPR also maintained good internal consistency, with alphas ranging from .81 to .89. Alphas for the seven parenting subscales were more varied but generally strong (Feinberg et al, 2012).

Instrument and version used	Purpose and suitability for this population	Description	Scoring	Psychometric properties
Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003)	As a guide to planning and to measure change in emotional regulation strategies, including their use of cognitive reappraisal.	The ERQ has 10 items that assess the individual's use of two emotion regulation strategies: cognitive reappraisal and expressive suppression on a 7-point Likert scale.	Scores are cumulative. High scores indicate use of either cognitive reappraisal or suppression.	The ERQ has been tested with student populations and community samples. Internal consistencies are acceptable for both the original and the modified version: reappraisal (Cronbach's alpha = .82) and suppression (alpha = .76) (Wiltink et al, 2011).
Relationship Questionnaire (RQ) (Bartholomew & Horowitz, 1991)	As a guide to treatment planning. To provide an approximate identification of participants attachment pattern.	The RQ is made up of four short paragraphs, each describing a prototypical attachment pattern as it applies in close adult peer relationships. The RQ was designed to obtain <i>continuous</i> ratings along a 7-point scale, of each of four attachment patterns.	Respondents rate the degree to which they resemble each style.	Compared to 24 other instruments that measure adult attachment, the RQ is reported to demonstrate acceptable convergent, discriminant, and predictive reliability and excellent properties with respect to validity. Cronbach's c values for different scales ranged from low for security (.32) to high for fearful (.79) (Ravitz et al, 2010).
Strengths and Difficulties Questionnaire (SDQ) (for children aged 3–4 years) (Goodman, 2001)	As a guide to planning and to measure change in parent perception of children's behaviours, emotions and relationships.	In Steps to Safety, it was used only to identify the attachment pattern that best fits the respondent. The SDQ is a 25-item screening tool that describes children's behaviours, emotions and relationships on a 3-point Likert scale. The SDQ has five subscales: Emotional symptoms; Conduct problems; Hyperactivity-inattention; Peer problems; and Prosocial behaviours.	A score of 16 to 18 is considered high, and of 19 to 40 very high.	Extensive testing of the construct and concurrent validity and test-retest and inter-rater reliability of the SDQ has been undertaken with families in industrialised and low-income countries, and the instrument is generally found to be strong in terms of these psychometric properties. Less work has been done in the areas of content validity, predictive validity, sensitivity to change and feasibility and utility, but studies that provide information in this regard indicate that the instrument performs well on these dimensions too (Pirkis et al, 2005).

Appendix 3: Demographic data, behaviour and risk factors

1. Demographic data

Demographic data was recorded for 70 people as of June 2018. Screening and assessment data were not kept for people who were screened out before beginning Steps to Safety, because of issues related to consent. The data on screening and assessment measures, therefore, involves only 18 people.

The majority of referrals (53 per cent) were from Social Care, although this probably includes a substantial proportion of families where the source of the referral is not recorded. Most couples (81 per cent) were white British, which to some extent reflects the demography of three project sites. However, the first family to complete the programme was white European. The majority (also 81 per cent) was heterosexual and since it is the decision of some practices not to ask about sexual orientation, the number is probably higher. Six per cent of the sample was bisexual, gay or unsure about their sexual orientation. Mental health needs over the life course were reported by 33 per cent of the sample. Seven per cent of parents referred had been raised in care – a figure significantly higher than the national average for the UK.¹⁹

Referral sources	%	N=70
Social Care	53%	37
Not recorded	39%	27
Health services	7%	5
Others (e.g. Family Nurse Partnership)	3%	2
Ethnicity	%	N=70
White British	81%	57
White European	7%	5
Other	9%	6
Not reported	3%	2
Age	Average	Range
Male	31	20–59
Female	29	18–41
Religious affiliation	%	N=70
Not stated or practice decision not to ask	36%	25
Christian	31%	22
No religion	26%	18
Other	7%	5

¹⁹ See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664995/SFR50_2017-Children_looked_after_in_England.pdf.

Muslim	4%	3
Sexual orientation	%	N=70
Heterosexual	81%	57
Not stated or practice decision not to ask	13%	9
Bisexual	4%	3
Lesbian	1%	1
Unsure	1%	1
Disabilities and special needs	%	N=70
Mental health needs	33%	23
Behavioural emotional disability	30%	21
Physical health needs	4%	3
Other learning difficulties	3%	2
Speech and language	1%	1
Mild learning difficulties	1%	1
Hearing impaired	1%	1
Other disability	1%	1
Visual impairment	0%	0
Autistic spectrum	0%	0
Childhood in care	%	N=70
Looked after child	7%	5

2. Screening data

i. Patterns of abusive behaviour

The following is a summary of Abusive Behavior Inventory (ABI) reports on partners' behaviour by 18 individuals who were screened into and engaged in Steps to Safety. The set is small as data from screening and assessment was not logged for respondents who did not begin Steps to Safety, as consent to use this data was requested after the couple had been screened in. These tables summarise the number of respondents reporting an abusive behaviour, whether a 'one off' or chronic form of abuse, perpetrated by their partner over the previous two months.

The most frequently reported forms of abuse were emotional – calling partner names, putting down partner's family and friends and other controlling behaviours. The most commonly reported forms of physical violence were pushing, shoving partner, threats to hit the partner and kicking their partner.

Abusive behaviour perpetrated over last six months – all respondents (N=18)	Perpetrated by partner to respondent	
	N=18	%
Called partner names and/or criticised partner	18	100%
Ended a discussion with and made the decision him/herself	16	89%
Put down partner's family and friends	15	83%
Gave partner angry stares or looks	14	78%
Tried to keep partner from doing something he/she wanted to do	13	72%
Threatened to hit or throw something at partner	13	72%
Pushed, grabbed or shoved partner	13	72%
Accused partner of paying more attention to someone/ something else	12	67%
Kicked partner	9	50%
Said things to scare partner (e.g. that something 'bad' would happen, threatened to commit suicide)	7	39%
Became very upset because of dinner/ housework	5	28%
Stopped/tried to stop partner from going to work/study	5	28%
Used children to threaten partner (e.g. told you that he would lose custody, said he/she would leave town with the children)	4	22%
Threatened with a weapon	4	22%
Put partner on an allowance	3	17%
Drove recklessly when he/she was in the car	3	17%
Physically attacked the sexual parts of partner's body	3	17%
Slapped, hit or punched partner	2	11%
Made partner do something humiliating or degrading (e.g. beg for forgiveness, ask permission to use the car or to do something)	2	11%
Checked up on partner (e.g. listened to phone calls, checked mobile, etc.)	2	11%
Used a knife, gun, or other weapon against partner	2	11%
Prevented partner from having money for their own use	1	6%
Pressured partner to have sex in a way that he/she did not want	0	0%
Refused to do housework or childcare	0	0%
Said partner was a bad parent	0	0%
Threw, hit, kicked or smashed something	0	0%
Physically forced partner to have sex	0	0%
Threw partner around	0	0%
Choked or strangled partner	0	0%

ii. Factors associated with risk of escalating violence

The following summarises the presence of factors associated with the risk of escalating violence recorded on the PARTNR scale in a sub-sample of eight parents (four men and four women) identified as having perpetrated violence. Data on one further parent is incomplete and not included. The most frequently occurring risk factors are partner depression, being under the age of 25, relationship discord, negative urgency and a personal history of depression.

PARTNR scale items – subsample (N=8)	%	N=8
Partner has depression	88%	7
Young age	75%	6
Relationship discord	75%	6
Negative urgency	63%	5
History of depression	63%	5
Difficulties with substance misuse	50%	4
Recent increase of conflict in relationship	50%	4
Unmarried or cohabiting less than 5 years	50%	4
Childhood history of trauma	38%	3
Partner difficulties with substance misuse	26%	2
Emotionally unstable personality disorder traits	25%	2
Respondent is male perpetrator; partner is female and aggressive	13%	1

iii. Alcohol consumption (3-item AUDIT scale)

Alcohol consumption was above the recommended daily and weekly limits for seven of the 18 respondents. Three respondents scored eight points, indicating problem drinking.

AUDIT scores – all respondents (N=18)	%	N=18
1–4 (moderate use)	61%	11
5+ (risk of problem drinking)	39%	7

iv. Depression, Anxiety and Stress (DASS)

The DASS contains three subscales for depression, anxiety and stress. Sixty-six per cent of the sample scored above the normal range for anxiety, while 37 per cent reported mild to extremely severe levels of depression. Scores for stress were lower, with 19 per cent over the normal range.

Depression		
Level	%	N=16 (data incomplete for two cases)
Extremely Severe 28+	6%	1
Severe 21–27	0%	0
Moderate 14–20	19%	3
Mild 10–13	13%	2
Normal range 0–9	63%	10

Anxiety		
Level	%	Number
Extremely Severe 20+	13%	2
Severe 15–19	6%	1
Moderate 10–14	25%	4
Mild 8–9	13%	2
Normal range 0–7	44%	7

Stress		
Level	%	Number
Extremely Severe 34+	6%	1
Severe 26–33	0%	0
Moderate 19–25	0%	0
Mild 15–18	13%	2
Normal range 0–14	81%	13

Note: Inconsistencies were observed in the application of the Relationship Questionnaire (Bartholomew & Horowitz, 1991). The results obtained are therefore unreliable, and they are as such not reported further here.

3. Assessment measures

i. Child outcomes

This represents the number of parents who responded positively to each question on the SDQ (parent report version). Responses pertain to 12 children, aged 2–4 (N=7) and 4+ (N=5). The remaining couple had a child under the age of 2 or were expecting their first child. The most commonly reported problems reported were temper tantrums, restlessness and distractedness. All parents highlighted children’s positive qualities more frequently than the children’s challenging behaviours.

Strengths and difficulties of child aged 2–4	%	N=12
Generally liked by other children	100%	12
Considerate of other people’s feelings	92%	11
Shares readily with other children (treats, toys, pencils etc.)	92%	11
Often has temper tantrums or hot tempers	92%	11
Rather solitary, tends to play alone	92%	11
Generally obedient, usually does what adults request	92%	11
Helpful if someone is hurt, upset or feeling ill	92%	11
Kind to younger children	92%	11
Restless, overactive, cannot stay still for long	83%	10
Has at least one good friend	83%	10
Easily distracted, concentration wanders	83%	10
Often volunteers to help others (parents, teachers, other children)	83%	10
Sees tasks through to the end, good attention span	83%	10
Constantly fidgeting or squirming	75%	9
Nervous or clingy in new situations, easily loses confidence	75%	9
Can stop and think things out before acting	75%	9
Often argumentative with adults	58%	7
Picked on or bullied by other children	50%	6
Can be spiteful to others	50%	6
Gets on better with adults than with other children	42%	5
Many fears, easily scared	33%	4
Often complains of headaches, stomach aches or sickness	25%	3
Often fights with other children or bullies them	25%	3
Often unhappy, downhearted or tearful	25%	3
Many worries, often seems worried	8%	1

ii. Co-parenting relationship: strengths and difficulties

This summarises data from the Co-parenting Relationship Scale (CRS). Responses are scored from 0–6, indicating disagreement (0) to a high level of agreement (6). This table presents the percentages and numbers of respondents who indicated agreement by scoring from 4 to 6 on the scale. Negative items are given a reverse score (R); for further details, see Feinberg, 2012).

The most commonly reported problems were differences in views on how to raise a child, saying spiteful things to each other (which is congruent with findings from the ABI [see above]) and a partner's unwillingness to stop 'doing their own thing' when they needed to focus on the child.

Co-parenting item	%	N=18
My partner and I have the same goals for our child	89%	16
My partner pays a great deal of attention to our child	94%	17
My partner and I have different ideas about how to raise our child (R)	56%	10
We are growing and maturing together through experiences as parents	72%	13
I feel close to my partner when I see him/her play with our child	89%	16
Parenting has given us a focus for the future	89%	16
My partner still wants to do his/her own thing instead of being a responsible parent (R)	28%	5
My partner appreciates how hard I work at being a good parent	56%	10
My partner and I have different ideas regarding our child's eating, sleeping, and other routines (R)	39%	7
My partner asks my opinion on issues related to parenting	28%	5
My partner is willing to make personal sacrifices to help take care of our child	72%	13
My partner is sensitive to our child's feelings and needs	78%	14
My partner undermines my parenting	28%	5
My partner does not trust my abilities as a parent	22%	4
It is easier and more fun to play with the child alone than it is when my partner is present too	28%	5
When all three of us are together, my partner sometimes competes with me for our child's attention	22%	4
I believe my partner is a good parent	94%	17
My partner does not like to be bothered by our child (R)	17%	3
My partner tells me I am doing a good job or otherwise lets me know I am being a good parent	56%	10
When I am at my wits end as a parent, my partner gives me the extra support I need	61%	11
My partner tries to show that he/she is better than me at caring for our child	17%	3
My partner makes me feel like I am the best possible parent for our child	56%	10
My partner has a lot of patience with our child	67%	12

Co-parenting item	%	N=18
My partner likes to play with our child and then leave the dirty work to me (R)	56%	10
My partner does not carry his/her fair share of the parenting work (R)	28%	5
My partner sometimes makes jokes or sarcastic comments about the way I am as a parent	28%	5
My partner and I have different standards for our child's behaviour (R)	44%	8
The stress of parenthood has caused my partner and me to grow apart (R)	33%	6
We often discuss the best way to meet our child's needs	67%	12
My relationship with my partner is stronger now than before we had a child	44%	8

Conflict subscales:		
Do you: Say spiteful things to your partner?	83%	15
Argue with your partner <u>about your child</u> , in the child's presence?	17%	3
Argue about your relationship or marital issues <u>unrelated to your child</u> , in the child's presence?	6%	1
One or both of you say cruel or hurtful things to each other in front of the child?	0%	0
Yell at each other within earshot of the child?	0%	0

iii. Emotional regulation

This summarises self-reported trends towards cognitive reappraisal and emotional suppression. The Emotional Regulation Questionnaire (ERQ) is scored from 1 to 7, with 1 indicating strong disagreement through to 7 indicating strong agreement, with a statement about their emotional regulation strategies. This table presents the percentages and numbers of respondents who indicated agreement by scoring from 5 to 7 on the scale. Overall scores were actually higher for cognitive reappraisal than for suppression.

Cognitive reappraisal item	% indicating agreement (5+ on scale)	N=19
When I want to feel more <i>positive</i> emotion (such as joy or amusement), I <i>change what I am thinking about</i>	89%	17
When I want to feel less <i>negative</i> emotion (such as sadness or anger), I <i>change what I am thinking about</i>	79%	15
When I am faced with a stressful situation, I make myself <i>think about it</i> in a way that helps me stay calm	74%	14
When I want to feel more <i>positive</i> emotion, I <i>change the way I am thinking</i> about the situation	74%	14
I control my emotions by <i>changing the way I think</i> about the situation I am in	84%	16
When I want to feel less <i>negative</i> emotion, I <i>change the way I am thinking</i> about the situation.	84%	16
Emotional suppression item	% indicating agreement (4+ on scale)	N=19
I keep my emotions to myself.	84%	16
When I am feeling <i>positive</i> emotions, I am careful not to express them	79%	15
I control my emotions by <i>not expressing them</i>	63%	12
When I am feeling <i>negative</i> emotions, I make sure not to express them	26%	5

Appendix 4: Risk factors for domestic abuse perpetration: summary of review-level evidence

The following is a summary of the NSPCC's review *Risk factors for domestic abuse perpetration: a summary of the evidence, 2000–2014* (Schrader McMillan et al, 2016):

1. Biological factors associated with an increased risk of violence and aggression, with specific reference to domestic abuse

Findings from these studies provide evidence that domestic abuse is not exclusively the outcome of social learning processes and underscore the importance of addressing genetic factors in research in this area.

Factors associated with domestic abuse

Traumatic Brain Injury (TBI): strong evidence that **TBI significantly increases the risk of domestic abuse**. These studies concluded that head injury cannot be the cause of domestic abuse, but that it might impair the impulse control mechanism, which in turn may increase the risk of aggressive behaviour. Also, personality changes resulting from head injury may have an impact on relationship quality, which consequently may lead to aggressive behaviour in the head injury survivor (Farrer et al, 2012; Pinto et al, 2010; see Ali & Naylor, 2013; Capaldi et al, 2012).

Physiopathology: Physiological reactivity refers to any changes in the body brought about by a stimulus. Examples include changes in heart rate, blood pressure or cholesterol in response to a stressor. To date, no consistent pattern of baseline physiological differences or physiological reactivity to laboratory tasks appears to distinguish domestic abuse perpetrators (Pinto et al, 2010; see Ali & Naylor, 2013).

Neurochemical, metabolic and endocrine factors: Researchers have explored the role of neurotransmitters, such as testosterone and serotonin, with deviant behaviours. There is substantial evidence that high testosterone levels are associated with a high probability of aggression, sensation seeking, depressed occupational achievement and criminal, violent and/or anti-social behaviour. **Decreased serotonin levels** have also been found to have an adverse effect on mood and behaviour, whereas increased serotonin levels have been found to result in improved social interaction and decreased aggression (Pinto et al, 2010).

Genetics: evidence based on a single, but very strong, study involving twins (Hines & Saudino, 2004) found that while the majority of variance is explained by non-shared environmental influences (i.e. unique experiences that operate on one, but not both, twins), a significant proportion of variance in domestic abuse in this study can be accounted for by heredity. Though it is unlikely any genes confer risk for domestic abuse specifically, **it is conceivable that genetic polymorphisms indirectly influence the development of maladaptive patterns of behaviour**, including domestic abuse, **through their influence on mediating factors**, such as personality and psychiatric symptomatology (Pinto et al, 2010).

2. Demographic risk factors

While demographic risk factors (and childhood experiences) do increase the risk of domestic abuse perpetration, a meta-analysis by Stith et al (2004) found that these factors were less predictive of the more proximal factors: impulsivity and the overall quality of the relationship.

Although there is no review-level evidence about ethnicity and domestic abuse in the UK, findings from the US show that domestic abuse levels are higher where there is active or tacit community level approval of violence in general and domestic abuse in particular. US-based studies find that abuse levels are higher among second-generation immigrants and point to stressors inherent in acculturation. These should be borne in mind in the UK, where the second-generation immigrant citizens may face multiple stressors and conflicting expectations.

Prevention of domestic abuse should also include specific programmes targeted at teenagers, including school-based violence prevention programmes that need to begin in primary school (see, for example, Adi et al, 2007; Weare & Nind, 2011). The intervention may need to include referrals to other services that relieve financial and other forms of stress on families as well as enabling perpetrators of domestic abuse to manage these stressors. Given the association between young age and domestic abuse, the intervention should target younger couples and first-time parents where possible.

Factors associated with domestic abuse

Age: The most robust systematic review (Capaldi, 2012) found that the **peak for domestic abuse occurs in late adolescence and young adulthood – a pattern consistent with patterns for crime and violence** more generally (Wiesner et al, 2007). Further research is needed to analyse differences between CCV and SCV in this context.

Education: Findings for education overall indicate **some association** (e.g. Cunradi et al, 2002; see Capaldi et al, 2012), which often dissipates when other more proximal factors, such as relationship conflict, are controlled for (Capaldi et al, 2012). Evidence reported by studies suggests that unemployment and low income are stronger and more robust demographic risk factors for domestic abuse than education level (Ibid).

Ethnicity: There is no review-level evidence about ethnicity and domestic abuse in the UK. **Minority group membership is predictive of domestic abuse** in the US, where prevalence is highest among African Americans and second-generation Hispanic Americans (Ramisetty-Mikler et al (2007), in Capaldi et al, 2012). Other factors may mediate the effects of ethnicity. Capaldi's studies in the US found higher levels of risk for second-generation Hispanics who are acculturating to the US, rather than first-generation immigrants, pointing to the **stress involved in acculturation**.

Immigration status: One recent study in the UK has found that being dependent for **immigration status** is significantly associated with higher levels of psychological perpetration, sexual victimisation and perpetration, and physical victimisation and perpetration (Hatzidimitriadou et al, 2012).

Low income and unemployment are consistently associated with domestic abuse. Cross-sectional work appears to support **a significant association between unemployment and domestic abuse**. Pan et al (1994) found that any male to female domestic abuse was associated with lower income and that severe violence was associated with lower income than mild violence. Cunradi et al (2002) found that, after controlling for alcohol use/abuse, childhood parent-perpetrated violence, approval of domestic abuse, impulsivity, age, and relationship factors, **annual household income was the most critical predictor of domestic abuse** across three major ethnic groups in the US.

School violence and perception of safety: Some studies have found an association between school bonding (i.e., the degree of endorsement of 'my school is like a family') and domestic abuse perpetration in a longitudinal study of a school-based sample of adolescents, but other factors mediate this. For instance, after controlling for demographic variables, Foshee et al (1996) found that **school bonding was associated with decreased odds of perpetrating both peer violence and dating violence for girls**; however, for boys, it was associated with increased odds of perpetrating peer and dating violence compared with peer violence only.

Stress: In cross-sectional work, Smith Slep et al (2010) examined financial and community stress among several other factors in predicting to men's and women's domestic abuse perpetration and victimisation for an Air Force sample. They found that – after controlling for many other factors at the relationship, individual, family, organisation, and community levels – **financial stress** predicted men's and women's domestic abuse perpetration.

3. Biological and demographic factors; Cognition, behaviour, emotion and mental health

While demographic risk factors (and childhood experiences) do increase the risk of domestic abuse perpetration, a meta-analysis by Stith et al (2004) found that these factors were less predictive of the more proximal factors: impulsivity and relationship factors. Conduct problems associated with higher risk of anti-social behaviour and domestic abuse perpetration can be traced to childhood while others crystallise in adolescence (e.g. through peer group influences). These again point to the need for school-based prevention/anti-violence programmes and early intervention with children at risk through upstream prevention and parenting programmes. Warm, involved parenting is associated with reduced risk of adolescents' involvement with deviant peers in adolescence.

Although the intervention will involve screening for alcohol and drug abuse, these are risk factors independent of domestic abuse and, at a certain level, present danger that makes a conjoint intervention unfeasible.

Factors associated with domestic abuse

Conduct problems/anti-social behaviour, anger and hostility: A relatively large number of prospective longitudinal studies have traced the relationship between problem behaviours related to the childhood diagnoses of conduct disorder and the adult diagnosis of anti-social personality disorder (e.g. impulsive and societal rule-breaking behaviours, including delinquent and aggressive behaviours) as developmental risk factors for domestic abuse. **Conduct problems or anti-social behaviour are consistently found to be a substantial risk factor for later domestic abuse involvement** (as it is for other kinds of adult violence), is implicated in the developmental histories of both men and women who perpetrate domestic abuse and is frequently found to be a mediator for earlier risk factors, such as harsh parental treatment.

Association with deviant peers: Association with deviant peers is a **strong predictor of problem behaviours** in general including dating aggression in adolescence (Dishion et al, 2006; 2010).

Depression: The association of depressive symptoms with domestic abuse has been studied mainly in samples of young adults. Findings for depressive symptoms indicate that they are associated with both domestic abuse perpetration and victimisation, but that **this association is not robust in multivariate analyses and may be stronger for women than for men** (Capaldi et al, 2012).

Psychopathology: There has been very little research on the relationship between severe mental illness (schizophrenia, psychosis) and domestic abuse. A systematic review by Lowenstein et al (2016) reported inconsistent findings, in part because comorbidity in diagnoses presents additional complexity in risk assessment.

Men's expectations of female partners (gendered norms): Men with more traditional, rigid, and misogynistic gender-role attitudes are more likely to practice violence towards women (see Flood & Pease, 2009). A meta-analysis aggregating an aspect of masculine ideology to the incidence of sexual aggression towards women found that all but one measure of masculine ideology were significantly associated with sexual aggression (Murnen et al, 2002). **Hostile talk about women** (observed during male peer interactions at ages 17–18 years) was significantly predictive of later male to female partner violence (see Capaldi et al, 2001); see Cognition, below.

However, there is consistent evidence from community-based samples that male entitlement is **one risk factor, of low to medium statistical significance** (e.g. Stith et al, 2004; O'Leary, 2007) and **less significantly associated with violence than men's exposure to domestic abuse in childhood, capacity to manage anger, and perception of social support**. While O'Leary (2007) also found a strong association for the exercise of violence with a desire for control, and with jealousy, this was true for both men and women, a finding confirmed by Caldwell et al (2010) on a study of women's perpetration of domestic abuse. Societal norms around masculinity do not explain violence by women towards men that is not in self-defence (i.e. woman perpetrated CCV or SCV) or violence in same-sex couples, pointing to the importance of other factors in attempted control or acts of actual violence. Studies on non-violent adolescents and men in violent settings, i.e. where hyper-masculinity is not only socially sanctioned but demanded draw attention consistently to meta-cognition and reflective functioning as a critical differentiator of non-violent, gender-equitable men (see, for example, Barker, 2005; Montoya, 1998).

Cognition and social attributions towards violence: Specific aspects of hostile cognitions or attributions have been examined in relation to domestic abuse. Capaldi et al (2001) found that hostile talk about women (observed during male peer interactions at ages 17–18 years) was significantly predictive of later male to female domestic abuse (at ages 20–23 years) in a path model controlling for other factors. Hostility was related to aggression and anti-social behaviour more generally, but it seems that **hostile thinking may add to the prediction of domestic abuse over and above conduct problems (e.g. poorly controlled or impulsive behaviours)**. Overall, hostility toward women is a low to moderate proximal predictor of domestic abuse. Attitudes approving of or justifying domestic abuse by either men or women are low to moderate proximal predictors of domestic abuse.

Alcohol and substance abuse: Alcohol is widely considered to be a critical proximal predictor of domestic abuse because of its hypothesised disinhibitory effect on aggression (Flanzer, 2005). Drug use has been less frequently examined as a predictor. Overall, these findings indicate that although there is evidence for an association of indicators of alcohol use with domestic abuse perpetration and victimisation, it is not as reliable or as consistent as has generally been supposed and is mediated by other factors. More recent research on domestic abuse perpetrating men (Romero-Martinez et al, 2013) finds that **alcohol abuse exacerbates socio-cognitive impairments and in the proneness to violence and its recidivism in perpetrators who are affected by other risk factors:** rejection during childhood and early androgen exposure.

One systematic review (Capaldi et al, 2012) found that the association between alcohol abuse and the risk of both perpetration and victimisation **may be stronger for girls and women than for boys and men**. There are fewer studies on the use of drugs and domestic abuse, but those that are there suggest that there **could be a stronger association between them** (Capaldi et al, 2012). A recent study by Stover and Kiselic (2014) found that perpetrators higher in hostility are more likely to use substances, leading them to perpetrate domestic abuse. Rejecting and aggressive parenting was more frequent when substance use was involved, so that other risk factors, such as hostility that increase the likelihood of substance use, also may increase the likelihood of poor parenting behaviour.

4. Marital and relationship factors

Marital or relationship conflict is a robust proximal predictor of domestic abuse for men and women, but the relationship between attachment status and relationship adjustment has been identified. For example, Henderson et al (1997) found that anxious attachment style is associated with shorter relationship length, more frequent separations, continued emotional involvement with partner post-separation and more frequent sexual relations with the partner post-separation. The pairing of dismissive and anxiously attached partners has been found particularly predictive of domestic abuse (see above).

Factors associated with domestic abuse

Relationship discord: Relationship discord is a proximal risk factor to domestic abuse and is theoretically and practically akin to psychological aggression toward a partner (Capaldi et al, 2012). Aldarondo and Sugarman (1996) examined persistence in male to female domestic abuse perpetration/victimisation over time and found that low levels of marital agreement increased the risk. In cross-sectional work, Coleman and Strauss (1986) found for male to female and female to male violence, egalitarian couples had the lowest rates of conflict and violence, and male-dominant, and female-dominant couples had the highest rates. Egalitarian couples experienced little increase in the violence rate when conflict increased, especially for male to female violence. **Male-dominant couples were most likely to have experienced a high degree of conflict, almost twice as likely as couples with an equalitarian relationship.**

Bookwala et al (2005) examined perpetration and victimisation for male to female partner violence. They found that **younger participants used more maladaptive (higher confrontation) conflict resolution strategies**, engaged in more physical arguments, and sustained more injuries than older participants; thus, marital discord was associated with domestic abuse.

After controlling for SES, ethnicity, and age, **men who witnessed parental male to female violence were more likely to be verbally aggressive during marital conflicts that were associated with greater likelihood of marital distress, and high levels of marital distress were associated with male to female domestic abuse.**

As noted above (see Men's expectations of female partners), a desire for control and jealousy are strongly associated with the perpetration of domestic abuse by both men and women (O'Leary 2007; Caldwell et al, 2010).

Communication skills: Evidence suggests that violent men tend to suffer from poor communication skills and engage in less positive or constructive communication (Berns et al, 1999; Holtzworth-Munroe et al, 1997) during interactions with their intimate partners, compared with non-violent men. It has been suggested that **violent partners tend to lack these skills and use violence when they are unable to resolve marital conflicts with other less destructive options** (Holtzworth-Munroe et al, Ibid).

Witnessing domestic abuse as a child, child abuse, and attachment security

Studies on perpetrators of domestic abuse have found that the majority witnessed or experienced parental violence, community violence, or multiple traumas (McKinney et al, 2009; see also Anda et al, 2006). Witnessing domestic abuse and experience of child abuse and neglect undermine the possibility of secure attachment and compromise the victim's capacity to respond to stressful situations and regulate stress in childhood and beyond.

Factors associated with domestic abuse

Witnessing domestic abuse as a child, as a risk factor for replicating domestic abuse: One review (Gil Gonzales et al, 2007) finds a **robust association** between exposure to violence in childhood and increased risk of domestic abuse, but the review conflates child abuse and witnessing domestic abuse between parents. Multivariate analyses show that for boys, witnessing domestic abuse as a child increases the risk of reproducing this pattern as an adult (O'Leary, 2007). Choice et al (1995) examined conflict resolution strategies and marital distress as mediating factors in the link between witnessing interparental violence and male to female partner violence. After controlling for SES, ethnicity and age, men who witnessed parental male to female domestic abuse were more likely to be verbally aggressive during marital conflicts that were associated with greater likelihood of marital distress, and high levels of marital distress were associated with male to female domestic abuse.

Child abuse and neglect: Studies have found a low to moderate significant association of child abuse and neglect with later domestic abuse. White and Widom's (2003) study indicated that effects appear to be **mediated by subsequent problematic development, including anti-social behaviour and substance abuse**. There is no indication of major gender differences in these associations.

Attachment status: A systematic review by Ogilvie et al (2014) included seven studies of men incarcerated for domestic abuse/battery. **A strong association was found in all studies between insecure attachment and domestic abuse**, as with other forms of criminality (i.e. sexual offending, violent offending, non-violent offending, and domestic abuse) encompassed by the review.

Research on domestic abuse **perpetrators had found that they were likely to be insecurely** attached (Dutton & Kerry, 1999) and that perpetrators were more likely to be violent toward their partners when they feared abandonment. The preoccupied and anxious attachment styles have also been found more prevalent among the victims of domestic abuse (see, for example, Bond & Bond, 2004; Siegel, 2013). Studies of violence at couple levels have echoed findings that **insecure partners use violence as a technique to regulate attachment needs** (Allison et al, 2008; Bond & Bond, 2004). There is evidence that hypersensitivity to rejection can set off violent behaviour in men and that anxiety over abandonment is a predictor of violence in both men and women (Babcock et al, 2000). It is particularly dangerous in men who are rejection-sensitive and have a stronger masculine identity (Downey et al, 2005).

The **pairing of avoidant and anxious partners is also associated with intimate partner violence in both men and women**. This 'mispairing' of an avoidant male with an anxious or preoccupied female is a very high-risk factor for domestic abuse perpetration and victimisation (Doumass et al, 2008). **Female attachment anxiety is predictive of female violence only when male perpetrated violence has occurred first** (Doumass et al, 2008). A recurring source of conflict is therefore likely to be around the need to define the relationship as a secure base (Johnson et al, 2006).

In addition to anxious attachment being a risk factor for victimisation, it is also an **obstacle to fully and successfully leaving a violent intimate relationship** (Henderson et al, 1997), since as Bartholomew and Allison (2006) noted, **the strength of the attachment bond in an abusive relationship is not related to the quality of that relationship**. Both partners can become locked in a dangerous pattern of seeking/avoiding proximity (Standish, 2012).

5. Aspects of individual functioning

The following are some aspects of individual functioning that have been identified in adults with an anxious attachment pattern. All mediate between distal risk factors and other difficulties (including problems in the relationship) and the act of violence. Findings draw in particular on work by Siegel (2013) and Murphy (2013).

Factors associated with domestic abuse

Mentalisation: Fonagy's (1999) concept of mentalising describes the process by which one implicitly and explicitly interprets the internal states of oneself and others based on the cues in their behaviour. The capacity to mentalise is rooted in very early, sensitive and attuned interaction between infants and primary carers; individuals with **fearful (disorganised) attachment have poor mentalising capacities**. Lack of self-awareness regarding gradual changes in emotional states and restricted tolerance of feeling states may lead to confusion about causation, as an internal state of distress may be perceived as being inflicted by a partner. Cognitive distortions and inaccurate appraisal increase the release of stress hormones and emotional memories that culminate in an overwhelming state of emotional distress (Wolf, 2007).

Reflective functioning: Recent literature indicates that men with histories of exposure to violence in their childhoods who themselves have used violence in their relationships have **very poor RF skills**; they often do not understand their feelings and emotions and even less so those of their children (Stover & Spink, 2012; Stover & Kahn, 2013). Strong dependency needs and emotional responses to frustration have also been described in domestic abuse populations (Carney & Buttell, 2006). The difficulty in recognising emotions makes it difficult to identify situations that generate fear, 'flooding' which can escalate to violence. High RF is strongly associated with optimal maternal parenting behaviours (e.g. flexibility and responsiveness); while low RF is associated with emotionally unresponsive maternal behaviours (e.g. withdrawal, hostility, intrusiveness) (Slade et al; 2001; Grienberger et al, 2001).

Specific triggers for domestic abuse in anxiously attached perpetrators: Noller and Robillard (2007) cite evidence that hypersensitivity to **rejection** can set off violent behaviour in men and that **anxiety over abandonment is a predictor of violence in both men and women**. Rejection may be closely **linked to shame and powerlessness**, which are particularly relevant to personal wellbeing and have been closely linked with anger and aggression; rejection is particularly stressful for individuals who have insecure attachment patterns (Sonkin & Dutton, 2003). An overwhelming sense of powerlessness may revive stored schemas of being victimised or abandoned (Siegel & Geller, 2000). Criticism may also be an active trigger in populations with domestic abuse (Siegel, 2013).

Social Information Processing (PIP): Compared with non-violent men, **male abuse perpetrators attribute more negative intentions to female partners** in hypothetical scenarios (e.g. Holtzworth-Munroe & Hutchinson, 1993; Holtzworth-Munroe, 2000), for example assuming that women engage in negative behaviours with the express intent of inflaming the situation or hurting their partner's feelings.

As noted above, there is evidence that domestic abuse perpetrators display **hostile cognitive biases**, and these biases are most intense among severely violent men. Together with cognitive bias, partner-violent men also exhibit an **emotional bias toward the experience of anger**. This is expressed as anticipating that they will experience more anger than non-violent men in response to a wide range of negative hypothetical aggressive and non-aggressive behaviours by their partners (Holtzworth-Munroe & Smutzler, 1996; Holtzworth-Munroe et al, 2000; Murphy, 2013).

Affect regulation: Using a multifaceted measure of emotional intelligence, Tweed and Dutton (1998) found that **men convicted of wife assault scored significantly lower than the general population of males on all components of EQ-I: Emotional Intelligence, including emotional self-awareness, stress management, self-regard, empathy, reality testing, stress tolerance, and impulse control.**

The exposure to childhood trauma in the absence of family security and attunement leaves some individuals **compromised in their ability to decipher and manage emotional triggers.** For example, many victims of violence become reactive to threatening facial and vocal expressions and may be more likely to interpret a partner's expression of frustration or annoyance as an attack (Siegel, 2013).

Poor affect regulation has been hypothesised to influence an individual's internal state via a series of routes: cognitive, affective and physiological (arousal), all of which interrelate. The cognitive route involves the increased accessibility of aggressive thoughts and hostility-related scripts that are activated by the interaction of the personal and situational antecedents. The affective route includes elevation in state anger, feelings of hostility or, simply, general negative affect. It also includes activation of aggression-related action tendencies. The arousal route refers to the propensity of arousal from an irrelevant source either to strengthen the dominant action tendency or to be mislabelled as anger. Together, these routes create an internal state that increases the likelihood of an aggressive behavioural outcome (Robertson et al, 2012).

Rumination has also been identified as a process that maintains emotional dysregulation (Siegel, 2013). **Rumination causes triggers to be re-experienced** and revives amygdala activity and HPA response in ways that suggest a continuation of high arousal (Haas et al, 2007; Phelps & LeDoux, 2005, cited in Siegel, 2013). Although there is limited study of specific triggers in domestic abuse populations, Fowler and Westen (2011) described a subgroup of male perpetrators who score high in measures for ruminative tendencies and rejection sensitivity; these perpetrators were found to have dependent/borderline features and contrasted with other subgroups of perpetrators who are more controlling and hostile.

'Splitting': Siegel & Forero (2012) proposes that another process relevant to domestic abuse is splitting – the mechanism by which events are experienced in an extreme form (all good or all bad), leading – in the case of negative events – to a rapid downward spiral. Splitting appears to be an amygdala-generated response activated by anxiety (McGaugh, 2014).

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