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What Helps? Mothers' and Children's Experiences of Community-Based Early Intervention Programmes for Domestic Violence

Melanie McCarry*
School of Social Work & Social Policy, University of Strathclyde, UK

Lorraine Radford
Connect Centre for International Research on Interpersonal Violence, University of Central Lancashire, UK

Victoria Baker
Connect Centre for International Research on Interpersonal Violence, University of Central Lancashire, UK

Early help or early intervention is increasingly recommended for safeguarding children living with domestic violence, but little is known about what is effective. This article discusses findings from an evaluation of a pioneering early help service in North West England. This new service aimed to improve the safety and wellbeing of families (mothers and children) who were assessed as below the level of 'high risk' domestic violence and below the threshold for a child protection order. Between January 2014 and March 2015, families (473 mothers and 541 children) were identified within multiagency safeguarding hubs and referred to the early help service. The service that emerged was somewhat different to the service expected. This article discusses findings from qualitative data gathered from 39 participants (mothers, children and service providers) involved in the programme. Three main issues emerged as themes from the interviews: the benefits of having any service at all for children living with domestic violence who slip off the agendas of professionals working with child protection and high-risk domestic violence; the importance of flexibility of key worker-led service delivery; and the suitability of current group work and therapeutic models for meeting the varied needs of families affected by domestic violence.

'Discusses findings from an evaluation of a pioneering early help service in North West England'

Key Practitioner Messages:

- Children, mothers and service providers reported both a perceived need for early help and a positive impact from domestic violence early help services on child health and emotional wellbeing.
- The ability of services to flex their delivery model in response to the needs of families is important for supporting engagement of, and fostering a sense of control for, families receiving support.
- Confidentiality, reliability, respect and trust are key factors in developing an effective key worker-family relationship.

Key Words: domestic violence; early intervention; children; young people; mothers

*Correspondence to: Dr Melanie McCarry, School of Social Work & Social Policy, University of Strathclyde, Level 6, Lord Hope Building, 141 St James Road, Glasgow G4 0LT, UK. E-mail melanie.mccarry@strath.ac.uk
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‘One in every six children in the UK is likely to experience living with domestic violence at some time in childhood’

Introduction

One in every six children in the UK is likely to experience living with domestic violence at some time in childhood (Radford *et al.,* 2013), and the resulting harmful consequences for their health and wellbeing are well known (Stanley, 2011). Providing earlier help and support for children and their families in response to emerging problems before they get worse is widely regarded as good safeguarding practice, but little is known about what forms of support are effective (Guy *et al*., 2014). The Anderson and Ee (2018) review of 17 (mostly North American) interventions identified a paucity of early interventions focused specifically on children and mothers. This review emphasised that where interventions do exist, those that work with both mothers and their children in both separate and joint sessions are ‘believed to help sustain any positive changes within the family unit. A combination of both [individual and joint sessions] likely brings about the most long-lasting impact on relationships and well-being’ (Anderson and Ee, 2018, p. 3). A review by Austin *et al*. (2019) also describes 26 interventions with nine specifically focused on the mother and child. This article discusses early intervention approaches to domestic violence, focusing specifically on the views of women and children who accessed a pioneering community-based early intervention project in the North West of England (UK).

There is some disagreement over the definition and goals of early intervention (Axford and Berry, 2018; Featherstone *et al.,* 2014). Early intervention can be defined as ‘taking action as soon as possible to tackle problems for children and families before they become more difficult to reverse’ (Early Intervention Foundation, 2017, p. 2). It is an important part of a preventive approach towards gender-based violence and child abuse (Butchart *et al.,* 2006). Since 1995 in the UK, changes have been made in policy and practice to shift from solely reactive child protection and investigation approaches to include earlier intervention (Parton, 2014). In the UK, and also the USA, differential responses have been promoted to cater for the continuum of children's needs, ranging from primary prevention to stop children from ever having to live with domestic violence in the first place, to the care, support and recovery of children who have suffered harm at different levels of risk/impact (Radford *et al*., 2011). There has been conceptual wooliness in public policy in the UK as to whether early intervention means ‘early years’, that is working with children in the early years age range; whether it means ‘early on’ or providing help as early as possible for children of all ages; or whether it simply means ‘earlier’, that is providing help earlier than the current response. The UK government-sponsored review of children's services - *Early Intervention: The Next Steps* (Allen, 2011) - for example, reaffirmed the trend in policy towards early intervention, but focused predominantly on early intervention as ‘early on’, for children aged under three years. Early intervention can however be helpful for children at any age (Axford and Berry, 2018; Guy *et al.,* 2014) and services should address their varied needs and ages. Policies that aim to divert young people from the criminal justice system by addressing the abuse-related harm that may contribute to offending are examples of early intervention as ‘earlier’, although responses are given to children at a relatively late stage when harm is already evident. In this paper, early intervention services are taken to mean services that aim to: respond ‘earlier’, ideally as soon as

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possible, to problems that are emerging for children and young people (CYP); and work preventively with children most at risk of developing them.

Early intervention responses to domestic violence are relatively new and research on how well they work is limited (Guy *et al.,* 2014). Outcome-focused evaluation research to test the impact of a particular intervention on the wellbeing of CYP who have experienced domestic violence is rare (Stanley, 2011), as are randomised control trials (RCTs) or experimental studies on interventions for children living with domestic violence (Anderson and Ee, 2018; Austin *et al.,* 2019; Howarth *et al.,* 2016). RCTs are important and can be helpful in making decisions about what interventions might work best, but they do not always cover the contextual factors that impact on service user experiences. A broader, more developmental and mixed-methods approach at this stage may help to explore key service design questions about what families might want and who benefits most from an early intervention service. This paper is based on the qualitative data gathered from an evaluation of a new early help service for children living with domestic violence in the North West of England.

'Early intervention responses to domestic violence are relatively new and research on how well they work is limited'

The Early Help Service – Meeting a Gap in the Continuum of Needs

The early help services were developed within existing specialist domestic violence services in a region of North West England. These specialist services were part of a consortium called *Safer Together* that covered eight organisations providing refuge, helpline(s), outreach and domestic violence advocacy services across the local area. Services across the region are tailored to the assessed level of domestic violence risk for adults and to the assessed level of need for children, with those with higher needs requiring more intensive multiagency and specialist service provisions. Assessment of risk for adults living with domestic violence can be done by a range of frontline services, including the police, using (at the time) the Domestic Abuse, Sexual Assault and Harassment (DASH) risk assessment tool (Richards, 2009). This aids professionals to make decisions about risk as being high, medium or standard, considering the responses to questions from a list of different risk indicators. Adult victims assessed by the DASH tool to be in the high-risk category have access to specialist and statutory service support, including access to specialist domestic violence services, independent domestic violence advocacy, and case planning and management in a multiagency forum called a multiagency risk assessment conference (MARAC). At the time of the research, there were no assessment tools in use that focused specifically on the impact of domestic violence and the level of risk that this created for a child. Instead, children's needs were assessed by childcare professionals using a Common Assessment Framework (CAF) approach (Cox and Bentovim, 2000). This is a common approach used by trained practitioners across different services to assess the child, family, and environmental strengths and vulnerabilities, drawing on an ecological theory of child development (Bentovim *et al.,* 2009; Bronfenbrenner, 1977). The CAF assessment in use in the area aimed to capture the continuum of needs that children might have if their families:

'The early help services were developed within existing specialist domestic violence services in a region of North West England'

- needs are met through universal services (described as 'thriving', level 1);
- face additional unmet needs and are 'just coping' (level 2);

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- have complex needs for support and are 'struggling to cope' (level 3);
- are 'not coping' and require a statutory response from child protection services (level 4).

The CAF approach is not static, recognising that children's needs may change, escalating to a higher level where more support is required, or deescalating to lower levels where families are thriving and require less monitoring and support. The dynamic aspects of risk are captured in a continuous, rather than a one-off, assessment process that takes into account the potential for risk to increase and the need for support to grow (invoking 'step up' processes), and for risk to decrease, typically, as specialist supports address the needs of the child(ren) (invoking 'step down' to less specialist and less intensive provision for children's social care).

'The early help service was designed to be part of a holistic care response for children and mothers across this continuum of need'

The early help service was designed to be part of a holistic care response for children and mothers across this continuum of need. The services operated in the context of coordinated multi-sector children's services, based upon a key worker leading a 'team around the family' approach of professionals working in the community. The focus for *Safer Together* was on families where needs were assessed at levels two and three, in the middle of the continuum of need, where families were assessed as 'just coping' or 'struggling to cope'. The domestic violence risk level generally fell into the 'medium' risk category, although many of the families had previously been rated as 'high risk' and had 'stepped down' after the high-risk support was withdrawn. Staff were allocated to families as key workers, coordinating and delivering services on an outreach basis, and meeting with the family at home and with the children often at an alternative safe venue, such as at school.

Families eligible for early help were each offered an age-appropriate programme for children and a programme for the mother. The programmes were mostly to be offered to families in separate groups for mothers and children but run in parallel, drawing on promising research evidence that this approach could bring the best health and wellbeing outcomes (Anderson and Ee, 2018; Graham-Bermann *et al.,* 2009). The eight services offered a range of support programmes with somewhat differing emphases and objectives (see Table 1).

'The remit of the *Safer Together* community-based programme was to ensure that all mothers and their children received 12 weeks of support'

The remit of the *Safer Together* community-based programme was to ensure that all mothers and their children received 12 weeks of support, including six weeks of one-to-one and six weeks of group work, to harmonise early intervention support across the region (even though they may receive a different support programme). The commissioners of *Safer Together* wanted to gain some data fairly rapidly on whether the early help service might be effective, and through a process of competitive tender, the research team was commissioned to conduct an independent evaluation to answer questions set by the local authority commissioners: Do the early interventions help to improve outcomes for children, young people and their families? What are the challenges? What do services/users need for the services to work better?

Swanston *et al*. (2014) note: 'To date, there has been no research which specifically speaks to both school-aged children residing in the community and their mothers about the child's experience of domestic violence' (p. 186). Katz (2016), in her research with CYP, reached a similar conclusion. This study aimed to partly address this deficit by prioritising the views of CYP

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Table 1. Domestic violence early intervention service programmes

Programme	Target audience	Description
Freedom Programme	Mothers	Explores attitudes/beliefs of perpetrators and the responses of victims; and addresses how children are affected by the abuse and how their lives can be improved when abuse is removed
Helping Hands	Children and young people	Addresses challenging issues of personal space, safety planning, and awareness of acceptable and unacceptable behaviours
Recovery Toolkit for Adults	Mothers not living with the perpetrator	Looks at ways to develop positive coping strategies
Recovery Toolkit for Children	Children and young people (up to 18 years)	Designed to run alongside the adult programme, which is informed by trauma-focused cognitive behavioural therapy (CBT), and addresses areas such as self-esteem, who is my family, talking positive, handling difficult feelings, healthy relationships and trust
Talking to My Mum	Mothers and children (5–8 years)	Picture workbook to help mothers and children affected by domestic violence and encourage communication
What About Me?	Mothers and children (4–16 years)	Aims to reduce children's self-blame and feelings of isolation, enabling children to express difficult feelings in safe ways, develop skills to ensure that their own relationships are safe and healthy, and develop vital safety planning. The programme includes a mothers' group, helping them to talk to the children about the violence and to cope with the impact of the violence on their children
You and Me Mum	Mothers	Helps mothers who have experienced domestic violence to explore their role as mothers, the impact of domestic violence upon their child(ren) and their relationship with their child(ren). Aims to promote the ethos of self-help and empowerment

on the effectiveness of the community-based *Safer Together* initiative and the qualitative data are reported in this article (see Radford *et al*., 2015, for the full evaluation report).

Method

The evaluation used mixed methods: analysing data from entry and exit measures of child and mother wellbeing to assess simple differences in global wellbeing scores before and after service delivery, as well as looking in depth at service users' and providers' experiences to gather information on implementation, quality and relevance to perceived needs. Despite considerable time constraints, the research team foregrounded a participatory model of research, involving the CYP in the design stages of the qualitative research tools. The research was subject to a thorough review by the University of Central Lancashire Research Ethics Committee.

Some 473 families with 541 children were referred to the early intervention services between 1 January 2014 and 31 March 2015. Of the 464 children for whom data on gender were available, 51 per cent were boys (n = 235) and 49 per cent were girls (n = 229). The majority of children were in primary school age ranges: 61 per cent were aged from five to 11 years (n = 330). Twenty-seven per cent were 12–15 years old (n = 148) and six per cent were aged 16 + (n = 30). Six per cent were newborn to four years old (n = 33). The ethnicity of families reflected the demographic pattern in the region (87% white British ethnicity; 10% Asian; 2% white Irish/other white; 1% dual heritage).

Quantitative data were collected on a range of child-level outcomes, including physical health, safety, relationships and self-esteem, using a range of standardised measures. Child-level, family-level and mother-level outcomes demonstrated significant improvements between pre- and post-test of 16 per cent, 17 per cent and 35 per cent, respectively. CAF assessments highlighted reductions in need in 58 per cent of cases (n = 196), no change in 30 per cent of cases (n = 101) and increases in need in 12 per cent of cases (n = 39).

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Although these results were promising, the high proportion of missing data limits the confidence in the findings. The insights from the qualitative data are therefore the focus of this paper.

Focus groups were conducted with four CYP referred to the early intervention services (one group comprising two 8- to 10-year-old girls and another comprising two 12- to 15-year-old girls) to inform the development of the interview questions (no boys wanted to participate in these focus groups). In these focus groups, participants were asked to organise a series of bespoke positive/negative statement pairs (e.g. 'the worker explained what she/he could keep confidential and what she/he could not' and 'the worker did not explain what she/he could keep confidential and what she/he could not') to describe their service experiences. They were also asked whether they had any questions that they wanted to put to the service providers. These focus groups lasted between 30 and 40 minutes. In addition to informing the development of the interview questions, the voices of these four youth participants are included in the main analysis in the Findings section.

'Telephone interviews were conducted with 13 mothers and … nine CYP were interviewed'

In addition to the focus groups with the CYP, telephone interviews were conducted with 13 mothers and five of their children (aged 8 to 18 years) who had received the early intervention services. (In total, nine CYP were interviewed: four in the focus groups and five over the telephone.) The telephone interviews lasted between six and 25 minutes, with the younger children having the shorter interviews. Participants were asked questions relating to: the service that they had received and their referral pathway; what they did and did not like about the service; whether they found it helpful or not; their views on what makes a good service; follow-up support after the service; and how the impact was measured. Language was adjusted to be appropriate for children, young people and adults.

'Two focus groups were also conducted with the service providers from across the eight services'

Two focus groups were also conducted with the service providers from across the eight services, including the *Safer Together* coordinator ($n = 17$ staff, all women), at the beginning (July 2014) and end (March 2015) of the evaluation period. Midway between these focus groups, one-to-one telephone interviews lasting between 30 and 70 minutes were conducted with nine of these staff including one from each of the eight services and with the *Safer Together* coordinator. These staff focus groups and interviews explored operational issues and the perceived impact of the early intervention service.

In terms of recruitment, the *Safer Together* coordinator encouraged staff from the eight services to participate in the focus group. The staff were then invited to participate in the one-to-one follow-up interviews, with one staff member from each service volunteering. It was also these staff that identified possible mothers for us to interview and with the mother's permission passed on first names and telephone numbers to us. We then contacted the women, asking whether they wanted to participate in the study. We aimed to include women from each of the services, but instead had three from service one, two from services two, three, four and five, one from services six and seven, and none from service eight ($n = 13$). Staff inclusion criteria for identifying possible participants were mothers who had engaged with the early intervention services and who were considered to be safe to contact, both in terms of physical safety and wellbeing. Once contacted, the mothers themselves agreed to participate, or not, and they also decided whether we could speak with their child. We then spoke with the CYP and gave them

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the opportunity to agree or decline to participate. Telephone interviews, as a methodology, can be used effectively when researching 'sensitive' subjects (see Chantler *et al.,* 2017; Chantler and McCarry, 2020) and may make it easier for a CYP to decline to participate than a face-to-face encounter. Once the CYP verbally consented to participate, the formal interview began (Källström and Thunberg, 2019). As no details of the mothers other than a phone number were known, high-street *Love to Shop* vouchers were given to the relevant service provider to pass on to the mothers as a thank you for their, and their child(ren)'s, time. The mothers were only made aware of the vouchers at the end of the interview(s) in order to avoid any financial inducement to participate. The research team was dependent on service users volunteering to be interviewed, so it is likely that there was some self-selection bias towards those who had good experiences, and resource constraints prevented us from following up on families who had dropped out of the service(s). As such, this sample of mothers and their children is not to be taken as representative, rather it is an exploration into mothers' and CYP's views of a unique regional community-based early intervention service for domestic violence.

To preserve anonymity, the services are referred to as service one through to eight. All mothers and CYP are assigned a pseudonym. Where the youth participants are from one of the focus groups, this is indicated (FG 1 or FG 2). In Table 2, where the CYP is the child of one of the mothers, she/he appears on the same row.

Analysis

All interviews were recorded and transcribed verbatim, coded and thematically analysed (Källström and Thunberg, 2019). Two of the research team (MM and LR) independently analysed each transcript, looking for themes to emerge. Coding frames were drafted separately and then discussed and refined into an overall coding frame comprising main and sub-themes. Throughout the process, transcripts were cross-coded and this iterative process ensured a level of consistency in how the transcripts were analysed both within and across interviews. Where both mothers and their children participated, transcripts were matched in order to identify points of convergence and divergence between their perspectives of the early intervention support that they received.

Findings

This section explores the findings from the interviews with service providers, mothers and their children and is organised into three themes that emerged from the data: the importance of having a service for children affected by domestic violence across a region; the importance of flexibility of key worker-led service provision; and the suitability of current group work and therapeutic models for meeting the needs of families affected by domestic abuse.

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Table 2. Key to participants

Service group	Name of mother	Names of children and young people	Programme
Service 1	Caroline		Freedom Programme Helping Hands
Service 1	Joanne		Freedom Programme Helping Hands
Service 1	Linda	Jack (age 18 years) Fin (age 12 years)	Freedom Programme Helping Hands
Service 2	Emma	Chloe (age 8 years)	Freedom Programme You and Me Mum Helping Hands
Service 2	Becca		Freedom Programme You and Me Mum Helping Hands
Service 3	Kara		Freedom Programme Helping Hands
Service 3	Anjali		Freedom Programme Helping Hands
Service 4	Kirsty		Freedom Programme Helping Hands What About Me?
Service 4	Samantha		Freedom Programme Helping Hands What About Me?
Service 5	Anna		Freedom Programme Recovery Toolkit
Service 5	Lucy	Lloyd (age 8 years)	Freedom Programme Recovery Toolkit
Service 6	Amy	Holly (age 9 years)	Recovery Toolkit Helping Hands
Service 7	Lisa		Freedom Programme Recovery Toolkit Helping Hands
FG 1		Laura (age 15 years)	Helping Hands
FG 1		Katie (age 12 years)	Helping Hands
FG 2		Layla (age 10 years)	Helping Hands
FG 2		Maisie (age 8 years)	Helping Hands

FG = Focus group.

A Service for Children

Overall, notwithstanding the sample bias, findings on the positive impact for children are supported by the interviews with mothers and staff, who noted changes in children's and young people's self-confidence, physical health, risk-taking, school attendance, school work, behaviour, relationships and ability to talk with their mothers. Mothers reported that the dedicated support from the service had a positive impact on their children:

'Mothers reported that the dedicated support from the service had a positive impact on their children'

> 'I can see a big difference in my nine-year-old. I mean my mum looks at her and says, she looks so sad behind the eyes, … But now she's like, she's smiling, her eyes are lit up a bit. And that's every time she's seen [support worker] we have noticed.' (Amy)

> 'The kids have loved it, they worship the girl that worked with them on a one-to-one basis. … she was wonderful, I knew the days that they'd seen her, when they came home from school, I knew they'd seen her, there was a difference in them.' (Joanne)

CYP similarly gave positive feedback on the services, particularly liking the key worker approach. The feedback was echoed in interviews with the service staff, where there was a shared view that the early help intervention had a positive impact on the mothers and CYP:

> 'A lot of feedback we have had, from the children and young people themselves, is that they better understand the situation they were in.' (Service 4)

> 'I think it's a really positive service, if I'm honest. And being given the opportunity to be able to deliver in our area is, obviously, really needed. And just seeing the positive outcomes at the end, is really good for you to know that what you are doing is working.' (Service 5)

Staff also noted the significant step taken towards a change in service delivery where, for the first time, the voice and rights of CYP could be prioritised:

> 'Well this service has been fantastic in that, at last, children and young people have been recognised. Because ever since I've been in this field, they have never been recognised. They're always the forgotten victims and hidden victims.' (Service 4)

Fear and feelings of self-blame are often experienced by women living with domestic violence, and these can act as powerful barriers to help-seeking and accepting help and support. One staff member explained that mothers' fears can create an ethical dilemma for services as the CYP usually need their mother's consent to participate:

> 'We're not working with that child just because mum's too frightened. For understandable reasons, mums are too frightened to engage, and especially when they are still living with the perpetrator.' (Service 2)

Persuading a mother to engage with a service in such a context when she is fearful and still living with the perpetrator requires a high degree of skill, sensitivity and awareness of the dynamics of domestic violence. Seeking support for the child can raise difficult issues for the mother. A growing awareness that the children have been damaged by the abuse can compound her feelings of guilt:

> 'It's hard for mums to accept that it is impacting on the children. So that's a huge step, to get a mum to even accept and look at and talk about the impact on the child, especially when, well I say especially, I mean the guilt is off the Richter scale for, mainly for women, guilt is felt more by women who have left, been out of that situation for a while and are in a position to look back. Because up until then you have got to keep your guilt pushed down, otherwise you'd just be a blob, you know, a blob of guilt.' (Service 2)

'A growing awareness that the children have been damaged by the abuse can compound [a mother's] feelings of guilt'

Some of the mothers did not want help themselves but concerns about the wellbeing of their children provided the motivation to engage with the service:

> 'Some mums, they do not want any support. They might have come through that abuse and moved on and not want any support from the adult's team but the child really does. So sometimes it is just the child that's accessing that support.' (Service 7)

Some were unsure that the support offered would be relevant or effective:

> 'I wasn't convinced at first that it would make a difference because I thought that [child's] problems were a lot deeper. I thought they were a bit more psychological and I wasn't really sure that they'd be able to help. But … [child] felt comfortable going, was happy going and it made me feel happy.' (Samantha)

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The interviews indicate that the mothers who wanted to have the service for their children were often aware, or becoming aware, that living with the abuse had an impact on their children's safety, wellbeing or behaviour. The interviews show that some of the children referred had relatively high levels of need for services to overcome the harm caused to them. Laura (FG 1) found the group work element of the support extremely helpful to break down feelings of isolation: 'It was nice to know that like you weren't alone and there were other people that like went through similar stuff'.

Flexibility of Service Delivery

When the early intervention services were originally commissioned, it was expected that parallel support sessions would be provided for mothers and their children, and that the *Safer Together* model was to offer all mothers and their children 12 weeks of support involving six weeks of one-to-one work and then six weeks of group work. However, while most of the mothers and their children were given 12 weeks of support work, programme fidelity was largely exchanged in favour of flexibility, particularly the need to respond without undue delay to a family's needs. There were several practical difficulties in organising the group-based interventions for the women and CYP, with timing and location of groups being a frequent barrier. For women in paid employment, the timetabling of the group work during the working week presented practical difficulties for attendance:

'For women in paid employment, the timetabling of the group work during the working week presented practical difficulties for attendance'

> 'Because I work, they were during the week, you know, on week days and things. And on a weekend, which is when I want to be spending time with my kids. … I would have been interested if I wasn't working, but I do work.' (Joanne)

All the staff discussed the challenges of organising the group work sessions for the CYP which required after-school hours, suitable locations and pickups from different locales. Additionally, depending on when the CYP were referred in, their times for starting the group work may not match the times of others. As there were twice as many children aged five to 11 years (61%) than older children aged 12 to 15 years (27%) referred to the services, the groups had to be organised according to age. For example, Layla (age 10 years) said that she did not think it worked to have children younger than her in the group as she 'wouldn't want to say anything inappropriate' in front of them. The two oldest youth participants also commented on this: Jack (age 18 years) stated: 'they offered me group work and stuff but I didn't really want to do it because for me, I don't want people to know my situation'; and Laura (age 15 years) commented: 'you might not like think about saying like what happened or might not be able to relate to it as the same, or you might feel less confident'. As a result, the workers often had to offer a different combination of group and one-to-one work to ensure that the mothers and the CYP received the 12-week input. Both the mothers and CYP valued this flexibility and having some control over the type of support work that they were offered. Whether this impacted the efficacy of the support that the women and their children received requires further investigation.

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Suitability of Service

Trust and confidentiality were highly valued, and both mothers and the CYP emphasised the importance of being able to fully trust the workers and know that information was being handled confidentially, as Becca explains: 'Approachability, comfortable, knowing that, knowing that what I say will be confidential I think is a massive help'. Being listened to and treated with respect was mentioned by many of the women including Anna: 'With the guarantee when they phone you when they say they'll phone you and like they make you feel better in yourself when they ring you up'. This was also echoed by Samantha:

> 'I know that when [support worker] says she's going to ring me and update me, I know she will do. Because I know I've had some people that I've spoken to, like the police in particular, they say, "oh we'll ring you and let you know" and this, that and the other, and then I do not receive a phone call. But I know that when [support worker] says she's going to ring me and update me, she will ring me and update me.'

Some of the CYP had been badly let down by some of the services that they had previously been in contact with, including serious and significant breaches involving the disclosure of confidential information to the abusive father:

> '[Child] still does not want it [to engage with the service]. He was let down a few years ago by the school. His dad had contacted the school that he attended and he'd gone to see the counsellor at school. She'd [school counsellor] raised concerns to the Deputy Head and he contacted his dad and told his dad. So [child] now will not speak to anybody, he does not trust anybody.' (Linda)

For these CYP, it was important that they felt they could trust their support workers:

> 'Yes, I liked the staff, the person that came, I had a lot of support, gave me like advice on what to do if, well my dad came near me or anything like that. It was just, basically, I could tell him stuff, and he would believe me. Like in the past I've had lots of problems where I've said stuff but even like my CAFCASS [Family Court] officers and my child psychologist would not believe, well it felt like they were not believing me, but he [support worker] believed me, so I thought that was good.' (Jack, age 18 years)

Källström and Thunberg (2019) have written on the value of young people being able to trust their workers and the importance of maintaining confidentiality because, for many, these elements are eroded when living with a domestic violence abuser:

> 'Being treated as an equal could be seen as a direct contrast to what it is like living with pervasive and ongoing control (…) which narrows children's and young people's space for action (Katz, 2016). Thus, experiencing being treated as an equal can be seen as an important prerequisite for young people's agency.' (Källström and Thunberg, 2019, pp. 560–561)

The CYP shared the view that they liked meeting their support worker in school but had concerns about others knowing so developed strategies for attending their weekly meetings without it being identified, as explained by 12-year-old Fin:

'Trust and confidentiality were highly valued and both mothers and the CYP emphasised the importance of being able to fully trust the workers'

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Fin: 'I saw them in a room at school where no one else could see us.'
Melanie: 'And did your classmates know who you were talking to?'
Fin: 'No, I just kept that private.'
Melanie: 'How did you manage to do that, did they ask you where you were?'
Fin: 'They asked me where I'd been, I just said I was doing jobs for teachers and other excuses.'

For the mothers and CYP, reliability and the provision of individual support were strongly valued. The main complaint from the women and children was the 12-week duration of the early help, with the prospect of this ending causing some anxiety, as Emma comments:

'I just think it's really helpful, do you know what I mean? The only thing that upset you, like I've only got 12 weeks, when it comes to the end of the 12 weeks, I'm kind of feeling a bit like, where do I go, you know, if I have a problem, where do I go after that?'

This concern was raised by many of the mothers, but in practice, many of the support workers kept their cases open and mothers could make contact at any point post the 12-week 'cut-off'.

Having the county-wide remit for services also enabled a more consistent response to emerge: 'It's the first time across the county there's been the consistency between domestic abuse services, where everyone's doing the same thing' (service 1), and '[w]e do have peer support meetings so we can share ideas and share knowledge … And stories of how we're getting on and what's working well' (service 3).

'The region-wide approach guaranteed a consistency of service for the women across the area'

The region-wide approach guaranteed a consistency of service for the women across the area ensuring that, even if they had to relocate, which many did, they would still receive the early help intervention. Overall, the staff were enthusiastic about a coordinated focus on outcomes, but mothers emphasised the relationship with the key worker for their child(ren). It remains unknown from our data whether the coordinated focus of service provision improved this relationship by giving a more structured approach to children's emotional and safety concerns, but it certainly had an overall positive impact in the short to medium term.

Discussion

Substantial cultural shifts in practice are required to move from a largely reactive and crisis-focused response towards domestic violence to an early intervention and more preventive approach. While clearly further research on early intervention and domestic violence is needed, there are promising messages from this research for practice. In this article, service delivery was explored in depth, but with the voices of the mothers and CYP receiving the service foregrounded to explore its impact. The timing, accessibility and location of group work for CYP and mothers in paid work meant that some missed out and/or there were long waiting lists before they could be run. The flexibility of staff providing the service on a one-to-one basis ensured that children especially were not left unsupported, even when this meant that programme fidelity was abandoned. A tension remains for those CYP who may want early help but whose mothers do not agree to it, as exemplified by Katie (age 12 years) who pointed out that if her mother did not agree then

'A tension remains for those CYP who may want early help but whose mothers do not agree to it'

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she would not be able to attend. Or where, in the case of Joanne, the children's father refused to allow them to attend. The time-limited approach was raised by the *Safer Together* coordinator who problematised it for a number of reasons, including the very real concern that CYP may take months before they feel confident to speak about their experiences of abuse and whereby in some occasions 'children disclose in the last appointment'.

Staff who were interviewed expressed high satisfaction with the area-wide coordinated approach of harmonising services, which they believed delivered a more consistent response for mothers and their children. It also meant that the workers had more support from each other through regular meetings to review service provision and caseloads, and also through having an official domestic violence early intervention coordinator to oversee the work. It also meant a clearer understanding of which schools, for example, were supportive of the work and which were more resistant. Being able to trust workers was highly valued by the women and the CYP particularly, as so many had previously had negative experiences from other services. The confidence in the workers and the services improved 'buy-in' from services users. However, it would be valuable to include women who disengaged from the early intervention service to explore their reasons for this. The confidence of the workers in terms of being able to adapt the six-week one-to-one and six-week group work model to suit women and children was valued by both the workers and the service users. Further research needs to be conducted to evaluate the impact of flexing programme delivery on efficacy of outcome (Fonagy and Luyten, 2019), but in the short to medium term, it was received positively.

On account of word constraints, we were unable to discuss a couple of issues that we believe to be crucially important and were raised in the interviews with the mothers, CYP and workers, namely, that of ongoing risk from the abusive partner and meeting the mental health needs of CYP. Findings from the interviews indicate that families had generally been exposed to higher levels of assessed risk of domestic violence at some stage, and although high-risk support services were withdrawn, problems were ongoing, often because post-separation abuse around child contact was not adequately addressed. The issue of measuring risk remains unsatisfactory, as risks to CYP can be quite different to the risks faced by the mother, and risk can vary considerably on a day-to-day basis if measured only on an incident basis. The early intervention service addressed unrecognised needs where mothers and/or children no longer fell into the category of high-risk domestic violence or high needs for child protection. Many had long-term and ongoing issues with staying safe from partners or ex-partners who continued low-level harassment and conflict, with a detrimental impact on children and victims/survivors.

'Many had long-term and ongoing issues with staying safe from partners or ex-partners who continued low-level harassment and conflict'

The services also saw children with behaviour and mental health issues that had not been addressed by children's mental health services or other specialist services. There is the potential to save on time, costs and harm to families that bounce in and out of services by dealing with domestic violence and its impact earlier on, drawing on trauma-informed approaches (Anyikwa, 2016; Graves *et al*., 2019; Kulkarni, 2019; Substance Abuse and Mental Health Services Administration, 2014; Wilson *et al*., 2015).

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Conclusion

From conducting this research, we learnt that it can be a very challenging task to gather evidence on the effectiveness of early intervention for children and adult victims/survivors living with domestic violence. Challenges encountered that could be addressed in further research include: engagement problems (few mothers took part in the envisaged group work but children did engage); balancing the need for programme fidelity with family needs for flexibility; addressing attrition (recognising that programme drop out may not always be a sign of programme failure); identifying and managing risk, particularly regarding child contact arrangements where there is a time-limited service; and measuring outcomes where needs are diverse. Differences in needs were observed in families where the perpetrator was still living with the family, where there was post-separation abuse or conflict over child contact, and where children had suffered emotional harm resulting from living with domestic violence.

We conclude that it is important to fine-tune research and practice on domestic violence and early intervention so that services better match the diversity of needs that adults and CYP may have. To date, the focus has been on women and children in shelters/refuges, with little on the experiences of those living in the community. There appear to be gaps between what families need/want regarding early intervention and what services can offer, particularly where the victim/survivor is still living with the perpetrator or when the children are having post-separation contact with him.

'There appear to be gaps between what families need/want regarding early intervention and what services can offer'

The focus of the services in this study was also entirely on support for children and mothers, with a lack of any working with the main problem, the perpetrator, beyond what the police usually do. Further work is needed to develop and evaluate more holistic approaches to working that include engagement and parallel work with the perpetrator as part of improving safety and wellbeing for adult and child victims/survivors.

It would also be beneficial to include a wider range of CYP's voices to hear directly what support they need in the immediate and longer term. Early help services provided valuable support specifically for CYP, and there are promising indications that this may help improve the relationship between children and their mothers, an important aspect in the healing process in the aftermath of domestic violence (Humphreys *et al.,* 2006; Katz, 2015; Mullender *et al*., 2002).

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