Evaluation of the Sandwell Families Together Service

Final Report

March 2020

family action

Building stronger families

Families Together

Preventing Domestic Abuse

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Any enquiries about this report should be directed to:
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Executive summary

This report sets out the findings of a small scale evaluation of Family Action's Families Together Service in Sandwell, a structured prevention programme for families where there is a risk of domestic violence and abuse (DVA).

The service works with men and women over 10 weeks (for women) or 12 weeks (for men) through weekly group sessions. It is designed to support men and women to recognise and overcome DVA, enabling families to develop greater awareness of problem behaviours, improve their confidence and self-esteem, and feel safer at home. The service does not distinguish between victims and perpetrators of domestic abuse, but focuses on the beliefs, attitudes and behaviours that lead to healthy and strong family relationships.

Much of the evidence underpinning the Theory of Change comes from the success of the Strength to Change perpetrator programme based in Hull, which has been adapted for Family Action by Mark Coulter from the specialist domestic abuse consultancy Mencentric, and forms the basis of the course content for men in the Families Together service. The course for women has been developed to mirror the content covered for men, which means that both partners can attend and benefit from the course simultaneously. However, this is not a requirement and the course is also suitable for only one partner.

The purpose of this evaluation was to examine the impact and effectiveness of the delivery model for the Sandwell Families Together service, for families where domestic abuse has been recognised as a potential risk. This includes the impact of the service on perceptions of safety among victims of DVA, levels of self-esteem and emotional wellbeing across whole families, and changes in abusive behaviours. The evaluation is intended to contribute to an evidence base around the delivery model's effectiveness so as to inform future developments of the service, and focuses on the delivery of the Sandwell Families Together Service from October 2017 to October 2019 (seven cycles).

The evaluation was co-designed with Family Action staff and included analysis of service activity and outcome data, interviews with a small sample of service users, analysis of service user feedback forms, and interviews with professionals working alongside the Families Together service in Sandwell.

A total of 235 referrals were made to the service between December 2017 and May 2019, 80% of which came from Sandwell Children's Trust (social services), and 9% from local early years services. This is in line with the efforts made by staff to build partnerships with those agencies most likely to identify low level DVA in families. The data collected by the service shows that only 16 of these referrals were considered unsuitable for the service (typically those who were deemed to be at high risk of criminal conviction or those who posed a risk to staff and others).

The evidence from this evaluation shows that Families Together is an incredibly effective intervention for tackling low level DVA. The delivery model shows a relatively high level of engagement among both men and women once the service starts. However, there remain challenges engaging with this group of people from referral through to pre-assessment and commencement. After taking account of those who could not be contacted after a referral was made, 169 people were then booked in for pre-assessment. Of these, 54 failed to attend that assessment, 39 were accepted into the service and booked a place on a cycle but failed to attend any sessions, and 24 dropped out after starting a course. In all cases, staff made a

number of attempts to contact people by phone and written communication in order to encourage engagement and participation in the service.

The data shows a very positive experience among service participants, in many cases accompanied by significant improvements in their relationships and life at home, along with evidence of reduced risk of harm. Additional analysis by the service in partnership with West Midlands Police and Sandwell Children's Trust showed that of 28 families who completed Families Together and were referred by the Trust, in all but three cases (90%) the risk reduced in the family and the case was stepped down from child protection (CP) to child in need (CIN) or early help (EH), or subsequently closed. There was also only one reported case of reoffending within those 28 families after completion of the programme.

There is evidence of significant improvements in mental wellbeing, particularly among men who have completed the service. There are also positive shifts in self-esteem, again most strongly among men, and especially with regard to reducing negative feelings of self-worth.

Greater confidence to manage potential conflict at home was one of the strongest themes to come through from participant feedback. The service has also helped many people to better understand their own behaviour, and to provide effective tools for making and sustaining positive change in their family relationships.

Professionals working in the area note that there is a huge gap in expert / targeted provision for low level DVA and few, if any, alternative referral options for people who are experiencing DVA at a point before it has escalated to high risk.

While this evaluation has shown that the delivery model is effective at reaching its intended target population, the number of course participants especially in the first three cycles was lower than expected. This is in part due to the capacity that was needed to process referrals and undertake pre-assessments, and the level of work involved in trying to engage with those who failed to attend appointments or return calls (rather than the number of places available in each cycle). We would argue that investment in additional staffing resources (including administrative support) would lead directly to greater coverage. This, combined with some element of outreach work in other settings (such as in schools, primary care, and early years services) would help to extend the service's reach and impact.

The service is delivered by a highly skilled and competent team, however, along with more administrative support to help manage the referral process, co-ordinate initial assessments, communicate with participants, and maintain effective record keeping, there are opportunities to consider whether the reliance on sessional staff to deliver group sessions provides the best mix of flexibility and retention. It may be that some combination of part-time staff alongside sessional workers and the existing senior workers, would provide the opportunity to respond better to fluctuations in demand and provide extra capacity to expand service provision. This would need to be accompanied by specific work on developing new referral pathways and building greater integration of the service within the existing governance, strategic and delivery arrangements for DVA across Sandwell.

Acknowledgements

We would like to thank Family Action for their support in conducting this evaluation, and in particular the staff from the Families Together service who gave up their time to shape the evaluation approach and provide feedback about the service, and who made considerable efforts to engage with service users and DVA professionals in Sandwell for the purposes of this evaluation.

We would also like to thank the service users and professionals who took part in the evaluation. Your openness, expertise and willingness to tell us about your experiences of Families Together provided valuable insights and evidence for this report.

Part 1: Context and scope of this evaluation

1 About this report

This report sets out the findings of a small scale evaluation of Family Action's Families Together Service in Sandwell. The evaluation combines activity and outcome data gathered by the service over the last two years, with information from participant feedback forms and telephone interviews with a small number of participants and professionals working with people who have experienced Domestic Violence and Abuse (DVA).

The report is presented in four parts:

- Part 1 sets out the context and scope of the evaluation, including a description of the Families Together service
- Part 2 provides an overview of the evaluation methods
- Part 3 describes our findings and the supporting evidence, and
- Part 4 sets out our conclusions from this evaluation.

2 Key definitions

The following definitions are used throughout this report.

Domestic violence and abuse (DVA)

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. The abuse can encompass, but is not limited to:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Multi-agency risk assessment conference (MARAC)

A regular, local multi-disciplinary meeting to discuss how to help victims at high risk of murder or serious harm from DVA.

Sandwell Domestic Abuse Strategic Partnership (DASP)

A multi-agency sub-group of the Safer Sandwell Partnership (SSP) Board, responsible for addressing domestic abuse in Sandwell on behalf of SSP. The DASP 'aims to lead a co-ordinated effort to prevent and reduce incidences of domestic and sexual violence, abuse and exploitation'.[1]

Service participant / service user

People (adult men and women) who were assessed as being suitable for the service and who attended the Families Together group sessions.

[1] For more information about the Sandwell DASP see: http://www.sandwell.gov.uk/info/200309/scorecard/2378/domestic_abuse_strategic_partnership

Service cycle

A 10 week (for women) or 12 week (for men) structured programme consisting of weekly group sessions run by a trained facilitator, with content in line with the agreed course manuals / materials.

3 Domestic violence and abuse (DVA) in context

According to crime statistics, nearly 2 million people in the UK suffer some form of domestic abuse every year.[2] More than 100,000 people in the UK each year are at high risk of being murdered or seriously injured as a result of domestic abuse.[3] However, fewer than 1% of perpetrators receive some sort of specialist intervention to change.[4] Furthermore, these figures are likely to significantly understate the scale of the problem, as many people (especially children) suffer abuse in silence and without reporting a crime. It is estimated that 30% of victims do not report or seek help from services.[5]

Not only does DVA cut across all socio-economic groups, ethnicities, neighbourhoods and communities, it can lead to significant and long term impact on the physical and mental health and wellbeing across whole families. National data shows that for every 100 people to receive support from a domestic violence outreach service, 127 children will be involved.[6] It is estimated that DVA costs more than £29 million per annum in Sandwell.[7]

Much of the support available to those experiencing DVA in Sandwell is designed to deal primarily with higher risk individuals and family situations. This includes services such as the My Time Perpetrator Programme run by the Richmond Fellowship (30 weeks)[8], or the Drive multi-agency intervention for high-harm and serial perpetrators.[9] For victims, Women's Aid provides a range of information and support services for women experiencing DVA and their children. These interventions are typically geared towards those at the point of crisis (or nearing crisis) and are designed (and resourced) to primarily offer more reactive rather than preventative support.

However, national data shows that interventions are generally effective for those who receive support. Among 21 adult outreach services in 2018-19, 81% of those who received support reported improved quality of life, 77% felt optimistic about the future, and 87% felt safer.[10]

[2] See http://www.safelives.org.uk/policy-evidence/about-domestic-abuse, accessed 24/6/19.

[3] See: http://driveproject.org.uk/

[4] Ibid.

[5] Sandwell DVA Needs Assessment 2017. Available at: http://www.sandwell.gov.uk/downloads/file/24860/sandwell_dva_needs_assesment

[6] Insights outreach England and Wales dataset 2018-19, Adult outreach services. Available at: http://safelives.org.uk/sites/default/files/resources/Outreach%20NDS%20201819.pdf

[7] Sandwell Domestic Abuse Strategic Partnership Strategy 2017-2020. Available at: http://www.sandwell.gov.uk/info/200324/domestic_abuse/2830/sandwells_strategy_to_tackle_domestic_abuse

[8] See: https://www.richmondfellowship.org.uk/birmingham/my-time-domestic-violence-perpetrator-programme/#toggle-id-1

[9] See: http://driveproject.org.uk/

[10] Insights outreach England and Wales dataset 2018-19, Adult outreach services, p. 3. Available at: http://safelives.org.uk/sites/default/files/resources/Outreach%20NDS%20201819.pdf

The Sandwell Domestic Abuse Strategy recognises the seriousness of the issue of DVA in Sandwell and sets out a wide ranging and co-ordinated multi-agency approach to DVA. This includes how different types of services (universal, targeted and specialist) will work together to deliver the best possible outcomes for families.

4 Family Action's Families Together Service

Sandwell Families Together is a structured prevention programme for families in Sandwell where there is a risk of DVA. The service works with men and women over 10 weeks (for women) or 12 weeks (for men) through weekly group sessions. Each session is approximately 2.5 hours. The service is designed to support men and women to recognise and overcome domestic abuse, enabling families to develop greater awareness of problem behaviours, improve their confidence and self-esteem, and ultimately support families to feel safer and have healthier family relationships.

Figure 1: Extract from Families Together information brochure

The effectiveness of the service is heavily reliant on participants being willing to recognise and change their behaviours, and who can commit to attending a full programme. The service does not distinguish between victims and perpetrators of domestic abuse, but focuses on the beliefs, attitudes and behaviours that lead to healthy and strong family relationships. Higher risk families, or those with a primary presentation of alcohol or drug misuse, are not suitable for the service.[11]

[11] The level of risk is assessed on a case by case basis at the point of referral and at pre-assessment. This may include use of the Dash (Domestic abuse, stalking and honour) checklist. Higher risk families include those where there has been more than one incident of abuse, those with a recent criminal conviction, serial perpetrators, ongoing abuse in the relationship or those who pose a risk to staff and others.

The emphasis within Families Together is on building stronger family relationships, regardless of who is the victim or who is the perpetrator of DVA, or who is to blame for different situations. This makes the service unique among traditional DVA support services.

Referral criteria for the Families Together Service
• Individuals or couples who are willing and committed to engage in all sessions of the programme • Families Together is a preventative programme and not suitable for high risk families • The programme is not suitable for people whose primary need is alcohol/drug misuse • Support cannot be provided for those with recent high risk criminal conviction(s) or who may be deemed to pose a risk to staff and others.

Table 1: Criteria for referral to the Families Together service

5 The Theory of Change

5.1 Resources (inputs)

The service is delivered by two part-time senior support workers (= 1.0 FTE) and three sessional support workers, and is currently funded by the Big Lottery Reaching Communities Fund. There is an office base at Burnt Tree Children's Centre in Tipton and group sessions are run at other community venues in the area. Family Action provide operations management and central support (data systems, evaluation, communications and marketing, finance, HR).

The service is delivered in accordance with a new intervention for men (Any Man Can, based on information learnt through the Strength To Change Programme[12]), and a modified intervention for women (based on the Victim Recovery Toolkit). These provide the structure and content for delivery of the service and are set out in detailed manuals.

Senior staff are all trained in the Any Man Can programme by its creator Mark Coulter. They then developed and documented the programme for women themselves and provide shadowing and coaching for sessional staff. The senior staff have a professional background in supporting people who have experienced domestic abuse.

5.2 Context

Sandwell is an area characterised by high levels of deprivation, below average life expectancy, poor health, high levels of homelessness and higher than average levels of depression and other mental illnesses. The incidence of reported domestic abuse in Sandwell is 22.4/1000 population, which is higher than the national and regional averages (20.4/1000 & 20.3/1000 respectively).[13] While this context provided a strong case for piloting this service in Sandwell, it is not assumed within the Theory of Change that the service is only relevant to such a context. Indeed, domestic abuse cuts across all facets of society and all socio-economic/demographic

[12] Strength to Change is an award winning programme for perpetrators of domestic violence and abuse, based in Hull, East Yorkshire. It is aimed primarily at enhancing the safety of women and children, while giving men an opportunity to change their behaviour. Strength To Change was one of the top three UK projects cited by the Home Office to the European Crime Prevention Network as an example of best practice in crime prevention. Working with predominantly high risk clients, it achieved an 80% reduction in offending based on client's previous histories and data supplied by Humberside Police.

[13] Sandwell JSNA – Adult Mental Health and Wellbeing, 2017.

groups. Furthermore, figures on domestic abuse are likely to significantly understate the scale of the problem, as many people (especially children) suffer abuse in silence and without reporting a crime.

As with any community-based intervention, the potential for strong cross-agency collaboration and co-operation is likely to be an important contextual factor for effective delivery of the service.

5.3 Actions (of the service)

There are seven key stages involved in delivery of the service:

Key stage	Delivery activities
Identification of problem/need	The point at which a professional (in the majority of cases) identifies the possibility of domestic abuse within a family unit. Currently, this is typically social workers, staff in Children's Centres, schools, and integrated family services teams across the NHS and local government. It may also include other charitable organisations. Self-referral is an option.[14] A phone call and/or email exchange with a senior support worker from the Sandwell Families Together team may take place with the referrer to discuss the potential referral, level of risk, other possible agencies to involve, and whether the person/family is likely to be suitable for the service. Suggestions for alternative support/intervention are discussed if the person/family is not suitable for the service. Initially only couples were included within service referrals, however this was changed after the first cycle to allow individuals to be referred and accepted into the service.
Referral	A written referral is received via a generic email address, which is then processed by a member of the team within 14 days. The referral should include explicit consent for Family Action to contact the person. Core data is captured on the team database and the client is contacted by phone to book a pre-assessment. Up to two dates are offered – if the person fails to attend both, the referrer is informed and the referral is closed. Guidance notes for referrers have been developed to accompany the referral form.
Pre-assessment	This is a face to face session following the specified format within the Any Man Can guidelines. Some assessments may take place over the phone, but only in exceptional cases. A decision to offer the person a place on the programme is made following the pre-assessment. In addition, advice/signposting on alternative support is given. Should significant underlying issues be identified that need to be addressed before the person is felt to be ready for the group sessions, this will be discussed with the person and the referrer, with appropriate advice given. A decision/confirmation letter is sent to the client within 14 days and a case file created.

[14] See Table 1 for a summary of the referral criteria for Families Together.

Key stage	Delivery activities
Booking	The service runs in cycles of just under three months. Two groups for women and one group for men typically run in each cycle. Each group should ideally have 6-8 participants, although the guidelines provide for up to 10. The person will be allocated to the next or subsequent cycle depending on availability and ability to attend. A reminder is sent two weeks prior to the group starting, along with a phone call or text message around one week prior. Groups are held during the day and in the evening.
Service delivery	10 x 2.5 hour sessions once a week for women (following content in the Recovery toolkit) 12 x 2.5 hour sessions once a week for men (following content in Any Man Can)[15] Up to two catch-up sessions are offered. Participants are withdrawn from the service if more than two sessions are missed, or if it becomes clear that the person is not engaging effectively in the group sessions. A referral back to the referring professional is made. Signposting and additional 1:1 support is provided by the workers during – and occasionally in between – group sessions to help people cope with and get through a service cycle effectively. Baseline outcome data is collected in the first session.
Closure	Final outcome data and evaluation forms are completed in the last session, and following this a report is sent to the referring practitioner (if requested). Participants are provided with advice on ongoing support options, such as the Family Action support line and other local services. Participants receive a certificate to show they completed the service.
Further support	This is currently beyond the formal boundary of the service. Some previous groups have formed ongoing peer support groups and the service has also arranged occasional events to bring people together as a way of helping to maintain support networks and lead to more sustainable outcomes.

Table 2: Summary of key stages and activities in the delivery model

5.4 Outcomes

Assuming that service participants engage in the whole cycle, and remain willing to reflect on and change their behaviour throughout, the Theory of Change assumes that this will lead directly to (for participants):

- Increased confidence and self-esteem
- Increased self-awareness and awareness around identity
- Better management of problem behaviours and understanding of behavioural boundaries

[15] Some changes to session 2 have been made, along with some re-ordering of content to introduce the topic on awareness of domestic violence earlier in the programme.

- Increased safety within the family environment, including lower risk of harm and victims of domestic abuse feeling safer (this could be men or women, or both)

These are the core outcomes of the service.

In addition to this, the opportunities offered at pre-assessment and throughout service delivery to identify additional support needs that participants may have, and to signpost to other services (and provide 1:1 support to access those services), means that the service can support earlier identification of these other needs (compared to traditional domestic abuse programmes), and improve access to support. In order to achieve these outcomes, the Theory of Change assumes that the person or family must be willing to engage in additional support, and there must be capacity available elsewhere in the system to provide that support.

The service also works closely with referrers and others across the support system at the point of referral and on closure. Assuming that there are mechanisms in place to work collaboratively together and to provide clear and timely communication and feedback, this in turn could lead to greater awareness of domestic abuse by other professionals working with men, women, children and families in other settings, improved access to alternative support, and the potential to lead to earlier intervention for domestic abuse.

These direct outcomes will in turn lead to a number of other less direct outcomes, which (a) are reliant on other factors beyond the control of the service, and (b) may take longer to come about. These include:

- Healthier family relationships
- Improved wellbeing of the whole family, and in particular of children in families that have experienced domestic abuse
- Improved mental wellbeing of the family
- Development of stronger support networks for those experiencing DVA.

Ultimately it is assumed that these outcomes will help to prevent escalation of domestic violence over the longer term, and contribute to the creation of stronger families.

There are also a number of enablers within the Theory of Change, which cut across all aspects of the service and on which its ability to deliver the intended outcomes is reliant. These are: effective and safe group environments, a highly skilled team with a degree of continuity, awareness of the service among other professionals working with individuals and families in other settings, and strong cross-agency collaboration and co-operation.

5.5 Summary of key assumptions underpinning the Theory of Change

Much of the evidence underpinning the Theory of Change comes from the success of the Strength to Change perpetrator programme based in Hull, which has been adapted for Family Action by Mark Coulter from the specialist domestic violence consultancy Mencentric.

While Strength to Change is focused primarily on supporting men with a higher risk of violence, through a combination of individual sessions (10 weeks), group work based around structured themes (40 weeks) and practical and emotional support for partners, much of the content is also suitable for lower risk men. Alongside the idea of providing more structured support for partners at an early stage, this content became the basis of the Families Together service. This is

important for the Theory of Change in that Strength to Change gave confidence that men would engage in this content and would benefit from structured group work, alongside their partners, leading to positive changes in behaviour in their relationship.

In September 2013, Strength To Change was identified as one of the top three UK projects cited by the Home Office to the European Crime Prevention Network as an example of best practice in crime prevention. Working with predominantly high risk clients, Strength To Change consistently achieved an 80% reduction in offending. Strength To Change was a Centre for Social Justice Annual Award Winner having been identified as 'an effective and exemplary agent of change' and in early 2014 Strength To Change was cited as an example of innovation by the Early Intervention Foundation in their report on Domestic Violence & the impact upon children.

In addition to this, existing evidence shows that:

- Domestic Abuse escalates over time, in 79% of high risk cases and 50% of medium risk[16]
- Early Intervention is a priority for addressing domestic abuse (feedback from two Family Action hosted learning events with domestic abuse organisations in 2015).

There is also limited provision for early intervention in domestic abuse for families in Sandwell (Family Action mapping of services in Sandwell, 2015 and 2016).

[16] Getting it right first time, SafeLives 2015.

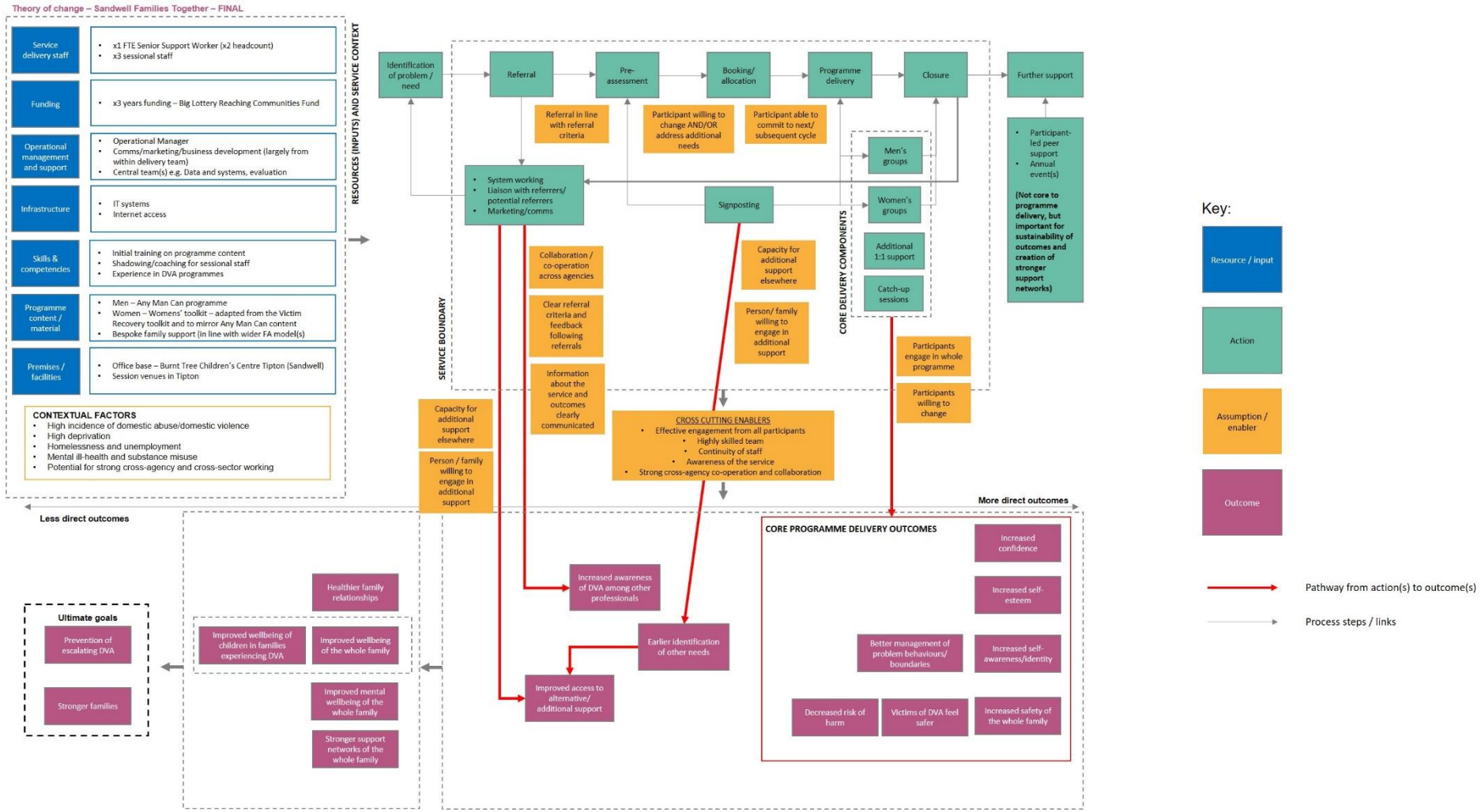

Figure 2: Families Together Theory of Change

6 Objectives of this evaluation

The purpose of the evaluation was to examine the impact and effectiveness of the delivery model for the Sandwell Families Together service, for families where domestic abuse has been recognised as a potential risk. This includes the impact of the service on perceptions of safety among victims of DVA, levels of self-esteem and emotional wellbeing across whole families, and changes in abusive behaviours. This evaluation is intended to contribute to an evidence base around the delivery model's effectiveness so as to inform future developments of the service.

The evaluation focuses on the delivery of the Sandwell Families Together Service from October 2017 to October 2019 (seven cycles).

7 Overall approach and evaluation methods

7.1 Introduction

This evaluation was undertaken between July and December 2019. Our approach was co-designed with Family Action staff and draws on insights from both qualitative and quantitative data and information, to assess the impact and effectiveness of the service in delivering a number of key outcomes – for women, men, and for whole families.

7.2 Evaluation methods

The work was undertaken in five phases as described in Table 3 below.

Phase of work	Methods / evaluation activities	Timescale
Inception, scoping and evaluation design	• Inception meeting • Process mapping and Theory of Change design session with Family Action staff • Development of evaluation and fieldwork materials	July 2019
Fieldwork	• Recruitment of participants (service users and professionals working with DVA) • Interviews with service users (plus supplementary online survey for those unable to arrange an interview) • Interviews with Family Action staff • Interviews with referrers and partner agencies	August – October 2019
Data analysis	• Data cleaning and analysis – service activity and outcome data • Coding and analysis of service user feedback forms • Comparison with national benchmarks where possible	September – November 2019
Synthesis	• Thematic analysis of qualitative data • Synthesis and triangulation with quantitative data and benchmarks • Development of draft findings and recommendations	November – December 2019

Phase of work	Methods / evaluation activities	Timescale
Reporting	• Preparation of final report	January 2020

Table 3: Summary of evaluation methods

Service activity data was available for 235 referrals made to the service between December 2017 and May 2019. Outcome data was available for 52 participants who completed a service cycle between February 2018 (cycle 1) and October 2019 (cycle 7). In addition to this, 33 people completed an end of programme evaluation form.

Despite considerable efforts from Family Action staff to contact participants who had completed a service cycle, we were only able to secure consent from a small number of people for the interviews (n=4). Three of those four were interviewed (2 women and 1 man) while the other person did not respond to both email and telephone contact. In many cases contact details had changed, or people did not wish to be involved in a telephone interview. As a result, we offered the opportunity for participants to complete a short online survey, which resulted in four responses meaning that seven users took part in the evaluation.

It was a similar situation with professionals. Four people gave their consent to take part in the evaluation and all four were interviewed (3 people working directly with people experiencing DVA and 1 person in a policy role). We had hoped for twice this number, and we expect that workloads, especially among staff from children's social services, were a factor in the lower than expected engagement.

The findings presented in this report therefore need to be seen within this context, however, where possible we have looked for consistencies (or inconsistencies) across the data and information available to us, and made some comparisons with national benchmarks, in order to draw meaningful and robust conclusions.

This part of the report sets out the evidence we have gathered during this evaluation and our interpretation of this evidence (our findings) in relation to the objectives of this work. The findings are organised under headings that broadly reflect the outcome areas set out in the Theory of Change.

8 Overall impressions of the Families Together Service

8.1 Effectiveness of the delivery model in engaging people experiencing DVA

Our findings from this evaluation show that overall the delivery model is an effective way of engaging people who are experiencing family conflict and / or low level DVA.

A total of 235 referrals were made to the service between December 2017 and May 2019, 80% of which came from Sandwell Children's Trust (social services), and 9% from local early years services. This is in line with the efforts made by staff to build partnerships with those agencies most likely to identify low level DVA in families. There are likely to be opportunities to extend this and to strengthen both strategic and operational partnerships should additional funding be secured for this in the future. This could, for example, enable referral pathways to be developed directly with schools, primary care, and a range of other family support services, including both statutory services and those provided by voluntary and community sector organisations.

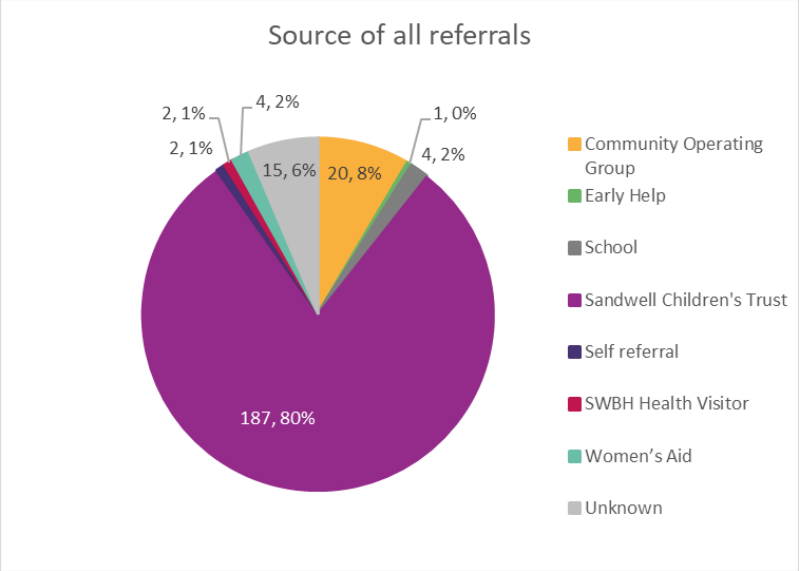

Figure 3: Source of all referrals to the Families Together service

As a comparison, referrals to Independent Domestic Violence Advisors (IDVAs) across England and Wales largely come from the police (60%), followed by self-referrals (14%). Only 4% come from children's services (see Figure 4 below). This highlights the effective reach of the Families Together service into families either before DVA has escalated to the criminal justice system, or before further intervention is felt necessary by the police.

We also heard from the professionals we spoke to that there is likely to be considerable unmet demand for support around low level DVA, in order to help prevent escalation and the corresponding negative impact on whole families.[17]

[17] It was outside the scope of this evaluation to undertake any analysis on possible levels of unmet need, however, all of the professionals we spoke to indicated that the level of support available for DVA in Sandwell is likely to be well below the level of need within the community.

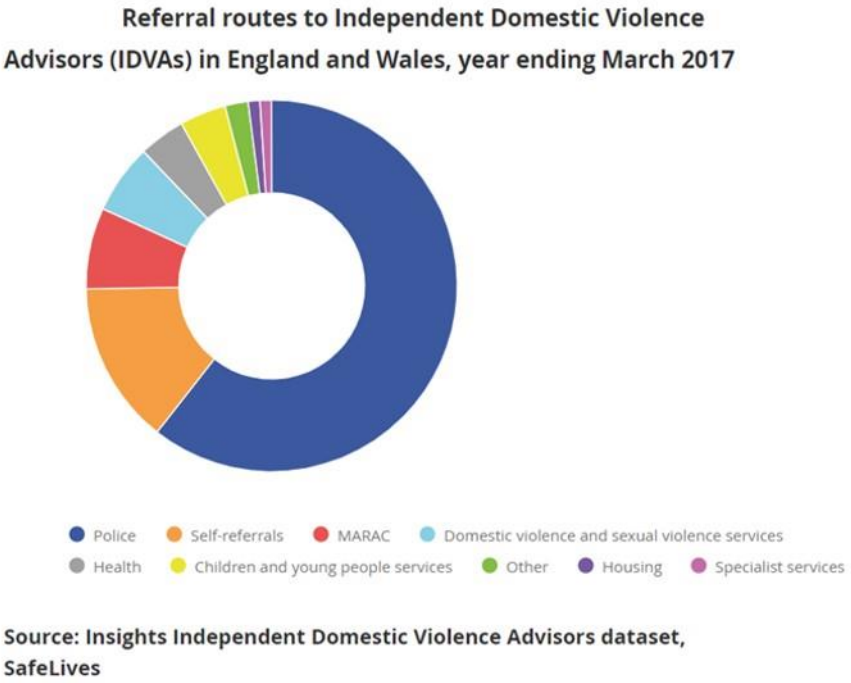

Figure 4: Referral routes to IDVAs – year ended March 2017[18]

The data collected by the service shows that only 16 of these referrals were considered unsuitable for the service (typically those who were deemed to be at high risk of criminal conviction or those who posed a risk to staff and others).

We did not hear any negative comments from participants on the referral and booking process. Overall, people felt that it was quick and straightforward.

> *"Very quick. [The Family Action Worker] was really efficient with processing the whole process." – Service user*

> *"It was quite simple for me." – Service user*

This is despite quite marked variation month on month in the number of referrals received (Figure 5), which, given the staff capacity available within the team, would most likely have a direct impact on how quickly people can be contacted, assessed, and then offered a place on the next cycle.

[18] Source: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017 accessed 2/12/19

Figure 5: Number of referrals to Families Together by month

After taking account of those who could not be contacted after a referral was made, 169 people were then booked in for pre-assessment. 115 were assessed and accepted into the service, 76 started a cycle, and 52 went through to completion. This is shown in Figure 6.

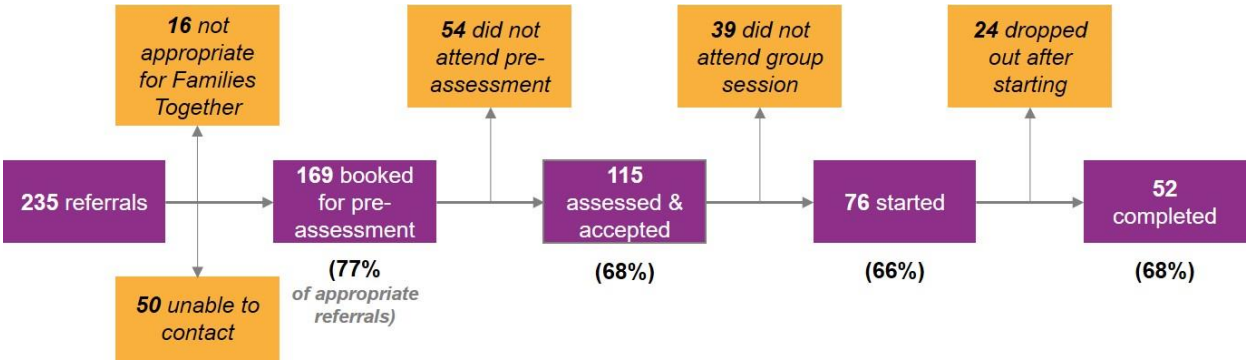

Figure 6: Number of referrals received, and pre-assessments and places offered by Families Together (cycles 1 – 7)

This means that at each of the main steps in the process, around a third of participants did not engage: 54 were booked for a pre-assessment but failed to attend, 39 were accepted into the service and booked a place on a cycle but failed to attend any sessions, and 24 dropped out after starting a course, typically due to a failure to attend more than two sessions. In all cases, staff made a number of attempts to contact people by phone and written communication in order to encourage engagement and participation in the service.

These numbers are important, since the capacity of the service is driven less by the number of places in each cycle (and ultimately how many people start and complete a cycle), and more by the capacity to process referrals and complete pre-assessments, which are undertaken exclusively by senior staff. This includes the time taken to attempt to contact people who do not engage at some point in the process.

The evidence we saw suggests that the service was operating at full capacity for processing referrals and undertaking pre-assessments, notwithstanding the number of people who went through to completion is lower than hoped.

Nevertheless, around two thirds (68%) of those who started a cycle went on to complete the sessions. We believe this is positive given the voluntary nature of the service. While it is difficult to make direct comparisons with other services (for example, male perpetrator programmes can often last considerably longer (30 weeks) and be a condition of probation), we consider this to be a good completion rate for this service. A piece of research undertaken in 2018 looking at published evaluations of European Domestic Violence Perpetrator Programmes[19] showed that drop-out rates for voluntary, community-based programmes varied between 19% and 65%, with an average (median) drop-out rate of just under 50%.[20] The completion rate for Families Together is broadly consistent across the cycles, with the exception of cycle 3, which had very low numbers.

What is disappointing (and incredibly frustrating for staff) is the number who were assessed and allocated a place but who did not attend any of the sessions (39) and the number who were booked for a pre-assessment (and in some cases two pre-assessments) but who did not attend (54). This takes up valuable assessment time and means that some of the places available in the group sessions were not able to be filled. The team did try a number of different measures (group assessment sessions, providing catch-up sessions, and offering flexible appointment times), however, none of these were successful in boosting the level of engagement.

More detailed analysis of who dropped out and why at each of the steps in the referral and intervention pathway was outside the scope of this evaluation. Further exploration of the reasons for non-attendance / disengagement would therefore be beneficial to inform future service delivery.

A total of 52 people successfully completed Families Together up to the end of October 2019 (cycle 7). Numbers in the later cycles were noticeably higher than earlier cycles.

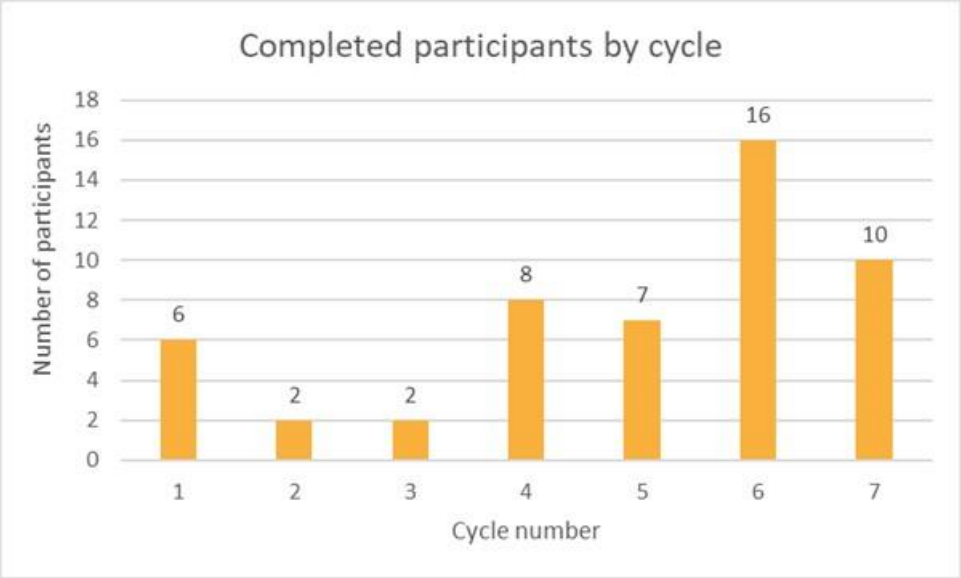

Figure 7: Number of completed participants by cycle

[19] Walker, S-J. , Hester, M., & Turner, W. (2018). Evaluation of European Domestic Violence Perpetrator Programmes: Toward a Model for Designing and Reporting Evaluations Related to Perpetrator Treatment Interventions. International Journal of Offender Therapy and Comparative Criminology, 62(4), 868-884.

[20] Calculated as a crude, unweighted median value, due to differences in sample sizes and research design. Based on drop-out rates reported for 13 studies.

8.2 Demographic profile of service participants

8.2.1 Age

All service participants were aged between 20 and 59, with nearly half (44%) between 30 and 39. Just over a quarter (27%) were in their 20s and just under a quarter (23%) in their 40s. 6% (3 people) were between the ages of 50 and 59.

The average age of all those who were accepted into the service was 35 which is consistent with the national average for DVA support services. Nationally, the average age of those accessing DVA support services is around 34 – 36 years (depending on the type of service). Two thirds (between 63% and 68%) will be in their 20s and 30s.[21]

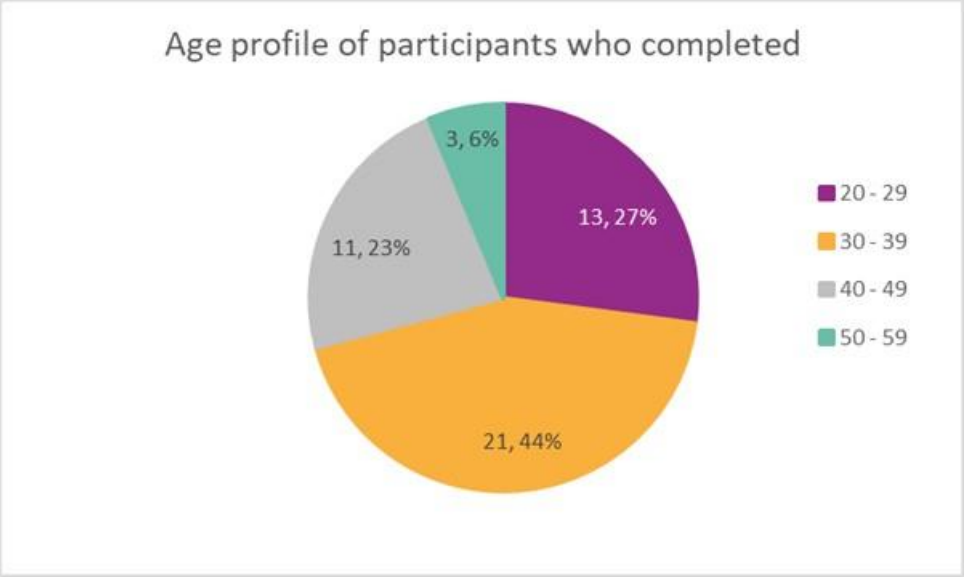

Figure 8: Age profile of Families Together participants who completed

8.2.2 Ethnicity

80% of participants in the Families Together service came from either a White ethnic background or an Asian / Asian British background (68% and 12% respectively).

This is broadly consistent with the population of Sandwell as shown in Table 4 below.

Service staff highlight that language is likely be a barrier locally for many people from an Asian background accessing services such as this, however, significant service design changes would be needed to deliver the Families Together service in other languages.

Nationally 83% of those accessing IDVAs are from a White background, with the second largest ethnic group typically Asian / Asian British, at around 6%.

[21] See: http://www.safelives.org.uk/latest-insights-national-datasets

Ethnic group	Families Together participants	Sandwell population[22]	National average for IDVA services[23]
White background	68%	70%	83%
Asian / Asian British background	12%	17%	6%

Table 4: Main ethnic groups among Families Together participants compared to Sandwell population and national averages

8.2.3 Gender

Figure 9 shows the split of service participants by gender. 43% of those who completed were men and 57% were women. The general population in Sandwell is 49% male and 51% female, which suggests that the service is effective at engaging with both men and women.[24] There was a slight tendency for women to be more likely to progress from referral through to completion than men.

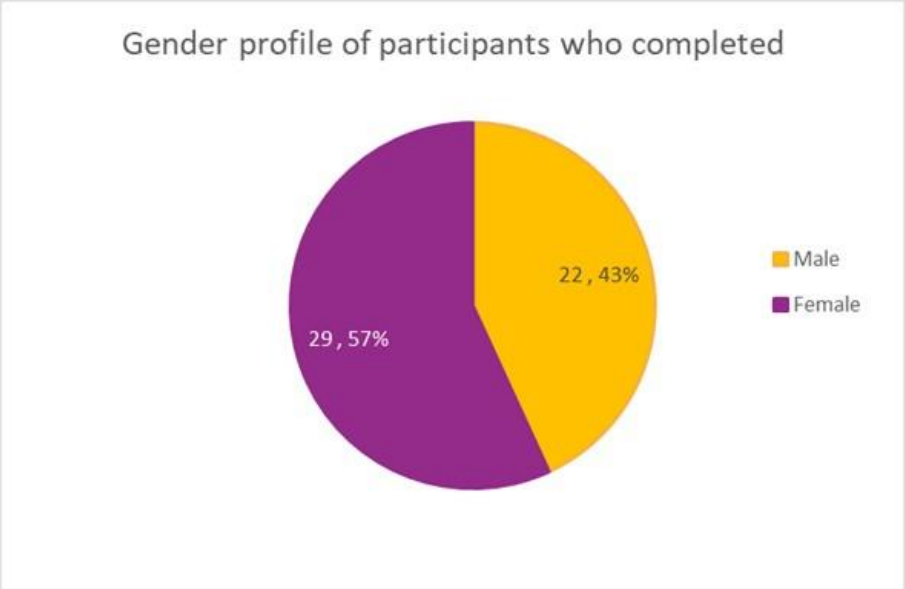

Figure 9: Gender profile of Families Together participants who completed

8.2.4 Experiences of service participants

On the whole, the experiences of service participants have been overwhelmingly positive. 94% rated the service overall as 'excellent' or 'very good'.[25] All of those who were asked whether they would recommend the service to others facing similar issues said 'yes'.[26] One of the participants we interviewed had also suggested the service to a friend.

[22] 2011 Census, see: https://www.sandwelltrends.info/2011-census/2011-census-ethnicity-hub/

[23] See Safe Lives 2018-19 dataset

[24] The service accepts either partner or both partners, which is why these numbers are not equal. There were no same sex couples referred to the service.

[25] Based on end of programme evaluation forms, n=33.

[26] Ibid.

Some also felt that the opportunity for both partners to attend – which differentiates Families Together from other DVA support services – was important for a successful outcome and should continue to be encouraged in the future.

Almost everyone who completed an evaluation form at the end of the service felt that the service had benefited them in some way (32 out of 33 participants). Most commonly this was because of the opportunity to talk with others facing similar issues, and to share feelings and be open about their own situation in a safe environment. Around a quarter of participants also found the course beneficial because it gave them time to focus on and understand themselves.

> *"[It was] quite nice to hear from the other people in the sessions. We understood each other, supported each other, spoke up for one another. It actually helped to cheer me up!" – Service user*

9 Outcomes for participants and their families

9.1 Mental wellbeing

Mental wellbeing of service participants was measured using the 14-item Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) at the beginning and end of each cycle. The scale is used widely, both nationally and internationally, for monitoring and evaluating the impact of projects and programmes on mental wellbeing. Each item is scored from 1 to 5, giving a total score of between 14 and 70.

Service participants showed notable improvements in mental wellbeing, with an average improvement in WEMWBS score of 8.7 across all seven cycles (n=48). The minimum level of change in score considered to be important is 3, with a sample size of 50 or more, suggesting that these results are likely to be statistically significant and attributable to the Families Together service.[27]

Average WEMWBS score at the start of the service (all participants)	Average WEMWBS score on service completion (all participants)	Change in average score (all participants)
44.5	53.2	8.7

Table 5: Average change in WEMWBS score among Families Together participants

The data also shows that 75% of participants' scores increased, with two thirds (67%) increasing by 3 points or more.

[27] See: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/

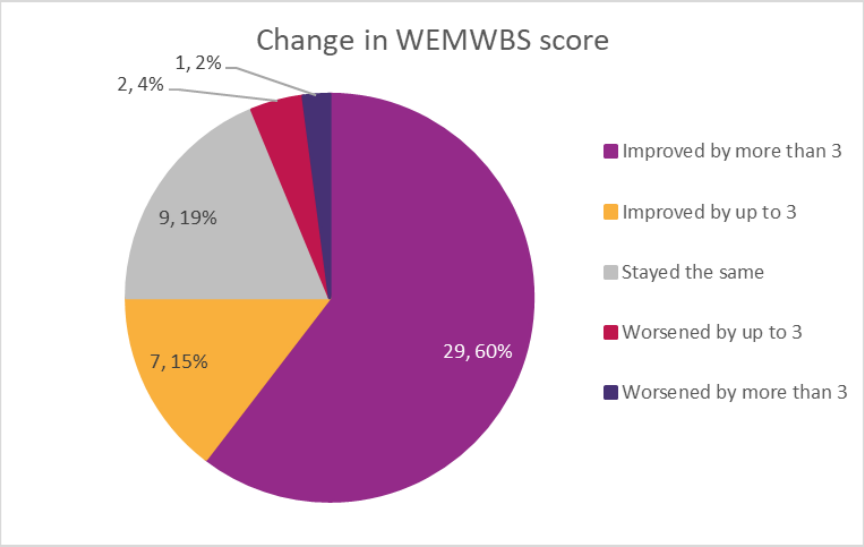

Figure 10: Change in WEMWBS scores – all completed participants

The changes in WEMWBS scores for men were especially positive:

Change in WEMWBS	Men	Women
Improved by more than 3	87%	61%
Improved by up to 3	7%	17%
Stayed the same	7%	9%
Worsened by up to 3	0%	9%
Worsened by more than 3	0%	4%

Table 6: Overall change in WEMWBS score for men and women

It is also important to note that mental wellbeing at a population level, measured using WEMWBS, tends to be fairly stable year on year at around 50 (out of 70).[28] This means that in all cycles except cycle 7, mental wellbeing of participants was better than the population average at the end of service (53.2). In all cycles the average mental wellbeing score was below the population average at the start of the service (44.5).

At an individual level, low mental wellbeing is generally recognised as a score of 40 or below (which has also been shown to indicate probable depression), while high mental wellbeing is a score of 59 and above.

[28] See for example: https://scotland.shinyapps.io/sg-scottish-health-survey/

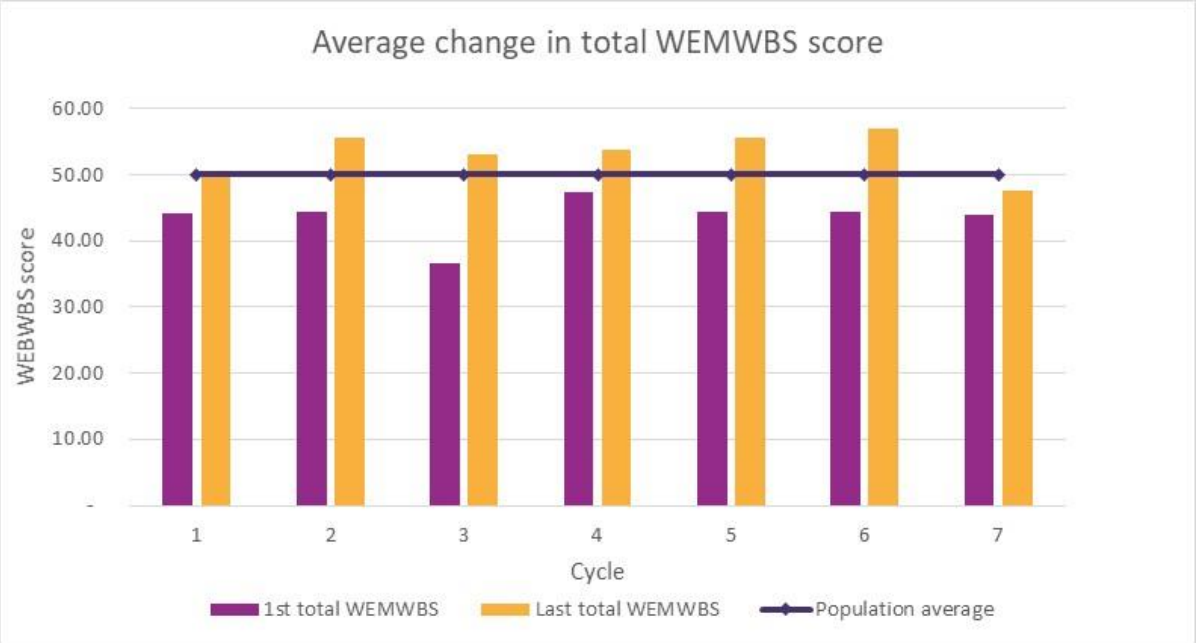

Figure 11: Change in WEMWBS score – all completed participants by cycle

9.2 Self-esteem

Self-esteem of service participants was measured using the Rosenberg Self-Esteem Scale (RSES). The scale consists of 10 items with each item scored from 1 to 5, giving a total score of between 10 and 50. Higher scores mean higher self-esteem. Being a measure of global self-worth, research suggests that the RSES may not change noticeably in response to a single, direct intervention, but is more likely to change over a longer period of time and in response to multiple changes in a person's life.[29]

Overall, self-esteem improved for 84% of service participants. This is a very positive outcome. In addition to this, average scores increased for all 10 items in the scale.

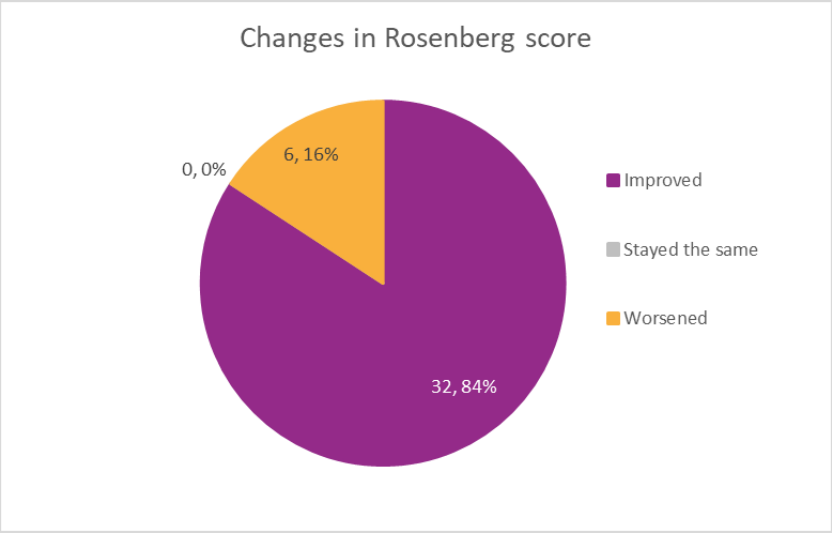

Figure 12: Change in RSES scores – all completed participants

[29] See for example: http://movingahead.psy.unsw.edu.au/documents/research/outcome%20measures/paediatric/Measures%20of%20Self/Website%20RSES.pdf

Figure 13: Change in RSES scores – all completed participants by scale item

Those aspects of the scale that showed most improvement are shown in Table 7 below.

Statement	Increased score means…	Change in average score
I am quite satisfied with myself	More satisfied with myself	0.50
At times I think I am no good at all	Less likely to think I am no good at all	0.40
I definitely feel useless at times	Less likely to feel useless at times	0.40
I tend to think I'm a failure	Less likely to think I'm a failure	0.40
I wish I had more respect for myself	Less likely to wish I had more respect for myself	0.38

Table 7: Most improved statements from the Rosenberg Self-Esteem Scale (RSES)

Apart from the first statement (I am quite satisfied with myself), these are all negatively worded statements, which would fit with the content of the course and the types of feelings associated with DVA situations.[30]

As with the wellbeing scores, improvements in self-esteem were slightly more positive for men than for women, however, we do not know how statistically significant this is.

[30] Note that negatively worded items are scored in reverse, so that a higher score always means improved self-esteem.

Change in RSES	Men	Women
Improved	92%	76%
Stayed the same	0%	0%
Worsened	8%	24%

Table 8: Changes in RSES scores for men and women

Figure 14 below shows that average changes in Rosenberg scores between the start and end of the service varied considerably by cycle with no particular trends identified, although some (including cycle 3) included only a very small number of participants which is likely to skew the results.

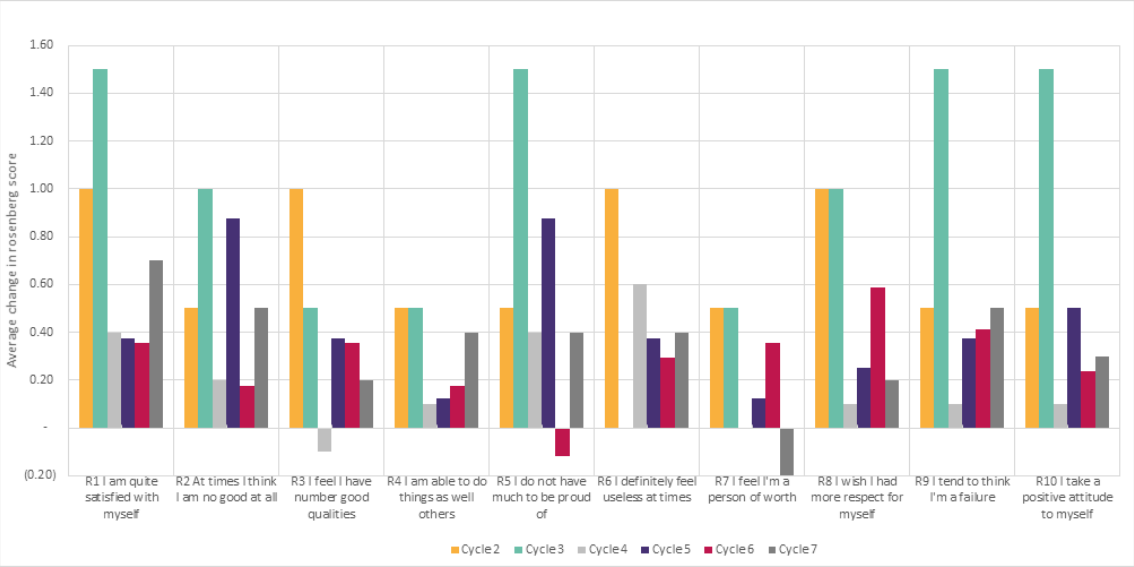

Figure 14: Average change in RSES scores by scale item and cycle (cycles 2 to 7)[31]

9.3 Self-awareness and behaviour change

The content of the Families Together service, and in particular the content developed for men who take part in the service,[32] is based on the premise that people can benefit from increased awareness of who they are, as individuals, as partners, as parents, and so on. This in turn leads to more informed choices and a greater chance that those choices will be better for both the individual and everyone they come into contact with.

Feedback from service participants (both men and women) clearly shows greater self-awareness as a key outcome of the service.

When asked to describe how they felt the service had been of benefit to them (open responses):

[31] Note that RSES data for cycle 1 was only captured for 1 participant and has therefore been excluded from this analysis.

[32] The Any Man Can Programme developed for Family Action by Mark Coulter.

- 31% of participants said that the course had opened their eyes to their own behaviour or situation, helped them to see what needed to change, and gave them the tools to start making those changes
- 22% of participants said that they felt they were now a better person, or felt calmer and more in control of their behaviour, and
- 13% of participants said they felt more confident and better able to manage different aspects of their family relationships.

"The sessions were great, I have benefited, as I have learnt about myself." – Service user

"I have been looking at my own behaviour and actions and trying to change/adapt to make myself a better more tolerant person." – Service user

"I have become more aware of my own behaviour and started listening to my partner and letting him support me more." – Service user

"Made me realise I'm not on my own. Made me more confident. Changed my way of thinking." – Service user

In addition to this, participants generally found that opening up about their past was the most difficult aspect of the course.

9.4 Safety and risk of harm

Improving the safety of family members and reducing the risk of harm is a key outcome of the service, both in the short and longer term. This is difficult to measure, and had we been able to interview more participants, and / or to track individuals and families over a longer period of time, we may have been able to evaluate this outcome in more depth. Despite this, there are a few indicators that point to the effectiveness of the service in this area:

- A number of participants (as noted above) said that they felt calmer, more in control of their behaviour, and better able to manage situations at home as a result of the service
- Two of the three interviewees said that the situation at home was now much more manageable and better for their children
- All of the front-line professionals we spoke to had their own anecdotal evidence about the impact of the service for those families they had contact with, which typically included: children coming off child protection plans once the course had been completed, and / or not seeing any re-referrals to social services for DVA related issues in those families where one (or both) parents had been on a course.

In addition to this, separate analysis by the service in partnership with West Midlands Police and Sandwell Children's Trust showed that of 28 families who were referred by the Trust and completed Families Together:

- In all but three cases (90%) the risk reduced in the family and the case was stepped down from child protection (CP) to child in need (CIN) or early help (EH), or subsequently closed
- There was only one case of reoffending reported after completion of the programme.

These all suggest a positive shift towards safer family environments and lower risk of harm as a result of the Families Together Service.

> *"The course has helped me to manage situations at home much better. It's less stressful. And I don't feel like I need to shadow my children when my partner is with them." – Service user*

> *"I can control my anger now. This has been the main thing from the course for me and means I can handle situations better. My son is doing really, really well since I went on the course." – Service user*

Case example – Bavinda and Emily
All names have been changed to protect anonymity.

Bavinda and Emily were referred by Sandwell Children's Trust. Both had experienced physical and psychological abuse in their childhood and experienced DVA from their current and previous relationships. Both have admitted being abusive towards each other. Emily also experienced DVA from her previous partner.

Bavinda engaged well in the group. He stated he struggles to talk about his feelings but as the group progressed, he appeared more confident and open about his feelings and experiences. He was able to identify some traits he felt he had inherited from his father and is determined to change his behaviour for his children and partner. Bavinda appeared able to reflect on his behaviour and experiences, which he shared in group discussions. He felt the programme benefited his children and partner in a positive way.

Emily engaged well in the group session from the beginning to the end, despite the challenges she faced with managing her child's acute illness and her own severe mental health challenges. Emily reflected well and rationalised how many of the issues which stem from her previous relationship and upbringing have impacted who she is today and adversely affected her current relationship. Emily particularly benefitted from the session exploring anger and she recognises how her anger issues require managing. She reflected well on how she could communicate more effectively and began to demonstrate improved communication skills, which have enabled her to better connect with Bavinda and their children. She also introduced healthy boundaries to create a healthier environment for herself, Bavinda and their children. Emily reported how this has in particular benefitted her son who presented with challenging behaviour.

Both Bavinda and Emily reported that they feel the programme has enabled them to improve their relationship as a family. Emily attended the Family Action Christmas Event along with her children and presented as happy, spoke about their wedding plans and how their relationship is better.

Both Bavinda's and Emily's feedback on the WEMWBS and Rosenberg scoring show an improvement in almost all questions from starting to ending the programme. They have had a positive attitude throughout attending the programme. Emily also fed back how this programme has better prepared her for completing her course in Psychology as she has been able to work on her self-awareness, confidence and self-esteem.

10 Outcomes across the wider support system

Our evidence in this area is, unfortunately, less than we would have hoped for due to the small number of interviews with professionals. However, there are some important themes from the discussions we did have with those professionals working with people experiencing DVA, and the staff delivering the Families Together service itself.

10.1 A focus on building stronger family relationships

This is a unique feature of Families Together and something that distinguishes it from more traditional DVA support services, which typically work with either perpetrators (usually men) or victims (usually women) in higher risk situations. Not only does this focus on stronger family relationships mean that the service can support both – or either – parent equally, it provides a clear and supportive narrative for working with people at lower levels of DVA and with a view to preventing escalation.

> *"He learnt a lot from it himself. How to behave. It has made a massive difference to the family." – DVA Professional*

> *"[Families Together has] made a lot of difference for the children. It's about parenting style as much as anything, and a better relationship. Children are much happier. They were off the child protection plan shortly after finishing the course." - DVA Professional*

10.2 A service that works effectively with lower level DVA, especially for men

In Sandwell, specialist support for people experiencing DVA is typically offered for either perpetrators (such as the My Time Programme delivered by the Richmond Fellowship[33] or the Drive multi-agency intervention[34]) or victims (such as the support provided by Women's Aid). Furthermore, notwithstanding there are prevention elements within them, these services only generally work with people who have already experienced high-harm and repeated incidents of DVA (or serial offending).

However, the experience of Families Together highlights that many men and women can be both potential victims and perpetrators, either within the same relationship or over more than one relationship.

[33] See: https://www.richmondfellowship.org.uk/birmingham/my-time-domestic-violence-perpetrator-programme/

[34] See: http://driveproject.org.uk/

Case example – Misha and Andy
All names have been changed to protect anonymity.

Misha and Andy were referred by Sandwell Children's Trust. They have both been perpetrators and victims of DVA, against each other both currently and historically. The difficulties in their relationship are around Andy's alcohol issues and money being sent home to Africa for Misha's children. Arguments have escalated to violence between Misha and Andy and their older children, aged 17 and 20 years.

Both Misha and Andy engaged well in the group sessions and have completed the programme. Misha feels she has benefited from being able to speak with her family without hurting their feelings. She feels Andy and her children listen to her when she wants to explain something without it turning into an argument. Misha felt the best thing about the programme was to be able to understand what you are dealing with in regard to your relationship.

Misha also spoke honestly about her own experiences of being sexually assaulted as a young child in Africa. Misha felt it was very important to face your feelings and talk about your past. Misha appears passionate about her children and wants a more positive relationship with them and Andy. She stated she would recommend the programme to others who have been in her situation.

Andy started the programme with a somewhat sceptical attitude and wished to prove the Social Workers wrong rather than considering what changes he will need to make to become a better partner and father. As the programme progressed, Andy began to reflect on the topics and relate them to his own behaviour, feelings and thoughts. Andy openly discussed his childhood and began to recognise how his intake of alcohol, which started as early as 8 years old, the cultural differences of being raised in Africa, the impact of losing his mother at such a young age and having no positive male role model have led to him developing a mask to protect him from appearing vulnerable, and using male power as a means of maintaining control in his life.

He went on to recognise how this behaviour and mind-set has hindered his relationship with his family and feelings of not being accepted by Misha and their children. Andy often expressed quite tender feelings and on occasions became tearful. Andy fed back how the programme has supported him to look closer at himself and changes he needs to make to re-establish a better relationship with his family. He expressed that he feels addressing these issues out of the family home might avoid further misunderstandings and relationship breakdown.

Towards the end of the programme, Andy developed close relationships with other men and reported how the group has made him feel like he has been listened to, and helped him to better start bettering himself.

10.3 Integration of Families Together across the support system in Sandwell

Much work has been done over the past two years to develop the Families Together service in Sandwell, raise awareness across the support system, and to work in partnership with other professionals and agencies supporting families in a range of settings. This has included developing strong links and pathways of referral at an operational level with staff at Sandwell Children's Trust, local children's centres, the Sandwell Domestic Abuse Team, and Action for Children. These partnerships have also enabled the service to use shared space at Burnt Tree Children's Centre at no charge, and to find suitable venues for delivering courses that provide a level of anonymity and safety for participants.

However, it is clear from this evaluation that there are now opportunities to build on this early work at an operational level, and to establish stronger and more formal arrangements at a strategic / governance level. This includes considering how best to embed Families Together in the wider system of support. Such action is particularly relevant in light of the emphasis on prevention within the Sandwell Domestic Abuse Strategy, notwithstanding there is very little, if any, other specialist preventative support available for both men and women in the area.

These opportunities could include:

- Representation of Families Together on the local MARAC and / or Domestic Abuse Partnership
- Sharing of information across agencies about participant profile and outcomes / impact
- Outreach work, which could consist of some combination of: further awareness raising with health, social services and education; working with professionals in other settings (schools, primary care, early years services) to help identify families experiencing low level DVA at an earlier stage and to take appropriate action[35]; and direct work with whole families in a 1:1 setting, such as in schools and / or children's centres.

All of these are likely to have resource and staffing implications and should therefore be considered as part of any future funding discussions.

> *"It's great that there are lower level interventions, but we need to ensure they are properly integrated, which means having the right pathways in place, and safeguarding, governance and communication arrangements to support those pathways. For example, perpetrators of DVA can escalate when they start a behaviour change programme, which highlights the importance of clear lines of accountability, communication and collaboration between different agencies." – DVA professional.*

[35] This is not intended to imply direct work necessarily, but could involve referral to Families Together along with appropriate signposting, for example.

"We would definitely be open to some outreach work, and this could really complement the work we do in the groups. For example, one of the children's centres felt they could get a group of parents together who would benefit from the programme, however, it never materialised and we just don't currently have the resources to organise something like this. But we should be thinking about how to open up new referral routes in the future." – Programme staff.

10.4 Improved access to alternative / additional support

This is a key outcome in the Theory of Change. Of the seven people who were asked whether they were given information about other services that might be helpful for them or their family, two said yes (although both subsequently didn't feel they needed it), three said no, and two couldn't recall. These small numbers make it difficult to draw any conclusions about the extent to which access to alternative or additional support was facilitated by staff from Families Together, and the extent to which it may have been taken up. We would suggest that any future reviews or evaluations look specifically at this aspect of the service and put in place measures to better understand the extent to which Families Together can – and does – help families to access other support during and beyond their involvement in the service.

11 Potential for longer term impacts

There are four longer term impacts that the Families Together service is designed to achieve for families:

- Stronger families and healthier family relationships
- Improved wellbeing of the whole family
- Stronger support networks, and
- Prevention of escalating DVA

While we cannot comment directly on whether these have been achieved given the timescales and data available for this evaluation, we can make some general observations from the evidence we have about the potential for these impacts over the longer term. This is drawn from across the quantitative and qualitative data and information available from this evaluation.

Longer term impact	Potential for the service to achieve the impact	Comments
Stronger families and healthier family relationships Improved wellbeing of the whole family	Medium - high	Strong evidence of significantly improved wellbeing for the vast majority of participants, along with increases in self-esteem. Consistent view among participants and professionals that the service has led to better family relationships for many, with a positive impact also on children.

Longer term impact	Potential for the service to achieve the impact	Comments
Stronger support networks	Low / uncertain	There is little evidence from this evaluation about the extent to which the service has helped (or can help) participants to access additional / alternative support. Additional data collection over a longer time period would be needed in order to draw more definitive conclusions.
Prevention of escalating DVA	High	Consistent evidence from participants (including outcome measures) and professionals that the service has helped many people to manage situations at home better, feel calmer and more confident, and reduce the likelihood of being 're-referred' to services.

Table 9: Summary of evidence around potential for longer term impacts

Part 4: Conclusions

The evidence from this evaluation shows that Families Together is an incredibly effective intervention for tackling low level DVA. The delivery model shows a relatively high level of engagement among both men and women once the service starts. However, there are challenges engaging with this group of people at each stage from referral through to pre-assessment and commencement, with just over half (55%) of those booked for pre-assessment either not attending that appointment, or failing to attend the course once assessed and allocated a place.

The data shows a very positive experience among service participants, in many cases accompanied by significant improvements in their relationships and life at home, along with evidence of reduced risk of harm. There is evidence of significant improvements in mental wellbeing, particularly among men who have completed the service. There are also positive shifts in self-esteem, again most strongly among men, and especially with regard to reducing negative feelings of self-worth.

Greater confidence to manage potential conflict at home was one of the strongest themes to come through from participant feedback. The service has also helped many people to better understand their own behaviour, and to provide effective tools for making and sustaining positive change in their family relationships.

DVA is an issue that cuts across society, however, much of the support available is designed to support either perpetrators or victims, and almost exclusively in cases of high risk, high-harm or serial offending. In addition to this, only a small proportion of perpetrators and victims ever seek or receive support. This makes Families Together unique in that it can offer support for both men and women (some of whom may consider themselves both perpetrators and victims of DVA), and provide that support concurrently. This enables both partners to make positive changes in their relationship. Professionals working in the area note that there is a huge gap in expert / targeted provision for low level DVA and few, if any, alternative referral options for people who are experiencing DVA at a point before it has escalated to high risk.

There is also strong evidence that the delivery model is effective at reaching its intended target population, however, the number of course participants especially in the first three cycles was lower than expected. This is in part due to the capacity that was needed to process referrals and undertake pre-assessments, and the level of work involved in trying to engage with those who failed to attend appointments or return calls (rather than the number of places available in each cycle). We would argue that investment in additional staffing resources (including administrative support) would directly lead to greater coverage. This, combined with some element of outreach work in other settings (such as in schools, primary care, and early years services) would help to extend the service's reach and impact.

The service is delivered by a highly skilled and competent team, however, along with more administrative support to help manage the referral process, co-ordinate initial assessments, communicate with participants, and maintain effective record keeping, there are opportunities to consider whether the reliance on sessional staff to deliver group sessions provides the best mix of flexibility and retention. It may be that some combination of part-time staff alongside sessional workers and the existing senior workers, would provide the opportunity to respond better to fluctuations in demand and provide extra capacity to expand service provision. This would need to be accompanied by specific work on developing new referral pathways and building greater integration of the service within the existing governance, strategic and delivery arrangements for DVA across Sandwell.

Apteligen Limited
Hille House
132 St Albans Road
Watford
England
WD24 4AE
phone: +44 (0)1923 253 220
email: corporate@apteligen.co.uk
www.apteligen.co.uk