DOMESTIC ABUSE, RECOVERING TOGETHER (DART)

EVALUATION REPORT

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Impact and Evidence series

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

This is a report about a group called DART, which stands for Domestic Abuse, Recovering Together.

What is Domestic Abuse? Domestic abuse is when a grown up threatens, bullies, or hurts another adult in the family. Sometimes, it is called domestic violence. Domestic abuse can happen to anybody1.

What is DART? DART is a group for mothers and children who used to live in a house where there was domestic abuse. The group helps mothers and children to talk about what happened and share their feelings with each other.

Mothers and children who went to DART filled in questionnaires and took part in interviews to find out if they had been helped.

What did the report find?

• DART helped mothers and children to talk about their feelings, which made them feel better about themselves. Sometimes, mothers and children got upset though, when they were talking about the bad things that had happened to them.

• Mothers and children liked spending time together in the groups and this helped them to feel closer to each other.

• Mothers and children trusted the workers from DART and thought they were very kind and helpful. This made it easier for the families to talk about what had happened.

• Before DART, some children felt very angry because of the domestic abuse and this could make them behave badly and feel unhappy. DART helped them to feel happier and control their anger.

• Some children and mothers found the activities in DART fun and helpful but others thought they were a bit babyish. The DART workers tried to change the activities a bit so that everyone enjoyed them.

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1 Adapted from the ChildLine definition of domestic violence.
KEY FINDINGS

The DART intervention is a group work programme for mothers and children who have experienced domestic abuse. The programme includes individual sessions for mothers and children, and joint sessions that work on the mother–child relationship. The joint sessions are the unique aspect of the intervention as most domestic abuse recovery programmes do not have this element.

The key findings from the evaluation are:

• After the programme, mothers had significantly greater self-esteem, more confidence in their parenting abilities and more control over their child’s behaviour. They were also more affectionate to their child according to their own and their child’s ratings on a standardised measure. Children experienced fewer emotional and behavioural difficulties following DART.

• The outcomes for children on the DART programme were compared with those for children involved in an alternative service for mothers and children affected by domestic abuse. The children from DART had substantially greater reductions overall in their emotional and behavioural difficulties than a comparison group, indicating that DART helps children to recover from domestic abuse.

• Practitioners, mothers and children said that the joint sessions helped them to work cooperatively together on a range of child-friendly activities. These activities enabled children to share their experience of the abuse, which in turn helped mothers understand how the abuse had affected their child and how this may relate to some of their child’s challenging behaviours.

• Barriers to improvements included challenging behaviour in some of the children’s groups, contact with the father, and some mothers resuming relationships with the perpetrator after the intervention.
EXECUTIVE SUMMARY

Background

The Domestic Abuse, Recovering Together (DART) intervention is a group work programme that runs for 10 weeks, with weekly sessions lasting between two hours to two and a half hours.

This approach is unique because it includes joint mother and child sessions, with a primary focus of the programme being to enhance the mother–child relationship, in addition to supporting other aspects of their recovery. For half of the sessions, mothers and children are in their separate peer groups. In the other sessions, mothers and children work on activities together, which aim to help them share their experience of the abuse and to acknowledge their related feelings and concerns while supporting one another. The first DART services started in October 2010 and the DART service was running in eight NSPCC centres during the course of the evaluation.

The approach used in DART is based on Humphreys et al’s (2006) research, *Talking To My Mum*, which found that outcomes for children who experience domestic abuse are improved when the non-abusive parent is involved in supporting their recovery. However, domestic abuse can be harmful to individuals’ physical and mental health in a number of ways (see, for example: Helfrich et al, 2008), and this can make it harder for mothers to provide children with support (Humphreys et al, 2006). Additionally, mothers often underestimate the extent to which children are aware of and affected by domestic abuse (Edleson, 1999) and struggle to address the subject with their children (Mullender et al, 2002). DART aims to help mothers to support their children by helping them understand how their child was affected by the abuse, helping mothers and children talk about their experiences with one another appropriately, and by working to strengthen their relationship. Additionally, the programme aims to support the mothers’ recovery, for example by raising the mothers’ self-esteem, which is likely to help to increase their capacity and emotional strength required to support their child’s recovery.

Methodology

DART was evaluated using a mixed method approach. The impact and process evaluation involved standardised measures collected at three time points: before (Time One); at the end of (Time Two); and six months after the intervention (Time Three). The children’s Strengths and Difficulties Questionnaire (SDQ) scores were compared with a comparison group. The measures were designed to address key programme outcomes, including emotional and behavioural difficulties
(in children), self-esteem, confidence in parenting (for mothers) and maternal warmth. A sample of mothers, children and practitioners took part in qualitative interviews about the service. All mothers and children (who completed DART) and referrers were invited to complete a survey that enabled them to rate DART according to a number of criteria.

**Strengths and limitations of design**

There are a number of strengths and limitations, which are detailed briefly below and in more depth in the main report.

The strengths of the design include:

- Mixed method design, including standardised measures, surveys and qualitative interviews;
- The inclusion of a (small) comparison group; and
- The range of perspectives included in the research, with views from mothers, children, referrers and practitioners.

The limitations include:

- Small numbers in the comparison group and small numbers of those who completed measures at Time Three;
- Differences between the comparison group and DART that could not be controlled for due to low numbers in the comparison group;
- Low response rate to the referrers’ survey; and
- Few interviews were conducted involving participants who had dropped out of DART.

**Key findings**

There were significant improvements between the mothers’ mean scores on the standardised measures from Time One to Time Two. Mothers had significantly greater self-esteem, more confidence in their parenting abilities and more control over their child’s behaviour following DART. Mothers were rated (by their child and themselves) as more affectionate to their child, and less rejecting following DART.

Children appeared to be experiencing significantly fewer emotional and behavioural difficulties following DART. The children’s self-esteem scores improved but this was not statistically significant. This may be partly because, unlike their mothers, their initial self-esteem scores did not appear to be low at Time One.

Some of these changes, such as the reduction in emotional and behavioural difficulties, and the improvement in mothers’ self-esteem were maintained six months after DART.
The strengths and difficulties scores, which measured indicated levels of emotional and behavioural difficulties for the children who received DART, were compared with the scores collected for children in another service. This service involved mothers and children who attended play therapy sessions at a women’s refuge. The data was collected before (Time One) and after (Time Two) each intervention took place. The analysis revealed that the children who had received DART had significantly greater reductions in their ‘total difficulties’ and ‘conduct problems’ scores than the comparison group following the interventions. This indicates that DART is an effective approach that supports children’s recovery from domestic abuse.

Qualitative interviews with mothers, children and practitioners identified factors that affected the achievement of programme outcomes. For example, the joint sessions enabled mothers and children to work together cooperatively and for mothers to understand how the abuse had impacted their child. Practitioners created an environment where service users felt safe, supported and comfortable about expressing their views. Barriers to outcome achievement included: challenging behaviour in some of the children’s groups; contact arrangements with fathers causing upset for mothers and/or children; mothers’ anxiety about coming to the group; and mothers feeling uncertain about participating in some of the more child-focused activities.

DART was highly rated by service users and referrers. On a scale of one to five (with one meaning very poor and five meaning very good), mothers rated the service on average as 4.8 and children rated it as 4.7. Referrers’ mean rating of the service was 4.5 in terms of how well they felt it met the needs of families.

Next steps

Early findings have been presented at international BASPCAN (British Association for the Study and Prevention of Child Abuse and Neglect) conferences and two peer reviewed journal articles have been published: one in *Child Care in Practice* and one in *Child Abuse Review*. Further opportunities to present and publish data are currently being explored.

The DART steering group are in the process of promoting the intervention to external organisations, some of which have agreed to adopt the model with support from the NSPCC. An evaluation of the implementation of DART by those other organisations is being planned in the first instance.
Chapter 1: Introduction

1.1 Background

In the UK, more than 750,000 children witness abuse and violence in their homes (Department of Health, 2002). For an estimated 130,000 children, this abuse is considered ‘high risk’, indicating that they are at significant risk of harm or death (CAADA, 2012). However, statistics such as these are likely to be an underestimation. Domestic abuse is underreported and data is not routinely collected on how many children are affected (Women’s Aid, 2007). Additionally, domestic abuse may be normalised in families where abusive behaviours occur regularly; therefore, it may not be recognised by those involved (Early Intervention Foundation, 2014).

Domestic abuse can involve physical violence, emotional abuse and sexual abuse, and can be perpetrated by the victim’s partner, ex-partner or family member (Welsh Assembly Government, 2005). Other aspects of domestic abuse include damaging the victim’s property, isolating them from potential sources of support, threatening other individuals in their lives, controlling their access to money and personal items, and stalking. Domestic abuse may also involve “violence inflicted on, or witnessed by, children...” (Welsh Assembly Government, 2005). This definition has more recently been altered to include abuse perpetrated and experienced by 16- and 17-year-olds, honour-based violence and female genital mutilation (Home Office, 2013; Early Intervention Foundation, 2014). Domestic abuse is highly gendered, with the majority of victims being women. However, men can also be victims of domestic abuse (Walby & Allen, 2004).

Effects of victimisation

There are a range of negative outcomes associated with being a victim of domestic abuse. In addition to the physical impacts of abuse, such as injury, death and disability (Plichta, 2004), the mental health of a victim may be damaged by the experience (Helfrich et al, 2008). Depression, anxiety (Jaffe et al, 1986), post-traumatic stress disorder (Hughes & Jones, 2000), self-harm (Boyle et al, 2006) and low self-esteem (Scott-Gilba et al, 1995) are among the mental health difficulties experienced by mothers following domestic abuse.

In addition, the problems they experience as a result of the abuse may drain them of the energy and emotional resources that are needed to parent effectively (Humphreys et al, 2006).
Effects on children

Living with domestic abuse can be detrimental to a child’s development, health and wellbeing (see, for example: Edleson, 1999). There is an elevated risk of child abuse within this context (Osofsky, 2003; Straus et al, 1990) and exposure to domestic abuse is increasingly recognised as a category of emotional child abuse in its own right (Graham-Bermann, 1998; Gilbert et al, 2009; Holt et al, 2008). Children can be physically hurt when trying to protect their mother (Humphreys et al, 2008), or abused as a method of controlling the mother (Kelly, 1994).

More recent research conducted by CAADA (Coordinated Action Against Domestic Abuse) (2014) found “a major overlap between direct harm to children and domestic abuse”, with 62 per cent of children who had been exposed to domestic abuse being harmed themselves. Even if children are not physically hurt, witnessing the abuse of a parent may in some cases be as damaging psychologically as if they were abused themselves. For example, one study (Kitzmann et al, 2003), found that there were no significant differences between the outcomes of children who had experienced physical abuse compared with those who had witnessed domestic abuse. Both groups experienced significantly greater problems than non-witnesses and children from verbally aggressive homes.

Children living with domestic abuse are more likely than other children to have mental health problems, such as post-traumatic stress disorder (Chemtob & Carlson, 2004; Kilpatrick & Williams, 1998), anxiety (Edleson, 1999) and depression (Russell et al, 2010). They are also more likely to perform less well academically and tend to be less socially competent than their peers (Peek-Asa et al, 2007; Edleson, 1999). They may become more aggressive and have behavioural issues as a result of their experience, with one study showing that children exposed to domestic abuse were almost three times as likely as controls to develop a conduct disorder (Meltzer et al, 2009). Children may also emulate the behaviours they witness once they have left the abusive situation (CAADA, 2014).

The role of the mother–child relationship

A key protective factor found to reduce the negative impact domestic abuse has on a child is a good relationship with a caring adult, usually the mother (Holt et al, 2008). Additionally, outcomes for children who experience domestic abuse are improved when the non-abusive parent is involved in supporting their recovery (Humphreys et al, 2006).
However, the mother–child relationship can sometimes be damaged by the experience of domestic abuse. Domestic abuse may affect the mother’s ability to care for and support her child. In addition, the mother’s parenting may be undermined by the child seeing her being insulted and belittled by the perpetrator, or if children are encouraged by the perpetrator to be rude and aggressive towards their mother. Children may feel angry at their mother for not preventing the abuse, or may think she may have done something to deserve it (Humphreys et al, 2006).

Once the abuse has ended, mothers and children are often reluctant to acknowledge or talk about their experiences, in an attempt to protect one another from the upset this may cause (Mullender et al, 2002). Mothers often underestimate the extent to which their children are aware of and affected by the abuse, which can also prevent talking about the abuse once it has ended (Edleson, 1999). For these reasons, working on the mother–child relationship is viewed as a critical aspect of domestic abuse interventions (Humphreys et al, 2008). However, this focus is not prioritised within most existing interventions.

The Domestic Abuse, Recovering Together (DART) service

The DART service was developed by the NSPCC for mothers and children who had previously experienced domestic abuse. The approach is unusual because, unlike the majority of domestic abuse interventions, half of the sessions involve both the mother and her child together (in a joint mothers and children group). During these joint sessions, mothers and children participate in a range of activities aimed at strengthening their relationship, promoting communication about the abuse and supporting one another through their recovery. The rest of the sessions are spent in their separate peer groups. The group is held once a week for ten weeks, with sessions lasting between two hours to two and a half hours.

The programme aims to:

- improve the mother–child relationship;
- enable the mothers and children to share their feelings about the domestic abuse with one another;
- reduce the difficulties experienced by the child, such as conduct problems, emotional distress and issues with their peer relationships;
• increase the self-esteem of the mothers and children;
• increase the mothers’ confidence in their parenting abilities; and
• promote a better understanding of healthy and unhealthy relationships.

The theory of change was developed with the DART steering group on the basis of the research cited above (for example, Mullender et al, 2002; Humphreys et al, 2006). The theory of change is illustrated below in Figure 1, which aims to illustrate the following:

How it was anticipated that the activities in DART sessions would help the families.

• How process outcomes\(^2\), in particular supporting mothers and children to share their feelings of domestic abuse with one another, may lead to the ultimate aims of the programme (for example, for mothers and children to start to recover from domestic abuse).

• How achieving outcomes for mothers may relate to child outcomes. For example, how improving the mothers’ self-esteem, confidence in parenting and relationship with their child may help them to be more emotionally equipped to support their child’s recovery.

• How helping mothers have a fuller understanding of the effects of the abuse on the child may be an additional incentive for them to avoid abusive relationships in the future.

• How these intermediate outcomes\(^3\) may relate to the ultimate aims of the programme: to support the mother and child recovery and to keep both parties safe from further abuse.

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\(^2\) Process outcome = an outcome of the delivery process that can promote change; for example, a safe space created for the child and mother to share their experiences of domestic abuse.

\(^3\) Intermediate outcomes = a change that is a necessary step to achieving other outcomes. For example, an improved parent–child relationship can lead to better outcomes for the child in terms of their emotional wellbeing.
Figure 1: DART theory of change*

- Experiencing/witnessing domestic abuse can be psychologically/physically damaging for mothers and children (for example, physical harm, depression, PTSD, low self-esteem) (See Note 1)
- Families struggle to talk about the abuse after it has ended, so trauma is often not acknowledged or addressed (See Note 2)
- Children recover better from domestic abuse if their non-abusive parent supports them, but due to effects of abuse, mother is not always able to provide this support (See Note 3)
- Mother and child attend the DART programme together and are able to talk about domestic abuse in a supportive environment (See Notes 4 and 5)
- Mother and child have better understanding of domestic abuse and healthy/unhealthy relationships (See Note 6)
- Mother has more understanding of how her child was aware and affected by domestic abuse (See Note 7)
- Mother and child less likely to become involved in an abusive relationship in the future (See Note 9)
- Mother and child have an improved relationship (See Note 10)
- Mother begins to recover from domestic abuse experience and is, therefore, in a better place to support her child (See Note 11)
- Mother and child are safe from further domestic abuse incidents (See Note 12)
- Child begins to recover from domestic abuse experience with mother’s support, as indicated by a reduction of emotional and behavioural difficulties (See Note 11)

*See Appendix 3 for notes that explain how the DART theory of change relates to relevant literature.

DART inclusion and exclusion criteria

The inclusion and exclusion criteria used during the assessment to decide whether or not the family is suitable for the DART group are as follows:

Inclusion:

- Children must be aged between seven and 11[^4]
- The family has previously lived with domestic abuse experience
- The family is considered harmed by this experience
- The perpetrator is no longer part of household

[^4]: This has now been extended to age 14.
Exclusion:

- Maternal inability to participate in the group (for example, severe mental health issues)
- Child inability to participate in the group (or example, severe cognitive impairment or behavioural issues)
- Child is known to have been subject to other forms of abuse (for example, sexual abuse), which are unresolved and may require alternative intervention

The NSPCC has been running the DART programme since October 2010. The first DART services were based in NSPCC service centres in Hull, Prestatyn, Northampton and York. Four additional service centres in Liverpool, Warrington, Belfast and Foyle started to run the programme in October 2012.

Some adaptions were made to the DART programme after the evaluation data collection ended: the children’s age range was extended to 14 and an adapted version of the programme (DART Plus) was trialled. DART Plus included pre-group sessions with the mothers in order to emotionally and practically prepare them for the core DART programme. However, there was a lack of appropriate referrals where this additional work was required; therefore, services have reverted back to the original model.

1.2 Method

Evaluation aims

The aims of the DART evaluation were:

- to measure the extent to which DART achieves its goals of improving outcomes for mothers and children who used the service;
- to identify factors that impact on the programme’s ability to achieve these outcomes; and
- to identify any ways in which the programme could be improved.

Design

The impact and process evaluation used a mixed methodology involving three elements. First, outcomes were measured using standardised psychometric tools, with a small comparison group included in the study. Second, surveys were carried out with participants and referrers to collect their views about the programme. Finally, qualitative interviews were undertaken to explore participants’ and practitioners’ experiences of the programme, and the barriers and
facilitators to its effectiveness. The approach to each of these elements is described below.

Measuring outcomes

Standardised psychometric tools were used to measure the changes to the key programme outcomes. The measures were administered by DART practitioners at the start (Time One) and end of the programme (Time Two) and six months after the programme finished (Time Three). The standardised tools, and the outcomes they were aiming to measure, are set out in Table 1. These tools were chosen due to their measuring key outcomes, which relate to the theory of change. For instance, the Strengths and Difficulties Questionnaire measures emotional and behavioural difficulties in children; a reduction of these issues suggests they may be starting to recover. The Rosenberg Self-Esteem measure and the Parental Locus of Control measure may indicate aspects of the mothers’ recovery, as increases in parental efficacy, parental control and self-esteem suggest the mother is feeling better about herself and more confident in her parenting abilities. Increases in maternal warmth on the Parental Affection and Rejection Questionnaire (PARQ) and reductions in the negative/rejecting behaviours are indications of an improved relationship between mother and child.

Table 1: Standardised measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Tool</th>
<th>Participants</th>
<th>Subscales/Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>Rosenberg Self-Esteem Scale</td>
<td>Mothers</td>
<td>N/A</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Adapted version of Rosenberg Self-Esteem scale</td>
<td>Children</td>
<td>N/A</td>
</tr>
<tr>
<td>Children’s wellbeing</td>
<td>Strengths and difficulties Questionnaire (SDQ)</td>
<td>Mothers (rating their child)</td>
<td>Conduct problems, emotional symptoms, peer problems, hyperactivity, prosocial behaviour</td>
</tr>
<tr>
<td>Mother’s interaction with her children</td>
<td>Parent Acceptance and Rejection Questionnaire (PARQ)</td>
<td>Mothers and children</td>
<td>Maternal warmth/affection, hostility/aggression, indifference/neglect, undifferentiated rejection</td>
</tr>
<tr>
<td>Mother’s belief in her ability to managing challenging behaviour</td>
<td>Parental Locus of Control (PLOC)</td>
<td>Mother</td>
<td>Parental efficacy and parental control of child’s behaviour</td>
</tr>
</tbody>
</table>

The scores for the standardised measure relating to the wellbeing of the children (the Strengths and Difficulties Questionnaire) were compared with those of children who had attended a different programme in order to better assess the impact of DART.
Sample size

There were 201 families who started DART between October 2010 and June 2014, and 147 of these (73 per cent) completed the programme; an attrition rate of 27 per cent. Table 2 shows the numbers of mothers and children who had completed one or more standardised measures (or had a standardised measure completed about them).

The number of measures completed at different time points varied for the following reasons:

- The pool of potential respondents was lower at Time Two and Time Three due to attrition from the programme.
- In some cases, participants declined to take part, and in other cases, practitioners believed particular measures, such as the PARQs, were too sensitive for some service users at that point in time; for example, if an incident like a death in the family had recently occurred.
- It was hard to contact some participants after the intervention ended; for instance, some had changed addresses/phone numbers, some did not respond to calls/voice messages.
- Some were unwilling/unable to visit the service centre to complete measures after the intervention ended, and some missed appointments to attend interviews and complete Time Three data.
- Practitioners felt that they did not always have the capacity to collect further data due to a heavy workload and other priorities.

The demographic characteristics of the sample are reported in Appendix 1.

Table 2: Numbers of participants

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th></th>
<th>Children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On the programme</td>
<td>Completed evaluation measures*</td>
<td>On the programme</td>
<td>Completed evaluation measures*</td>
</tr>
<tr>
<td>Time One</td>
<td>201</td>
<td>158 (79%)</td>
<td>201</td>
<td>166 (83%)</td>
</tr>
<tr>
<td>Time Two</td>
<td>147</td>
<td>88 (60%)</td>
<td>147</td>
<td>96 (64%)</td>
</tr>
<tr>
<td>Time Three</td>
<td>NA</td>
<td>22</td>
<td>NA</td>
<td>27</td>
</tr>
</tbody>
</table>

*These columns refers to the percentage of those on the programme at the time of data collection who completed evaluation measures.

5 Data used here is based on DART administrators’ records of the service users who started and completed the programme.
Comparison group

A comparison group was recruited in order to increase the robustness of the evaluation so that any changes observed could be more confidently attributed to the intervention. The comparison group data was collected by a women’s refuge service that supported mothers and children who experienced domestic abuse and offered an intervention based on play therapy.

Between 2008 and 2011, this service collected SDQs completed by mothers, children and teachers of children before and after children attended the intervention. The service signed a data sharing agreement that gave the NSPCC evaluation department permission to use this data. Only the SDQs completed by the mothers were used for comparison, as teachers and children involved in DART had not been asked to complete SDQs.

The play therapy intervention involved sessions between a child and the therapist that lasted between 45 minutes and an hour, and were held once a week. The number of sessions that the child attended ranged from four to 40, with the mean number attended being 15. This is a higher number of sessions than DART, which involves ten weekly sessions with the mother and child. However, the DART sessions are longer, lasting between two and two and a half hours per session.

The age range of the comparison group sample, from two years to 11 years, was also wider than that for DART, which ranged from seven years to 11 years. In order to decrease the differences in the age groups, without lowering the sample size too drastically, children in the comparison group aged below five were excluded from the analysis. This left a comparison sample of 18 children from a total of 20 children whose mothers had completed SDQs at Time One and Time Two. Additionally, the ethnicity of the comparison group was more diverse than the DART group (see Appendix 1 for further details).

Analysis

All standardised measure data was analysed using SPSS. Descriptive statistics, such as means and standard deviations, were calculated. For the DART Time One, Time Two and Time Three data, a series of paired samples t-tests were conducted in order to see if any of the difficulties they were experiencing before DART had reduced after they received the intervention.
In order to compare the changes between the DART group and the comparison, the change in scores for both of the groups were compared using a series of independent samples t-tests. Due to low numbers of children in the comparison group, non-parametric tests were additionally conducted. The same results were obtained with the non-parametric tests, and are these are included in Appendix 1.

Summary data for the results of the standardised measure scores are included in Chapter 2: Outcomes later in this report, with the full results given in Appendix 5.

Survey of views

Mothers and children on the programme, along with professionals who made a referral to DART, were invited to complete a survey about their views and experiences of the intervention. The surveys enabled participants to rate different aspects of the service on a scale of one to five and share their views on its effects. DART practitioners gave input on the design and content of the survey. End of programme surveys were completed by 95 mothers and 92 children (response rates of 65 per cent and 63 per cent respectively).

An online survey was sent to all referrers who had referred families to DART at two different time points (October 2012 and September 2013). In total, 99 referrers were sent the survey, 19 of whom responded, giving a response rate of 14.4 per cent.

Copies of the questionnaires for both surveys can be found in Appendix 6.

Qualitative interviews

Interviews with mothers and children

Twenty-two mothers and 14 children were interviewed about their experience of DART. These participants had attended one of the six DART services that had run at least one DART group. At the time of the interviews, the Belfast and Liverpool services had not fully completed any DART programmes; therefore, interviews were not conducted at these services. The demographics of this sample are reported in Appendix 1.
A purposive sampling strategy was used to select participants for interviews. Mothers and children were selected on the basis of their scores from standardised measures and their ratings of the programme from the surveys in order to ensure that the sample included those who had both positive and negative experiences of the programme. Participants were assigned to a ‘positive’ or ‘negative/neutral’ group. The aim was to recruit a balanced sample of those who had positive and negative outcomes, including those who had dropped out.

This was challenging as not all individuals approached agreed to be interviewed and not all attended their scheduled interview. Additionally, few participants rated the service poorly, which limited the numbers of potential interviewees; therefore, this group was extended to include those who had given more average or neutral ratings of the programme. Interviewees who appeared more likely to agree to participate in and attend their interview were those who viewed the service more positively; therefore, there were greater numbers in the ‘positive’ group (see Table 3).

Table 3: Sampling for interviews

<table>
<thead>
<tr>
<th>Mothers</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Negative/Neutral</td>
</tr>
<tr>
<td>14</td>
<td>8</td>
</tr>
</tbody>
</table>

Interviews with practitioners

A sample of practitioners delivering the DART programme was interviewed at two different time points. The first set of interviews were conducted after the first DART groups finished, in May 2011, and the second set were conducted a year later, in May 2012. The aim of the first set of interviews was to explore practitioners’ perspectives of the programme in terms of what was working well, and to identify potential barriers to outcome achievement.

The follow-up interviews a year later were conducted to see how well the services were progressing and to look at how practitioners perceived the slight change to the manual on the basis of their early feedback. The change to the manual enabled practitioners to be slightly more flexible when selecting activities for the groups, in order that they were suitable for the varied ages and needs of the individuals. The follow-up interviews also revisited issues raised by practitioners in the original interviews to see if anything had changed.
Practitioners from all services were sent an email inviting them to take part and at least one practitioner from each service agreed to be interviewed. All practitioners who gave their consent were interviewed. The first set of interviews included nine practitioners and the second set involved five practitioners and one service manager. Four of the practitioners who were originally interviewed took part in the second set of interviews. Some of the original interviewees were no longer involved in running DART, while others were not available at the time of the interviews.

Data collection

The mother and practitioner interviews ranged from 20 minutes to an hour, and the children’s interviews lasted between 10 to 25 minutes. Topic guides were used to prompt interview questions but a semi-structured approach enabled the interviewer to be responsive to the participant and allow them to help guide the interview. Copies of the topic guides can be found in Appendix 7. Interviews were audio-recorded and transcribed verbatim.

Analysis

The interviews were themed for analysis using the Framework approach developed by Ritchie and Lewis (2003). The Framework approach involves familiarisation with the data, identifying recurring themes or ideas, developing a conceptual framework and then developing sub-themes from the broader categories. This is informed by the interview topic guide and the recurring themes that emerged from the interviews. The broader themes were entered into an MS Excel spreadsheet and each interview was themed according to these categories; for example, overall experience, perception of outcomes, positive factors, negative factors, and suggestions for improvement. These themes were then broken down further into sub-themes, such as programme-related factors, emotional/behavioural factors and external factors. These sub-themes were divided into more specific themes identified under the broader categories. Theme categories were double-checked and refined with a second researcher.
1.3 Ethics

The research was approved by the NSPCC Research Ethics Committee, which follows Government Social Research (GSR) standards. Details of the ethical issues and steps that were taken to address these are in Appendix 2.

1.4 Limitations of the research

There are a number of limitations to this evaluation:

**Differences between the comparison group and DART:** The comparison group was small, which meant that differences between the groups, such as age and ethnicity, could not be controlled for.

**Small numbers who completed measures at Time Three:** Attaining Time Three data was challenging for a number of reasons: the mothers’ contact details often changed; some participants did not give consent; it was not always considered appropriate to contact some individuals (for example, if they had recently experienced a distressing event); and, at times, practitioners’ workload did not allow for the time following up these families could take. On occasions, Time Three data could not be matched to Time One data. This further reduced the numbers that could be used in the analyses.

**Low response rate to the referrers’ survey:** Despite several reminders, the response rate to the referrers’ survey remained low, which undermines the representativeness of the data.

**Few interviews were conducted involving participants who had dropped out of DART:** The evaluation aimed to interview a number of families who had not completed the DART programme, in order to identify potential barriers. Some of these families were approached to be interviewed but only two mothers consented. Families who had dropped out were not approached if practitioners thought this would be inappropriate or unsafe for the family involved; for example, if they had resumed a relationship with the perpetrator. One of the mothers who had agreed to be interviewed did not attend on the day; therefore, only one mother with this experience was interviewed.

Despite these limitations, this evaluation has a number of strengths, including: the mixed methods used; the range of perspectives included in the research, with views from mothers, children, referrers and practitioners; and the inclusion of a comparison group.
Chapter 2: Outcomes

This chapter briefly summarises the experiences of the mothers and children at baseline and describes the changes for those mothers and children who attended the DART programme. It also compares the changes experienced by children on the DART programme with those in the comparison group.

2.1 Service users’ baseline scores

Baseline scores collected before the families attended DART (at Time One) indicated that both mothers and children were experiencing some difficulties at this time point. For instance, most children (71.2 per cent, n=116) had total SDQ scores that indicated they had ‘some’ or ‘high’ needs in relation to their emotional and behavioural difficulties. Almost half (45 per cent, n=72) of the mothers had self-esteem scores that were below the normal range and their mean self-esteem score was only just above the lowest point within the normal range (at 15.22 – normal range is between 15 and 25).

Mothers’ scores on the Parental Locus of Control scale indicated that they tended to have low confidence in their ability to parent and little control over their child’s behaviour. The PARQ scores from both mother and child questionnaires indicated that most families were not experiencing major difficulties in terms of mothers showing affection or rejecting their child. However, there was a minority of mothers (13.5 per cent, n=19) and children (20 per cent, n=27) who self-reported or reported their mothers as having high levels of rejecting behaviours and showing little affection. Children’s self-esteem scores were not below the normal range. Appendix 4 provides further details and full tables of participants’ mean scores with comparisons against population norms.

2.2 Mothers’ outcomes

The standardised measures indicated that mothers had greater self-esteem, more confidence in their parenting and had greater influence over their child’s behaviour following DART. There were also significant improvements in the mothers’ PARQ scores, which suggested that they felt warmer and more affectionate towards their child and were less hostile, aggressive and rejecting towards them after the programme. The key improvements are reported in Table 46.

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6 For full results, see Table 11 in Appendix 5.
### Table 4: Key changes for mothers at Time Two

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T2 mean</th>
<th>Significance level*</th>
<th>Numbers of mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem**</td>
<td>14.77</td>
<td>19.66</td>
<td>p&lt;.001</td>
<td>83</td>
</tr>
<tr>
<td>Parental efficacy (PLOC)**</td>
<td>22.92</td>
<td>19.93</td>
<td>p&lt;.001</td>
<td>85</td>
</tr>
<tr>
<td>Parental control of child’s behaviour</td>
<td>30.34</td>
<td>25.62</td>
<td>p&lt;.001</td>
<td>85</td>
</tr>
<tr>
<td>(PLOC)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PARQ**</td>
<td>35.32</td>
<td>31.65</td>
<td>p&lt;.001</td>
<td>72</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001. ** For the self-esteem scores, a greater score suggests higher self-esteem. For the PLOC, lower scores indicate high parental efficacy/parental control. For the PARQ, lower scores indicate high affection and less rejection.

Mothers’ scores were categorised according to whether they were below, within or above the normal range for each of the measures, apart from the Parental Locus of Control scale, where norms were not available. Categorisations of mothers’ before and after scores were compared using a statistical test\(^7\). This test revealed a significant difference in the mothers’ self-esteem categorisation between Time One and Time Two (p<0.001).

Chart 1 shows that the majority of those (62 per cent, n=23) with low self-esteem before DART had improved after DART, as their scores moved into or above the normal range. The majority of those who scored within the normal range before DART (70 per cent, n=31) still had scores within this range following DART, and 23 per cent (n=10) had moved above the normal range (indicating very high self-esteem). However, three of the mothers (7 per cent) who had initially scored within the normal range had lower self-esteem following DART. Only two mothers had scores indicating they had very high self-esteem before they started the programme. One of these mothers had scores within the normal range following DART and the other stayed above the normal range.

A comparison of the mothers’ categories based on their total PARQ scores at Time One and Time Two was also conducted. As the numbers who had problematic scores at Time One for the PARQ were very low (n=9), statistical comparisons of the category changes could not be conducted.

Chart 2 focuses on mothers whose scores at Time One indicated difficulties with their relationship with their child. Six of the mothers (67 per cent) had scores within the normal range after DART, indicating their relationship had improved, but three (33 per cent) still indicated their relationship continued to be difficult.

\(^7\) A marginal homogeneity test.
Impact and Evidence series

Chart 1: Changes in the mothers’ self-esteem following DART

<table>
<thead>
<tr>
<th>Status</th>
<th>Below normal range at T1 (n=37)</th>
<th>Within normal range at T1 (n=44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deteriorated</td>
<td>62%</td>
<td>7%</td>
</tr>
<tr>
<td>Stayed the same</td>
<td>38%</td>
<td>70%</td>
</tr>
<tr>
<td>Improved</td>
<td>0%</td>
<td>23%</td>
</tr>
</tbody>
</table>

n=81

Chart 2: Improvements following DART: Mothers who reported high levels of difficulties with relationship with child

<table>
<thead>
<tr>
<th>Status</th>
<th>Improved (n=6)</th>
<th>Stayed the same (n=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

n=9. Table 12 in Appendix 5 shows the changes for the mothers in the other categories.

All mothers whose scores were within or below the normal range (indicating low levels of rejection) at Time One remained below the normal range at Time Two.

Improvements in mothers’ self-esteem, confidence in their parenting and control of their child’s behaviour were maintained six months after the end of the intervention. Chart 3 illustrates the improvements in the mother’s self-esteem at different time points. However, the improvements in the mothers’ warmth and the reductions in their hostility and rejecting behaviours, as measured by the PARQ, were no longer statistically significant, though this may be due to the small sample size at Time Three.

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8 For full results, see Table 15 in Appendix 5.
Chart 3: Changes in mothers’ self-esteem scores

n=22. Chart only includes those who had completed self-esteem measures at all three time points. Higher scores = higher self-esteem.

2.3 Children’s outcomes

Significant improvements were found for all of the ‘difficulties’ subscales on the SDQ, indicating that children had fewer emotional and behavioural difficulties following DART. As with the mothers’ scores, children’s scores on the PARQ indicated that they perceived that their mother was warmer, more affectionate and displayed less aggressive or rejecting behaviour by the end of the programme. Although the children’s self-esteem score slightly improved, this was not statistically significant. The reason this improvement may have not been significant might be partly because the children’s self-esteem scores did not appear low at Time One, and, therefore, there may be less potential for these scores to improve in comparison to their mothers’. Table 5 illustrates the key changes between Time One and Time Two.

Table 5: Key changes for children at Time Two

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T2 mean</th>
<th>Significance level*</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem**</td>
<td>19.92</td>
<td>21.04</td>
<td>NS</td>
<td>77</td>
</tr>
<tr>
<td>Total PARQ**</td>
<td>37.68</td>
<td>33.86</td>
<td>p&lt;.01</td>
<td>72</td>
</tr>
<tr>
<td>Total difficulties (SDQ)**</td>
<td>18.65</td>
<td>14.24</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001. **For the self-esteem scores, a greater score suggests higher self-esteem. For the PARQ, lower scores indicate high affection and less rejection. For the SDQ, higher scores indicate greater levels of overall difficulties and lower scores indicate fewer difficulties. NS = non-significant.

9 For full results, see Table 13 in Appendix 5.
Children’s scores were also categorised according to whether they were in the ‘high need’, ‘some need’ or ‘low need’ categories for the SDQ at each time point. A marginal homogeneity test revealed a significant difference in the categories children were placed into based on their ‘total difficulties’ score on the SDQ (p<.001). Chart 4 shows that those children (71 per cent, n=10) who were classified as having ‘some needs’ at Time One moved into the ‘low need’ category after DART, and the vast majority (96 per cent, n=24) of those who were initially ‘low need’ remained ‘low need’ after the intervention.

It is positive that 45.5 per cent (n=25) of children with high levels of need at Time One moved into the lower need categories after DART, and also that most who initially had ‘some needs’ moved into the ‘low need’ group.

However, it is a concern that over half of the children (54.5 per cent, n=30) with high needs at Time One remained with high needs after DART. This suggests that although children’s emotional and behavioural difficulties may reduce following DART, some, who have more entrenched or higher levels of difficulties before the programme, remain with problems that may warrant further intervention.

Chart 4: Changes in children’s ‘total difficulties’ categories following DART

The change in the children’s PARQ categories according to their total scores was also compared. The marginal homogeneity test only revealed an overall difference that was approaching significance (p=0.61); however, the majority of children (87.5 per cent) who had indicated that their mother showed high levels of rejection at Time One (with scores above the normal range) had moved to within or below the normal range at Time Two (see Chart 5). This indicated that there were improvements for the majority of those children with the most problematic relationships with their mothers.
Nevertheless, two children still had PARQ scores above the normal range, indicating that they still felt rejected by their mother following DART. The vast majority (91 per cent, \(n=51\)) of those who had scores within or below the normal range (which indicated that their mother was not rejecting or unaffectionate) at Time One remained within or below the normal range at Time Two (see Table 12 in Appendix 5).

![Chart 5: Improvements following DART: Children who reported high levels of difficulties with their relationship with their mother](image)

\(n=16\). Table 14 in Appendix 5 shows the changes for the children in the other categories.

Some of the improvements observed between the children’s scores at Time One and Time Two were maintained at Time Three\(^{10}\). Children had significantly fewer conduct problems, emotional symptoms and overall difficulties at Time Three compared with Time One. Chart 6 illustrates how the children’s total SDQ scores changed over time for the individuals who completed measures at all three time points. This shows that the total difficulties score reduced significantly from Time One to Time Two and stayed around the same at Time Three.

![Chart 6: Changes in children’s total difficulties SDQ scores](image)

\(n=22\). Chart only includes children who had SDQs completed at all three time points. Higher numbers = higher levels of difficulties.

\(^{10}\) For full results, see Table 16 in Appendix 5.
The changes in the SDQ scores indicate that some of the benefits from the intervention were maintained six months later. However, the differences between the PARQ scores were no longer significant. It is possible that if larger numbers had completed these measures at both Time One and Time Three more significant differences would have been found. However, it is also possible that the positive effects of the intervention were not sustained after the support the NSPCC provided had ended.

### 2.4 Comparison group analysis

Comparison of SDQ scores between DART and the other intervention indicate that children attending both groups improved by the end of the programme; however, the children who attended DART had improved more. Children from DART had significantly greater reductions in the ‘total difficulties’ scores and the ‘conduct problems’ scores than the comparison group (see Table 6). Other differences between the subscales were non-significant.

#### Table 6: Comparison of changes in SDQ scores

<table>
<thead>
<tr>
<th>Reduction in:</th>
<th>Comparison group</th>
<th>DART group</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Difficulties</td>
<td>-1.33</td>
<td>-4.40</td>
<td>p&lt;.05</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>-0.22</td>
<td>-1.22</td>
<td>p&lt;.05</td>
</tr>
<tr>
<td>Emotional Symptoms</td>
<td>-0.67</td>
<td>-1.68</td>
<td>NS</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>-1.04</td>
<td>-0.79</td>
<td>NS</td>
</tr>
<tr>
<td>Peer problems</td>
<td>0.56</td>
<td>-0.78</td>
<td>NS</td>
</tr>
</tbody>
</table>

NS = non-significant.

A key factor when interpreting these results on change is that the mean SDQ scores for children differed between the DART and comparison groups at Time One (see Table 17 in Appendix 5). Although both groups had mean ‘difficulties’ scores that would place them in the ‘high needs’ group for each ‘difficulties’ category, the DART group had higher mean ‘total difficulties’ scores than the comparison group at Time One. Therefore, it is possible that the children from DART had more scope for change than the comparison group, which may partially contribute to the greater extent of improvement in the pre- and post-intervention scores.

However, it is also possible that children in the DART group had more entrenched problems and, therefore, it would be more difficult to reduce their emotional and behavioural difficulties. Despite these limitations, this provides some evidence that the DART programme directly led to reductions in the emotional and behavioural difficulties of children who used the service and that the reductions were not simply the result of changes over time.
Chapter 3: Views of the programme

This chapter details mothers’ and children’s views of the programme (based on their responses to end-of-programme surveys), as well as the views of referrers.

3.1 Mothers’ and children’s views

The service was rated very highly by mothers, who gave a mean rating of 4.8 (on a scale of one to five; with one meaning very poor and five meaning very good), and also by children who rated the service at 4.7 on average. Reasons participants gave for their positive ratings included that they made friends and met supportive people, the staff were kind and there were enjoyable activities and activities that children found helpful.

I liked talking about the fighting and arguments with my mum because [my mum] can help me.

(Child)

Mothers also stated that the intervention was something different and additional to other related support they had received, and described how the group sessions helped children to understand their perspective of the abuse.

My daughter stopped blaming herself. She attended a group for kids but attending the group together really helped as she saw my issues too.

(Mother)

Not all children rated the service highly, and those who gave it a lower rating said it was because they found the programme ‘boring’ or because they had to talk about their father and did not want to. Even those who enjoyed the programme overall were sometimes distressed by the group.

I enjoyed being in the DART group because it has helped me learn and understand what domestic abuse is. But it made me feel a bit upset sometimes.

(Child)
The vast majority of mothers (98.8 per cent, n=88) felt that DART had helped them in some way; the most common way was by helping them relate to their child. Chart 7 breaks down the ways in which these mothers felt that DART helped.

Chart 7: Ways in which mothers felt helped by DART

- being able to relate to your child: 89.8%
- coping with your past experiences: 84.1%
- how you feel about yourself: 69.3%
- other: 8.0%

Similarly, most children (79.3 per cent) felt that DART had helped them in some way; the most common way was by helping them talk to their mum. Chart 8 shows the ways in which these children (who had indicated that DART had helped) felt that they had benefited from the programme.

Chart 8: Ways in which children felt helped by DART

- talking to your mum?: 100.0%
- how you feel about yourself?: 82.2%
- other?: 23.3%

Some children (19.6 per cent) said that ‘maybe’ DART had helped them, and one mother and one child surveyed said it had not helped. One mother stated that she did not feel the programme had helped because she was not at the right stage for DART.

I just feel that for me personally it has brought up the past. Maybe if I went on this programme straight after the relationship ended then I would have benefited from it more.

(Mother)
In response to open questions, mothers and children said that the intervention had affected their relationship with each other by helping them to understand one another better, which could lead to more considerate behaviour from children. Some mothers felt it renewed the love they had for their child.

[I] understand my daughter and fell in love with her again. [I am] feeling a lot closer to my daughter now.

(Mother)

As well as saying it helped them, the vast majority of children (94.3 per cent, n=88) also felt their mother had been helped by DART, and most mothers (83.3 per cent, n=75) felt that their child had been helped by the intervention. Four children (4.5 per cent) felt ‘maybe’ it had helped their mother, fifteen mothers (16.6 per cent) thought ‘maybe’ it had helped their child, and one child said it had not helped. In open responses, mothers said that they felt their children had been helped to learn to control their anger, understand that the abuse was not the fault of the child or mother, and to talk about their worries and emotions.

[My son] has learned that it’s OK to talk about his feelings, that all feelings are OK and that it’s OK to miss and love his daddy.

(Mother)

Children who thought that DART had helped their mothers said in response to open questions that their mother appeared more confident, happier, less afraid, less angry, less inclined to shout at the child and was more considerate.

[Now my mother is] thinking of me more and says lovely things about me.

(Child)

3.2 Referrers’ views

Referrers also rated DART highly in terms of how well it met the needs of families, giving it an average rating of 4.5 (on a scale of one to five, with one being very poor and five being very good). Their ratings of the referral process were also high (see Table 7).
Table 7: Ratings of the referral process

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean rating</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>How clearly the referral process was explained?</td>
<td>4.6</td>
<td>3 to 5</td>
</tr>
<tr>
<td>How clearly the nature of the service was explained?</td>
<td>4.6</td>
<td>4 to 5</td>
</tr>
<tr>
<td>The process of referring clients?</td>
<td>4.7</td>
<td>4 to 5</td>
</tr>
</tbody>
</table>

Respondents found the referral process fairly straightforward but felt that certain criteria could be made clearer, such as the age that children needed to be to attend DART.

Three of the young people that were referred were 11-years-old but were turned down for the course as they were going to high school in September, even though they were still 11 for quite a while longer. We felt that this wasn’t clear for referrals.

(DART referrer)

Referrers felt that the service met the needs of the families well, and most had seen at least one improvement for the service users following DART. Referrers described changes they had observed in open responses.

My client has seen a marked improvement in her son’s behaviours. Prior to the programme he was angry and flew off the handle…Since DART this has really improved. Prior to DART, his mother was very worried about her relationship with her son and stated that she hated to see him coming home. Her son was unable to process the domestic violence that occurred in his mother and father’s relationship. This course has helped him realise it has happened in other families and that none of it was his fault.

(DART referrer)

Some referrers desired more contact with the service during and after the programme so they could be more aware of how the family had progressed. Other suggestions made by respondents included an end-of-programme meeting between the referrer and the service to identify further support for the family.
Chapter 4: Facilitators and barriers to success

This chapter summarises the factors that influence the programme’s effectiveness, based on an analysis of the qualitative interviews with mothers, children and practitioners.

4.1 Programme design and structure

Both aspects of DART – the individual sessions and joint sessions – were seen as important in the process of helping mothers and children recover from the effects of experiencing domestic abuse.

**Individual sessions**

Practitioners felt that separate sessions enabled mothers and children to interact with their peer group, engage in more age-appropriate activities, and for mothers to share their experiences in greater detail than would be appropriate if their child had been present. Activities that helped children to learn about healthy and unhealthy relationships were also considered important. Some mothers had reported that children had previously been emulating the perpetrators’ aggressive behaviours and felt that the programme helped to teach them that these were wrong. The emphasis that abuse was not the fault of the mother or the child additionally helped to stop both mother and child from blaming themselves or each other.

Activities that involved writing could create anxiety for participants who had literacy issues; for example, those who had English as a second language. However, these individuals felt that practitioners provided them with the support needed to enable them to participate.

**Joint sessions**

Joint sessions were seen as important by practitioners. They felt that these sessions provided a space within which mothers and children could interact with one another positively and helped mothers to better understand the effects of abuse on their children. They also enabled practitioners to give tailored parenting advice after observing mother–child interactions; something that they said had not been possible in other domestic abuse programmes they had worked on, where mothers and children were seen separately.
One thing which stood out was how the mum and child sessions worked so well. Most parents and children mentioned it as something they liked. It helped the mothers to understand the impact of domestic abuse on their own and other children. All the other [domestic abuse] groups I've worked on before don't have this...You can see the progression with their relationship. One example is when a boy leant down and got a cup of tea for his mum while she was talking about something distressing. It gives you a bit of a lump in the throat.

(DART practitioner)

Practitioners felt that the creative activities worked particularly well with the mothers and children as they were more child-friendly and engaging, promoted positive mother–child interactions and the messages the activities promoted resonated heavily with mothers and children.

On the whole, the children really enjoyed the creative activities [and] we were surprised by the amount of information that children recalled from these activities at the end of the programme.

(DART practitioner)

This view was echoed by mothers and children, who said that they appreciated the chance to spend positive time together. The creative activities in these sessions helped them to discuss and acknowledge the abuse in a child-friendly way, which many families enjoyed. Children found the activities fun, but also meaningful and took away powerful messages.

I liked doing all the activities. It was fun doing them, but they [also] had a story behind them...The volcanoes [activity] meant that the more and more anger you keep inside you, it just maybe bursts out on a person who hasn't done anything.

(Child, DART)

Not all service users viewed the activities positively; for example, some mothers said that they felt silly engaging in activities they thought were for children. However, practitioners felt these methods could help children to share difficult and sensitive feelings with their mothers. Activities and topics covered in the group that were considered particularly beneficial included those that generated discussions about the abuse and that highlighted to mothers how their child had been affected.
... he made a house, showing me crying in the bedroom, and [the perpetrator] on top of me and [my son] crying, it hit home to me. I thought he’d forgotten about it... But these things were still in his mind. I never thought he thought about it [any more].

(Mother, DART)

This could be distressing at times, though mothers felt it was important to hear about their child’s experience in order that they could understand and support them. It also could help to reinforce the mother’s determination to avoid an abusive relationship in the future. Although service users found it difficult to share their experiences, this could be followed by feelings of relief.

Creating a virtuous circle

Practitioners felt that, where it was working well, the programme created a virtuous circle where some improvements, for example in parenting skills, led to greater engagement and better communication with children, that in turn led to greater improvements in the mother–child relationship. Practitioners reported that, when they joined the programme, some of the mothers had real difficulties in relating to their child and showing affection. Over the course of the programme, practitioners observed changes with this, with mothers more readily accepting and showing affection to their children and vice versa.

There was one child who initially did not want to do the activities with his mum. He did not want to be near her and would sit away from her. The physical affection was not there. As the group progressed he became more accepting of his mum’s affection, they were laughing together, she was stroking him, he would go to his mum for affection and she would respond appropriately.

(DART practitioner)

Changes to the programme structure

A key barrier that was identified in the first set of interviews with practitioners was that the programme was overly prescriptive and restricted their ability to adapt activities or sessions to meet the particular needs of service users. This also related to the amount of time specified for each activity, which was sometimes considered too short, the order in which they were presented and the language used in activities, which was at times considered overly complex.
As a result of practitioners’ feedback, the service’s management team altered the DART manual in order that it could allow for a degree of flexibility in terms of the activities used to achieve session outcomes. Even though the session order remained the same, practitioners were able to choose from a menu of activities designed to achieve the session outcomes and were able to use their professional judgement to adapt activities when necessary. Practitioners felt that this enabled them to better respond to the individual needs of service users.

It made us look more professional and [the families] trusted us more and were able to open up more. They had more time and space to deal with the issues that they presented rather than feeling that they were in a very prescribed programme where we didn’t have time to [fully] acknowledge their feelings.

(DART practitioner)

4.2 Practitioners’ skill and peer support

Service users felt that DART was a safe environment where they felt comfortable with sharing their experience due to the personal and professional skills of the practitioners. Practitioners were described as friendly, open-minded and non-judgemental, and this enabled families to speak openly without worrying about being judged.

All of [the practitioners] were so nice, they didn’t push you to talk about anything, it was up to you, and if you’d had enough you could walk away. Just by looking at them I could tell they weren’t judging me and I could trust them, one hundred per cent… They helped me to see it wasn’t my fault and they helped me to pick myself up a bit. I smiled for the first time in years, because I wasn’t hiding something. I talked about things I had never talked about and I really saw a difference in [my daughter]. It was amazing.

(Mother, DART)

Mothers and children also benefitted from spending time with other families who had experienced domestic abuse as they felt better able to share their own experiences with people who would understand. Some maintained friendships with these families after the DART programme had finished.
Nevertheless, some mothers were considered to behave inappropriately at times; for example, by talking too much about their abusive ex-partners in front of their children. This also contributed to a mother’s decision to drop out of DART. Although this was not reported as a problem when the families were in the group, it could be an issue once they were out of the group situation, as described by the mother quoted below.

[The other mother from DART] got all [friendly] with me saying ‘I’ll pick you up’ so I got in her car and she was talking about her ex-boyfriend in front of my child and I didn’t appreciate it… She started going on about equipment that he used to smoke (drugs) and all sorts in front of my lad.

(Mother)

4.3 Emotional and behavioural issues

Anxiety and shyness before coming to the DART group was identified as an issue by both mothers and children, and in some cases these levels of anxiety appeared to be extreme; for example, there were mothers who said they were afraid to leave their house. Some of the mothers said they had almost dropped out of DART as a result. Although some mothers overcame these difficulties, as they and their children had eventually got over their initial fears, it could potentially be a barrier for other mothers who either drop out of DART or do not start the programme.

I [wasn’t] going to come, right up until I was getting in the taxi I thought ‘I can’t do it’. It’s just anticipation not knowing what’s going to be happening. [Before DART] I didn’t leave the house, my daughter was doing the school runs…and I would stay in the house, keep the curtains drawn, wouldn’t see anyone, didn’t want to see anyone. When I came [to DART] it was totally different to what I’d expected.

(Mother, DART)

During the group, although mothers felt that the topic of domestic abuse was sensitively raised, they could still become upset by hearing their child’s perspective of the abuse, re-living the past and thinking of themselves as ‘a victim’. Some mothers had mental health issues, such as depression and anxiety, which they felt could make this even harder.
However, mothers on the whole believed that going through this process was an important aspect of the programme as this enabled them to address unresolved issues with their child, helped them to understand reasons for their child’s behaviours and encouraged them to not become involved in another violent relationship. Children could also find it hard to talk about the abuse but mothers felt that doing so helped in terms of their child’s recovery.

Practitioners reported that sometimes children’s behaviour could be challenging to manage in the group setting, though they developed strategies to tackle this, such as having two practitioners in the children’s groups so that one could take a child out of a session to talk to them if they were being very disruptive.

However, children thought that DART helped to improve their behaviour and described strategies they learnt in DART to deal with their anger, such as counting to 10 or taking their anger out on an inanimate object like a pillow. Children illustrated that they understood the principle of this activity: that their anger could not damage the object but that it could hurt a person.

When I got angry I used to, like, jump up and down on the top of the stairs so it echoed. I go and shout in a cushion now... because you’re kind of getting all your anger out and making the cushion feel unhappy and not anybody else.

(Child, DART)

However, the way in which the programme impacted on the children’s behaviour varied, with some mothers reporting improvements and others saying that their child’s behaviour had worsened following DART. Mothers attributed the increase in challenging behaviours to the emotional content of the programme, and some believed that children thinking about the abuse that they or their mother had experienced could make children feel angrier. Nevertheless, some mothers reported that although their child’s behaviour initially worsened, this improved at a later date.

4.4 External influences

Factors external to the DART programme that affected the achievement of outcomes included the degree of contact with the perpetrator, the level of support provided by other services, and mothers forming new relationships.
For some children and mothers, contact with the perpetrator could limit the impact of DART. Mothers embroiled in legal court cases related to contact also found that this could drain them of the emotional energy to attend DART, in particular when they were unhappy with the court’s decision to allow the father to have contact. Children could resume their negative behaviours towards their mother after visits to their father. One mother had briefly resumed a relationship with her ex-partner and this had led to her being attacked, which understandably had a detrimental effect on her and her daughter.

[After DART] my daughter picked up, we got on really well for months... Then I started seeing [the perpetrator] again, just for two weeks and he smacked me in the jaw and strangled me. My daughter saw him [do that] and saw his cousin grab me by my face and push me into a wall. This is when she started getting really violent again... and crying constantly.  
(Mother, DART)

Children could also feel anxious and upset when their mothers formed new relationships. This appeared to undo some of the improvements to the mother–child relationship that had occurred following DART.

We were getting on better [after DART] but then she got a new boyfriend and now we are arguing again.  
(Child, DART)

Some mothers had attended other domestic abuse services, such as the Freedom programme11, prior to, or in addition to DART. These programmes were viewed positively on the whole and mothers felt that they had helped to prepare them for the DART programme. Mothers felt that these programmes mainly covered their own issues related to the abuse, whereas DART had more of a focus on the child.

Some mothers were continuing to receive support, such as counselling, from other services but others either felt that they did not need further support or could not access anything they felt was appropriate. Sometimes, there were long waiting lists for services, so families had to wait for a period of time before receiving additional support.

11 The Freedom Programme is a service for women and men who are victims of domestic abuse or who want to change their abusive behaviour. The programme states that it provides information about domestic abuse rather than giving therapy. For instance, by looking at the attitudes and beliefs of the abusers and the responses of the victims and highlighting how children can be impacted by the abuse (www.freedomprogramme.co.uk).
Other barriers identified from the practitioners’ interviews included the fact that conflict and difficulties outside the group could affect service users’ ability to engage in the programme, and mothers occasionally made inappropriate comments during the joint sessions that could upset their child.

Implementation issues included low levels of referrals to DART for the early groups, but for most services this was no longer an issue when the second interviews took place a year later. Practitioners said that a lot of work went into promoting the service and generating referrals, and this could take time. This included face-to-face visits with relevant agencies, which helped to build relationships with referrers and ensure they fully understood the service. Some services also invited potential referrers to open days, and practitioners described how the DART service might complement existing local programmes.

One of the key things we did was an open day where we invited other professionals from lots of different agencies to come and learn about the DART service…We wanted to portray how we fit in with the other good work which is going on around the county because we didn’t want to just come in and people feel like we were taking over. So it was important for us that they could see how there was a need for DART alongside the other work that was taking place. People could see how DART fitted in within other programmes like the Freedom program and children’s groups that run in the county…it works quite well if they have come from the Freedom programme…especially if a mum has recently left the perpetrator…I think that provides a good foundation [for] the DART group.

(DART practitioner)

Other contextual issues included practical difficulties that made it harder for families to attend, such as lack of childcare, and some practitioners felt that, following DART, a family still needed support but there was not always a relevant service available.
Chapter 5: Discussion and Conclusion

The evaluation provides evidence that DART helps to support the recovery of mothers and children who have experienced domestic abuse. This was one of the ultimate aims of the programme. It was highly rated by mothers, children, practitioners and DART referrers, and the majority of service users felt that DART had helped their recovery. A number of significant improvements were found for both mothers and children following DART; for instance, children had fewer emotional and behavioural problems, and mothers had greater self-esteem and confidence in their parenting, indicating they may be beginning to recover from domestic abuse.

Mothers were also reported to be more affectionate and less rejecting to their child following DART, suggesting an improved mother–child relationship, and children had greater reductions in their ‘difficulties’ scores than the comparison group. There is evidence that some of the positive outcomes experienced by mothers and children, such as a reduction in the emotional and behavioural difficulties experienced by a child, may be maintained in the longer term.

It appears that some of the families who had high levels of initial difficulties before DART still had needs that might warrant further intervention following DART. DART practitioners are currently instructed to refer on to other appropriate services in these instances; however, it is possible that a more intensive or longer DART programme may be useful for families who are identified as having higher levels of needs at an early stage. Alternatively, a different intervention, or a longer overall period of intervention, may be required for some families.

The joint sessions involving the mothers and children, which is the innovative element of the model, played a key part in helping to strengthen the relationship between mothers and children, and equip mothers with the ability to support their child’s recovery. Activities in these sessions also helped mothers to learn more about how their child was affected by the abuse. Some reported that understanding how their child had been negatively impacted was a key incentive that prevented them from returning to the perpetrator. Creative activities helped to engage the young children and introduce the topic of domestic abuse sensitively.
Nevertheless, not all service users enjoyed or understood the purpose of these activities.

Following the change made to the DART manual, which followed the first practitioner interviews to allow for more flexibility, practitioners felt better able to adapt activities to suit the varying needs and preferences of the service users, which could help to increase parental/family engagement.

The qualitative work with service users identified a number of barriers to the programme’s success. These included high levels of anxiety experienced by mothers before the groups and in early DART sessions, challenging behaviour in the children’s groups, issues related to contact with the perpetrator, and the length of time and effort needed in order to generate appropriate referrals. Another key issue raised in the evaluation was the absence of services that were appropriate for onward referral after the end of the programme. Further work would be useful to identify what services were most commonly needed, which could inform future NSPCC service development.

Next steps

The NSPCC has recently been promoting the DART intervention to other services and supporting them to adopt the model. Services like Family Action in Bradford have recently started delivering DART. An implementation evaluation is planned to look at the extent to which other services take up this model, how they perceive the support they have received, and to look at the barriers and facilitators of implementation. Additionally, another impact evaluation is planned involving these external sites, in order to find out how well DART works in other settings.
References


APPENDICES

Appendix 1: Demographics

Participants who completed standardised measures

The mothers’ ages ranged from 24 to 54, with a mean age of 34 years two months. The majority of mothers were White British (71.6 per cent, n=83), 26.7 per cent (n=31) were categorised as ‘Any other White background’ and two mothers identified themselves as Irish. Ethnicity data was missing for 60 of the mothers and there was no data about the age of 84 of the mothers.

The children’s ages at the point of the referral ranged from six years to 12 years two months, with a mean age of nine years. This indicates that there were a few children on the programme who were slightly older or younger than the previous programme guidelines of seven to 11, depending upon when the children started the group. The majority of the children (61.7 per cent, n=79) were boys and 38.3 per cent (n=49) were girls.

Most of the children (77.6 per cent) were White British, 14.9 per cent (n=2) were categorised as ‘Any other White background’, four children were Mixed Race, two were ‘Any other Mixed background’ and three children were classified in other categories. Data on gender was missing for 86 children, age data was missing for 84 children and there was no data on ethnicity for 80 of the children.

Service users who took part in interviews

The ages of the children interviewed ranged between seven years one month and 11 years four months (mean age = nine years two months). Three girls and eleven boys were interviewed. The mothers’ ages ranged from 27 years seven months and 41 years eight months (mean age = 34 years six months). The majority of the participants were White British (83.3 per cent, n=30), two were Mixed Race, two were Irish and two participants identified themselves as Welsh.
Comparison group

The ethnicity of the comparison group was also more diverse than the DART group, with only two individuals (11.1 per cent) out of the 18 included in the comparison group classified as White British, five (27.8 per cent) identified as White European, five (27.8 per cent) who were Mixed Race and three from other ethnic backgrounds (16.7 per cent). Information on ethnicity was missing for the other five individuals. The mean age of the comparison group (once those under five were excluded) was eight years eight months. Due to low numbers, further exclusions that would have enabled participants to be matched more closely on ethnicity for the analyses would not have been possible.
Appendix 2: Ethical issues

The ethical issues that were considered were as follows:

Risk of harm (physical or psychological) to the participant

Participants had experienced and/or witnessed abuse; therefore, questions that might prompt them to discuss this or remember events could potentially be distressing. Even though the evaluation questions focused on the participants’ experience of the programme, this often prompted individuals to reflect on the abuse they had suffered in relation to how these issues had been addressed by the groups.

Several precautions were taken to minimise the risk of distress:

- Participants were interviewed in quiet, private rooms at the service centres in order that practitioners were available to provide support when necessary.
- Details of other helplines and related services were also provided.
- Research questions were considered by the DART steering group and DART practitioners to ensure that they were worded sensitively.
- The researcher who conducted the interviews has received specialist training related to interviewing vulnerable people. She had several years of experience interviewing children and young people including those who have been bullied, who have learning difficulties and Looked After children.
- DART practitioners administered the standardised measures and questionnaires. Due to their skills and experience with supporting families who have suffered from abuse, they were able to provide emotional support if any questions caused distress. Before the measures were administered, practitioners took time to explain the nature of the questionnaires and prepare participants for the sensitivity of some of the questions.

It was also essential to ensure that the families could participate safely in both the DART group and the evaluation. A series of assessments were conducted by practitioners prior to the programme in order to consider this and only those who were judged to be able to participate safely attended DART. One of the criteria for acceptance onto the programme was that, in order to be eligible for the programme, the perpetrator must no longer be living with the family or in a relationship with the mother. The assessment would rule out families in these situations due to them not being considered able to safely participate in, or be appropriate for, the programme at this stage.
Interviews were held at the service centres, which were considered safe and private locations that had been risk assessed. Practitioners contacted mothers to arrange these interviews and used agreed phone numbers or email addresses. If practitioners were aware of anything that might compromise the families’ safety or wellbeing then they would not be approached. For example, some of the mothers resumed relationships with the perpetrator, and when practitioners were aware of this, the mothers would not be contacted. Mothers and children were interviewed separately to enable both to speak freely in their responses without fearing any repercussions. However, there were instances where the child wanted the mother or a practitioner to be in the room and in these cases their wishes were respected.

If anything was revealed during an interview or from a questionnaire that suggested a participant may be at risk from harm, the NSPCC child protection policy was followed.

Informed consent

All mothers and children who participated in DART were invited to participate in the evaluation unless practitioners were concerned that participating may affect their wellbeing. The mothers were given a consent form that described the study and what it would involve. They were asked to consent on behalf of themselves and/or their child if they agreed to participate in the evaluation. They were given an information letter for their records, which included the contact details of the Evaluation Officer that they were instructed to use if they had any concerns or questions. Children who participated were asked for consent verbally, after they were given an age-appropriate explanation of the study. They were also able to take an information letter about the study that was written in child-friendly language. Only mothers and children who gave informed consent were involved in the evaluation.

Ability to withdraw from the study

Before giving the interview or completing a questionnaire, participants were assured that if they did not want to respond to a particular question they could leave it out, and were able to stop the interview/questionnaire and withdraw their data any time up until the study was published. This information was contained in the consent and information forms, and was reiterated to participants when they were interviewed and completing questionnaires.
Confidentiality
Information that was collected about the family, which could include personal details about the participant’s experience of the abuse, was very sensitive; therefore, it was important to ensure that this was stored securely in locked cabinets at NSPCC centres at all times. If data was sent to the researcher, data protection procedures were followed and hard copies of forms were sent via recorded delivery. All data was kept confidential, with names and information that could identify the participants, not being used. ID codes were used to identify participants and general information like age, ethnicity and gender was recorded, but this was only used in the evaluation report to identify means and ranges (for example, of ages) of the whole sample.

Although participants were told that the information they shared would be strictly confidential, they were made aware that there were some limits to this confidentiality. They were told that if they shared any information that suggested a child may be at risk from harm, the NSPCC child protection procedure would be followed.

Data protection
Data was kept securely in a locked cabinet at all times and will be shredded after the final report is produced. Electronic data was stored in the researcher’s private files, which were only accessible through her password.

Age- and stage-appropriate materials
Standardised measures used in the evaluation were designed for and previously used by young children of primary school age. Interviews and questionnaires were designed to be appropriate for young children and cater for children with learning difficulties/additional needs, with simple questions used and visual aids where appropriate.
Appendix 3: Theory of Change: reference to supporting research


Note 4: This is the activity/input rather than an outcome.

Note 5: This is a process outcome. Mullender et al (2002) found that mothers and children often did not acknowledge or talk about the abuse after it ended. DART aims to support this process.

Note 6: Evidence from dating violence prevention programmes, such as Safe Dates, which was designed to promote healthier attitudes to dating and less acceptance of violence in relationships, suggested there were some positive attitudinal and behavioural improvements following the intervention. For example, there were less accepting attitudes towards violence in relationships in the treatment compared with the control group (Foshee et al, 2004; see Note 9 for further details).

Note 7: Edleson (1999) found that mothers underestimated how their child was affected by the abuse. DART aims to help mothers understand this better by supporting children to communicate their feelings in child-appropriate ways. Humphreys et al (2006) reported that mothers who attended their Talking to my Mum programme (on which DART is based) learnt more about how their child was affected during the programme and needed some support to come to terms with this newly acquired knowledge.

Note 8: The mental health of the mother, the mother–child relationship and the mother’s capacity to parent can be damaged by domestic abuse (see, for example: Helfrich et al, 2008; Scott-Gilba et al, 1995; Humphreys et al, 2006; see introduction). A systematic review of other interventions involving domestic abuse survivors found positive improvements for women involved in some of the programmes, such as a reduction in PTSD symptoms and depression and increased self-esteem (Warshaw et al, 2013).
Although these interventions are different from DART, it is encouraging that other domestic abuse programmes can achieve these positive impacts.

Note 9: The evaluation of the Safe Dates programme (see Note 6) used a randomised control design (RCT) involving 14 schools. The study reported “25% less psychological abuse perpetration, 60% less sexual perpetration, and 60% less physical violence” in the treatment schools compared with control schools (Foshee et al, 2004). Although this is a different programme to DART, the research shows that work on healthy relationships positively impacts on young people’s related attitudes and behaviours.

Note 10: Preliminary evidence from the Talking to my Mum programme (also designed to support children to communicate their feelings about domestic abuse with their mothers) indicated that they benefited from the one-to-one time together. Mothers and children reported improved communication and better relationships with one another (Humphreys et al, 2006).

Note 11: This is an ultimate programme outcome. Other domestic abuse recovery group work programmes, such as the CEDAR project (Sharp et al, 2011), have reported positive outcomes for mothers and children, such as having a better understanding of domestic abuse, better relationship with one another and a more positive outlook on life.

Note 12: This is an ultimate programme outcome. Logically, it would be expected that mothers and children are safer if they are less likely to be in an abusive relationship due to healthier attitudes and related behaviours (see Note 9). Additionally, if mothers and children are safer this is likely to increase their chances of recovery.
Appendix 4: Characteristics of service users at Time One

Mothers

Almost half of the mothers had self-esteem scores that were below the normal range and their mean self-esteem score was low, but just within the lowest end of the normal range (See Table 11). Consistent with other research on victims of domestic abuse (see, for example, Scott-Gilba et al, 1995), this shows that, before the intervention, many of the mothers had low self-esteem.

The majority of mothers had scores within or below the normal range for the PARQ (see Table 8). This could suggest that most mothers were not displaying many of the negative behaviours measured by the PARQ and did not have difficulties displaying affection. However, the authors of this measure advised caution against accepting very low scores at face value as, in some cases, low scores indicate the presence of response bias (for example, children indicating how they would like their mothers to be rather than the reality).

This can be more common in the parents’ version of this measure, according to Rohner (2010, personal correspondence), who stated that parents sometimes have difficulty in recognising and admitting their hurtful behaviours towards their child and that children’s reports tend to be more reliable. As more than half of the mothers scored below the normal range, this may suggest high levels of response bias within this population.

Alternatively, it is possible that many mothers from DART did have close and affectionate relationships with their child. As the children’s scores did not appear to contradict their mothers, although they were slightly more negative, this may be possible. Nevertheless, there were a small proportion of mothers (13.5 per cent, n=19) who scored above the normal range. This suggests that these mothers, by their own admission, showed high levels of negative behaviours, such as hostility, indifference and aggression, and low levels of affection towards their child before they attended DART.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>n=</th>
<th>Range</th>
<th>Percentage outside of normal range</th>
<th>Meaning of scores</th>
<th>Population norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>15.22</td>
<td>160</td>
<td>1–30</td>
<td>45% (n=72) below normal range. 3% (n=5) above normal range</td>
<td>Low scores = low self-esteem</td>
<td>15–25*</td>
</tr>
<tr>
<td>Warmth/affection PARQ</td>
<td>10.84</td>
<td>140</td>
<td>8–27</td>
<td>Low scores = high affection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility/aggression PARQ</td>
<td>8.75</td>
<td>140</td>
<td>6–19</td>
<td>Low scores = low hostility,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indifference/neglect PARQ</td>
<td>9.66</td>
<td>140</td>
<td>6–19</td>
<td>Low scores = low neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undifferentiated rejection PARQ</td>
<td>5.68</td>
<td>140</td>
<td>4–12</td>
<td>High scores = high rejection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PARQ</td>
<td>35.17</td>
<td>140</td>
<td>24–75</td>
<td>High scores = high levels of difficulties</td>
<td></td>
<td>36–44*</td>
</tr>
</tbody>
</table>

*Population Norms are provided by Rosenberg (1965) and Rohner (2010, personal correspondence). Normal ranges are not available for all measures. Population norms are not available for all measures.

Scores on the PLOC scale indicated that, on the whole, mothers had little confidence in their ability to parent and little control over their child’s behaviour (see Table 9). Although Campis et al. (1986) do not give population norms for this measure, they provide scores on each subscale from a study of 60 parents who reported no difficulties in their role as a parent (Group A) and 45 parents who had sought professional help for their parenting or whose children were reported to have emotional and behavioural difficulties (Group B). In order to make comparisons with the DART data, the scores from each group and the mothers from DART are reported in Table 9.
Table 9: Campis et al (1986): Mean scores on PLOC subscales

<table>
<thead>
<tr>
<th>PLOC subscale</th>
<th>Group A</th>
<th>Group B</th>
<th>Mothers from DART</th>
<th>Meaning of scores</th>
<th>Range (Mothers from DART)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental efficacy</td>
<td>17.62</td>
<td>19.27</td>
<td>22.3</td>
<td>Low scores = few difficulties</td>
<td>10–38</td>
</tr>
<tr>
<td>Parental control</td>
<td>26.63</td>
<td>31.44</td>
<td>29.9</td>
<td>Low scores = few difficulties</td>
<td>10–48</td>
</tr>
</tbody>
</table>

*Group A = parents who reported no difficulties with parenting. Group B = parents who sought professional help for parenting.

The mothers’ mean scores on the parental efficacy subscale was higher than the scores of both of the other groups of parents (higher scores indicate greater levels of difficulties), and their scores on the parental control subscale were higher than Group A and slightly below the scores of the mothers from group B. This indicated that mothers from DART were also experiencing some difficulties with their parenting.

The children’s mean self-esteem scores (see Table 10) at Time One did not indicate any problems in this area and were significantly higher than the mothers’ self-esteem scores. The self-esteem measure used by children was an adapted version of the Rosenberg scale that their mother completed, so there are currently no population norms for comparison. However, they scored above the normal range that is used for the original scale for the adolescent and adult population.

Nevertheless, the mean scores for the SDQ indicated that the children were experiencing a number of emotional and behavioural difficulties when they were first seen by the service. Their mean scores for all the ‘difficulties’ measured (which included conduct problems, emotional disorders, hyperactivity and peer problems) were above the normal range. Additionally, at least half of the children had scored above the normal range for the hyperactivity and peer problems subscales, and the majority scored above the normal range for the conduct problems, emotional symptoms and total difficulties subscales.

In accordance with their mothers, most of the PARQ scores were below or within the normal range. However, a higher proportion of the scores (19.6 per cent, n=27) were above the normal range compared with the mothers. This indicated that the mothers of these children displayed high levels of aggressive/rejecting behaviours and low levels of affection.
### Table 10: Children’s scores at Time One

<table>
<thead>
<tr>
<th>Factor</th>
<th>Mean</th>
<th>n=</th>
<th>Range</th>
<th>Percentage outside of the ‘normal range’</th>
<th>Meaning of scores</th>
<th>Population norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>20.18</td>
<td>136</td>
<td>5–30</td>
<td>-</td>
<td>Low scores = low self-esteem</td>
<td>Not available</td>
</tr>
<tr>
<td>Warmth/affection (PARQ)</td>
<td>11.65</td>
<td>138</td>
<td>8–32</td>
<td>-</td>
<td>Low scores = high affection</td>
<td>Not available</td>
</tr>
<tr>
<td>Hostility/aggression (PARQ)</td>
<td>8.43</td>
<td>138</td>
<td>6–21</td>
<td>-</td>
<td>Low scores = low hostility</td>
<td>Not available</td>
</tr>
<tr>
<td>Indifference/neglect (PARQ)</td>
<td>10.39</td>
<td>138</td>
<td>6–24</td>
<td>-</td>
<td>Low scores = low neglect</td>
<td>Not available</td>
</tr>
<tr>
<td>Undifferentiated rejection (PARQ)</td>
<td>6.62</td>
<td>138</td>
<td>4–16</td>
<td>-</td>
<td>High scores = high rejection</td>
<td>Not available</td>
</tr>
<tr>
<td>Total PARQ</td>
<td>37.07</td>
<td>138</td>
<td>24–69</td>
<td>58% (n=80) above 19.6% (n=27) below</td>
<td>High scores = high levels of difficulties</td>
<td>36–44*</td>
</tr>
<tr>
<td>Conduct problems (SDQ)</td>
<td>4.21</td>
<td>163</td>
<td>0–10</td>
<td>77.9% (n=127) above</td>
<td>High scores = high levels of difficulties</td>
<td>0–2*</td>
</tr>
<tr>
<td>Hyperactivity (SDQ)</td>
<td>5.83</td>
<td>163</td>
<td>0–10</td>
<td>55.2% (n=90) above</td>
<td>High scores = high levels of difficulties</td>
<td>0–5*</td>
</tr>
<tr>
<td>Emotional symptoms (SDQ)</td>
<td>5.01</td>
<td>163</td>
<td>0–10</td>
<td>70.6% (n=115) above</td>
<td>High scores = high levels of difficulties</td>
<td>0–3*</td>
</tr>
<tr>
<td>Peer problems (SDQ)</td>
<td>2.98</td>
<td>163</td>
<td>0–10</td>
<td>50.9% (n=83) above</td>
<td>High scores = high levels of difficulties</td>
<td>0–2*</td>
</tr>
<tr>
<td>Total difficulties (SDQ)</td>
<td>17.93</td>
<td>163</td>
<td>2–35</td>
<td>71.2% (n=116) above</td>
<td>High scores = high levels of difficulties</td>
<td>0–13*</td>
</tr>
<tr>
<td>Prosocial (SDQ)</td>
<td>7.52</td>
<td>163</td>
<td>0–10</td>
<td>21.5% (n=35) below normal range</td>
<td>High scores = highly prosocial</td>
<td>6–10*</td>
</tr>
</tbody>
</table>

*Population norms are provided by Goodman & Goodman (2011) and Rohner (2010, personal correspondence). On the SDQ, the norms provided are in relation to those who would be defined as ‘low need’, rather than ‘some need’ or ‘high need’.*
Appendix 5: Additional tables

Table 11: Comparison of mothers’ Time One and Time Two scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T2 mean</th>
<th>Significance level</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>14.77 (5.24)</td>
<td>19.66 (5.98)</td>
<td>p&lt;.001</td>
<td>83</td>
</tr>
<tr>
<td>Parental efficacy (PLOC)</td>
<td>22.92 (6.66)</td>
<td>19.93 (5.75)</td>
<td>p&lt;.001</td>
<td>85</td>
</tr>
<tr>
<td>Parental control of child’s behaviour (PLOC)</td>
<td>30.34 (7.95)</td>
<td>25.62 (7.31)</td>
<td>p&lt;.001</td>
<td>85</td>
</tr>
<tr>
<td>Warmth/affection (PARQ)</td>
<td>11.01 (3.41)</td>
<td>9.50 (2.37)</td>
<td>p&lt;.001</td>
<td>72</td>
</tr>
<tr>
<td>Hostility/aggression (PARQ)</td>
<td>8.58 (2.72)</td>
<td>7.83 (2.72)</td>
<td>p&lt;.001</td>
<td>72</td>
</tr>
<tr>
<td>Indifference/neglect (PARQ)</td>
<td>9.81 (2.89)</td>
<td>9.07 (2.78)</td>
<td>p&lt;.01</td>
<td>72</td>
</tr>
<tr>
<td>Undifferentiated rejection (PARQ)</td>
<td>5.83 (1.97)</td>
<td>5.33 (2.01)</td>
<td>p&lt;.05</td>
<td>72</td>
</tr>
<tr>
<td>Total PARQ</td>
<td>35.32 (8.72)</td>
<td>31.65 (7.01)</td>
<td>p&lt;.001</td>
<td>72</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001.

Table 12: Changes in mothers’ PARQ categories

<table>
<thead>
<tr>
<th>Time One</th>
<th>Time Two</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Below normal range</td>
</tr>
<tr>
<td>Below normal range</td>
<td>44</td>
</tr>
<tr>
<td>Within normal range</td>
<td>20</td>
</tr>
<tr>
<td>Above normal range</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 13: Comparison of children’s Time One and Time Two scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T2 mean</th>
<th>Significance Level</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>19.92 (5.45)</td>
<td>21.04 (5.06)</td>
<td>NS</td>
<td>77</td>
</tr>
<tr>
<td>Warmth/affection (PARQ)</td>
<td>11.92 (3.79)</td>
<td>10.58 (3.26)</td>
<td>p&lt;.05</td>
<td>72</td>
</tr>
<tr>
<td>Hostility/aggression (PARQ)</td>
<td>8.63 (3.30)</td>
<td>7.72 (2.39)</td>
<td>p&lt;.05</td>
<td>72</td>
</tr>
<tr>
<td>Indifference/neglect (PARQ)</td>
<td>10.28 (3.61)</td>
<td>9.52 (3.23)</td>
<td>NS</td>
<td>72</td>
</tr>
<tr>
<td>Undifferentiated rejection (PARQ)</td>
<td>6.79 (2.90)</td>
<td>5.78 (2.02)</td>
<td>p&lt;.01</td>
<td>72</td>
</tr>
<tr>
<td>Total PARQ</td>
<td>37.68 (11.13)</td>
<td>33.86 (8.39)</td>
<td>p&lt;.01</td>
<td>72</td>
</tr>
<tr>
<td>Conduct problems (SDQ)</td>
<td>4.36 (2.34)</td>
<td>3.16 (2.37)</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
<tr>
<td>Hyperactivity (SDQ)</td>
<td>6.02 (2.74)</td>
<td>5.24 (2.60)</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
<tr>
<td>Emotional symptoms (SDQ)</td>
<td>5.26 (2.56)</td>
<td>3.61 (2.54)</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
<tr>
<td>Peer problems (SDQ)</td>
<td>3.39 (3.46)</td>
<td>2.67 (3.24)</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
<tr>
<td>Total difficulties (SDQ)</td>
<td>18.65 (7.58)</td>
<td>14.24 (7.15)</td>
<td>p&lt;.001</td>
<td>93</td>
</tr>
<tr>
<td>Prosocial (SDQ)</td>
<td>7.72 (1.97)</td>
<td>8.04 (2.02)</td>
<td>p=0.57, NS</td>
<td>93</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001.

NS = non-significant. Scores that are non-significant but approaching the .05 significance level are also reported.
Table 14: Changes in children’s PARQ categories

<table>
<thead>
<tr>
<th></th>
<th>Time One</th>
<th>Time Two</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Below normal range</td>
<td>Within normal range</td>
</tr>
<tr>
<td>Below normal range</td>
<td>38</td>
<td>30 (78%)</td>
<td>6 (16%)</td>
</tr>
<tr>
<td>Within normal range</td>
<td>18</td>
<td>7 (39%)</td>
<td>8 (44%)</td>
</tr>
<tr>
<td>Above normal range</td>
<td>16</td>
<td>6 (37.5%)</td>
<td>8 (50%)</td>
</tr>
</tbody>
</table>

Table 15: Comparison of mothers’ Time One and Time Three scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T3 mean</th>
<th>Significance level</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>14.89 (5.32)</td>
<td>21.95 (6.09)</td>
<td>p&lt;.001</td>
<td>23</td>
</tr>
<tr>
<td>Parental efficacy (PLOC)</td>
<td>26.37 (6.59)</td>
<td>20.74 (6.63)</td>
<td>p&lt;.01</td>
<td>19</td>
</tr>
<tr>
<td>Parental control of child’s behaviour (PLOC)</td>
<td>31.95 (7.60)</td>
<td>26.21 (9.60)</td>
<td>p&lt;.05</td>
<td>19</td>
</tr>
<tr>
<td>Warmth/affection (PARQ)</td>
<td>10.94 (2.70)</td>
<td>9.94 (2.59)</td>
<td>NS</td>
<td>20</td>
</tr>
<tr>
<td>Hostility/aggression (PARQ)</td>
<td>9.58 (3.25)</td>
<td>8.42 (3.02)</td>
<td>NS</td>
<td>20</td>
</tr>
<tr>
<td>Indifference/neglect (PARQ)</td>
<td>9.47 (2.80)</td>
<td>9.94 (3.88)</td>
<td>NS</td>
<td>20</td>
</tr>
<tr>
<td>Undifferentiated rejection (PARQ)</td>
<td>6.42 (1.80)</td>
<td>5.58 (2.29)</td>
<td>NS</td>
<td>20</td>
</tr>
<tr>
<td>Total PARQ</td>
<td>36.05 (9.17)</td>
<td>34.05 (9.80)</td>
<td>NS</td>
<td>20</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001. NS = non-significant. Scores approaching the .05 significance level are also reported.

Table 16: Comparison of children’s Time One and Time Three scores

<table>
<thead>
<tr>
<th>Factor</th>
<th>T1 mean</th>
<th>T3 mean</th>
<th>Significance level</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>22.86 (2.61)</td>
<td>24.00 (7.77)</td>
<td>NS</td>
<td>8</td>
</tr>
<tr>
<td>Warmth/affection (PARQ)</td>
<td>10.53 (3.36)</td>
<td>9.41 (1.70)</td>
<td>NS</td>
<td>18</td>
</tr>
<tr>
<td>Hostility/aggression (PARQ)</td>
<td>7.59 (2.87)</td>
<td>6.88 (1.45)</td>
<td>NS</td>
<td>18</td>
</tr>
<tr>
<td>Indifference/neglect (PARQ)</td>
<td>9.18 (2.58)</td>
<td>8.59 (3.06)</td>
<td>NS</td>
<td>18</td>
</tr>
<tr>
<td>Undifferentiated rejection (PARQ)</td>
<td>6.18 (3.34)</td>
<td>5.18 (1.78)</td>
<td>NS</td>
<td>18</td>
</tr>
<tr>
<td>Total PARQ</td>
<td>33.41 (9.90)</td>
<td>30.06 (7.28)</td>
<td>NS</td>
<td>18</td>
</tr>
<tr>
<td>Conduct problems (SDQ)</td>
<td>4.45 (1.84)</td>
<td>3.45 (2.52)</td>
<td>p&lt;.05</td>
<td>22</td>
</tr>
<tr>
<td>Hyperactivity (SDQ)</td>
<td>5.50 (2.67)</td>
<td>4.86 (2.80)</td>
<td>NS</td>
<td>22</td>
</tr>
<tr>
<td>Emotional symptoms (SDQ)</td>
<td>4.96 (2.21)</td>
<td>3.32 (2.30)</td>
<td>P&lt;.01</td>
<td>22</td>
</tr>
<tr>
<td>Peer problems (SDQ)</td>
<td>2.40 (1.79)</td>
<td>2.80 (2.14)</td>
<td>NS</td>
<td>22</td>
</tr>
<tr>
<td>Total difficulties (SDQ)</td>
<td>17.48 (5.67)</td>
<td>13.33 (7.74)</td>
<td>p&lt;.05</td>
<td>22</td>
</tr>
<tr>
<td>Prosocial (SDQ)</td>
<td>7.71 (1.71)</td>
<td>7.76 (2.49)</td>
<td>NS</td>
<td>22</td>
</tr>
</tbody>
</table>

*Results are statistically significant if p<.05. They are considered highly significant at p<.001. NS = non-significant. Scores that are non-significant but approaching the .05 significance level are also reported.
Table 17: DART and Comparison Group: SDQ mean scores at Time One

<table>
<thead>
<tr>
<th>SDQ factor</th>
<th>DART Mean at T1</th>
<th>Comparison Group Mean at T1</th>
<th>Population Norms*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperactivity</td>
<td>5.83</td>
<td>5.33</td>
<td>0–5</td>
</tr>
<tr>
<td>Emotional symptoms</td>
<td>5.01</td>
<td>3.62</td>
<td>0–3</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>4.21</td>
<td>3.24</td>
<td>0–2</td>
</tr>
<tr>
<td>Peer problems</td>
<td>2.98</td>
<td>3.04</td>
<td>0–2</td>
</tr>
<tr>
<td>Total difficulties</td>
<td>17.93</td>
<td>14.85</td>
<td>0–13</td>
</tr>
<tr>
<td>Prosocial</td>
<td>7.52</td>
<td>7.29</td>
<td>6–10</td>
</tr>
</tbody>
</table>

*The range of scores are for those who would fall into the ‘low need’ category on the SDQ.
Appendix 6: Surveys

Questionnaire for children

ALPHA NUMBER __________  Date __________  WORKER __________

Your experience of the DART programme

1a) On a scale of 1 to 5 (with 1 meaning very little and 5 meaning very much) How much have you enjoyed being in the DART group?

1 2 3 4 5

1b) Can you explain why you chose your score? For example, why you enjoyed or didn’t enjoy DART?


2a) Do you think the DART group has helped you in any way?

Yes □  No □  Maybe □

2b) If you answered ‘yes’ to question 2a, have they helped you with:

(please tick as many as you like)

Talking to your mum □
How you feel about yourself □
Other □

Please explain a bit more about how they have helped you.


2c) If you answered ‘no’ to Question 2a is there anything that could have been done differently to help you more?

Yes □  No □  Maybe □

If you answered yes, please explain your answer


3a) What have you found helpful or unhelpful about these groups?

<table>
<thead>
<tr>
<th>Helpful</th>
<th>Ok</th>
<th>Not helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing activities with my mum</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Doing activities with the other children</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Talking to staff from DART</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

4a) Do you think you have learnt anything new from these groups?

Yes □ No □ Maybe □

4b) If you answered yes to question 4a, have you learnt anything about: (please tick as many as you like)

- Your mum □
- Yourself □
- Domestic □
- Other □
- Abuse □

Please explain a bit more about what you think you have learnt from DART

5a) Do you think your mum has been helped by the group?

Yes □ No □ Maybe □

5b) If you answered yes to question 5a, can you explain how you think she has been helped?

6) Any other comments about DART?

Thank you very much for completing this questionnaire

Copyright © 2010 NSPCC – All rights reserved. National Society for the Prevention of Cruelty to Children, Weston House, 42 Curtain Road, London EC2A 3NH. Incorporated by Royal Charter. Registered charity number 216401. NSPCC, charity registered in Scotland, charity number SC037717
Questionnaire for mothers

ALPHA NUMBER _____________ Date _____________
WORKER _____________ _____________

Your experience of the DART programme

1a) From a scale of 1 to 5 (with 1 meaning very poor and 5 meaning very good), how would you rate your overall experience of attending DART?

1 □ 2 □ 3 □ 4 □ 5 □

1b) Please explain your rating for Q1a (e.g. why you have rated it low or high)

2a) Do you feel you have learnt anything new from attending DART?

Yes □ No □ Maybe □

2b) If you answered yes to Question 2a, did you learn something related to any of the following: (please tick as many that apply)

Your child □ Yourself □ Domestic abuse □ Parenting □ Other □

*Please give further details of what you feel you learnt*

3a) Do you think attending DART has helped you in any way?

Yes □ No □ Maybe □

3b) If you answered yes to Question 3a, has this helped you in terms of: (please tick as many that apply)

Coping with your past experiences □ Being able to relate to your child □ How you feel about yourself □ Other □

*Please give further details about how you feel the programme has helped you*
4) If you think the programme has helped you, what aspects of the programme have you found the most helpful?


5) If you feel that attending DART hasn’t helped you, (if you answered ‘no’ to question 3a) Are there any particular reasons for this?

Yes ☐ No ☐ N/A ☐

If you answered yes to Q5, please give further details


6a) Do you think attending DART has helped your child in any way?

Yes ☐ No ☐ Maybe ☐

6b) If you answered yes to Question 6a, has this helped your child in terms of: (please tick as many that apply)

- Coping with their past experience ☐
- How they feel about themselves ☐
- Dealing with their emotions ☐
- Other ☐

Please give further details about how you feel the programme has helped your child


6c) If you answered no to Question 6a are there any reasons you think attending DART hasn’t helped?


7a) Do you feel that your relationship with your child has been affected in any way by attending DART?

Yes ☐ No ☐ Maybe ☐
7b) If you answered yes to question 7a how has this been affected?

- Our relationship is worse
- Our relationship is better
- Other

*Please give further details about how you feel your relationship has been affected*

8a) Do you know where to go if you needed further support?

- Yes
- No
- Maybe

8b) If you answered yes to question 8a, where do you think you would go to get this support?

9a) Has anything happened in your life that has affected your ability to participate in the DART groups?

- Yes
- No
- Maybe

9b) (If yes to Q9a), please give details

10a) Has anything else changed in your life since you began attending DART?

- Yes
- No
- Maybe

10b) If you answered yes to Q10a please give details.

11a) Do you have any suggestions as to how DART could be improved?

- Yes
- No

11b) If you answered yes to Q11a please give details.
12) Do you have any other comments about the DART programme?

Thank you very much for completing this questionnaire, your views are valuable and may help to improve the service.


Referrer’s survey

Your experience of the DART service and referral process

This survey is for professionals who have referred their service users to the DART (Domestic Abuse Recovering together) service. We would like to know about your experience of making a referral and how you feel DART may have affected the families who attended. Your responses are very valuable to us and will inform the DART evaluation. External and internal NSPCC reports will be produced on the evaluation data, however data which could identify you will not be used. You do not have to complete this survey and are able to leave out questions if you do not wish to answer them. If you would like to find out more about this study or have any questions or concerns please contact the NSPCC Evaluation Department on 0207 8251368

1. How many families have you referred on the DART programme?
   ______________

2. How many of those families were accepted onto the programme?
   ______________

3. How many of those families completed the programme?
   ______________

4. In your opinion, was the DART referral criteria:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Somewhat</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Appropriate?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Any other comments about the referral criteria?
5. From a scale of one to five (with one meaning very poor and five meaning very good) How would you rate the overall referral process in terms of:

   1  2  3  4  5

   How clearly the referral process was explained? ☐ ☐ ☐ ☐ ☐
   How clearly the nature of the service was explained? ☐ ☐ ☐ ☐ ☐
   The process of referring clients? ☐ ☐ ☐ ☐ ☐

   Any comments about the referral process?

6. How much contact did you have with these families:

   No contact    A little contact    A lot of contact

   Before they attended DART? ☐ ☐ ☐
   During their attendance at DART? ☐ ☐ ☐
   After they attended DART? ☐ ☐ ☐

7. Based on your contact with these families following their completion of the programme, on a scale of one to five (with one meaning very little and five meaning very well), how well would you say DART met their needs?

   1  2  3  4  5

   ☐ ☐ ☐ ☐ ☐

8. Please give a reason for your score for Question 7
9. Please could you indicate how you think the families’ situations have changed/not changed overall after completing DART, based on the following:

<table>
<thead>
<tr>
<th></th>
<th>Worsened on the whole</th>
<th>Unchanged on the whole</th>
<th>Improved on the whole</th>
</tr>
</thead>
<tbody>
<tr>
<td>The mother and child relationship?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The mothers’ emotional wellbeing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The children’s emotional wellbeing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The children’s behaviour?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The mothers’ parenting resources?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Do you have any suggestions about how the DART service, or referral process could be improved?
Appendix 7: Interview topic guides

Topic guide for children

Introduction
I’ll tell you a bit about what I am doing: I am interviewing lots of children and mums who have been to DART and writing a report about it so people can find out if it helps people or not. But I don’t use anyone’s names or anything like that. What you say to me is kept private unless something you say makes me think someone might be in danger. Then I might have to tell one of the workers here. I’m going to ask you a bit about some of the things you did at DART and what you think about it. Is that ok? If you don’t want to answer any of the questions just tell me and I’ll leave it out.

Topic guide
Warm up questions
First I’m going to ask you a bit about yourself:

• How old are you?
• Do you have any brothers and sisters?
• How old are they etc?
• Can you tell me a bit about what kinds of things you like doing when you’re not at school?

Views about the DART groups
So now I’m going to ask you about the DART groups:

• What the child thought DART would be like (before they got there)
• Something they wanted to do or not?
• What the child thought about the group when they first arrived
• What they liked/disliked
• Anything they found particularly helpful/not helpful
• How the child thought their mother found the programme
• Any ways the child feels DART could be improved
Effects of the DART programme
• Anything which has changed in the child’s life after the groups
• Ways in which the group has helped/not helped the child

Barriers/facilitators which affect the degree to which outcomes are achieved
• Anything which stopped the child enjoying the groups
• Anything which stopped the groups working so well

Additional support
• Does the child know where to go if they want help? (Information leaflets, e.g. ChildLine could be provided and a practitioner will be available for the child to talk to after the interview)

Topic guide for mothers
Thank you so much for taking the time to talk to me. Have you been told a bit about what this? It is to find out about how you found DART, things you might have liked about it, things you might not have liked about it and if you felt it helped you and your child.

So if there are any questions you don’t want to answer please let me know and we’ll move on. Everything you tell me is confidential unless something you said suggests a child is at risk, and your interview will be anonymised. So I’m doing a number of interviews with other mothers and children and will be writing a report about them to see how well the service is working. Is this all ok? Any questions before we start?

Topic guide
Warm up questions
First I have a few questions just about yourself:
• Can I ask a bit about your family – how many children you have and how old are they?
• Have you been living in the area for long?
Views about the DART programme
• How they first heard about DART
• Initial perceptions of the service
• Overall experience of the programme
• Positive and negative aspects of the programme
• Anything they found difficult
• Anything that particularly helped
• Anything they would change
• Participant’s perception of child’s experience of DART
• Anything child found difficult
• How did mothers cope with any difficulties
• Suggestions for improvements

Effects of the DART programme
• Positive/negative effects of the programme for mothers
• Participant’s perceptions of positive/negative effects of the programme for their children
• Ways in which participants felt the programme helped (if relevant)

Barriers/facilitators which affect the degree to which outcomes are achieved
• Factors which affected the participant’s ability to participate in and/or benefit from DART

Additional support
• Participant’s awareness and use of additional support following the programme. (A practitioner will be available for the participant to talk to after the interview if necessary to discuss this)