CONJOINT COUNSELLING PILOT PROJECT
Final Report (2015-2018)

Prepared for the Ministry of Community and Social Services
June 12, 2018

Contents

Acronyms used in this report

CFDCTB	Catholic Family Development Centre of Thunder Bay
CFSPD	Catholic Family Services of Peel Dufferin
CSI	Couples Satisfaction Index
MCSS	Ministry of Community and Social Services
DV	Domestic Violence
EFT	Emotionally Focused Therapy (couple's therapy in this context)
EOI	Expression of Interest
HITS	Domestic Violence Screening Tool, Hurt, Insult, Threaten, Scream
MOU	Memorandum of Understanding
PAR	Partner Assault Response Program
REACH	Haldimand-Norfolk REACH
TBCC	Thunder Bay Counselling Centre
VAW	Violence Against Women

Language use

Family Service Ontario agencies collectively serve diverse victims and survivors of violence. Family Service Ontario agencies recognize the gendered nature of violence and take an anti-oppressive and inclusive approach to service delivery. For purposes of this report, the term "domestic violence" is used as a term inclusive of intimate partner violence, domestic violence, and violence against women.

Attribution

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Executive Summary

This is the final report for the *Conjoint Counselling Pilot Project*, prepared for the Ministry of Community and Social Services (MCSS). The goal of this pilot project was to assess the effectiveness of the Emotionally Focused Therapy (EFT) intervention in reducing the risk of domestic violence in couples who are experiencing adult conflict.

Background

The target population of this early intervention model was women and their partners in relationships where there is a risk of escalating conflict. The project responded to a service gap in cases of situational couple violence, when the woman wants to remain in the relationship. To support this early intervention counselling pilot project, MCSS granted Family Service Ontario $172,700 between 2015 and 2017, with a $103,000 extension to the pilot in 2017-2018.

Family Service Ontario agencies are experienced in providing triaged VAW services, with therapists trained to provide evidence-based psychotherapy interventions like EFT. Four family service agencies were contracted to deliver services in this pilot: Catholic Family Services Peel Dufferin (lead agency and urban site), Haldimand-Norfolk REACH (rural site), Thunder Bay Counselling Centre, and the Catholic Family Development Centre of Thunder Bay (northern site). Family Service Ontario designed and wrote the business case for support, the proposal for this pilot project, provided four members to the pilot project steering committee, as well as administrative support to the steering committee and funding flow through for the project.

Methods

The pilot focused on couples who were experiencing adult conflict that was chronic and beyond their ability to manage. Couples were first screened for safety and domestic violence risk, along with other inclusion criteria[1], prior to participating in a 2-hour assessment. All couples who were eligible for the project after the assessment received up to 10 hours of counselling service from a therapist trained in EFT. Therapists used standardized tools to assess domestic violence risk and couple satisfaction before and after therapy.

Results

More than 300 couples were interested in the conjoint (couples) counselling intervention (about 100 referred per year for three years). In phase one, 98 of the planned 100 couples met inclusion criteria and were recruited into the pilot program. In phase two, as of mid-May 2018, 51 of the planned 80 couples met inclusion criteria and were recruited into the program, and 8 couples were in assessment. The remainder were provided with other agency or community services.

Quantitative and qualitative data show that the couples counselling EFT intervention was successful. In a statistical analysis of the assessment data, couples' satisfaction increased from the beginning to end of EFT, while risk of domestic violence decreased. Qualitative data from clients and pilot site staff point to similar positive outcomes. Focus groups of counsellors who were directly involved in providing therapy

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and client survey results both indicated that the model was effective at improving relationships and reducing domestic violence risk.

Conclusions

The outcomes of the pilot project have been positive. Implementation of this pilot provided important knowledge about counselling timing, referral sources, and outreach.

Through three years of implementation and outcome measurement, this pilot study provides evidence that EFT conjoint counselling in a 10-session model can decrease domestic violence risk while increasing relationship satisfaction and skills. This pilot project also identified areas for enhancement and refinement. These include broader inclusion criteria for participating couples, research and tool development, and updating implementation guidelines.

Appendices

Appendices of this report include the following documents and information:

1. Business case for support
2. EOI for pilot site agencies
3. Steering committee membership
4. Conjoint counselling assessment areas and inclusion criteria
5. (a) Conjoint Couples Therapy treatment manual and (b) CFSPD Conjoint Counselling manual
6. HITS Domestic Violence Screening Tool
7. Couples Satisfaction Index CSI
8. A summary of expenditures (estimated and actual budget)
9. Evaluation framework

Introduction

Overview of report

This final report provides a summary of the pilot project rationale, methods, findings, and conclusions. It includes background on the project and on participating organizations, methodology for service provision, and a summary of qualitative and quantitative findings, based on data from clients and service providers. Overall results and operational learnings are discussed, along with recommended next steps.

Purpose and scope of the project

Project rationale: An early intervention approach to ending domestic violence

Ending domestic violence in Ontario requires an array of strategies and moving away from "one-size-fits-all" approaches[2]. The principle of early intervention has been part of Ontario's Domestic Violence Action Plan since 2004[3]. Early intervention programs need to reach men, as well as women, and provide supports to reduce conflict and the risk of domestic violence in relationships.

There is a lack of services for women who wish to remain with their partners and reduce conflict in their relationship. Family Service Ontario member agencies frequently receive requests from women for couples counselling to address low-risk situational couple violence. Their desire is to work together for the conflict to end, not for the relationship to end.

However, finding timely and accessible counselling and supports for men and couples has been an ongoing challenge. There is also increasing recognition that interventions to end gender-based violence need to provide different types of early intervention for partners experiencing situational violence, to prevent escalation of risk and violent behaviour.

Different types of domestic violence require different interventions

Two main types of domestic violence[4] have been identified over the course of a decade of research (Johnson, 2008; Hardesty, 2015; Kelly & Johnson, 2008), with important implications for intervention strategy:

> Coercive Controlling Violence is a "pattern of emotionally abusive intimidation, coercion and control, coupled with physical violence against partners."[5] This type of violent behavior is assumed in the Partner Assault Response (PAR) principles and the Power and Control Wheel.
>
> Situational Couple Violence is not marked by power- and control-related behaviours, and results from arguments, based on situations that escalate into violence. Partners involved in situational couple violence "benefit from intervention[s] focuse[d] on relationship skills (e.g., anger

[2] Wells, 2013
[3] MCSS, 2012
[4] Johnson, 2008; Hardesty, 2015; Kelly & Johnson, 2008
[5] Wells, 2013; Kelly & Johnson, 2008

management and communication) as well as cognitive skills (e.g., avoiding negative attributions of their partner's behaviour)"[6].

This early intervention conjoint counselling pilot project targeted couples experiencing low-risk situational violence[7]. These couples wished to remain in their relationship but did not have appropriate and accessible supports for reducing escalation, conflict, and domestic violence risk.

Conjoint (couples) counselling is an early intervention strategy for reducing situational couple violence

The *Conjoint Counselling Pilot Project* described in this report tested an evidence-based early intervention model for women and their partners in relationships at risk of escalating conflict. The project responds to a service gap in cases of situational couple violence where the woman wants to remain in the relationship.

This conjoint (couples) counselling model aligns with Ontario's plan to expand enhanced counselling and community support services for women[8] and is part of the broad differential response needed to help ensure that couples have the supports they need for safe and violence-free relationships.

Pilot project with three years of MCSS funding

Ministry of Community and Social Services (MCSS) provided funding for a pilot project of $69,683 in the 2015/2016 fiscal year, $103,017 in the 2016/2017 fiscal year, and $103,000 in the 2017/2018 fiscal year. These resources were intended to fund a two-year initial study and one year-extension to measure the outcomes (including but not limited to the prevention of escalating conflict in couples) of providing conjoint counselling for lower-risk situational couple violence[9].

Pilot sites represented Family Service Ontario agency approach and expertise

The pilot project was coordinated via Family Service Ontario, and four agencies collaborated to deliver conjoint counselling services across communities that were: urban (Peel Dufferin), rural (Haldimand-Norfolk) and northern (Thunder Bay).

Family Service Ontario (Family Service Ontario) represents 48 not-for-profit member agencies from across the province who provide a wide range of mental health, trauma, and wellness services throughout Ontario. Family Service Ontario developed a business case for the conjoint counselling pilot project (see Appendix 1) and issued an EOI to its membership for interest in becoming a pilot site (see Appendix 2), receiving proposals from 11 sites. Family Service Ontario and MCSS worked together to review and score the proposals and to select the successful pilot sites. Family Service Ontario then signed an MOU with the lead pilot agency (CFSPD) and provided administrative and funding flow-through support to the project, as well as four members to the project steering committee[10].

[6] Wells, 2013; Kelly & Johnson, 2008
[7] Conjoint counselling is not appropriate for all couples. The model screens higher risk couples and individuals into appropriate services. See details on inclusion criteria below.
[8] MCSS (2012).
[9] Grant Letter, cover page one
[10] The membership of the steering committee was as follows: MCSS Community Supports Branch, MCSS Community Supports Policy Branch, Family Service Ontario, Executive Directors from each of the Pilot sites and a Community Member. See membership list in Appendix 3.

Catholic Family Services of Peel Dufferin (CFSPD) is a multi-service not-for-profit counselling agency located in the Region of Peel (Brampton, Mississauga, Caledon) and Dufferin, Ontario. It focusses on strengthening individual, family and community life while reducing family violence. Agency services are wide-ranging and when possible offered in many languages. CFSPD was the lead in this project and was the urban pilot site.

Haldimand-Norfolk REACH is also a multi-service not-for-profit agency with children's mental health services, autism services, developmental services, youth justice services, family services and children's early learning and care services. REACH was the rural pilot site, and satellite offices participating in this pilot were in Townsend, Dunnville, Caledonia and Simcoe, Ontario.

Thunder Bay Counselling Centre (TBCC) is an accredited, not-for-profit, multi-service organization that is also a leading provider of personal and workplace support services. TBCC works in diverse areas such as violence against women and children, support services for male survivors, trauma, financial literacy, addiction, and mental health. TBCC was a northern site for the pilot.

Catholic Family Development Centre of Thunder Bay (CFDCTB) is a not-for-profit, non-denominational family services agency dedicated to supporting families through programs for men, women, and parents in the Thunder Bay area. CFDCTB was a northern site for the pilot.

In addition to representing geographically varied communities, from dense urban to rural and northern, these agencies have capacity to meet the needs of diverse populations, including French-language and Aboriginal couples[11].

Family Service Ontario agencies provide integral community VAW response services

Family Service Ontario agencies provide evidence-based psychotherapy interventions to individuals, couples, and families as a core competency. An integral part of the VAW landscape, Family Service Ontario agencies have a strong history of working with a triaged risk model, creating differential service responses to meet women's diverse needs, and meet standards that reflect best practices for providing community-based health and social services[12].

The Family Service Ontario *Triage Model*[13] recognizes that not all domestic violence is the same and ensures that women get the right amount of service at the right time. Family Service Ontario agencies provide evidence-based psychotherapy interventions in individual, couple, and group formats, depending on clients' risk profile, needs, and preferences. Family Service Ontario agencies also refer to (and from) shelters and shelter services, and other VAW community supports.

Together, Family Service Ontario agencies collaborated to identify and create a business case and rationale around the EFT early intervention model as an evidence-based early intervention for situational couple violence[14].

[11] We note that expanded language services were beyond the scope of this project.
[12] Family Service Ontario agencies are accredited or eligible for accreditation through the Canadian Centre for Accreditation.
[13] Family Service Ontario (2017a,b)
[14] Wells, 2013

Pilot project start-up and scoping

Northern, rural, and urban pilot locations

Family Service Ontario, in consultation with representatives from MCSS, chose three pilot sites within Ontario: one northern (housed across two locations), one rural, and one urban (see more details under *About participating agencies*).

Specifically, the pilot sites provided conjoint counselling to couples using Emotionally Focused Therapy (EFT), "established to be an effective approach for reducing relationship distress in couples experiencing life challenges"[15]. EFT draws on attachment theory and encourages the cultivation of a strong bond between partners[16].

Definition of exclusion/inclusion criteria and recruitment

The pilot project focused on couples who had low social or relationship skills and had experienced low-risk situational violence or low-risk conflict. Prior to being recruited into the program, each couple was screened for safety and other inclusion criteria (see *Pre-program assessment* below and detailed list in Appendix 4). This pilot excluded clients where the couples had experienced *any* past police charges/convictions in their relationship, even if they otherwise met inclusion criteria for safety. Couples who did not meet screening inclusion criteria were offered other services in-house or referred to another agency.

Recruitment took place through diverse methods, including community agency referrals, social media and media outreach, word of mouth, and in-agency referrals.

Conjoint counselling project methodology

The couples counselling intervention

All couples received up to 12 hours of service (including 10 one-hour EFT counselling sessions and a two-hour assessment) from a therapist specifically trained in EFT. Pre- and post-program assessment helped to document couples' clinical progress in the program.

Step one: Pre-program development

There was strong support within the community for the pilot; partner organizations and the broader community were aware of the program as a resource. Pilot sites' work to develop a communications strategy and increase awareness and referrals netted a significant response to the program with less than expected marketing.

Steering Committee

A Project Steering Committee (Ministry, Family Service Ontario, the community) was convened[17] to assist in addressing issues and challenges, to provide orientation to the third-party evaluator, and to provide advice and input into the project work plan as required[18].

[15] Steering Committee Terms of Reference, page one.
[16] http://www.iceeft.com/index.php/about-us/what-is-eft
[17] See Steering Committee membership in Appendix 3.
[18] Steering Committee Terms of Reference, page one.

The clinical and evaluation instruments in the pilot project were identified through a fulsome dialogue among clinicians, EFT expert Dr. Sue Johnson, and the project steering committee, including MCSS representation. More detail about the instruments is provided below.

Therapist Training

Other work included the co-ordination, facilitation and monitoring of orientation, and clinical training for EFT practitioners[19], including liaising with the clinical consultant. Finally, financial and other project systems were established, and evaluation measures and assessment tools were developed collaboratively and harmonized across all sites. See Appendix 5a for the conjoint counselling treatment manual and Appendix 5b for lead agency conjoint counselling process.

Step two: Screening and the HITS instrument

Couples were screened for safety prior to being admitted to the program. Couples who did not meet the criteria were offered other agency services or referred to other community services.

Participants were screened using the HITS (referring to, Hurt, Insult, Threaten, Scream – see Appendix 6). The HITS was developed as brief tool for physicians to screen for domestic violence, and shows good concurrent validity with similar instruments, including the Conflict Tactics Scale[20]. The HITS was selected due to its brief nature, in order to minimize survey burden and allow quick screening of couples interested in the pilot study, as well as pre-post comparison with a validated measure of domestic violence risk.

Step three: Pre-program assessment and the Couple Satisfaction Index

Couples who met the screening assessment criteria and who wished to participate in the program were asked to complete a 2-hour pre-program assessment, including completion of the Couple Satisfaction Index (CSI, see Appendix 7). The CSI provided a baseline measurement of relationship satisfaction and quality[21].

To ensure safety, the screening focused on coercive controlling behaviours, physical assault, lethality risk factors, client vulnerability factors and dynamic risk factors (see Appendix 4 for complete details).

Specifically, this meant that the couples:

- Had not experienced ongoing patterns of coercion or prior domestic violence charges;
- Had not accessed a PAR program or VAW service funded by MCSS;
- Were not dealing with unresolved mental health, uncontrolled substance use or other significant personal vulnerabilities;
- Expressed commitment to avoiding violence and respecting each other's boundaries and feelings; and,
- Possessed sufficient stability to commit to 10 counselling sessions.

Step four: Counselling

Couples participated in up to 10 conjoint counselling sessions with therapists using EFT techniques.

[19] Family Service therapists have a Master's degree in family therapy. This pilot project required EFT therapy training for high conflict couples.
[20] Sherin et al., 1998; Shakil et al., 2005
[21] Funk et al., 2007

Step five: Post-program assessment

At the end of these sessions, the couples completed two post-program assessment surveys (HITS and CSI). This provided the post-program measurement of domestic violence risk and relationship satisfaction. In phase two, couples also completed a post-program question about the biggest change for them during counselling.

Step six: Evaluation

In phase one, the pilot program was evaluated by a third-party evaluator, Goss Gilroy Inc. The evaluators also administered pre-, mid- and post-surveys, which were not connected to the agency screening and assessment. However, separating the evaluation from the intervention created data collection challenges, and the pilot evaluation plan was revised accordingly.

Specifically, in phase two, existing in-program data was leveraged and systematized to answer key evaluation questions around need, effectiveness, and sustainability. Specifically, client assessment and outcome data collected by project partners, feedback from project stakeholders, and review of program documents and agreements are the data sources for the final pilot project report (and this interim final report). See the detailed phase two evaluation framework in Appendix 9.

Pilot project goal and extension questions

The overarching goal of this pilot project was to assess the effectiveness of the EFT intervention in reducing the risk of domestic violence[22].

The pilot extension was designed to investigate and document the following questions:

Is the intervention a service the community needs?

1. What was community demand for the program during the pilot across the sites?
    a. Among couples who met screening criteria?
    b. Among couples who didn't meet screening criteria?
2. What kinds of advertising and promotion were used by the sites during the pilot?

Is the intervention effective?

1. Does providing 10 hours of Emotionally Focused Therapy (EFT) to couples experiencing adult conflict improve relationship quality and decrease the risk of relationship violence?
    a. Do program outcomes differ for men and women, or across pilot site location?
2. What can we learn about outcomes for couples who leave the program? (e.g., due to separation or other reasons)

Is the intervention efficient and sustainable?

1. What is the cost of EFT pilot program delivery?
2. What are promising practices and lessons learned about EFT delivery at the pilot sites?

The evaluation framework developed to answer these questions is provided in Appendix 9.

[22] Steering Committee Terms of Reference, page one

Pilot project data sources

As noted above, this report draws on assessment data collected by project partners, feedback from project stakeholders, and review of program documents and agreements, in both phase one and two of the program.

Direct evidence of outcomes for couples comes from analysis of HITS and CSI pre-and post-program measures. Supporting data sources include minutes and notes from meetings with therapists, Executive Directors, program administrators and consultants, as well as interviews with staff and other community stakeholders. These qualitative data were used to expand and confirm quantitative findings from the client assessments.

Pilot project findings

Ongoing strong community demand and need for couples counselling intervention

Most participants self-referred to the program

Instead of outreach via other agencies, self-referrals played a larger role than expected. That is, most couples self-recruited into the pilot project sites, without targeted outreach to partners[23].

Program promotion needs to use formal and informal networks

Program promotion required multiple communication approaches. Project partners at the northern and rural sites had success using social media (Facebook, Twitter, website, etc.) to promote the conjoint counselling program. In urban sites, social media was less effective and more in-person promotion was required, including word of mouth outreach to agency partners, faith communities, and community leaders, together with physical advertising (road signs in trafficked areas, posters, etc.).

High community demand for the program across the three sites

The pilot program ran for three years in total and yielded more than 300 referrals to the program. Recruitment occurred during the months of October 2015 to November 2016[24] and April 2017 to March 2018. There were 284 referrals in the first two years (phase one) and 124 referrals in the final year (phase two).

Program eligibility criteria excluded half of interested couples

The pilot sample size was intended to be 180 couples – 100 in phase one and 80 in phase two. The overall sample after screening and assessment was 129 couples in phase one and 62 couples in phase two, resulting in 76 couples completing the intervention in phase one and 28 in phase two.

The intervention program was in relatively high demand from couples who did not meet eligibility criteria. In phase one, 45% of couples referred to the program met inclusion criteria and 55% were excluded after screening or assessment. In phase two, 50% of couples referred to the program met inclusion criteria, and 50% were excluded after screening (n=43) or assessment (n=19).

[23] If the couple did not pass the screening assessment they were offered other agency services or if necessary referred out to other agencies.

[24] Counselling started in January 2016, once consent and evaluation materials were ready. Counselling ended March 2017.

Of the sample who started counselling, 59% completed the EFT intervention in phase one and 41% completed some therapy and withdrew[25]. In phase two, 19% are still mid-service, while 45% have completed the entire EFT intervention, and 35% completed some therapy and withdrew.

Phase One: Client numbers by intervention phase

Intervention phase	# couples	percent	
Referred to the pilot	284		
Excluded after screening or assessment	155	55%	Interested but did not meet inclusion criteria
Met inclusion criteria	129	45%	Interested and met inclusion criteria
Completed some therapy and withdrew[25]	53	41%	Completed some therapy and withdrew
Completed EFT intervention (at least 10 sessions)	76	59%	Completed the EFT intervention (at least 10 sessions)
Receiving service	0	0%	Currently completing service

Phase Two: Client numbers by intervention phase

Intervention phase	# couples	percent	
Referred to the pilot	124		
Excluded after screening or assessment	62	50%	Interested but did not meet inclusion criteria
Met inclusion criteria	62	50%	Interested and met inclusion criteria
Completed some therapy and withdrew[25]	22	35%	Completed some therapy and withdrew
Completed EFT intervention (at least 10 sessions)	28	45%	Completed the EFT intervention (at least 10 sessions)
Receiving service	12	19%	Currently completing service

[25] For example, withdrawal due to separation, life circumstances, feeling satisfied with improvements before 10 sessions.

Unmet needs for counselling for men: Opportunities for prevention and early intervention

Figure 1. Frequency visualization of the top 25 words in client feedback about the biggest change .

The strong demand and self-referral numbers, as well as the number of participants excluded, highlighted the need for diverse programs that provide prevention and early intervention support to men in relationships. In this pilot, participants could not have accessed any other MCSS funded service (such as shelters) or have been enrolled in PAR. These stringent criteria (see Appendix 4) meant that half of interested couples were not eligible, and that pilot site agencies often struggled to find commensurate services. **Recommendations around inclusion and exclusion criteria are provided in the conclusion section.**

The conjoint counselling EFT model is effective

Providing 10 hours of Emotionally Focused Therapy (EFT) to couples experiencing adult conflict improves relationship quality and decreases the risk of relationship violence

Based on available pilot data, the EFT intervention improved relationship quality and decreased the risk of couple violence. The pilot data suggest that the EFT intervention is well suited to helping couples experiencing situational couple violence to improve their relationship skills and quality and reduce the risk of violence[26].

Therapists describe how EFT improved relationship quality for couples

Focus groups were held with therapists during the first year of the program, and again in January 2018 and April 2018. At all three points in time, the therapists described the positive impacts of the pilot program. Specifically, couples were better able to identify their cycle of conflict in their relationship during and at the end of the EFT intervention. Couples gained strategies to de-escalate conflict and learned to listen to partners without defensiveness and stay engaged longer.

> *"For me I think it's working rather well….it's usually around the fifth session that I'm noticing that they're really getting [it], they're understanding the cycle [of conflict] and really changing their part in it" (January 19 Therapist Focus Group*

> *"I agree, before the ten sessions they do all seem to de-escalate." (January 19 Therapist Focus Group)*

After the EFT intervention, couples could more easily talk about their feelings and fears and became closer to each other.

> *"I really like this model. I think that it works well. I see a lot of improvement using this model for a couple." (January 18 Therapist Focus Group)*

[26] In this pilot project, the risk of situational couple violence was clinically assessed, guided by the criteria in Appendix 6, and measured quantitatively using the HITS screening tool.

Therapists also noted that this program filled a service gap, as similar couples therapy would not otherwise be available to these couples.

> *"Couples we saw got some help that they wouldn't have had otherwise. And that's great to be able to offer that." (April 2018 Therapist Focus Group)*

Conjoint counselling can lead to positive outcomes for couples who leave the program

Although not all couples completed the conjoint counselling intervention, withdrawal from the program due to separation or other reasons did not necessarily mean failure. Some couples left because they felt they had gained skills in less than 10 session, and didn't feel the need to complete the program. Some couples left because they were separating, and EFT techniques contributed to making separation more harmonious, through building relationships skills that supported amicable separation and improved communication. This is an important result, as research indicates that women are at their most vulnerable during the separation process[27]. Even if EFT conjoint counselling does not "save" the relationship, it still reduces the risk of situational couple violence/domestic violence.

Biggest changes for clients were improved communication and reduced stress and conflict

In the final year of the pilot, clients had the chance to report on the "biggest change" that resulted from engagement with the program. Major themes in responses (n=37 responses) were improved understanding of emotions and triggers, improved relationship communication and functioning, less conflict, and improved wellbeing. There was no evidence of differences in response themes by gender.

> *"Could be more vulnerable with my partner, and feel compassion for her and understanding, at times that previously I was triggered. More open communication, less time spend arguing or mad. Understanding triggers better and to support her rather than become defensive." (M)*

> *"To be able to communicate my feelings at a better and more freely. To be more able to open up and break away from patterns that were taking our relationship nowhere. Self-reflection and self-understanding, self-growth." (F)*

> *"Understand my primary emotions better and how to stay in them to communicate better. The assistance in finally getting to the proper diagnosis with my mental health." (M)*

> *"I feel as if we are able to communicate and get to the root of what we are feeling or is bothering us. We went from arguments lasting several hours because we were not using primary emotions addressing things using primary emotions which allows us to connect and become closer. It has truly saved our marriage." (F)*

> *"We are more able to defuse situations before they get out of hand. Better understanding of each other." (M)*

> *"I feel that my relationship has improved drastically. We are now able to recognize what causes distress in our relationship and work through it together instead of avoiding issues or having extended arguments. We are generally nicer to each other and less prone to conflict." (M)*

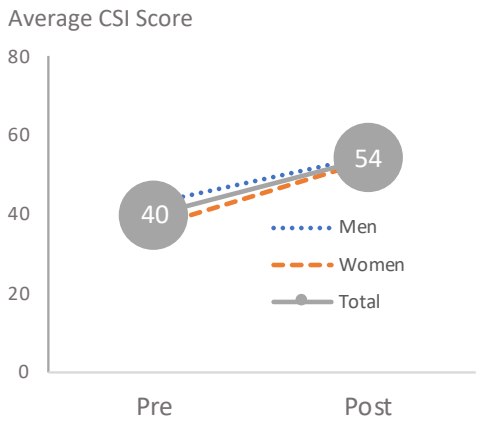
Quantitative client outcomes show improved relationship quality and reduced risk of domestic violence

Quantitative results from client assessment surveys corroborate qualitative perspectives that the conjoint counselling model is effective at improving relationship quality and reducing DV risk.

[27] Brownridge 2006; Brownridge et al. 2008

Couple's relationship satisfaction increased after EFT conjoint counselling

Couple satisfaction increased after conjoint counselling (n=126).



In the May 2018 analysis, there were 126 CSI assessment surveys with matched pre/post counselling results across the three sites. This included 44 pairs from the urban site (CFSPD), 16 from the rural site (HN REACH), and 66 from the northern site (TBC and TBCFDC). Possible scores on the CSI range from 0 to 81; scores in the sample ranged from 1 to 78, and showed good internal consistency as a scale.[28]

Statistical analysis of the pre- and post-program assessment data found that overall, couple's satisfaction with their relationship increased significantly and substantially after the EFT conjoint counselling intervention. Comparing these matched CSI scores with a 2 (time) by 2 (gender) mixed model ANOVA, there was a large and significant increase in couple satisfaction over time[29].

As illustrated below, overall CSI scores increased by about a standard deviation from the beginning to end of counselling.

Relationship improvements similar for men and women

Although women's CSI scores trended slightly lower than men's, especially at the start of counselling, there was no evidence of an overall significant gender difference in CSI scores[30]. However, a marginally significant interaction occurred with a small effect size[31], such that women rated couple satisfaction significantly lower than men at the start of counselling[32], but not at the end[33].

Overall, differences between men's and women's scores were small compared to the overall improvement in relationship satisfaction.

	CSI Before Counselling			CSI After Counselling		
	M	*SD*	*N*	*M*	*SD*	*N*
Men	**42.6**	14.4	63	**54.7**	15.0	63
Women	**36.9**	13.8	63	**53.4**	16.1	63
Total	**39.8**	14.4	126	**54.1**	15.5	126

Relationship quality differences across locations but intervention improvements similar

CSI scores improved at all pilot sites. Analysis by site showed a main effect for location, such that couples' overall CSI scores were significantly lower at the urban site than at the northern and rural sites[34]. There was evidence a difference in CSI improvements across agencies[35], such that the rural site showed higher

[28] Cronbach's α = .97 at pre- and post-counselling
[29] Overall increase in CSI scores from before to after counselling, with a large effect size $F(1,124)=135.08$, $p<.001$, $\eta^2_p = .52$
[30] No evidence of significant main effect of gender on CSI scores, $F(1,124)=2.29, p=.13$, $\eta^2_p = .02$
[31] Significant interaction between time and gender, with small effect size $F(1,124)=3.15, p=.08$, $\eta^2_p = .03$
[32] Women's CSI scores were lower than men's at counselling baseline, with moderate effect size, $t(240)=2.82, p=.005, d=.4$
[33] No evidence of difference between men and women's CSI scores at end of counselling, $t(136)=.68, p=.50, d=.1$
[34] Overall effect of pilot site on relationship satisfaction, with a small-moderate effect size $F(2,123)=5.07, p=.008$, $\eta^2_p = .08$
[35] Significant interaction between time and site location, with a small-moderate effect size $F(2,123)=6.26, p=.003$, $\eta^2_p = .10$

CSI scores than the urban and northern sites after counselling[36], but not at baseline[37]. However, this finding was based on only 16 clients and is not considered a robust effect.

Overall, the differences across locations were small and improvements in relationship quality were similar across locations.

	CSI Before Counselling			CSI After Counselling		
Site	*M*	*SD*	*N*	*M*	*SD*	*N*
Urban	**35.2**	14.8	44	**49.6**	19.5	44
Rural	**40.8**	16.3	16	**65.6**	8.3	16
Northern	**42.6**	12.9	66	**54.2**	12.2	66
Total	**39.8**	14.4	126	**54.1**	15.5	126

No evidence of differences in CSI data from phase one to phase two

There was no evidence of differences in CSI trends from phase one (n=82) to phase two (n=44)[38].

Domestic violence risk decreased after EFT conjoint counselling

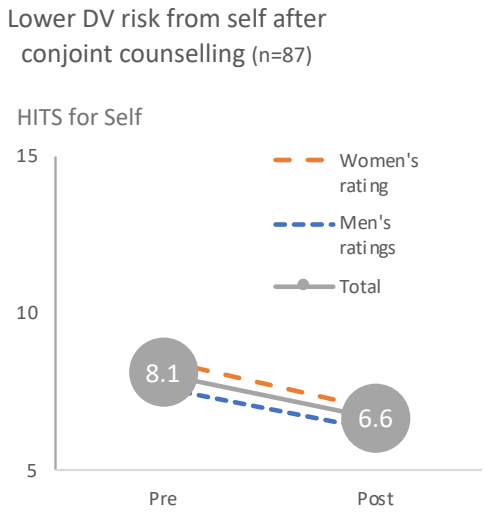
In the May 2018 analysis, there were 87 HITS surveys with matched pre/post counselling results across the three sites. This included 21 pairs from the urban site (CFSPD), 10 from the rural site (HN REACH), and 56 from the northern site (TBC and TBCFDC). Possible HITS scores range from 4 to 20; scores in this sample ranged from 4 to 16 and showed adequate to good internal consistency as a scale[39].

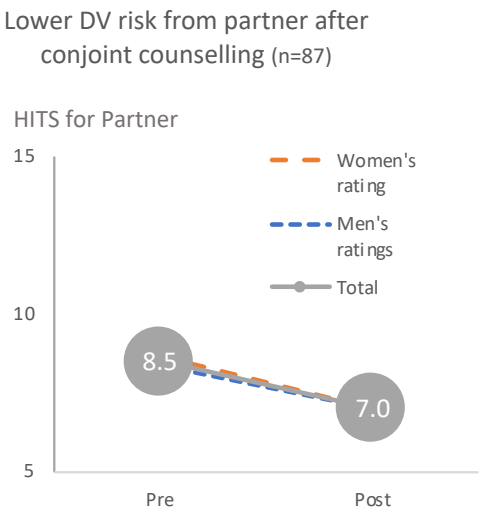
To better understand how the program decreased domestic violence risk, HITS assessment data were compared before and after EFT conjoint counselling. HITS ratings of self and partner violence risk significantly decreased significantly and substantially from before to after the EFT intervention[40].

DV risk reduction similar for men and women

There was no evidence that DV risk decreased differently across genders for self[41] or partner[42] ratings after counselling. Men and women reported similar decreases in partner HITS scores from pre- to post-counselling[43]. However, women reported higher HITS scores for self than men did: this was a statistically significant but very small effect[44].

[36] Rural site clients reported higher CSI scores after counselling, with a small-moderate effect size, $F(2,135)=6.43, p=.002\ \eta^2_p = .09$
[37] No evidence of CSI difference among sites at baseline, $F(2,240)=1.33, p=.27,\ \eta^2_p = .01$
[38] There no evidence that CSI scores increased differently in phase one and two, $F(1,124)=0.05, p=.83,\ \eta^2_p = .01$
[39] Cronbach's α = .65 (HITS for self, pre), α =.69 (HITS for partner, pre), α =.70 (self, post), and α =.79 (partner, post)
[40] Significant decrease in DV risk with a large effect size for self $F(1,85) = 46.05$, $p < .001$, $\eta^2_p = .35$, and partner $F(1,85) = 36.58$, $p < .001$, $\eta^2_p = .30$.
[41] No evidence that self DV risk decreased differently for men and women, $F(1,85)=0.25$, $p=.80$, $\eta^2_p = .001$
[42] No evidence that partner DV risk decreased differently for men and women $F(1,85)=0.09$, $p=.62$, $\eta^2_p = .00$
[43] No evidence of gender differences in rating partner DV risk, $F(1,85)=0.15$, $p=.70$, $\eta^2_p = .00$
[44] Overall women's self-rated DV risk was higher than men's, with a small effect size, $F(1,85)=4.31$, $p=.04$, $\eta^2_p = .05$





Small DV risk profile differences across pilot sites but intervention risk reduction similar

HITS scores decreased at all pilot sites from before to after counselling[45]. There was no evidence that DV risk reduction (decrease in risk after counselling) differed across agencies[46]. However, there was some evidence of overall differences in DV risk across pilot sites[47]. It appears that the urban site clients were of higher risk than the rural and northern sites. Clients from the northern site were similarly higher in risk than clients from the rural site. There may be a different profile of northern vs. urban clients served in the pilot (higher risk, lower relationship satisfaction). However, this was a small effect size, compared to the large intervention effect. The small sample size (n=10) from the rural site limited robust comparisons across all three sites.

	Pre-Counselling HITS for Self			Post-Counselling HITS for Self		
Site	***M***	*SD*	*N*	***M***	*SD*	*N*
Urban	**8.6**	2.4	21	**7.3**	2.4	21
Rural	**6.7**	1.9	10	**5.0**	1.2	10
Northern	**8.1**	2.5	56	**6.7**	1.7	56
Total	**8.1**	2.4	87	**6.6**	2	87
	Pre-Counselling HITS for Partner			**Pre-Counselling HITS for Partner**		
Site	***M***	*SD*	*N*	***M***	*SD*	*N*
Urban	**9.1**	2.3	21	**7.8**	3.1	21
Rural	**7.3**	2.4	10	**5.1**	1.2	10
Northern	**8.4**	2.8	56	**7.0**	2.2	56
Total	**8.5**	2.7	87	**7.0**	2.5	87

[45] Multivariate decrease in DV risk over time for self and partner with a large effect size, λ=.74, $F(2,83)$=14.43, p<.001, η^2_p = .26
[46] No evidence of significant multivariate time by location interaction for DV risk, λ=.99, $F(4,166)$=.22, p=.93, η^2_p = .01
[47] Overall DV risk differed across sites, with a small effect size, $F(2,84)$=4.51, p=.01, η^2_p =.10 for self and $F(2,84)$=3.77, p=.03, , η^2_p =.08 for partner. Clients from the urban site had slightly higher overall DV risk scores than the northern site.

Pilot costs show EFT pilot program delivery is efficient and sustainable

Overall, actual budget costs were within 10% of budgeted values.

Budget totals over the two phases resulted in less spending than planned on counselling. This was due to slower recruitment in phase two, resulting from the lag in community referrals and self-referrals that occurred when service promotion was put on hiatus between the two phases.

Budget expenses for research assistance, coordination (teleconference fees and steering committee time), and training travel time were higher than anticipated. Overall, training and coordination of the project as a clinical intervention and evaluation project required significant in-kind investments in steering committee and clinician time and effort.

Detailed budget totals for phase one and two of the pilot are presented in Appendix 8.

With a model similar to the pilot program, EFT early intervention delivery could be scaled up and implemented across the province. As in the pilot, sustainable EFT interventions would require ongoing training and professional development resources, and ensuring increased support for training and travel for clinicians working at northern and rural locations.

Conjoint Counselling Pilot Budget Summary (overall)			
Item	Actual	Budget	Difference
Counselling	$143,935	$196,500	$52,566
Project Management (Family Service Ontario)	$36,120	$17,000	($19,120)
Lead agency	$2,794	$3,725	$931
Administration and Site Coordination	$33,204	$33,475	$271
Clinical consultation (Dr. Sue Johnson)	$18,000	$18,000	$0
Marketing	$856	$2,000	$1,144
Research assistant	$5,891	$5,000	($891)
Teleconference fees	$1,522	$0	($1,522)
Steering committee (ED)	$4,000	$0	($4,000)
Time/travel for training	$8,211	$0	($8,211)
Total	$254,532	$275,700	($21,168)

Operational Lessons for EFT Intervention Success

Based on focus groups with clinicians and pilot site leads, operational learnings were identified around the intervention timing, impact, and implementation success.

Timing matters: Aim for weekly sessions

Clinicians identified that frequent sessions were a key enabler of client success. Clients needed regular exposure and practice to learn how to avoid emotional triggers and change maladaptive patterns to de-escalate conflict.

Intervention fit improves with strong screening and assessment

The EFT intervention was designed to address low-risk situational couple violence. Program success and therapeutic “fit” depends on screening and assessment for eligibility. Clinician experience and in-person

discussion with both partners is essential to understanding which couples are a good fit for the EFT intervention.

Screening and assessment time may be a barrier to client success or engagement

Screening and assessment instruments may not provide therapeutic value to clients. Overall, clients in the pilot were less likely to complete post-program assessment or evaluation surveys when they perceived higher survey burden. Clinicians often have a challenging role in connecting clients with post-program measures.

External data collection is challenging with this population of clients

External evaluation requests yielded low uptake from participating couples. It may be that the low perceived value of assessment instruments contributed to decreased uptake. There may also be stigma around providing feedback on relationship quality and conflict to outside evaluators (outside of the trusted clinical relationship). Future research and evaluation on the conjoint counselling intervention needs to ensure that couples receive benefit from the data they are providing. This could include online platforms that offer visual displays of "relationship health" through completed surveys or financial incentives for participation in research and evaluation activities.

There needs to be some flexibility in the number of sessions

This pilot provided a 10-session model of conjoint counselling. Some couples will need more than 10 sessions to identify their cycle and learn to de-escalate. Others need only 6 or 8 sessions to achieve improved relationship quality and reduced risk of conflict. It may be that booster or follow-up sessions could help couples ensure that change "sticks" over time, but overall the pilot approach of a 10-session model was effective for most couples served.

Inclusion and exclusion criteria should be expanded when the intervention is scaled up

The exclusion criteria in this pilot phase did not include participants from post-PAR and voluntary post-PAR programs. Expansion of inclusion criteria to include these participants is strongly encouraged, in response to strong demand at pilot sites. As long as other screening and assessment criteria are maintained, the potential range of clients can be increased to include these groups without increasing risk of violence (e.g., people with DV charges, who have received other MCSS services, etc.).

Training and supervision ensures model fidelity

There are two important aspects of delivering the EFT counselling intervention: (1) training and (2) case consultation.

To ensure model fidelity, participating therapists were specifically trained in EFT by Dr. Sue Johnson and her team at the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT). Regular training cycles are an expected cost of scaling up the conjoint counselling model and will yield a broader capacity for EFT counselling across the province. Planning for ongoing training and providing additional travel support to northern and rural sites will help ensure EFT therapist capacity at agencies offering the intervention.

EFT model adherence during implementation occurred through ongoing clinical consultation teleconferences with ICEEFT trainers. This allowed therapists to ask questions around specific issues arising during EFT screening, assessment, or core intervention sessions. Therapists reported that smaller case consultation groups built more individual capacity for EFT model delivery by providing answers to

time-sensitive questions. As only a few questions can be explored in-depth during any case consultation call, options for support by email or secure online forums may help therapists answer questions and build capacity for EFT. Other options for support are a "community of practice" for participating therapists or exploring train-the-trainer models to build specific regional capacity.

Recruitment lags promotion and requires sustained effort

It takes a significant period of time to raise awareness among clients and community partners about a new program. Recruitment lags behind promotion, with most programing taking six months to ramp up outreach efforts and create broad community awareness. If there is a delay or interruption in service delivery, previous work can be quickly undone. It is also typically difficult to recruit during break times and holiday periods. Had the conjoint counselling pilot project been consistently marketed and available, rather than pausing between phase one and two, recruitment and uptake would have been faster in the second phase of the program.

Conclusions

The EFT model reduces DV risk and improves relationship skills and satisfaction

This pilot project demonstrated clear benefits of investing in EFT conjoint counselling as an early intervention to reduce the risk of domestic violence. The intervention is effective, efficient and sustainable, and is in demand within local communities across Ontario.

Qualitative and quantitative data from clients and therapists, as well implementation data, were all supportive of the EFT conjoint counselling model as an effective early intervention for situational couple violence. Through three years of implementation and outcome measurement, this pilot study provides evidence that EFT conjoint counselling in a 10-session model can decrease domestic violence risk while increasing relationship satisfaction and skills.

Next steps for scaling up

This pilot project demonstrated an effective model and also identified areas for enhancement and refinement. In particular, these relate to broader inclusion criteria for participating couples, research and tool development, and updating implementation guidelines.

Broader inclusion criteria to meet community demand

Beyond this pilot, an expansion of the inclusion criteria should occur in future conjoint counselling early intervention programs to partners who are past PAR participants (mandated or voluntary) who wish to stay in their relationship and for whom coercive control is not present.

Implementation guidelines

The pilot was based on a treatment and implementation manual (see Appendix 5). As a result of learnings during the pilot, it is now possible to clarify guidelines and suggested practices. Creating an updated set of guidelines will help ensure lessons learned during the pilot are translated to future therapists implementing EFT conjoint counselling.

Appendices

1. Business case for support
2. EOI for pilot site agencies
3. Steering committee membership
4. Conjoint counselling assessment areas and inclusion criteria
5. (a) Conjoint Couples Therapy treatment manual and (b) CFSPD Conjoint Counselling manual
6. HITS Domestic Violence Screening Tool
7. Couples Satisfaction Index CSI
8. A summary of expenditures (estimated and actual project budget)
9. Evaluation framework

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