June 2023 | **Report**

Domestic abuse programmes for children & families

PROGRAMME PROMISE & EVALUATION FEASIBILITY

Foundations
What Works Centre for Children & Families

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Acknowledgments

We'd like to acknowledge the contribution of several groups to this project.
We would like to extend particular thanks to the four delivery partners who partnered with us on this work. We would like to thank the practitioners and parents that took part in interviews and focus groups for their invaluable insight. We appreciate the time and effort each of you gave.
Our Head of Practice Development, Nimal Jude, for social work practice and groupwork expertise, for supporting the theory of change workshops, and being on hand for reflective conversation throughout the project.

Our Expert Advisory Group, who offered valuable guidance throughout the design and delivery of the project. We hope they will remain with us for future work in this space. Four freelance researchers supported us with at-pace analytic work on the qualitative data.

We would also like to thank Foundations colleagues past and present for their contribution to this project, including: Tash Marsh for organising us; Anna Bacchoo for practice advice and as our safeguarding lead; Katherine Osthwaite for policy and outreach; Olivia Martin for her practice knowledge; and Kelly Kettlewell, Aleisha Clarke, Eleanor Briggs and Stephanie Waddell for their work in shaping the direction of the project.

About Foundations - What Works Centre for Children & Families[1]

At Foundations, the national What Works Centre for Children & Families, we believe all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home and lead happier, healthier lives.

Foundations was formed through the merger of What Works for Children's Social Care (WWCSC) and the Early Intervention Foundation (EIF).

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[1] If you'd like this publication in an alternative format such as Braille, large print or audio, please contact us at: communications@foundations@org.uk

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ABBREVIATIONS AND ACRONYMS

Abbreviation	Description
AVA	Against Violence & Abuse
DA	Domestic Abuse
DSAs	Data Sharing Agreements
DfE	Department for Education
EDIE	Equality, Diversity, Inclusion and Equity
EYA	Early Years Alliance
IDVA	Independent Domestic Violence Advisers
WWEICSC	What Works for Early Intervention in Children's Social Care

EXECUTIVE SUMMARY

Introduction

Domestic abuse is highly prevalent, affecting as many as one in five children. It is the most common reason for referrals to children's social care. Research has found consistent associations between children's exposure to domestic abuse and an increased risk of negative behavioural and health outcomes.

However, the evidence base regarding the effectiveness and cost-effectiveness of programmes to improve outcomes for children exposed to domestic abuse in both early intervention and children's social care is insufficiently understood. As a result, there is a scarcity of evidence on "what works" for children who are exposed to domestic abuse.

In response to this, Foundations completed work for the Department for Education to start building a pipeline of evidence to understand "what works" in this space. This brief study sought to lay foundational knowledge and feed into the wider research aim of improving the effectiveness of the domestic abuse system and programmes, by addressing challenges with evaluation capacity and capability, and enhancing the wider evidence base on domestic abuse that can apply to other local areas and programmes.

Objectives

The key aims of this study were to:

- Better understand programmes being delivered to reduce domestic abuse and to lessen its harmful effects on children, including the mechanisms/processes leading to the intended or perceived outcomes of the programmes
- Explore the evidence of promise of the programmes we worked with, and the acceptability of the programmes for the stakeholders involved
- Explore the readiness for impact evaluation of the programmes we worked with.

Methods

We explored the feasibility of programme delivery and evaluation, and readiness for impact evaluation through:

- Theory of change development via a workshop with stakeholders and qualitative interviewing with practitioners and beneficiaries (i.e., parents who have or currently are taking part in the programme)
- The collection of administrative data, or exploration of the conditions needed to do so.

Foundations worked with delivery partners to explore why their programme is necessary, what it aims to achieve, and how. Following the workshop with stakeholders and practitioners, the theory of change for each programme was updated and further desk research was carried out to underpin and develop this.

Following the theory of change workshops, a series of interviews were conducted with professionals within the delivery partner organisations (22 interviewed across the four sites). Those involved in interviews were sampled to reflect a range of roles and levels of seniority within the organisations. Where possible, a small number of interviews with beneficiaries were conducted (six interviewed across two sites). Interviews were analysed thematically, by comparing accounts and identifying themes and patterns within and across the dataset for each programme.

Researchers also sought to gather administrative and monitoring data from the delivery partners to meet two objectives: to test the feasibility of evidencing outcomes; and to explore how acceptable and scalable the programme is.

Findings

This report is intended to inform future evaluation in the domestic abuse sector and, though it is recognised that there is evidence of promise and acceptability for each of the four programmes, it is not intended to provide evidence of findings about specific programmes or delivery partners. The findings in brief below summarise key factors and commonalities we found across the four programmes.

Outcomes and mechanisms

Across the four programmes, there was variation in who was described as the main beneficiaries of the programme and why. Where some focus their understanding of outcomes almost entirely on children, others focus on one or both parents, others a combination of the two. Across the four programmes, there were clear themes that were repeatedly named as key outcomes. These were often described as intertwining, i.e., as mechanisms to other outcomes as well as outcomes themselves. These include: increased safety; improved wellbeing or mental health; improved relationships; improved motivation; improved emotional regulation; and improved engagement with (other) services.

Child outcomes were frequently described as directly influenced by parent outcomes. This was particularly important in terms of the parent/s improving their communication and self-regulation, which in turn better enables them to support the child with theirs. Indeed, emotional regulation was described as a "gateway to all other outcomes" for parents. Developing these skills, and passing on the benefits, was seen to occur as a result of the safe environment, education and tools provided to parents, which enables them in turn to provide a safe environment and respond to their child's behaviour from a place of understanding, attunement and improved communication skills, that enable the child to feel validated too.

Implementation

Several key **barriers** to effective implementation were identified. On an individual beneficiary level these included:

- Fatigue with service engagement
- Substance misuse and/or mental health problems
- Concerns about interacting with others in the local community in group settings
- Beneficiaries moving out of the programme catchment area
- Having to take time off work or school to engage with the programmes
- Parents not giving consent or support for their child to engage in the service.

At an organisational level, the following key barriers to effective delivery were identified:

- Staff turnover, both in local authorities or within delivery partner organisations
- High thresholds and level of risk for beneficiaries to qualify for the programme
- Lack of resource for wider workforce development and opportunities
- Language barriers.

A number of **enablers** were also named as aiding successful delivery of outcomes. On the individual beneficiary level, these included:

- Prior therapeutic work has been undertaken which can aid with programme engagement/ effectiveness
- Programme is flexible in response to individual needs
- Confidentiality is ensured
- Location of programme is convenient
- Low-cost activity resources.

At the organisational level, enablers to successful delivery of outcomes included:

- Multi-agency working
- A multidisciplinary approach
- Adequate funding and resources
- Understanding in local services of a trauma-informed approach.

Several contextual factors and adaptations, i.e. adaptions for groups with different needs, were noted that may be worth exploring in future impact evaluations or implementation and process evaluations.

Generally, practitioners saw the potential for rolling out their services, though they described several necessities for this to be acceptable and viable. These included considering the needs of new populations, local contexts and communities to reflect in adaptations to the service. Relatedly, it was felt that manualisation should not be rigid to allow for this. Delivery partners emphasised the need for a skilled workforce who can maintain fidelity, while accounting for staff turnover. They also reiterated that funding needs to be sufficient, and there needs to be good relationships with partners in local areas.

Perceptions of impact evaluation

Delivery partners generally monitored outcomes, or data relevant to outcomes, using a host of data sources including referral information, demographic information and qualitative data, and using validated measures for outcomes. Additionally, non-validated measures were used by practitioners. Further discussion of the tools used for measuring outcomes is available in the main report.
There was a general understanding that it's important to pilot and evaluate new services, to improve support for children and families, and a concern that key outcomes are not currently measured as well as they could be. There was a strong view that removing programmes or withholding services from at risk families who need them in order to accommodate research design (e.g. control group in a standard randomised control trial), is not acceptable. However, opportunities for further impact evaluations are discussed in the main report below, including further discussion of randomised control trials and quasi-experimental designs – i.e. random assignment to the programme or service as usual, or comparing the outcomes of the group taking part in the programme to another group of people who are not, for example in another borough. Several barriers and enablers to impact evaluation are discussed in the full report.

Conclusion

This project has generated a wealth of learning about the evaluation of domestic abuse programmes. We provide our "lessons learned", what we see as the next opportunities for research in this space, and key considerations for moving forward with pilot evaluation.

Lessons learned

These included the recommendation that there must be significant time and capacity accounted for the preparation of future evaluation work, especially around data sharing agreements. On outcomes, there was broad agreement that parent outcomes feed into child outcomes, and there was significant alignment on the key outcomes and mechanisms.
The sector may benefit from focusing on agreeing key outcomes alongside an exploration of the key concepts underlying mechanisms. This will aid in the selection of validated outcome measures to be used more widely and consistently. Emotional regulation in particular should be explored as this was felt to be the most challenging to monitor using validated measures.
The complexity of some domestic abuse programmes poses challenges and opportunities for evaluation. Further theory-of-change development and feasibility and pilot testing would be useful for a wider range of domestic abuse programmes.

Opportunities

The opportunities for future work that we highlighted included testing new programme modules alongside treatment as usual, rapid cycle testing of new programme content, and testing of cultural adaptations to programmes. We also suggest new geographical roll-out of a full programme, or programme module where it is already well codified or manualised – this could also include models from outside the UK which show promising evidence, i.e. from the US. These approaches need testing for viability and acceptability on a smaller scale initially, via pilot impact studies.

Key considerations for moving forward with pilot evaluation

These included the need to balance the importance of flexibility in delivery of a programme with the need for consistency and fidelity in impact evaluation. Factoring in adequate timelines, funding and staffing issues. Relationships and building shared understanding will be crucial to success. Some practitioners showed a strong interest in exploring the potential for making better use of qualitative research in exploring impact.
Finally, there were several insights that, while not rigorously grounded, may prove useful for government, commissioners and programme providers to consider:

- Providing adequate and focused support for staff in local authorities as well as for delivery partners, to enable more people to spot the signs of abuse and make the right referrals
- Training in how to respond to those experiencing the different forms of domestic abuse may also help to create a more joined-up system across multiple agencies within family help and children's social care leading to better experiences and outcomes for those in need of support. This is a topic ripe for intervention development and evaluation.

Further, other services are important in the local area to work alongside domestic abuse programmes, such as social housing, substance misuse and mental health services, to provide the support that is needed before, during and following a domestic abuse programme for it to be as effective as possible. More widely, attention also needs to be focused on:

- Access issues such as the variation in offer across areas
- Difficulties in transitions for those fleeing domestic abuse
- The availability of translators.

BACKGROUND

Domestic abuse is highly prevalent, affecting as many as one in five children. It is the most common reason for referrals to children's social care.[2] Children and young people exposed to domestic abuse are at an increased risk of negative behavioural and health outcomes. Research reports consistent associations between children's exposure to domestic abuse and anxiety and depression, behavioural problems, poor academic attainment, risky health behaviours (including misuse of drugs and alcohol), and other physical health consequences (Howarth et al, 2016; Royal College of Psychiatrists, 2017; UNICEF, 2006), as well as likelihood of experiencing abuse in their own relationships (ONS, 2017).

However, the evidence base regarding the effectiveness and cost-effectiveness of programmes to improve outcomes for children exposed to domestic abuse in both early intervention and children's social care is insufficiently understood. Local authorities and voluntary sector organisations have developed a wide range of programmes and services, yet there has been very little robust impact evaluation of these. One particular challenge is the lack of consensus about which outcomes should be prioritised by services or how to measure them. This variability significantly hampers attempts to compare different programmes in terms of their effectiveness or to draw out widely applicable lessons for those working in the sector (Howarth et al, 2015). The majority of "outcomes" used by services are process measures (for example, referrals to a service, engaging with a service, completing a service) rather than anything which is a specific reduction in risk or an improvement in child safety or wellbeing.

As a result, there is a scarcity of evidence about "what works" for children who are exposed to domestic abuse. In response to this lack of evidence, Foundations completed work for the Department for Education to start building a pipeline of evidence to understand "what works" in this space. The first part of this ongoing body of work was to conduct exploratory work with four programme providers across England to better understand what is being delivered to support children and families affected by domestic abuse, and the feasibility of robust evaluation of these programmes.

This brief study sought to lay foundational knowledge and feed into the wider research aim of improving the effectiveness of the domestic abuse (DA) system and programmes, by:

- Addressing challenges with evaluation capacity and capability
- Enhancing the wider evidence base on DA that can apply to other local areas and programmes.

[2] In 2020/21 domestic violence was the most common factor identified at the end of assessment for children assessed by a local authority. This reflects cases where a child has been referred for assessment.

Research aims

The key aims of this study were to:

- Better understand programmes being delivered to reduce domestic abuse and to lessen its harmful effects on children, including the mechanisms leading to intended or perceived outcomes
- Explore the evidence of promise and acceptability of the programmes we worked with
- Explore the readiness for impact evaluation of the programmes we worked with.

Research questions

The feasibility study sought to address the following research questions.

Programme promise and feasibility

a. What potential impacts of the programmes do different stakeholders identify?
b. How acceptable is the programme to different stakeholders?
c. How effectively does the programme appear to meet the needs of families?
d. Does there appear to be any unintended consequences or negative effects? (How) Can these be mitigated?
e. Is there evidence to support or extend our understanding of the theory of change for each of the programmes i.e. the mechanisms or conditions leading to desired outcomes?

Evaluation feasibility

f. What is the likely timeframe to achieve a given sample size and what conditions need to be in place to achieve this, i.e. capacity of staff, acceptability of evaluation to different stakeholders, recruitment strategies, retention and drop-out rates and perceived causes?
g. Are there likely to be any unintended consequences or negative effects of evaluation? Will these effects impact some groups more than others? (How) Can these be mitigated?

Readiness for impact evaluation

h. What outcomes should be measured and how readily available is the data to do so?
i. How well understood and acceptable to stakeholders are the different options available for evaluation?
j. How well understood and acceptable to stakeholders are different levels of randomisation of different stakeholders?
k. Are providers able to support an evaluation while delivering the programmes? How could this be enabled?

Selection of delivery partners

Foundations released a call for evidence partners in July 2022. Applicants were asked to provide a programme description and any evidence available on the programme. We sought to work with

those who focus on early intervention or children's social care programmes. Specifically, we sought to work with partners that deliver programmes that fall under the following categories:

- Parenting programmes for parents who have been identified as at risk of domestic abuse
- Parenting support for families experiencing domestic abuse which aims to help parents understand how family violence and abuse is negatively impacting their child/children
- Therapeutic support for children who have experienced domestic abuse
- Advocacy, mentoring, or relationship building support for children who have experienced domestic abuse
- Perpetrator programmes which aim to change the attitudes and behaviours of perpetrators, which also have a focus on children's experiences and outcomes.

Once the call for partners closed, a Foundations team – with a range of experience and backgrounds – scored applicants on criteria which included:

- A strong programme description
- Whether it was part of a DfE priority such as interventions for children aged under one year
- A clearly defined target population
- A clear description of equality, diversity, inclusion and equity (EDIE) considerations
- Whether the programme has already been implemented
- A plausible theory of change, and the extent to which it is evidence based
- Whether a primary outcome focused on the child
- Potential for impact
- Feasibility of implementing the programme (i.e., whether feasibility had already been demonstrated through monitoring and evaluation, judged promising through similar interventions, plausibly feasible, or considered not feasible).

Applicants that met most of these criteria were then shortlisted.
In addition to these criteria, the shortlisted pool of applicants was chosen to ensure a variety of different local areas and programme characteristics, including but not limited to:

1. Local area characteristics such as deprivation, region, ethnic minority population percentage
2. Target population characteristics such as child age groups, perpetrators and/or survivors, types of domestic abuse perpetration, children's social care environment, EDIE considerations (such as cultural adaptations, serving LGBTQ+ populations)
3. Programme characteristics such as delivery setting, psychological therapeutic underpinnings, delivery dosage, multi-agency working, and extent of whole-family approaches.

Final decisions were completed in October 2022 following a scoring and ranking exercise that identified the top four programmes. More information on these can be found in Appendix A.

Terminology

Different terms are used within the sector and literature to describe violence that occurs in interpersonal relationships, including “Domestic Abuse”, “Domestic Violence and Abuse” or “Intimate Partner Violence”. This report used the term Domestic Abuse to align with the terminology used within the wider government and policy framework, but with an understanding that this would be interpretated in the most comprehensible manner to encompass all forms of interpersonal abuse and violence.

Similarly, terminology used to refer to projects that aim to prevent domestic abuse or support families who have/are experiencing it is varied across the sector and literature (e.g., “interventions”, “programmes”). This report uses the term “programmes” and “delivery partners” when referring to the four sites we worked with during the research.

Finally, the delivery partners we worked with used a range of terms to refer to those who take part in their programmes or services including “service users”, “clients”, “participants” and “beneficiaries”. This report uses the term “beneficiaries” when referring to those who took part in the programmes proposed by the four delivery partners.

METHODS

This study received ethical approval from the Foundations ethics committee in November 2022. The protocol and detailed methodology, including a summary of the ethics review process, for the study can be found on the Foundations website.[3] Partner selection ran alongside the development of our research protocol, and our approach was adapted in partnership with each of the four delivery partners as we worked with them between November 2022 to March 2023. Each delivery partner was assigned a lead researcher within the Foundations research and evidence team, who was their main point of contact throughout.

Expert Advisory Group

An Expert Advisory Group was formed at the beginning of the project to support decision-making throughout. The group comprised academics, experts by experience, professionals in relevant voluntary sector organisations and representatives from the DfE. The group met during the initial stages of the project to advise on the design of the study. Group members separately provided input on researcher training, and recruitment and interview materials.

Theory of change workshops

As a starting point, Foundations worked with the delivery partners to explore why their programme is necessary, what it aims to achieve, and how. This workshop sought to establish a shared understanding among the various roles in the delivery partners, including those in developer, delivery and administrative roles and of varied levels of seniority, as well as the research team delivering the study. The design of the four tailored half-day workshops were informed by an initial review of available documentation about the programme beforehand. The workshops sought to broadly cover the following:

1. Introducing a theory of change, facilitators and participants
2. Why is the programme needed (and what needs does it address)?
3. Who is the programme for (and who does it not include)?
4. What outcomes are sought to be achieved by the programme?
5. What are the key activities and how do they enable the outcomes, i.e., mechanisms?
6. What are the potential unintended consequences?
7. What are the barriers and enablers to effective implementation?
8. What are the contextual factors that affect the programme's design and implementation?
9. What outcomes should be measured and how feasible is collecting this data?
10. How sustainable is this programme? What factors impact this?

The core workshop guide, which was subsequently tailored to each programme, can be found in Appendix B. Following the workshop, the theory of change for each programme was updated and further desk research was carried out to underpin and develop this. These were utilised to inform

[3] See https://whatworks-csc.org.uk/research-project/domestic-abuse-interventions-in-childrens-social-care/

the ongoing work (see below) and were provided to the delivery partners to aid their own thinking and theory of change development.

Interviews

The theory of change workshops and accompanying desk research informed the development of interview guides for a series of interviews with professionals within the delivery partners. These interviews sought to develop a greater understanding of:

- Perceived or evidenced outcomes
- Perceived or evidenced mechanisms of outcomes
- Effectiveness and acceptability of the programme
- Potential unintended consequences of the programme
- Barriers and enablers to effective implementation
- Acceptability of evaluation
- Barriers and enablers to evaluation, and mitigation of barriers.

Again, those involved in interviews were sampled to reflect a range of roles and levels of seniority within the organisations.

Following interviews with professionals, where possible, a small number of interviews with beneficiaries were conducted. These interview guides, and the accompanying engagement and safeguarding approaches, were initially developed by the research team, then reviewed by the Expert Advisory Group and professionals from the partnering organisations. They were then adapted according to feedback prior to use. Interviews with beneficiaries sought to answer key questions, but also to inform future practices for interviewing those who have been exposed to domestic abuse in future Foundations studies. Prior to conducting the interviews, researchers were trained in safeguarding, sensitive interviewing skills, informed consent, and researcher welfare, as well as engaging in briefings and peer support to practise working with the tailored interview guides.

Both core interview guides, adapted to each programme, can be found in Appendix C.

Administrative data

Researchers also sought to gather administrative data from the delivery partners to meet two objectives:

1. To test the feasibility of evidencing outcomes (including the quality, and relevance to outcomes, of data that is currently collected by the delivery partners).
2. To explore how acceptable and sustainable the programme is (e.g., the costs of the programme training resources and timing, staff turnover and recipient retention, satisfaction or attitudinal measures used prior to and following the programme).

We were not able to meet these objectives to the extent we had hoped. The barriers to undertaking this work differed between the sites. For some, barriers included difficulties surrounding data protection processes, such as privacy notices and data sharing agreements. Others struggled with

adequate capacity and time to identify and gather the relevant data within the timeframe. In light of this, we adapted our approach and strove to gather a limited amount of data, e.g., one or two timepoints from one or two cohorts of beneficiaries to provide insight into these questions. Where this was not possible, we explored questions on the data through interviews. The team sought to explore the potential for future data collection through discussion while gathering lessons learned from the process of attempting to gather this data in partnership with the delivery partners.

Other data sources

Alongside workshops, interviews and administrative data gathered with each of the four delivery partners we worked with, we also:

- Held three focus groups that brought together professionals from across the four sites, exploring use of beneficiary data in local practice and systems. These sought to explore the current availability, collection and use of beneficiary data in detail, as well as the capacity and appetite for linkage across agencies within an area (or wider). While our feasibility work focused on exploring each site individually, this strand of work sought to bring together insights and share learning across the four organisations regarding data availability and sharing.
- Case studies were also generated from the wider research literature on steps to take to improve evaluation of domestic abuse programmes.
- An evidence review was commissioned by Foundations and carried out by Oxford University, which aimed to: (1) identify "what works" in improving outcomes for children (for example, children's emotional wellbeing); (2) identify barriers and facilitators to implementing services for children exposed to domestic abuse and their families and what is needed to help achieve fundamental changes; (3) identify what makes it more difficult or easier for parents, children or families to get involved in a service, complete it and achieve their goals.

Analysis

Workshops

Researchers took notes during workshops alongside updating a live theory of change, which aided the discussions. These notes were utilised alongside desk research to aid updates to the theories of change and inform interviews and administrative data requests.

Interviews

Interviews were largely transcribed by a professional third party. Where this was not possible – due to technical problems with audio recording – notes were taken by the interviewers. Pseudonymised transcripts, or notes, were entered into NVivo software to conduct a thematic analysis, comparing accounts and identifying themes and patterns across the dataset for each programme. The thematic approach followed the widely used cyclical stages of thematic analysis: familiarisation with data, generation of codes, searching for themes, reviewing themes and defining themes (Clarke, Braun & Hayfield, 2015).

Coding of the transcripts utilised a deductive coding framework, which was designed using the research questions and known key findings. Initial coding was conducted by the lead Foundations researchers assigned to each of the four programmes alongside four freelance researchers, one of whom was assigned to each of the four programmes. The initial deductive coding framework can be found in Appendix D. Following initial double-coding of transcripts, which enabled all involved to change or build additional codes, most of the coding was then carried out by the assigned freelance researchers. Coding was largely conducted independently by the four freelance analysts (i.e., the four programmes) with a small number of meetings to align coding frameworks and share reflections, building inductive codes into the deductive framework as appropriate.
Following this, the Foundations researchers assigned to each of the four programmes generated a summary report that reflected the findings for each of their respective programmes. These summary reports were written for internal use only, to inform ongoing discussions internally and with the organisations, and to utilise as a basis to form this report. The senior researcher then analysed these reports, summarising key findings across all four programmes, providing an output that reflects the aims and limitations of the work.

Administrative data

To inform the summary reports, a brief paper was written by the research team using either the administrative data gathered, or notes from informal discussions where this was not possible. These were structured around the following key questions, for each of the four programmes:

- What data does the provider collect, and how well does this align with evidencing intended (short- or long-term) outcomes?
- How well does the programme appear to be delivering the intended outcomes?
- How well could the data that is currently collected by the provider evidence outcomes in the future?
- What drives decision-making in terms of what providers collect and share?

Equality, diversity, inclusion and equity (EDIE)

As part of our organisational strategy to prioritise equality, diversity, inclusion and equity in our work, our project team committed to several principles and associated actions within the research project. The learning from this will inform future research and strives to address societal inequality in our approach to this research project, with the hope to influence beyond it as well. Our aims, which can be found in detail in the protocol,[4] included:

- Reflecting diversity in lines of questioning: striving to explore differing characteristics and intersectionality in terms of experiences and outcomes for beneficiaries
- Challenging bias in narratives: continually consulting literature, peers and those in advisory positions to challenge assumptions regarding domestic abuse
- Reflexivity: embedding a reflexive process through delivery and analysis.

[4] See https://whatworks-csc.org.uk/research-project/domestic-abuse-interventions-in-childrens-social-care/

Reflexivity[5]

This project was commissioned and funded by the Department for Education and was therefore partly led by their policy priority areas. It was also the first time that What Works for Children's Social Care and the Early Intervention Foundation, who have since merged into one organisation, had partnered on a project together, which meant marrying our aims and objectives. While reflexivity was a relatively new practice to some of the team, the merged organisation is increasingly placing emphasis on reflexivity and formalising the process in our work. We aim to learn from this work for future projects.

Reflexivity was an ongoing process through the project, with researchers encouraged to reflect on their decisions at different stages and discuss these with other members of the group. During fieldwork planning and activity, formalised reflexive group discussions were facilitated by a colleague not involved in the project who is experienced in reflexivity in qualitative research. In these discussions, we took time to consider the way our experience, knowledge base and assumptions may impact on the project. We also reflected on the ways in which we may be biased by the relationships we had with the programme developers and practitioners. We then shared some of our reflections among the group. Freelance researchers also took part in reflexive discussions.

Members of the research team involved in interviewing were particularly sensitive to the fact that the research topic is deeply personal and could provoke anxiety or distress in participants, particularly victims/survivors. Researchers did a positionality exercise and spent time acknowledging our social position, our power dynamic as researchers, and the way we may present to participants – including how our gender, ethnicity and socioeconomic background may be perceived. This involved considering the ways in which we are both insiders and outsiders, including any lived experience of domestic abuse we have, and how this might impact the way we view the research and the emotional impact it may have on us.

By weaving reflexivity throughout the research process, we increased our awareness and paid critical attention to how our subjectivity and personal and organisational context influenced our work. We aimed to ensure this did not negatively impact on our work, particularly in our interactions with beneficiaries.

[5] Reflexivity refers to the researcher's awareness of and reflection upon their own values, biases, assumptions, and personal experiences that may influence the research process and findings. It involves acknowledging the potential impact of the researcher's subjectivity on all stages of the research, including the formulation of research questions, data collection, analysis, and interpretation.

FINDINGS

Introduction

This report is intended to inform future evaluation in the domestic abuse programme sector and, though it is recognised there is evidence of promise and acceptability for each of the four programmes, this report is not intended to provide evidence of findings about specific programmes or delivery partners. The report is therefore intentionally brief and seeks to present key findings across all four programmes that will be useful to future evaluation. We do not provide evidence regarding the impact or implementation of the individual programmes; this was not what our project set out to do. While the above questions drove the research throughout the lifetime of the project, lines of questioning were refined on an ongoing basis in line with learning around conducting feasibility work (which is a new practice for the organisation) and while designing the report to be as useful as possible. Though organisations provided more data in some areas than others, all organisations contributed significantly to the data generated regarding outcomes, mechanisms and implementation, and on the potential for impact evaluation.

Programme descriptions

Children Overcoming Domestic Abuse (CODA) is a psychoeducational, recovery-focused programme for mothers and children who have experienced domestic abuse. *CODA* is licenced by Against Violence & Abuse (AVA), while this report focuses on *CODA* as delivered by the Early Years Alliance (EYA) in Lewisham, London. *CODA* takes a multi-agency approach to service provision, staff include children's social care practitioners, health visitors, family practitioners, staff from voluntary organisations and charities, midwives, school staff, nurseries, therapists and police officers. The group-based programme provides 12-weekly sessions, each covering a specific theme. The mother and child sessions are held separately but run concurrently. Children are aged 4–11 years, with groups organised by age group. The programme aims to enhance child-centred thinking for mothers and increase emotional literacy in children to enable them to process their feelings in response to domestic abuse. Aims also include creating safety plans.

For Baby's Sake is a trauma-informed, attachment-based therapeutic programme, integrated within local adult and children's services and working with all relevant stakeholders, including domestic abuse and child safeguarding services and systems, GPs, health visitors, midwives, probation officers, and so on. The vast majority (79%) of potential participants are referred by children's social care services. *For Baby's Sake* provides intensive, individual support for each parent (the person experiencing the abuse and the parent perpetrating the abuse), their baby and any other children, tailored across a number of modules. The programme aims to improve birth outcomes, babies' social, emotional and cognitive development, parental and infant mental health and emotional wellbeing, sustained behaviour including reduction in risk and fewer domestic abuse incidents, and to reduce contact with children's social care.

LEAP Enhanced Casework Service is a programme for parents/carers who are experiencing, or at risk of, domestic abuse during pregnancy or before their child's 4th birthday. Lambeth Early

Action Partnership (LEAP) commissions Refuge to deliver Enhanced Casework as part of The National Lottery Community Fund's 'A Better Start' initiative, and the service is embedded within Lambeth's Violence Against Women and Girls Community Service. A small team of Enhanced Caseworkers works alongside other agencies and services to proactively identify and engage parents as early as possible. The team provides practical and emotional support, working with parents – primarily mothers – in a holistic, trauma-informed and client-led way, without time limits. This can include connecting to services such as housing and financial support. Group work is also offered, allowing mothers to focus on their wellbeing and reducing isolation. The aim is for victims and survivors to have improved wellbeing and feel they are safe and moving in a positive direction, and for their children to have a better environment in which to grow and thrive.

Family Action Survive and Thrive Integrated Children's Service in Bradford provides support for children and families. It is part of a consortium bringing together 3 charitable organisations commissioned to provide Bradford Council's Domestic Abuse Services. Referrals are made via the Survive and Thrive One Front Door. They work with children (aged 5-18), their parents and sometimes other family members and professionals to provide tailored support that addresses their needs, builds on their strengths, and creates resilience for the future. The project is delivered by children and family workers, play and attachment workers, qualified systemic practitioners, a qualified children's IDVA and a trained trauma therapist. They deliver a range of tailored activities, including psychoeducation and trauma-informed work. They aim to increase children's feelings of safety and security while rebuilding family relationships, reducing trauma symptoms and strengthen parent child attachment. Trauma processing can also be offered by their trauma therapist.

For more detail on each programme see Appendix A, and we recommend that interested readers visit the websites to explore each programme in more detail. To provide more context to the findings, below is a brief combined description of the four programmes.

All four programmes are based in locations across England. Two are based in one local authority district only and two are based across multiple areas in England, including one that utilises phone and video calls to host therapeutic sessions with parents in certain parts of the country. Several of the programmes cover areas with high levels of deprivation, low-income households, ethnic minority populations and families with English as an Additional Language, and at least two target those in rural as well as urban areas. Business-as-usual varies for the range of programmes that are based in different areas, according to the local services that are commissioned and are available (see the Domestic Abuse Commissioner's Office report, "Patchwork of Provision", which maps domestic abuse services across England and Wales).[6] Individual sites described different relationships with the business-as-usual services in their area. Two sites described their own services as "add-ons" that are meant to complement already existing specialist services. Though some of those programmes, and the two based only in one area, were described as offering

[6] See https://domesticabusecommissioner.uk/wp-content/uploads/2022/11/A-Patchwork-of-Provision_Technical-Report_Nov-2022_Final.pdf

something unique, e.g. bridging of adult and child elements of support and having a child-centred focus or an additional focus on 1:1 support.
The aims of the four programmes broadly focused on supporting those who have been exposed to domestic abuse, with two focusing largely (though not exclusively) on women and children, and the two others taking a whole-family approach, i.e. involving both parents. One had a strong focus on recovery and was aimed at those not in crisis or immediate risk, another focused on outreach and a client-led flexible programme, where the other two focused on therapeutic programmes that varied in length and intensity to break cycles, address trauma and support beneficiaries to overcome relationship difficulties. As is discussed below, there was a great deal of crossover in ethos, including being trauma-informed, flexible to adaptation and tailoring, focusing on strengths and being client led. Some programmes were developed using a place-based approach, i.e. taking into account the specific needs and social factors that shape the community in their geographic area. Other programmes were implemented in areas outside of the local context where they were originally developed; however, all aim to be flexible and adaptive to the communities they serve.
Structure of the programmes varied greatly across the four delivery partners we worked with, with different levels of stability and/or developmental maturity, manualisation[7] and complexity:

- Two programmes were considered fairly mature, relatively well defined and stable in their delivery. They were also manualised and operating across several areas (although our study has focused on delivery in specific areas and contexts). The other two programmes were at an earlier stage of development, developing and/or refining their programme blueprints as they were implementing the programme for the first time.
- However, most programmes – regardless of their level of maturity and manualisation – were described as complex, requiring at least some degree of dynamic implementation to ensure they were sufficiently tailored to meet the needs of individuals and participants.

Sample

The theory of change workshops involved a minimum of five practitioners across a range of roles and levels of seniority, with most workshops involving approximately ten practitioners.
The research team then strove to interview five to eight practitioners in each delivery partner organisation, again at differing levels of seniority and in different roles or parts of the service. Where partnering organisations were willing and able to support us, we also strove to invite two to three beneficiaries to be interviewed so that we could both hear about the programme from their perspective, and to learn about how best to engage beneficiaries of domestic abuse programmes in future studies. The following table sets out how many practitioners and beneficiaries were interviewed in total.

[7] Manualisation refers to the process of outlining the specific procedures involved in a programme to serve as a standardised guide for practitioners who are delivering the programme. This aims to ensure consistency and fidelity across different settings and individuals.

Table 3.1. Number of interviews per programme

Programme number	No. of practitioner interviews	No. of beneficiary interviews
1	6	2
2	6	4
3	4	0
4	6	0
Total	**22**	**6**

Outcomes and mechanisms

The research team sought to answer the following refined questions regarding outcomes and mechanisms:

- What potential impacts of the programme do stakeholders identify?
- How well is the programme perceived to be meeting service user needs?
- What outcomes are felt to be most achievable and/or important? Why?
- Are there any unintended consequences, and how are they mitigated?
- What are the perceived, or known, mechanisms that lead to identified outcomes?

While this study was limited by a self-selecting sample of participants, those we spoke to were open to discussing barriers to outcomes and potential unintended consequences as well as more positive aspects of the programmes. That being said, all participants were selected directly by delivery partners in a convenience sample.

Across the four programmes, there was variation in who was described as the main beneficiaries and why. Where some programmes focus their understanding of outcomes almost entirely on children, others focus on one or both parents, others a combination of the two. Interestingly, some practitioners were reluctant to describe outcomes that cannot be evidenced as part of their programme as part of their theory of change. This was driven partly by a discomfort in assuming that long-term outcomes that are hoped for will come to fruition for all who take part in the programme, or if the outcomes were regarding someone who does not directly interact with their programme, e.g. children, where the programme's delivery focuses only on parents.
Across the four programmes, there were clear themes that were repeatedly named as key outcomes. These were often described as intertwining i.e. as mechanisms to other outcomes as well as outcomes themselves. Practitioners often did not feel comfortable prioritising one outcome (or mechanism) over another, as they "feed into each other" and it was felt all were important. The following sections outline the key outcomes according to the frequency and strength with which the topic came up across all interviews in all programmes. For this reason, outcomes that apply to both

parent and child are prioritised. While the following describes all key outcomes discussed in interviews, it is noteworthy that many of the key outcomes described separately for both parent and child also overlap, and that child outcomes were frequently described as being achieved through the parent outcomes.

Increased safety was described as a key outcome, achieved via risk assessment and practical safety planning. Basic survival improvements were also noted as important by some delivery partners, such as access to donations, e.g. via foodbanks. The word safe or safety often featured as a descriptive term for environments and relationships that formed part of the programme, with participants describing the importance of *feeling* safe, as well as having practical issues resolved or eased, as a contributor to other outcomes.

Improved wellbeing or mental health, including specifically addressing trauma symptoms, was also described as a key outcome. Though it was noted that this outcome is fragile and dynamic, as it can shift rapidly depending on changing personal circumstances, e.g. relationship or financial difficulties. Improved wellbeing was thought to be influenced by a number of other outcomes, including improved relationships and safety. Some participants described the importance of clients being provided with a space to prioritise focusing on themselves (which they may not have previously been able to). Improved wellbeing, relationships and safety can also help to improve confidence. That improved confidence then enables clients to seek support from other services, which can then reinforce other positive outcomes like wellbeing, and so on.

Improved relationships were described as a key outcome, both in terms of relationships among a family where one or more members is receiving a service, and in terms of building relationships more widely with peers, the community or professionals. Within these discussions, the importance of reducing isolation, “breaking silence” and validating emotions was often highlighted; by feeling connected to and understood by others. Again, improved relationships were described as both a mechanism to other outcomes as well as an outcome unto itself, especially as it was perceived by some delivery partners as a means of maintenance and sustaining beyond the duration of the programme outcomes achieved during the programme. Building trust between programme practitioners and clients was described as especially important as this is the basis for the building of other relationships. This is felt to be achieved through the application of trauma-informed practice, which was frequently referenced, enabling clients to feel safe, heard, validated and empowered. Other techniques included providing choice and information, and a space to develop at their own pace. This experience contributes to them feeling safe and able to engage with the service, and those they are seeking to improve relationships with.

Motivation was felt to be an important mechanism for the intertwining outcomes, which is heavily influenced by the key relationships built with practitioners, along with learning about the impact of trauma and domestic abuse. Learning about the impact of domestic abuse on their children was felt to be a particularly important motivating factor for parents, and one delivery partner went so far as

to formally implement motivational interviewing[8] when beginning to work with parents. The same delivery partner, as well as others, made use of psychoeducation.[9]

As previously mentioned, child outcomes were frequently described as directly influenced by parent outcomes. This was particularly important in terms of the parent/s improving their communication and self-regulation, which in turn better enables them to support the child with theirs. Developing these skills, and passing on the benefits, occurs as a result of the safe environment, education and tools provided to parents, which enables them in turn to provide a safe environment and respond to their child's behaviour from a place of understanding, attunement and improved communication skills, that enable the child to feel validated too. Closely linked to wellbeing and emotional regulation, some interviewees raised the importance of reduced self-blame and increased self-esteem as crucial to a parents' recovery journey. This was described as both a key outcome and mechanism for some programmes. Becoming more child-centred in decision-making was also flagged as a key mechanism to developing the relationship between the parent and child. However, some practitioners felt that reducing self-blame and changing ways of thinking to be more child-centred may be more or less achievable for different parents, depending on their trauma history, substance misuse issues and history of mental illness.

Emotional regulation was also raised as a key outcome for both children and parent, which was described as a "gateway to all other outcomes" for parents. Key mechanisms for emotional regulation were described as addressing guilt and shame, through being reassured and validated while talking about past trauma, as well as learning about abuse and the effects of abuse, trauma and grounding techniques. A trauma-informed approach was often described as a crucial mechanistic approach to several outcomes, particularly this one, as it reduces potential feelings of judgement or rejection and enables the safe exploration of emotions and experiences. Linked closely to emotional regulation was emotional literacy and communication; an increased ability to recognise, share and process emotions which in turn meant that feelings are expressed in a non-harmful way, i.e., improved behaviours. Some delivery partners also highlighted the importance of "co-regulation", where the parent learns to understand their child's communications and cues, which then supports the child's emotional regulation. Emotional literacy was generally described as being achieved through psychoeducation and discussion about trauma, emotions and relationships. Deep therapeutic work was a key transformational mechanism for some delivery partners, with one in particular noting that it supported parents to identify their own patterns of abuse in childhood in order to address it and break the cycle for their own child. Emotional regulation was often linked to improved relationships, as it was felt that a parent who is better able to regulate their emotions can do the same for their child and through providing this support can repair or improve their bond and relationship.

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[8] Motivational Interviewing (MI) is a collaborative and client-centred counselling approach that aims to evoke and strengthen an individual's intrinsic motivation to change behaviour.

[9] Psychoeducation refers to an approach that involves providing individuals or groups with structured information, knowledge and education about psychological or mental health-related topics. It aims to enhance understanding, awareness and skills related to mental health conditions, treatment options, coping strategies and self-management techniques.

Improved engagement with (other) services was also raised as an important outcome. As previously mentioned, increased self-esteem and self-agency were identified as key mechanisms for improving willingness and ability to engage with other services. It was also noted that practising discussion of their experiences and emotions with others can help them to discuss these topics in new settings more effectively. A further mechanism described by participants was the relationship formed between the beneficiary and the practitioner they were working with, which helped to challenge and overcome difficulties in past relationships with services. Through engaging with specialist services, such as drug misuse support, this outcome can also act as a mechanism for improved wellbeing. An additional mechanism was creating changes to other systems. Two delivery partners noted that a critical part of their programme was to change the sort of stigma and give better training to other agencies that historically may have viewpoints perceived as "problematic" around domestic abuse.

To a lesser extent, other child outcomes were discussed, which were felt likely to be impacted by the above mechanisms, such as educational outcomes like school attendance or engagement, social and cognitive development, reduced impact of childhood adversity and trauma, and children and social care outcomes. Other parent outcomes noted as mechanisms for child outcomes were parents having healthy relationships and improved wellbeing and, as a result, improved social environments. Where parents were actively involved in a service alongside their child, or in supporting the child to engage, the importance of the parents enabling the young person to engage through psychoeducation was highlighted.

To a lesser extent, broader goals such as ending DA – e.g. controlling behaviour or reducing likelihood of experiencing DA in future – were discussed. Though these were generally noted as more difficult to achieve, and certainly more difficult to capture evidence for, compared to more short-term outcomes such as increased understanding of domestic abuse and its impacts and a decrease in fear.

A few key unintended consequences were also raised:

- Beneficiaries may become dependent on the service or have unmet needs when the programme comes to an end, particularly if there is no other support available to pass them on to and where current services cannot meet the level of demand. This is a gap in provision and may have negative consequences.
- There is an inevitable postcode lottery as not all postcodes are always included in delivery partner programmes, and this may exacerbate inequalities. Furthermore, some programmes may not address the needs of children of all ages creating inequity.
- Not all the other services that beneficiaries may be accessing take a trauma-informed or non-judgemental approach. This can be challenging to accommodate for practitioners and can negatively impact beneficiaries.
- Parents who do not have the emotional and psychological capacity to engage (for example by never undertaking previous therapeutic work themselves) and/or are not supported by change in other family members (for example the perpetrator) could be at risk of negative impacts due to the burden of the work and the responsibility for change falling on them.

Implementation

The research team sought to answer the following refined questions regarding implementation and contextual factors:

- What are the key barriers and enablers to identified outcomes?
- What adaptations are made, or key design features, for services working with people in particular places, circumstances or with specific demographics?

Barriers

Several key barriers to effective implementation were identified. On an individual beneficiary level these included:

- Fatigue with service engagement, particularly where beneficiaries have experienced labelling and judgement previously as this makes it harder for them to engage with new services.
- Substance misuse, mental health problems and triggering traumatic history issues can interfere with the ability of beneficiaries to maintain self-regulation once they have learned the skills to do so (during or following the programme).
- In a group setting, concerns about interacting with others in the local community may discourage taking part, or where this occurs can lead to early disengagement.
- A beneficiary may need to move area, and so no longer in the right catchment area to continue (and the new area may not have a similar service to refer them to).
- Having to take time off work or school were also key barriers for some beneficiaries, though having a workplace that is aware and supportive is also an enabler.
- Finally, where parental consent or support is required or preferred for a child to engage in a service, if they do not support the child to engage this can stop or hinder their engagement.

At an organisational level, the following key barriers to effective delivery were identified:

- Staff turnover in local authorities can lead to confusion or missed opportunities for referral, due to misunderstanding or simply not knowing about the programme.
- Staff turnover within delivery partners can lead to capacity problems, limiting the number of new cases that can be accepted.
- Limited funding, and therefore capacity, means that thresholds and levels of risk need to be high for beneficiaries to qualify as there isn't capacity to support more beneficiaries, meaning those who would benefit from support are not always eligible.
- A lack of resource for wider workforce development opportunities, such as training health visitors to spot signs of domestic abuse and make referrals.
- Language barriers presenting challenges, with interpreters not always available.

Finally, participants raised the barrier of societal stigma on multiple levels; both in terms of how this influences how others – including professionals – interact with those who have been impacted by domestic abuse, and in terms of how victim-blaming rhetoric acts as a barrier to beneficiaries reducing self-blame and moving forward in their journey.

Enablers

At the individual beneficiary level, the following enablers were explicitly named (outside of the mechanisms discussed in detail above and those forming part of the ethos, e.g. "whole-family approach" of specific programmes) as aiding in the successful delivery of outcomes:

- Therapeutic work has already been undertaken or is done so during or following the programme as most appropriate.
- Flexibility in response to individual needs within a manualised programme; for some, 1:1 work can be better than group work due to worry around community connections compromising confidentiality, or general anxiety around others. One-to-one work can also accommodate individual needs and the tailoring of the programme effectively; for others, group work is effective and peer support is a key appeal.
- Confidentiality, both from school and home as relevant.
- Convenience of location, i.e. a local or easily accessed setting.
- Low-cost activity resources, particularly where these are provided to participants.

At an organisational level, key enablers identified were:

- Multi-agency working; reducing risks and better enabling families to get the right help at the right time. This was described as better value for money, and linked to:
- A multidisciplinary approach, sharing skills and knowledge across backgrounds (such as therapeutic, social work, probation, etc.) and drawing on this pool of knowledge to inform the ongoing design and delivery of tailored services. However, an accompanying barrier was flagged around the availability of staff to deliver.
- Funding and resources at the local authority level, not just for DA programmes but also for general health and support such as specialist trauma therapies that would enable them to engage or gain better results from engaging in DA programmes.
- An increased understanding in local services of the trauma-informed approach.

Adaptations

Several contextual factors and adaptations were noted that may be worth exploring in future impact evaluations or implementation and process evaluations.[10] First, it was flagged that the gender, or other characteristics, of those facilitating a group or acting as the 1:1 practitioner may have an impact on some participants, especially children. For example, having a shared characteristic could help adults engage better, and children can benefit from engaging with a male practitioner modelling behaviours that challenge what they've seen in their personal environment. Second, some programmes are better able than others, depending on their local context and available resources, to accommodate specific groups. In particular, different ways of thinking about domestic abuse may make programmes more or less suitable for LGBTQ+ parents as there may be

[10] Impact evaluations assess a programme's effectiveness in achieving its ultimate goals, whereas implementation and process evaluations aim to determine whether programme activities have been implemented as intended and resulted in certain outputs.

less-applicable narratives involved regarding gender and patriarchy. Practitioners repeatedly discussed the importance of being flexible and client-led, and this underpins their ongoing development of adaptations to manualised programmes to account for different groups such as varied cultural or religious backgrounds, same sex co-parents, specific neurodivergent groups or those with lower literacy levels. Some also noted the importance of cultural sensitivity while being client led; for example, not everyone would involve the police in their safety plan, and practitioners need to be comfortable and accepting of that. Practitioners noted that tailoring may also happen in accordance with what services are available in the local area.

Practitioners flagged the key challenges regarding adaptations as language barriers, and ensuring the inclusion of those who are not from the dominant culture in a group setting, in the knowledge they may not experience the same benefits of those with more shared experiences. They discussed the importance of drawing on their facilitation skills and remaining sensitive and curious. Those who often work in group settings also noted that 1:1 work can be more appropriate for those with higher needs. Practitioners discussed the lack of availability of translators acting as a significant barrier to communicating with non-English-speaking families, and that where translators are available this would be challenging to facilitate in a group setting. However, focusing on activities that prioritise "showing" over "telling" was felt to be helpful in engaging people with lower literacy levels. Ongoing reflection and debriefs among staff, particularly the multidisciplinary teams that they work in, was said to be especially helpful in working on the adaptations to programmes, including those that are manualised.

Scalability

The research team sought to answer the following refined questions regarding scalability, such as potential for roll-out via manualising and monitoring fidelity:

- What potential is there for scaling this programme?
- What would the barriers and enablers be for scaling this programme?

Generally, practitioners saw the potential for rolling out their services, though they described several necessities for this to be acceptable and viable.

Barriers

- Manualising should not be rigid; manualising was felt to be achievable for most programmes providing it retained flexibility around core materials or modules to adapt and tailor to individuals. Though for some elements, the family or survivor-led aspect of their design was so fundamental that manualising did not appeal as an approach. This flexibility presents issues to consider while designing impact evaluation/s.
- Funding would need to be sufficient so that the programme was not "watered down". This included maintaining the full programme of materials and/or modules, staff supervision and support, training and development opportunities, ensuring a full staff were in place to deliver the programme, and ongoing communication among all levels of staff to continually improve and adapt services appropriately.

- Even with sufficient funding and support, staff turnover/staffing problems would need to be factored in, in terms of the impact on the programme (including resource investment and recruitment), capacity to deliver on and measure outcomes, and approach to programme roll-out.

Enablers

- Consideration of the demographics and needs of new populations, to reflect in adaptations to the service, including factoring in local area services and strategies.
- A skilled workforce who can maintain fidelity to a manualised or clearly defined approach while connecting to clients and adapting appropriately to individual needs.
- Forming good relationships with partners in local areas, especially later service pathways, and the importance of being clear on what the service is and who it is for.

Some practitioners also noted that any larger roll-out of their service must be underpinned by an increased recognition at the national level of the need to support families affected by domestic abuse. Being a low-cost/small-scale programme was also described as a key enabler for potential scalability by some.

Perceptions of impact evaluation

The research team sought to answer the following refined questions regarding the potential for evaluation of similar programmes in the future:

- How does the programme provider currently monitor outcomes?
- How effective are these tools for evidencing impact?
  - Are validated measures used to evidence outcomes?
  - What are the perceptions of validated measures? Why?
- How well understood and acceptable to different stakeholders are different types of evaluation and/or randomisation? Why?
- What are the barriers and enablers to impact evaluation for programme providers?
- Are there likely to be negative effects of evaluation on delivery (and, if so, will this impact some groups more than others)? How can this be mitigated?

Programme providers generally monitored outcomes, or data relevant to outcomes, by:

- Referral information regarding beneficiaries, e.g., names and key contact details
- Demographic information about beneficiaries, including age, gender, disability, ethnicity, parental and relationship status, DA and referral context *(if available)*
- Qualitative data, such as (non-validated) questionnaires that focus on questions relating to outcomes and goals set by beneficiaries, and feedback on services
- Tracking data such as type and frequency of engagement *(not always linked)*
- Outcome measures using (sometimes modified) validated measures, including:
  - Domestic Abuse, Stalking and Harassment (DASH 2009) (in relation to outcomes around increased safety)
  - Clinical Outcomes in Routine Evaluation (CORE-10)

- Ages and Stages Questionnaire (ASQ)
- Adverse Childhood Experiences questionnaire (ACEs)
- General Anxiety Disorder-7 (GAD-7)
- Patient Health Questionnaire-9 (PHQ-9)
- Mothers Object Relations Scales (MORS)
- Child Revised Impact of Events Scale (CRIES-13)
- Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE).

Additionally, non-validated measures such as outcome star tools were used by practitioners with their service users.

Effectiveness of tools for measuring outcomes

DASH 2009 was felt to be useful (particularly when the "flow" of the questions was modified so it serves better as a discussion tool) for assessing outcomes around risks and safety planning. However, it was felt to have more limitations around identifying and capturing emotional abuse and coercive control. CORE questionnaires utilise psychological questions regarding wellbeing, coping, mental health and support, linking to several key outcomes. The ASQ was felt to be particularly useful to capture social emotional outcomes, although a number of other tools are also used (as listed above).

The Severity of Abuse Grid, along with ACEs, GAD-7, PHQ-9, and Outcome Star were all felt to be helpful to "profile" – i.e., better understand – the needs of parents. Validated measures are used at practitioner discretion throughout the beneficiaries' journeys to monitor and evidence outcomes and inform decision-making around tailoring services to individuals. Whereas module reviews and surveys (i.e., qualitative data) enable beneficiaries to use their own voice to describe their journey and provide feedback that further informs adaptations. This is key to the trauma-informed approach outlined above, although this work is more challenging with children and those with English as an Additional Language.

Embedding the measures in practice by using them as tools for discussion and for enabling clients to monitor their own progress helps to make the tools non-threatening and useful for beneficiaries as well as practitioners. Some practitioners noted that validated measures can be difficult to pitch in a meaningful way, especially to children, and concerns were expressed that some practitioners and beneficiaries have negative perceptions of the measures (including potentially finding them triggering to engage with), opting to focus on the work rather than completing them. Participants also felt that some language is better than others, for example using a scale of 1–10 across a set of questions elicits less in-depth thought and conversation, than, for example, the ASQ. There were also concerns around validated measures, such as the Strengths and Difficulties Questionnaire, in that mood varies day-to-day so to accurately see changes overall a measure would have to be taken very frequently. More generally there were concerns that emotional regulation and recovery cannot be measured as they are not linear and, the point of their programme is not to enable beneficiaries to become emotionally regulated, but to give them tools to use when they are emotionally dysregulated.

Qualitative data was felt to be helpful for exploring beneficiary perspectives and could be used to get a sense of emotional regulation, which validated measures are not perceived to be as good at gathering as they are other outcomes. Further concerns about validity were that language barriers can affect understanding and/or translation of the questions. This was reported to result in variation in completion with some beneficiaries self-reporting and others completing with a practitioner. Wellbeing and social connectedness were also felt to be difficult to measure, particularly where services vary for different beneficiaries, given there is no clear linear journey in a flexible service with high degrees of tailoring to individual service users. For example, it was felt that Warwick-Edinburgh can be used in some but not all instances given that answering questions on emotions/mood "in the last two weeks" doesn't necessarily work that well in all situations and not all questions are suitable, especially if being used across a range of services. The value and impact of early intervention was also noted as especially challenging to evidence.

Effectiveness of data collection to evidence outcomes

Generally, delivery partners strive to gather data regarding their clients at multiple specific timepoints across their engagement or a set programme period. This includes baseline as well as a mid and end point, and sometimes includes follow-up (this is more challenging for shorter-term programmes) or further timepoints between baseline and endpoint. The number of beneficiaries varies significantly across programmes depending on their size and structure. This could mean that generating datasets will be simpler with programmes that are cohort based with waiting lists, than those that are more ad hoc and responsive to referrals. However, the latter may provide larger sample sizes.

Based on discussions and a limited data set from some, but not all, programmes, there are several key considerations for gathering data to evidence outcomes in future studies:

- Dosage will vary across individuals within a service based on need, level of engagement and type/s of service offered.
- Data regarding individuals is not always linked to data about their other activities, e.g., casework may not be recorded in a way that is linked with group work.
- There are likely to be substantial gaps in demographic and referral information gathered about beneficiaries, especially disability, ethnicity and parenting/history of abuse or the circumstances around the referral.
- Validated outcome measures are not always collected consistently, as this is dependent on practitioner views on their usefulness and the needs of the beneficiaries. This includes collecting data at regular timepoints, but also includes the number of questions answered within a given set of survey questions.

More widely, and with the gaps within individual services in mind, there is wide variation in what outcome measures and other data is sought to be collected by programmes in the DA space. So, it is hard to compare administrative data as well as validated outcome measures, even when outcomes, mechanisms and ethos of approach broadly align. For example, one programme may see the gathering of Children's Social Care engagement as relevant to the long-term outcome of reducing domestic abuse; however, another may see this as an unjustified gathering of personal data as they aim to achieve shorter-term outcomes.

Acceptability of impact evaluation

There was a general understanding that it's important to pilot and evaluate new services, to improve support for children and families, and a concern that key outcomes are not currently measured as well as they could be. However, there was a strong view that removing programmes or leaving at risk families without the services they need, is not acceptable.

Randomised control trials (RCTs) were not well understood and needed careful explanation before exploring. Some simply did not see RCTs as a viable way of demonstrating what happens in practice in their programme. They described previous experiences of seeing programmes decommissioned due to RCTs that gave results that didn't do justice to the programme, as RCTs taking a long time, which programmes do not easily accommodate. Quasi-experimental designs (QEDs) were generally preferred as this avoided withholding services from those who need them, though finding a statistical neighbour with similar business-as-usual and potential beneficiaries was acknowledged as a significant challenge.

There were mixed views on what would make an RCT ethically acceptable. Participants often had a better perception of an RCT where services are provided to all those who are eligible, then within that group the impact of an additional service is evaluated across two randomised cohorts of treatment groups. However, concerns were raised about designing a new module for the sake of research rather than the development of modules to meet clear existing needs as done in the past, and initial ideas explored such as comparing a model that is similar to their own programme with two groups, or varying courses to compare the impact. Value was placed on testing the effectiveness of elements of a service for particular people, though this was part of an initial discussion where an understanding of research on the participants' part was likely limited.
For some, it was felt to be acceptable to trial a new programme in an area without any existing provision and compare this to an area without existing provision, as this would provide new services in one area where there otherwise would be no services in both areas. This still felt unfair to others, as it is due to a lack of funding that services are being withheld from some and not others. They felt that if this work would evidence and therefore justify more funding for DA services, ultimately leading to more services for more people, then it is ethically sound. Though, given eligibility is already significantly restricted, there was confusion as to why that eligibility should be restricted further when those without services (in other areas) can simply "act as the baseline".

Participants also returned to concerns about the complexity of understanding why one family may "succeed" and another doesn't, with lots of reasons that could influence this outside of an additional service, and they flagged other concerns that could act as barriers and enablers.

Enablers and barriers to impact evaluation

Several barriers and enablers to impact evaluation were discussed in interviews, and further in reflective discussion among the research team. The barriers are listed below, with suggestions of how to account for these to enable and support evaluation.

- An impact evaluation, particularly offering a service to some people and not others could lead to perceptions that **damage programme relationships with professionals in other organisations** and impair their working together to support families. It is therefore crucial that adequate time be spent on designing an approach, and an approach to communication, that addresses this. This requires **understanding of the potential/current community before designing an approach**, thinking through implications for both the potential roll-out of a service and for an impact evaluation.
- Offering services to some people and not others was felt to risk trust between programme providers and beneficiaries, reducing their impact. To make an informed decision whether to take part, beneficiaries should be aware that they are taking part in an evaluation, and the approach should be explained to them. Relatedly, it is important that researchers consider the implications of what funding will be available for services they create and/or evaluate after impact evaluations are complete, and how this will impact potential beneficiaries.
- **Data Sharing Agreements** (DSAs) often act as a significant barrier to sharing data with evaluators, particularly where there is a consortium of organisations involved.
- **Plenty of time** should therefore be factored in in advance of the study to work through DSAs with partners.
- **Capacity** of programme providers to engage with evaluation was perceived as a key barrier. To account for this, focus should be given to **engagement strategies** and ways of reducing burden for those participating in or supporting the evaluation. **Time and resource** must also be provided for data to be cleaned and checked for accuracy before sharing. This can be supported through ensuring **adequate funding for training and supporting staff** so that implementation does not hinder the delivery of the programme being evaluated.
- **Staff turnover** will likely hinder delivery. Steps should be taken to reduce this, and account for it in design.
- **Practitioners may not always understand the value of the evaluation**, in particular collecting outcomes data through validated measures. Resource must be given to gaining understanding and buy-in. This can be supported by working closely with **engaged senior staff members** who can practically support and input into the design of the evaluation, along with advocating for it among staff.
- **Getting endpoint and follow-up data may be especially difficult**, as beneficiaries do not always attend the final sessions where this is collected, and may be difficult to get in contact with. Where they do, they may give responses which aim to encourage practitioners to provide them with more services – understandably, given there may be limited services available to them after finishing the programme. Again, a practitioner base that recognises the value of evaluation and strong communication with beneficiaries, combined with adequate resourcing, may enable follow-up with participants.

Further lessons learned specifically regarding the engagement of beneficiaries were:

- Beneficiaries are more likely to engage with the evaluation if the programme practitioner, who they trust to keep them safe, invites them to take part. This may be sold or understood

as a means of having a greater impact beyond themselves. It is therefore crucial that the researchers involved are trustworthy in that they understand and clearly communicate what participants can and cannot influence.

- Processes which ensure confidentiality are exceptionally important when contacting and interviewing beneficiaries of domestic abuse programmes, as participants often do not want others knowing they attend these programmes. Sensitivity must be made in contacting participants (i.e., warning them not to watch a video which introduces the research in front of anyone they are not comfortable with) and in planning an interview (i.e. offering to interview with their camera off or in person).
- Beneficiaries put forward to participate in the evaluation by practitioners are likely to be in a relatively late stage of their programme journey, and a stable and positive enough place to consent to talk to us without putting their wellbeing at risk. This is appropriate but will limit our understanding of beneficiary experiences. This should be acknowledged.
- Due to restrictions around previous consent processes, delivery partners may only be able to put us in touch with current beneficiaries. Where possible, this should be identified and addressed early on so that other processes are put in place.
- It is likely that interview preparation, including relationship building with practitioners and then beneficiaries, will take a long time if more than a few interviews are being sought. This should be accounted for in project planning.
- Interview and engagement materials should be designed in partnership with practitioners, who can advise on many key factors but especially use of language.

DISCUSSION

This project has generated a wealth of learning about evaluation of domestic abuse programmes. In this section we summarise lessons learned and make recommendations for enhancing evaluations in the future.

Lessons learned

- For the preparation of future evaluation work, significant time and capacity must be planned into projects to allow for flex according to the needs of delivery partners, and to give time to developing relationships and a deep understanding of the programme ahead of agreeing and starting evaluation activities.
- This time should also account for dedicated time to reflective and reflexive practice and setting up Data Sharing Agreements.
- While some programmes do not easily align on who their target beneficiaries are, there is significant alignment – at least across these four programmes – on key outcomes and mechanisms, and acknowledgment that domestic abuse programmes are generally complex, with outcomes and mechanisms feeding into each other.
- There was also a broad agreement that parent outcomes feed into child outcomes. Discussions with the sector going forward may benefit from focusing on agreeing key outcomes, allowing for some tailoring but keeping to their core meaning, such as increased safety, improved wellbeing, improved relationships and improved engagement with other services. Emotional regulation in particular should be explored, as this was felt to be the most challenging to monitor using validated measures. Key concepts underlying mechanisms can also be explored such as feelings of safety, shame, trust, motivation, confidence, knowledge and self-esteem. Trauma-informed practice and psychoeducation literature will likely aid this conversation, as widely accepted tools for supporting people who have been exposed to domestic abuse. This will both aid in the selection of validated outcome measures[11] to be used more widely and consistently.
- In developing validated measurement tools that could be widely adopted, the clear steer from this study is that they need to be useful and non-burdensome in practice to both clients and practitioners. Time must be invested into exploring what outcome collection tools would best align with widely accepted underlying outcomes across programmes[12] and would best suit the largest number of beneficiaries and practitioners.

[11] For a review of the tools and measures currently being used by practitioners to capture core outcomes for children who are victims and survivors of domestic abuse, see https://www.ucl.ac.uk/children-policy-research/sites/children_policy_research/files/dva_measures_ho_report_06122022.pdf

[12] For more information on child outcomes used in domestic abuse interventions, see: Powell et al. (2022) 'Child and family-focused interventions for child maltreatment and domestic abuse: Development of core outcome sets', BMJ Open, 12(9). doi:10.1136/bmjopen-2022-064397.

- The complexity of some domestic abuse programmes poses challenges and opportunities for evaluation. Further development and refinement of complex programme theory using cycles of evaluation will help programmes to better understand their mechanisms of change, key contextual factors (e.g., beneficiary diversity, local system context) influencing these mechanisms, and where there is evidence of promise for outcomes. Further theory-of-change development and feasibility and pilot testing would be useful for a wider range of domestic abuse programmes, using evaluation as a basis for programme refinement and development.
- However, to more conclusively provide evidence of the impact of domestic abuse programmes on family and child outcomes, programmes (or components of programmes) that are well developed via feasibility testing could upscale their evaluations to pilot impact studies testing the viability and acceptability of various forms of impact evaluation.
- To make such impact evaluation more feasible, there could be more codifying and manualisation of programme content, which can include guidance on tailoring and personalisation around (more systematic or standardised) core common elements and components.

Opportunities

Opportunities for pilot impact testing of domestic abuse programmes that could be explored include:

- Rapid cycle testing of new programme content and testing of cultural adaptations to programmes. This could include mini-RCTs of new programme content or methods for retention within programmes (domestic abuse programmes and parenting support programmes have known challenges with attrition and participant dropout).
- Testing new programme modules alongside treatment as usual, with the possibility of randomising participants to receive treatment as usual only or treatment as usual plus a new programme module.
- New geographical roll-out of a programme module or a full programme where it is already well codified or manualised. This will lead to opportunities for quasi-experimental comparison, and possibly randomisation at local authority-level (e.g., cluster design) or at beneficiary level (e.g. using a waiting list design).

These approaches need testing for viability and acceptability on a smaller scale initially, via pilot impact studies. Doing so will lead to vital methodological learning and potentially serve as proof of concept of the viability of such approaches. Foundations's evidence synthesis work has identified domestic abuse programmes outside of the UK, which robust impact evaluations have suggested are effective in achieving positive outcomes. We see no reason why such programmes could not be piloted and evaluated in the UK (especially where there is variation in service availability between and within local areas). For more information on individual programmes, we recommend taking a look at our recently commissioned rapid review of these types of programmes.

Key considerations

Key considerations for moving forward with pilot impact evaluations include:

- Needing to balance the importance of flexibility in delivery of a programme (including a manualised programme) alongside the need for consistency and fidelity in an impact evaluation.
- Factoring in the potential impact of staffing issues. Adequate timelines and resourcing will help, but staff turnover should be anticipated and planned for. Funding must be sufficient for the programme to be rolled out successfully, with a dedicated role to evaluation support, and careful attention paid to the beneficiaries likely to be affected during the design stages.
- Relationships and building shared understanding will be crucial to success. Trust was consistently raised as a key barrier/enabler to the success of an impact evaluation. Significant resource should be spent on building awareness of types of evaluation and their value alongside collaborative relationships, grounded in a clear commitment on what will happen following a programme of pilot impact evaluations.
- Type of evidence being collected, by whom and how. While, likely due to lines of questioning, discussions of using qualitative research in impact evaluation did not come up in interviews, some practitioners showed a strong interest in exploring the potential for making better use of qualitative research in exploring impact in workshops and more informal discussions. This avenue may also be worth pursuing in future studies.

Finally, there were several insights that, while not rigorously grounded, may prove useful for government, commissioners and programme providers to consider. These largely centred on:

- Providing adequate and focused support for staff in local authorities as well as for delivery partners, to enable more people to spot the signs of abuse, and make the right referrals. Training in how to respond to those experiencing the different forms of domestic abuse may also help to create a more joined-up system across multiple agencies within family help and children's social care leading to better experiences and outcomes for those in need of support. This is a topic ripe for intervention development and evaluation.
- Further, other services are important in the local area to work alongside domestic abuse programmes, such as social housing, substance misuse and mental health services, to provide the support that is needed before, during and following a DA programme for it to be as effective as possible. More widely, access issues such as the variation in offer across areas, difficulties in transitions for those fleeing domestic abuse, and the availability of translators, needs focus.

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APPENDIX A: DELIVERY PARTNER DESCRIPTIONS

For Baby's Sake

a. **Website:** https://www.forbabyssake.org.uk/
b. **Population: Both co-parents and their baby (starting in pregnancy), also includes other children in the family.**
c. **Approach:** Whole family therapeutic approach, working individually with each co-parent (whether they are together as a couple or not), robust adult and children's safeguarding
d. **Location:** Bi-borough area of London (Westminster and Kensington & Chelsea), Hertfordshire, Blackpool, further locations via video/phone sessions ('CONNECT')
e. **Description:** *For Baby's Sake* is a trauma-informed, attachment-based therapeutic programme, delivered by practitioners who build meaningful, trusting relationships with parents and integrate with local adult and children's services, including domestic abuse and child safeguarding services and systems, GPs, health visitors, midwives, probation, etc. The majority (79%) of participants are referred by children's social care services.
f. *For Baby's Sake* provides intensive, individual support for each co-parent (the person experiencing the abuse and the parent perpetrating the abuse), their baby and any other children, tailored across a number of modules, including:
   - Getting Started – holistic assessment, stabilisation, physical and emotional safety
   - Attachment-focused parenting – from pregnancy to nurture sensitive, attuned parenting
   - Healthy expression of feelings – processing guilt, shame and dissociation
   - Inner child (therapeutic core) deepens exploration and processing of unresolved trauma within recovery framework, builds sense of self, empowers behaviour change
   - Building self-esteem, healthy adult relationships.

Each parent has their own pPractitioners, who has completede intensive in-house *For Baby's Sake* training plus external training, including on Motivational Interviewing, Video Interaction Guidance (VIG) and Newborn Behavioural Observations (NBO). Sessions are usually weekly from pregnancy to the baby's first birthday, and may continue less frequently up until age two. Sessions are matched to parents' individual needs and risk assessment and delivered face-to-face and/or remotely via video/phone (*For Baby's Sake* CONNECT delivers the same programme wholly remotely).

g. Outcomes:
   - Improved birth outcomes – gestational age and birth weight
   - Improved early social, emotional and cognitive development – ASQ-3 and ASQ:SE-2
   - Reduced contact with children's social care – social care data
   - Sustained behaviour change, reduction in risk and fewer domestic abuse incidents – reports of incidents, severity and type

- Improved mental health and emotional wellbeing, reduced anxiety and depression – GAD-7 and PHQ-9.

Other info: Evaluation / research highlights For Baby's Sake for working with fathers perinatally and for addressing limitations to whole-family responses to domestic abuse

Family Action: *Survive and Thrive Integrated Children's Service*

a. **Website:** https://www.family-action.org.uk/what-we-do/children-families/bradford/survive-and-thrive-children-and-families-service/
b. **Population:** Children who have experienced Domestic Abuse and their parents and carers
c. **Approach:** Systemic, trauma informed, psychoeducative
d. **Location:** Yorkshire and the Humber (Bradford)
e. **Description:** Family Action is a national charity providing practical, emotional and financial support to those experiencing poverty, disadvantage and social isolation across England. The organisation delivers a Children and Families Domestic Abuse Service as part of Survive and Thrive a consortium of 3 organisations who work in partnership to deliver Bradford Council's Domestic Abuse contract. Referrals are made via the Survive and Thrive One Front Door, which is run by the partner agency Staying Put, or from other parts of the Survive and Thrive Partnership. They will work with children (5 to 18), parents and whole families who have experienced domestic abuse and are living in the Bradford district.

They deliver the following activities:

- Psychoeducative work with parents, children and young people to aid understanding of the impact of DV on children and support recovery.
- Trauma-informed work with children and young people to create safety/stability and reduce trauma symptoms. **Whole family** work to rebuild relationships.
- Parent/child group work (aged 0 to 5 years) to strengthen parent/child attachments in supported accommodation. Children groups (aged 5 to 11) in supported accommodation to build confidence and self-esteem.
- Advocacy, safety planning, healthy relationships and support to return to mainstream education for young people (aged 13 to 17).
- Trauma Therapy with CYP who require support to process trauma.

The project is delivered by children and family workers, play and attachment workers, qualified systemic practitioners, a qualified children's IDVA and a trained therapist. They state they work systemically, and work closely with key workers – e.g., social workers, early help practitioners, teachers or health professionals, or other professionals working with families.

f. Outcomes:
   - Increase in child's feeling of safety and security
   - Improved family functioning
   - Reduced trauma symptoms in children

- Increased awareness of the impact of domestic abuse for children, parents and professionals
- Improved child/parent attachment.

They use the following outcome measuring tools:

- CRIES 13 (trauma symptoms)
- IES-R Parental trauma symptoms
- Score 10 (family functioning)
- MORS (parent/child attachment)

g. **Other info:** Clearly stated and tested evidence base, highly experienced organisation that works with a large number of families.

LEAP Enhanced Casework Service

a. **Website:** https://www.leaplambeth.org.uk/families/stresses/safer-families-enhanced-caseworkers
b. **Population:** Parents who are experiencing, or at risk of, domestic abuse during pregnancy or before their child's 4th birthday.
c. **Approach:** Interagency collaboration, individually tailored, holistic, intensive approach
d. **Location:** Greater London (Lambeth)
e. **Description:** *LEAP Enhanced Casework* is a bespoke service for parents who are experiencing, or at risk of, domestic abuse during pregnancy or before their child's 4th birthday. It is embedded within The Gaia Centre, run by Refuge: a community-based 'one stop shop' for victims and survivors of gender-based violence that is commissioned by Lambeth Council. Lambeth Early Action Partnership (LEAP) commissions Enhanced Casework as part of The National Lottery Community Fund's A Better Start initiative. A small team of Enhanced Caseworkers provide practical and emotional support for clients. Support is holistic and non-time-limited, taking place virtually or in safe venues. Wellbeing groups for clients are also held at a children's centre.
f. Unlike traditional risk-led services, outreach is a strong component. The team aims to work with victims and survivors to identify their experiences as abuse at an earlier stage, thus seeking to prevent escalation and reduce the impact on non-abusive parents and their children. They seek out new clients by offering general advice surgeries in children's centres, building relationships with practitioners and taking part in community activities. The ultimate aim is for clients to have improved wellbeing and feel they are safe and moving in a positive direction, and for their children to have a better environment in which to grow and thrive. In the medium term, (expectant) parents will feel safer and have increased awareness of the dynamics of abuse and healthy relationships.
g. **Outcomes:** Are measured using the Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH) Risk Identification and Assessment and Management Model, the CORE-10 measure of psychological distress, and feedback questions.
h. **Other info:** Clear connection to CSC, also has a comparatively large outreach component that works with parents at an early stage, whilst they learn about and consider their options, including separation from perpetrator.

Children Overcoming Domestic Abuse

a. **Website:** *CODA* as licensed by Against Violence and Abuse: https://avaproject.org.uk/coda/; *CODA* as delivered by Early Years Alliance: https://www.lewishamcfc.org.uk/children-overcoming-domestic-abuse-coda-programme-returns-to-in-person-courses/
b. **Population:** Mothers and their children (aged between 4 and 11 years)
c. **Approach:** Psychoeducational, trauma-informed, attachment-based approach to group work, multi-agency (referring agencies include CSC, early help, Health services, Education, Police, mental health services)
d. **Location:** Greater London (Lewisham)
e. **Description:** Parents can self-refer, or professionals can refer on the family's behalf

Referring agencies include:

- Children's Social Care
- Early Help Services
- Health Services
- Education
- IGVA Services
- Police
- Mental Health Services.

Referrals are assessed against programme eligibility criteria, then allocated to *CODA* team for programme enrolment. Running concurrently, *CODA* provides two-hour sessions for mothers and their children, weekly for 12 weeks. Each week covers a theme (e.g., safety planning, self-esteem, sexual abuse) and follows the same structure. The programme is delivered by multi-agency trained and accredited facilitators face-to-face in a group, and 1:1 format within various community settings. They have also digitalised the programme to enable safe/appropriate delivery online.

f. **The desired outcomes of the programme include:** Children and adult survivors to: understand what abuse is; understand they are not to blame; feel their experiences are validated; feel safe; have an enhanced mother–child relationship; have improved emotional wellbeing.
g. Adult survivors to: have improved understanding of children's experiences of domestic abuse and that the impact of trauma can affect all aspects of their development and behaviour.
h. Child survivors: to have improved ability to communicate their experiences, have improved problem-solving strategies, have improved ability to manage emotions.
i. **Other info:** Voluntary nature, running in the area for 12 years.

APPENDIX B: THEORY OF CHANGE WORKSHOP CORE QUESTION GUIDE

1. Introducing a theory of change; to get on the same page on its purpose.
2. What needs does your work address?
3. Who benefits from your work?
4. What are the end goals for your work with those you support?
5. What do you do in order to achieve these end goals (day-to-day activities, and what needs to happen so that these activities create the desired goals)?
6. What are the risks in your work, and how do you mitigate these?
7. What helps and hinders you to do your work effectively?
8. What has driven your decisions about how to design and deliver your work?
9. What outcomes (end goals) are most important and how might we evidence these?
10. How sustainable do you feel your work is? What influences that?

APPENDIX C: PRACTITIONER AND SERVICE USER INTERVIEW GUIDE TEMPLATES

A template interview guide for both practitioner and parent interviews was developed and adapted for each programme.

Interview schedule – Practitioners

Note: prior to the chat/interview, the interviewer should be familiar with the intervention, particularly the activities/context, and know the role of the interviewee as well as any access needs to accommodate. Interviews should ideally be scheduled for 60 minutes, with time for small talk to begin. The interviewer should make a judgement call (drawing on support as needed) on what to prioritise across the two sections, given the role of the practitioner, and have pre-prepared prioritised probes. ***The most important questions are bolded.***

Interview guide

Introduction (5 MINUTES)

- Hi again, thanks so much for agreeing to take part.
- Do you have any questions about what was in the information sheet, before we start?

If participant has not read/can't remember the information sheet, re-cap:

- The aim of this interview as part of the research is to understand the services provided by [site name], why you do things the way you do, the impact you think the services have and why that is. We'll also explore what information might be okay for researchers to gather so we can help explain services like [site name] to other people, like the government, and evidence impact.
- Your personal information will be stored securely and kept confidential and you won't be identifiable in any of our outputs or reports from the research, including when we may use anonymous quotes – we would only need to pass on information that identifies you if we are concerned for the safety of yourself or someone else. If this were to happen, we would pass on information to our safeguarding lead and – unless we had a really good reason not to – would let you know we were going to do this.
- The report will be published in 2023 and the findings will help us to understand what's working for people accessing support with their close relationships and why, and how best to go about evidencing the impacts of this support, which will inform future research to ultimately help decision-makers decide what support to provide across England more widely.

- Your participation is completely voluntary, and you are free to withdraw any and all of your responses following the interview until approximately mid-February when we will start the next bit of the process. You can end the interview at any time or skip a question without giving a reason and you're welcome to take a break or come back to things.
- Do you have any questions about this, or anything else about the research?

/ I've got a fair few questions to ask you and I want your opinion on all of them, so I might move you on sometimes too and I apologise in advance if I have to.

/ Are you okay with the interview being audio recorded (so we have a good record of what we have discussed – if not I can take notes, but recording means I can talk to you properly)? IF THE INTERVIEWEE HAS PROVIDED WRITTEN CONSENT BUT DOES NOT CONSENT TO AUDIO RECORDING, TAKE NOTES. IF THE INTERVIEWEE CONSENTS TO AUDIO RECORDING BUT HAS NOT PROVIDED THE WRITTEN CONSENT FORM STATE/ASK:
- I need to capture your consent as we don't have the form. I will begin the recording by stating my name, the time and date then run through some basic consent items. Is it okay for me to start recording now?

BEGIN RECORDING

1. Researcher's name, date and time
2. I am going to start by asking a few questions to record your consent to take part in this interview.
3. Can you confirm that you are over the age of 16?
4. Can you confirm that you've read our information sheet or had the study explained to you?
5. Can you confirm that you have had the opportunity to ask questions and are satisfied with the answers?
6. Can you confirm that you understand that taking part is voluntary, you are free to withdraw at any time without giving a reason?
7. Can you confirm that you understand that everything you tell me will be confidential, unless I'm concerned an adult or child is at risk, in which case I would need to inform another professional?
8. Can you confirm you agree to take part in this study?
9. Can you confirm you agree to having anonymised direct quotes used in our report?

Thank you for bearing with me on that.
Over the next half hour or so we'll first talk about your views on the services you provide, then what information we could potentially be gathering to evidence the impacts of [site name]. We're not trying to understand everything, we're looking to understand what's most important. I've got a lot of questions to ask you so I might move us on, please excuse that!

Intervention (30 minutes)

1. Let's start with the basics, **what <u>key</u> needs are you meeting in the work you do?**
    a. **Is there anyone your service misses or excludes?** [probe on demographics if there are different versions of the service, e.g. geographic area]

   b. **What would those you work with be receiving if your service wasn't available?**
2. **What has informed the way you've designed and the way you deliver services?**
   a. **What academic lit./theory/evidence has been used/underpins the work?**
   b. What has been developed through experience and intuition?
   c. How is it adapted to different contexts or people?
3. In the workshop, **we discussed these <u>key</u> outcomes: [insert/narrate outcomes]**
   a. **Which do you think are the most achievable? What makes you say that?**
   b. **Which do you think are most important? What makes you say that?**
   c. **Of those [prioritise a few key outcomes], how long do you think it takes to see those outcomes? What makes you say that?**
4. **What do you think are the <u>key</u> drivers for reaching those outcomes?**
   a. **What are the most important activities/features of activities that lead to these outcomes for participants? What makes you say that?**
      i. *Probe on mechanisms: specifically what leads to an attitude and then behaviour change? [insert: probe hypotheses/interests]*
   b. **If relevant: how is this different to what would otherwise be available?**
5. Lastly, before we move onto how we might evaluate impact, **how plausible do you think it would be to roll out your service to more people, in more areas?**
   a. **How easy would it be for you to manualise your offer, and monitor how well those delivering stick to the manual? What makes you say that?**
   b. What are the <u>key</u> barriers and facilitators when delivering your work?

Evaluation exploration (20 minutes)

Thank you for sharing that with me – we're going to spend the last 20 minutes thinking about how we might evidence the impact of your work, and similar interventions. I'd first like to explore some measurement tools for evidencing outcomes with you.

1. **I believe you've worked with [insert x, y, z measures] measures – which ones do you have personal experience of using, and in what context?**
   a. **Which ones were easiest and most fit-for-purpose to use? Which were the most challenging? What makes you say that?**
   b. **Which would be the most feasible for collecting *from everyone* as they enter your service, and at checkpoints throughout their time with you? What makes you say that?**
2. Are you familiar with the Warwick-Edinburgh wellbeing measure?
   a. [if yes] Would you consider using this measure? What makes you say that?
3. Outside of these measures, I understand you use [insert x, y, z monitoring tools] to monitor the progress of people using your service.
   a. Of those, which are the most useful to you day-to-day?
   b. And which are most useful when telling others about your impact?

Thank you, that's very helpful to understand. Lastly, I want to discuss potential ways of doing impact evaluations. We're particularly interested in how we might go about randomised control trials, as this is the strongest way to evidence the cause of a change. *[check for understanding of*

RCTs and explain if not already known]. However, we're mindful of the practical and ethical challenges that might come with conducting RCTs with a service like yours. So, we are exploring a couple of options, which we'd look to pilot before we did anything full-scale, so they are just hypothetical for now and your views will help us think about our next steps.

4. **Firstly, we're interested in the potential for adding and testing additional services – for example modules in a course – to existing services for some participants but not others. In this case, we would be looking at understanding what impact the additional services have had on participants, without withholding existing services from anyone. What conditions would need to be met for this to be feasible, and ethically sound?**
5. **Secondly, we're interested in the potential for rolling out aspects of, or full, programmes in new (geographical) areas and exploring the differences between participants in an area that receive new services and ones in an area without the service, and aren't receiving anything new. This is tricky because without the funding, no new people would receive those services. However, it could be said that services are being held back from those who need it in the new areas. Again, what conditions would need to be in place for this to be feasible, and ethically sound, to you?**

Thank you, that's very helpful to understand.

Ending (5 minutes)

Thank you so much for answering those questions. Everything you've told me will be brought together with what others have said in similar discussions to help us and others decide what to do next. Lots of people are waiting for this work to be completed so we can get onto figuring out how best to show the impact of services like [site name] and ultimately inform national policy, so it's been incredibly useful to talk to you.
Is there anything else that you'd like to tell me before we wrap up?
I'm going to switch off the recording now, we're all done.

- Thank you again for sharing what you have and sparing the time to talk to me.
- Do you have any final questions for me? If you think of anything, just get in touch.
- I just want to remind you that you'll be anonymous in our report, and we'll be publishing that later this year.
- If you want to retract from or add anything to what you've told me today, or check over your transcript before it goes in with the others for analysis, please get in touch.
- Thank you so much for your time!

Interview schedule – Parents

Note: prior to the chat/interview, the interviewer should be familiar with the intervention and know where in the journey the participant is, as well as any access needs to accommodate – e.g., a preference regarding the gender of the interviewer or a planned break during the call. Interviews should ideally be scheduled for 45–60 minutes, with time for small talk to begin.

Introductory meeting

- Introduce yourself and your role on the team
- Ask: have you had a chance to look over the information sheet? If so, any questions?

Note: if they have read it and have questions, answer their questions then cover only what hasn't already been discussed from the below. If they have read it but have no questions, or if they haven't read it at all, go through the below.

- No worries at all! I'm going to run through some of the key points about the research. Please ask me any and all questions if you have them:)

Note: this should feel conversational, with plenty of checking in/drawing on interview skills.

- The aim of this interview as part of the research is to understand what's helpful, or less so, about the services you get from [DELIVERY PARTNER] and why that is, and to explore what information might be okay for researchers (like us) to ask for so we can help explain services like [DELIVERY PARTNER] to other people, like government. We're not here to dig into your personal experiences or anything you don't want to share with me, I just want to understand your views.
- Your personal information will be stored securely and kept confidential and you won't be identifiable in any of our outputs or reports from the research, including when we may use anonymous quotes – we would only need to pass on information that identifies you if we are concerned for the safety of yourself or someone else. If this were to happen, we would pass on information to our safeguarding lead and – unless we had a really good reason not to – would let you know we were going to do this.
- The report will be published in 2023 and the findings will help us to understand what's working for people accessing support with their close relationships and why, which will inform future research to ultimately help decision-makers decide what support to provide across England more widely.
- We're going to ask you questions about what helped you to work with [DELIVERY PARTNER], what challenges you faced and if and how you were able to overcome them, and what impact you think working with [DELIVERY PARTNER] has had on you and why. This will help us explain what [DELIVERY PARTNER] provides and how, to decision-makers.
- We're also going to ask you questions about what information you might be comfortable with us gathering about you – like sessions attended or missed, demographic information like age and ethnicity, or information about your interactions with other services, like health or social services. We don't want you to give us that information, we just want to talk about what you would be comfortable with if asked in future. This is going to help us understand what information we could ask people who use services like [DELIVERY PARTNER] to give us, which will help us to show the impact of services like [DELIVERY PARTNER] to decision-makers.

- Your participation is completely voluntary, and you are free to withdraw any and all of your responses following the interview until March 3rd when we will start the next bit of the process. You can end the interview at any time or skip a question without giving a reason and you're welcome to take a break or come back to things. Whether you take part, how much you answer and whether you withdraw anything later won't impact the support you get from [DELIVERY PARTNER] in any way. Telling us something negative about [DELIVERY PARTNER] also won't impact the services you receive in any way.
- In the interview, I'll be trying to stay neutral and that might feel a bit strange, I won't offer personal views because I'm there to learn about yours. I'll have several questions to ask you so I might move you on at times, just to make sure we cover everything. I'll be asking you about things that are emotional so I want you to know it's always okay to take a break or skip a question and I'll try to be mindful of how challenging my questions might be – is there anything you'd like me to do if you become upset? Is there anything more generally that might help, e.g. we could take a longer time to chat but with breaks?
- Do you have any questions about this, or anything else about the research?
- You don't have to decide now if you want to take part, and there's no pressure to do so – have a think and if you'd like to, make sure you're clear on all the info (I know there's a lot of it so I'd be happy to help!), then sign the consent form to send over to us and we can book in a time and place to talk that suits you. I'm also happy to talk again and answer questions before you decide.
- Lovely to meet you – thanks for your time!

Interview guide

Introduction (5 MINUTES)

/ Hi again, thanks so much for agreeing to take part.
/ Do you have any questions about what we discussed and why we're here before we start? // I believe you've gone through the information sheet about why we're here and what will happen with what you tell me – do you have any questions about it?
/ Before we start, here is/I'm going to email you your incentive.
/ As I said last time, it's totally natural if you feel emotional at times while we chat – please skip questions and take breaks whenever you want to. You can withdraw at any time without giving a reason, and nothing you do or say here will impact the services you receive.
/ I've got a fair few question to ask you and I want your opinion on all of them, so I might move you on sometimes too and I apologise in advance if I have to.
/ Are you okay with the interview being audio recorded (so we have a good record of what we have discussed – if not I can take notes, but recording means I can talk to you properly)?

Over the next half hour or so we'll first talk about your views on the support that you've had from [DELIVERY PARTNER], then what information researchers like me could potentially be gathering about that support and your experiences, if were to interview you or people like you in the future.

For example, you might think something is too sensitive or that there would be something better to ask for.

Intervention experiences (20 minutes)

1. **How did you first hear about [Delivery partner]?**
    a. Probe: what made you decide to put yourself forward/be referred, and have that first conversation?
    b. Probe: was there anything that made you reluctant?
        i. (if yes) What helped you to overcome that?
    c. Probe: what made you decide to work with them, after that first conversation?
2. **What made you decide to keep working with them once you got started?**
    a. Probe: specific people/relationships?
    b. Probe: what did you want to get out of it?
3. **How has what they've offered you affected you?**
    a. Probe: has it changed anything about your relationships? (if yes), how so?
    b. Probe: has it changed anything about yours or others wellbeing? (if yes), how so?
    c. Probe: what do you think has led to those changes? (particular people, specific sessions – what was it about those that affected you?)
    d. Probe: were there anything that affected you that you found harder to manage? (if yes) what helped you to overcome or cope with those?
4. **What has helped you to get and stay involved with [DELIVERY PARTNER]?**
    a. Probe: location, getting information, timings, relationships? Virtual vs. F2f
    b. Probe: has there been anything that has made working with [DELIVERY PARTNER] challenging? e.g., location, timings, getting information, relationships
5. **Is there anything you think could be improved about what's offered?**
    a. Probe: were there some bits that were more helpful than others?

Evaluation exploration (15 minutes)

Thank you for sharing that with me – we're going to spend the last 10 minutes talking about what researchers could collect in future to help explain services like [DELIVERY PARTNER] to others. Remember, this is all hypothetical as we're just exploring what we could do in future. Your views along with others will help us decide what to do next.

1. I'm going to read out four types of information that could be collected about people who use services like [DELIVERY PARTNER] then shared with researchers. We'll chat about each type of information, and what would and wouldn't be okay with you. Researchers wouldn't be able to link this information to your name or contact details.

/ Monitoring information, like how you were introduced to working with the service (referral, by who/self-referral, from where), levels of attendance to sessions:
    – Would this be okay for us to collect? What makes you say that?
    – Who would you be comfortable having access to what? (researchers, other public services like social services, the NHS or police/housing) What makes you say that?

/ Questionnaires and notes, like the questionnaires you fill out in your assessment and review sessions and notes that are taken about the sessions you take part in:
    – Would this be okay for us to collect? What makes you say that?

  - Who would you be comfortable having access to what? (researchers, other public services like social services, the NHS or police/housing) What makes you say that?
  - Of the questionnaires you've done in your sessions sometimes, were there some you preferred over others? What makes you say that?
  - How often would you be comfortable doing these questionnaires (once a year, twice a year, four times a year, monthly)? What makes you say that?
- Demographic information, like age, gender, ethnicity, disabilities or health conditions:
  - Would this be okay for us to collect? What makes you say that?
  - Who would you be comfortable having access to what? (researchers, other public services like social services, the NHS or police/housing) What makes you say that?
- Service use information, like information about your use of other services like social services, police, housing associations and NHS or other health services:
  - Would this be okay for us to collect? What makes you say that?
  - Who would you be comfortable having access to what? (researchers, other public services like social services, the NHS or police/housing) What makes you say that?

And would you have felt the same way at the beginning of your journey with [site name]?
Thank you, that's very helpful to understand.

2. Sometimes researchers do interviews and group discussions, like this one, themselves. It can help others to feel confident in what we find about people's experiences, as we are independent from the people who support you, and have more time and skills. To help us think about future work I have a few questions about this:

- What made you want to take part in this research?
- Was there anything that made you reluctant, and what helped you overcome that?

Ending (5 minutes)

Thank you so much for answering those questions. Everything you've told me will be brought together with what others have said in similar discussions to help us and others decide what to do next. Lots of people are waiting for this work to be completed so we can get onto figuring out how best to show the impact of services like [DELIVERY PARTNER] so others can know and learn from it, so it's been incredibly useful to talk to you.
Is there anything else that you'd like to tell me before we wrap up?
I'm going to switch off the recording now, we're all done.

- Thank you again for sharing what you have, I know it's personal stuff so I appreciate it. Please reach out to [DELIVERY PARTNER] for a chat. How are you doing – do you feel okay about carrying on with your day? (stay and chat for a while if they don't: no worries, I've got some time!) – It's completely normal to need support, we all do sometimes and it's what it's there for, so please reach out to someone you trust, like someone at [DELIVERY PARTNER] or call a support line like Samaritans, Mind or Refuge. (can provide details)
- Do you have any final questions for me? If you think of anything, just get in touch.
- I just want to remind you that you'll be anonymous in our report and we'll be publishing that later this year. If you want a copy, let us know.

- If you want to retract from or add anything to what you've told me today, or check over your transcript before it goes in with the others for analysis please get in touch with me or let [DELIVERY PARTNER] know.
- Thank you so much for your time!

Note: researcher should follow up with the site following the interview to confirm it took place, flag any concerns about wellbeing or safeguarding if relevant and nudge them to provide a support offer. We are also very open to feedback on how it went if this is offered by the participant to the site and they're happy for it to be shared, but this isn't necessary.

APPENDIX D: DEDUCTIVE CODING FRAMEWORK

Due to the tight timescales of the project, the parent and practitioner interviews were deductively coded, with flexibility for the addition of inductively deduced codes. The basic framework can be viewed below:

Analysis coding framework

Use the below deductive coding framework during the familiarisation and initial/continued coding. Many passages will need to be coded more than once/fall into more than one code. The below framework uses **bolded text** to indicate an overarching node, and within it are a series of underlined nodes. These underlined nodes should be nested within the **bolded node** they sit underneath. Similarly, the nodes that are *in italics* should be nested within the underlined node they sit within, which is nested underneath the overarching **bold node**. A coding of a passage should go as far down the chain as possible, i.e., ideally a node *in italics*, and if not a node in italics then a node which is underlined (failing that, the **bolded node**).

Inductive codes can be created for emerging themes within underlined or **bolded nodes**, where they are not covered by the framework. These codes will be reviewed across the whole coding team to agree the same nodes that can be used across all sites/transcripts. All new nodes being created should be written down as a list and circulated prior to meetings.

Context
Service offer
Environment
Staff
Addressed by service
Service user needs
Demographics of service users
Not addressed by service
Service user needs
Demographics of service users
Activities
Referral
Identification
Referral
Assessment
Staff training
Supervision
Psychoeducation (adult-participant)
Child
Self

Relationships
Communication
Trauma and abuse
Emotional regulation
Psychoeducation (child-participant)
Parent
Self
Relationships
Communication
Trauma and abuse
Emotional regulation
Therapeutic
Group (child)
Group (adult)
Individual
Dyadic
Parallel – child/parent
Parallel – parent/parent
Outreach
Advice surgery
Coffee mornings
Practical
Legal support
Legal education
Housing advice
Signposting
Delivery partnership
Multi-agency
Social services
Mental health support
Police
Co-location
School setting
Intermediaries
Training and capacity building
Advocacy
Business as usual
Similar to service
Dissimilar to service
Design of services
Absence
Literature based
Attachment theory
Ecological approach
Neurological development
Trauma-informed

Relationship-based
Client-led
Experience based
Adaptations (actual) / Adaptations (desirable)
Tailoring (individual)
Tailoring (group)
Of previous models
Of manualised model
Age group
EDIE
Local population
Outcomes
Parent-perpetrator outcomes
Wellbeing
Resilience
Safety
Emotional regulation
Engagement with services
Trauma symptoms
Relationships (dyadic)
Family functioning (communication, boundaries)
Parent-victim outcomes
Wellbeing
Resilience
Safety
Emotional regulation
Engagement with services
Trauma symptoms
Relationships (dyadic)
Family functioning (communication, boundaries)
Child outcomes (direct/mediated)
Wellbeing
Attachment
Environment
Development
Engagement with services
Trauma symptoms
Relationships (dyadic)
Family functioning (communication, boundaries)
Family outcomes (immediate/extended)
Wellbeing
Resilience
Safety
Relationships
Engagement with services
Trauma symptoms

Relationships (dyadic)
Family functioning (communication, boundaries)
Most achievable
Least achievable
Most important
Least important
Short term
Long term
Barriers
Enablers
Flexibility
Skills of facilitators
Risks/unintended consequences
Mechanisms (how change is achieved/the "why" – what the participant goes through)
Motivation
Feelings
Understanding
Impacts/progress
Relationships
Attachment and bonding
Support network
Understanding
Child
Self
Relationships
Communication
Trauma and abuse
Feelings
Safety
Hope
Shame
Self-blame
Empowerment
Value
Trust
Responsibility
Acceptance
Self-esteem
Validation/being heard
Self-regulation
Roll-out
Manualising
Barriers
Enablers
Fidelity monitoring
Barriers

Enablers
Validated measures
[may include a nesting node for specific measures that come up a lot]
Positive
Negative
Enablers
Barriers
Feasibility
Monitoring tools
Risk assessment
Reflective notes (including discussions)
Debriefs
User feedback
Attendance monitoring
Check-ins
Negative
Positive
Usefulness
In practice
Demonstrating impact
Impact evaluation
General evaluation
Ethics
Feasibility
Positive
Negative
Enabler
Barrier
Additional services
Ethics
Feasibility
Positive
Negative
Enabler
Barrier
Scaled services
Ethics
Feasibility
Positive
Negative
Enabler
Barrier