October 2025 | **Report**

A feasibility study

RESTART

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What Works Centre for Children & Families

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FOREWORD

This feasibility study benefited greatly from involvement from the SafeLives Changemakers and Pioneers groups.[1] The Changemakers are a group of dedicated young people aged 13 to 21 who share a passion to end domestic abuse and tackle the social challenges facing today's youth. The Pioneers are a group of adults with lived experience of domestic abuse, who bring their expertise and passion to ensure work that aims to tackle domestic abuse is meaningful, authentic, and effective. In this foreword, some group members reflect on their experiences of contributing to the study.

From Ellie, a Changemaker at SafeLives

Being involved in the Restart evaluation has opened my brain to a whole new world of possibilities. I've known for a long time that I want to work in the violence against women and girls (VAWG) sector, but now I know that there are meaningful careers working with those that harm and that this work can make a huge difference to the lives of survivors. It's a full circle effect, by helping the people who harm we are helping the survivors.

As soon as I saw the opportunity advertised to be involved in the Restart evaluation, I knew I wanted to be involved. I'd never been involved in a project focused on working with those that harm and I was keen to have the opportunity to speak to professionals who are involved in this work. I also felt that this project would challenge me and help to expand my knowledge.

A highlight for me was co-facilitating the interviews. I was involved in five interviews which varied from strategic-level professionals to frontline workers. I felt like this variety really helped me understand the Restart project and helped highlight the amazing work it does. When we carried out the interviews I felt like I was a researcher.

I think one of the biggest things I learned was how much judgement there still is for those that harm. For example, in some of the boroughs people said that the housing teams were refusing to house those that harm which then ultimately impacts on the family. I was pleased to hear from boroughs that had a supportive housing team. It was surprising the different levels of knowledge that different interviewees displayed.

It was great working with the Cordis Bright team, we always had a pre meet to go over the questions for the interview and to discuss who the professional was that we were interviewing. I was able to choose what questions I wanted to ask, and processes were put in place to help me

[1] See: https://safelives.org.uk/survivor-voices/ypav-and-changemakers/; https://safelives.org.uk/survivor-voices/our-pioneers/

engage with the interview schedule as I am dyslexic. We had a debrief after each interview and we were involved in the analysis stage.

I want to say a thank you to the Cordis Bright team for being so generous with their time, for treating us as equals, there was no power imbalance, and I felt heard by them. I would love to be involved in future projects with Cordis Bright and, one day, I would love the opportunity to have a career in the VAWG sector and, who knows, perhaps work for SafeLives, Respect, or Drive Partnership!

Ultimately, I think there needs to be more support for those that harm, more research into why they harm and less judgement on those that harm, as judgement will not help end domestic abuse.

From the Pioneers at SafeLives

Two members of our Pioneer group at SafeLives took part in the Restart project; planning and co-facilitating interviews, analysing the findings, and reviewing drafts of the final report. Throughout this project the Cordis Bright team have been open to collaboration and feedback, consistent in their contact and generous with their time to make sure both Pioneers and Changemakers were prepared for interviews, debriefed, and feedback reflected. They made necessary accessibility amendments to support those with neurodiversity and were open to honest feedback throughout. Thank you for having us work alongside you on this evaluation

About Foundations

Foundations, the national What Works Centre for Children & Families, believes 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 with the foundations they need to reach their full potential.

About the evaluator

Cordis Bright was commissioned to conduct a feasibility study of The Drive Partnership's Restart programme.[2]

Cordis Bright believes that public sector services can change lives for the better. We work collaboratively with our clients to improve outcomes for service users and their families. We provide research, evaluation, consultancy, and advice aimed at improving public services. Our team has a unique combination of consultancy, research, and evaluation skills with previous experience in practice, management, leadership, and inspection. Cordis Bright offers a range of research and evaluation services which aim to improve the evidence base from which public services are delivered.

The feasibility study was co-produced with members from the SafeLives Changemakers and Pioneers groups. The Changemakers are a group of dedicated young people aged 13 to 21 who share a passion to end domestic abuse and tackle the social challenges facing today's youth. The Pioneers are a group of adults with lived experience of domestic abuse, who bring their expertise and passion to ensure that work that aims to tackle domestic abuse is meaningful, authentic, and effective.

The evaluation team for this project consisted of:

- Dr Kathryn Lord (Principal Consultant)
- Emma Andersen (Senior Consultant)
- Hannah Nickson (Director)
- Professor Darrick Jolliffe (Associate, University College London)
- Scarlett Whitford-Webb (Consultant)
- Ashna Devaprasad (Researcher)
- Dr Jordan Tomkins (Researcher)
- Dipty (SafeLives Pioneer)
- Hannah (SafeLives Pioneer)
- Ellie (SafeLives Changemaker)
- Haseeba (SafeLives Changemaker)
- Lybah (SafeLives Changemaker)

[2] See: https://www.cordisbright.co.uk/

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- Dr Kathryn Lord (Principal Investigator): kathrynlord@cordisbright.co.uk
- Emma Andersen (Co-Principal Investigator): emmaandersen@cordisbright.co.uk

About the delivery partners

The Drive Partnership

Established in 2015, The Drive Partnership was founded on a shared ambition to change the way statutory and voluntary sector agencies respond to high-harm, high-risk perpetrators of domestic violence and abuse.[3] It is a partnership between the following three organisations:

- Respect leads on developing safe and effective work with domestic abuse perpetrators, male victim-survivors, and young people who use violence in their close relationships.[4]

- SafeLives is a UK-wide charity dedicated to ending domestic abuse for good. It works with organisations across the country to transform responses to domestic abuse.[5]
- Social Finance is a not-for-profit organisation that partners with government, the social sector and the financial community to develop new approaches to tackling social problems.[6]

All partners provide ongoing governance and leadership for all of the work through a joint project board.

Cranstoun

For more than 50 years, Cranstoun has supported people to rebuild their lives, inspired transformation, and empowered positive change. It provides services for adults and young people facing challenges related to alcohol and other drugs, domestic abuse, housing, and criminal justice.[7]

Acknowledgements

The evaluation team are extremely grateful to everyone who made this feasibility study possible. In particular, we would like to thank colleagues from The Drive Partnership and Cranstoun for their unwavering commitment, flexibility, and collaborative approach to problem solving, which enabled the delivery of a complex and evolving programme in often challenging contexts. We are especially thankful to the SafeLives Pioneers and Changemakers groups, whose insight and reflections enriched the quality and nuance of the study findings at every stage. We also extend our sincere thanks to the local area stakeholders, and to the Children's Social Care and Early Help practitioners

[3] See: https://drivepartnership.org.uk/
[4] See: https://www.respect.org.uk/
[5] See: https://safelives.org.uk/
[6] See: https://www.socialfinance.org.uk/
[7] See: https://cranstoun.org/

who generously gave their time to contribute to interviews and share their perspectives. Finally, we are grateful to Foundations for funding this work and for their clear commitment to improving outcomes for children and families. This work would not have been possible without the openness, honesty, and continued dedication to improving responses to domestic abuse from everybody involved.

GLOSSARY OF TERMS

Throughout this report language is used in the following way:

- **Domestic abuse perpetrators** are people who use abuse against their partner or ex-partner.
- **Adult victim-survivors** are people who have experienced domestic abuse from their partner or ex-partner.
- **Child victim-survivors** are children and young people who have witnessed or experienced domestic abuse, either from a parent or from a partner or ex-partner of their parent.
- **Service users** are domestic abuse perpetrators who have received support from Restart.
- **(Ex-) partner victim-survivors** are people who have experienced domestic abuse from the service user. As people are eligible for Restart from age 16 and over, the term adult victim-survivor would not be accurate.

In addition, we use the term **minoritised and marginalised groups** to refer to people who may be disadvantaged or excluded on the basis of a range of characteristics or identities, including (but not limited to) race, disability, gender, literacy, and income. We use this terminology to acknowledge structural inequalities and the ways in which people's experiences may be shaped by overlapping forms of disadvantage.

Throughout this report, where we are referring to people from specific group(s), we specify. However, we note that preferences around language vary, and should always be guided by the wishes of the individual.

Abbreviations

Acronym	Definition
BAU	Business as Usual
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CHI	Centre for Homelessness Impact
CIFA	Culturally Integrated Family Approach

Acronym	Definition
CiN	Children in Need
CSC	Children's Social Care
DAHA	Domestic Abuse Housing Alliance
DARAC	Domestic Abuse Risk Assessment for Children
EDIE	Equality, Diversity, Inclusion, and Equity
IDVA	Independent Domestic Violence Advocates
LHA	Local Housing Allowance
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MDES	Minimum Detectable Effect Size
MHCLG	Ministry of Housing, Communities and Local Government
MOPAC	The Mayor's Office for Policing and Crime
OCD	Obsessive Compulsive Disorder
PTSD	Post-Traumatic Stress Disorder

Acronym	Definition
QED	Quasi-experimental design
RCT	Randomised Controlled Trial
REA	Research, Evaluation, and Analysis
SEND	Special Educational Needs and Disabilities
SMART	Specific, measurable, achievable, relevant, and time-bound
SSC	Strategic Steering Committee
URICA	The University of Rhode Island Change Assessment Scale
VAWG	Violence Against Women and Girls
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale

CONTENTS

KEY FINDINGS SUMMARY

About the Restart programme and feasibility study

The Restart programme aims to improve responses to low-to-medium-risk domestic abuse perpetrators in families known to Children's Social Care (CSC) or Early Help. Developed by The Drive Partnership and delivered across six London boroughs, it involves two strands:

- **Safe & Together model implementation.** A system-level approach supporting CSC, Early Help, and Housing professionals to adopt child-centred, perpetrator-focused practice, delivered through multi-day training and case consultations.

- **The Restart intervention.** A family-level intervention including direct work with perpetrators, parallel support for (ex-) partner victim-survivors, and an optional housing pathway to enable the perpetrator's safe removal from the home.

The feasibility study examined Restart's programme theory and implementation, and focused on building capacity for future impact evaluation.

Key findings

Safe & Together model implementation	The Restart intervention
Local stakeholders highly valued the model rationale and core aims. Model is structured, replicable, and delivered with fidelity. Potential to adapt for the UK context without compromising fidelity. High training uptake and completion; scope to increase manager buy-in to increase local reach and influence of the approach. Early signs of practice change, increased practitioner confidence and focus on perpetrator accountability.	Local stakeholders described as filling a critical gap in support. Lower-than-expected referral rates, which need to increase in future. Reached families from a range of marginalised backgrounds. Housing pathway was underused due to systemic and cultural barriers. More consistent intervention delivery and data collection with service users are needed. Practitioners suggest that service users demonstrate improved motivation for behaviour change and accountability.

Safe & Together model implementation	The Restart intervention
Suitable for future impact evaluation using RCT and QED designs, subject to further preparatory and scoping work.	No participants were recruited to the feasibility study, limiting evaluability. A pre- and post- cohort study may be an appropriate future design.

Recommendations

Each component is at a different level of maturity and evaluation readiness. We recommend co-designed preparatory work for a potential pilot RCT of Safe & Together; and model adaptations with further capacity building work for the Restart intervention.

EXECUTIVE SUMMARY

Overview

This feasibility study explored Restart's programme theory and the feasibility and acceptability of a future impact evaluation using a Randomised Controlled Trial (RCT) or Quasi-experimental Design (QED). It was commissioned by Foundations – the What Works Centre for Children and Families, and conducted by Cordis Bright between April 2024 and September 2025.

About the Restart programme

The Restart programme[8] aims to **improve responses to domestic abuse** and address a long-standing gap: the lack of timely, coordinated responses for low-to-medium-risk domestic abuse perpetrators, who often fall outside statutory thresholds. The Restart programme uses a multi-agency approach to hold perpetrators accountable for change, prevent risk escalation, and ensure (ex-) partner and child victim-survivors have the option to remain safe and together at home.

The Restart programme operates at both the system-level and family-level and comprises two core components:

1. **Safe & Together model implementation:** A system-level approach delivered by Respect, designed to improve responses to domestic abuse by increasing awareness, knowledge, and understanding, to build child-centred, perpetrator-focused practice within CSC, Early Help and Housing workforces. Delivery includes (a) four-day CORE training for CSC and Early Help, (b) one-day Overview training for multi-agency stakeholders, and (c) case consultations and audits.
2. **The Restart intervention:** A family-level intervention delivered by Cranstoun, that supports low-to-medium-risk domestic abuse perpetrators in families known to CSC or Early Help. It consists of three strands:

    - **One-to-one domestic abuse perpetrator intervention:** A four-to-eight-week intervention delivered through weekly one-to-one sessions. It is designed to build motivation, accountability, and readiness for behaviour change and support onward referral to longer-term behaviour change programmes. The intervention also aims

[8] Please note that the term 'Restart programme' is used throughout this report to encompass both core components. However, it should be noted that the Restart intervention is not a behaviour change programme. In addition, The Drive Partnership intends to rename the initiative from the Restart programme to the Restart Model, and this will take effect after the feasibility study period concludes.

to support with a range of unmet needs[9] through the optional housing pathway (described below) and by facilitating referrals to wider support services.

- **Parallel support for (ex-) partner victim-survivors.** While the service user engages in the one-to-one domestic abuse perpetrator intervention, Restart provides parallel support and risk monitoring – such as weekly phone check-ins – guided by the needs and wishes of the (ex-) partner victim-survivor.
- **An optional housing pathway.** This offers temporary accommodation for service users (typically a hotel stay of up to four weeks), along with support to access longer-term housing. Accommodation support workers can provide advice to service users, (ex-) partner victim-survivors and referrers on longer-term housing options. It aims to create space for reflection and ensure (ex-) partner and child victim-survivors have the option to remain safe and together at home.

Programme stakeholders described the Restart intervention as a "tool in the toolbox", supporting the broader systems change that the Restart programme seeks to embed through the Safe & Together model implementation work.

About the feasibility study

This feasibility study aimed to explore programme theory and build capacity for future impact evaluation, focusing primarily on the **Restart intervention**. It also gathered early insights into the **Safe & Together model implementation**.

Feasibility study research question(s)

1. Programme theory validation: To what extent is the Restart programme's theory of change rooted in evidence?

2. Intervention feasibility: To what extent was the Restart programme implemented and delivered as intended?

3. Evidence of promise: To what extent does the Restart programme show evidence of promise?

4. Impact evaluation feasibility: To what extent would an experimental or quasi-experimental methodology be feasible and acceptable?

5. Equality, Diversity, Inclusion, and Equity (EDIE): To what extent do these findings vary based on EDIE?

[9] Unmet needs may include poor mental health, trauma, substance misuse, chronic physical health conditions, or disability, and housing and/or employment insecurity.

Key findings

Programme theory validation

Local area stakeholders recognised that the Restart programme fills a **critical gap in support** for families affected by domestic abuse, particularly where responses to perpetrators are limited or fragmented. They endorsed its value in supporting earlier intervention and improving CSC and Early Help practice.

Future refinements to the programme theory could usefully clarify Restart's role within a wider system response for children and families affected by domestic abuse by:

- **Clarifying shared aims and objectives across components:** Both components are individually well evidenced, but currently operate relatively independently in practice. Future theory development should better articulate how they interact and what Restart aims to achieve as a unified programme. This would support clearer communication, coherent implementation, and future evaluation.
- **Defining achievable outcomes for children:** The study identified three potential routes Restart may improve outcomes for children as an adult-facing intervention: (1) service users achieve and sustain behaviour change, due to an onwards referral after completing Restart; (2) (ex-) partner and child victim-survivors have the option to remain safe and together at home due to the optional housing pathway; and (3) children are better supported by CSC due to Safe & Together model implementation work.

Future evaluations may wish to consider explicit child-level outcomes in line with the Domestic Violence and Abuse Core Outcome Set (DVA-COS),[10] such as child and caregiver emotional health and wellbeing, feelings of safety, family relationships, and freedom to go about daily life. These outcomes are likely to emerge over the medium to longer term, as a result of sustained engagement and behaviour change following Restart. As such, future evaluations should carefully consider appropriate timescales and mechanisms for measurement over time.

Programme-level implementation and evaluability

Implementation progress and learning

Both core components of the Restart programme were implemented across all six Restart sites (see Figure 1). While there were variations in delivery across each component, all six sites took active steps to mobilise the programme.

- Implementation success varied by local system readiness. Factors including recognition of local need, strategic buy-in across CSC, Early Help, and Housing, alignment with local

[10] See: https://foundations.org.uk/our-work/publications/selecting-and-validating-outcome-measures-for-the-dva-cos/

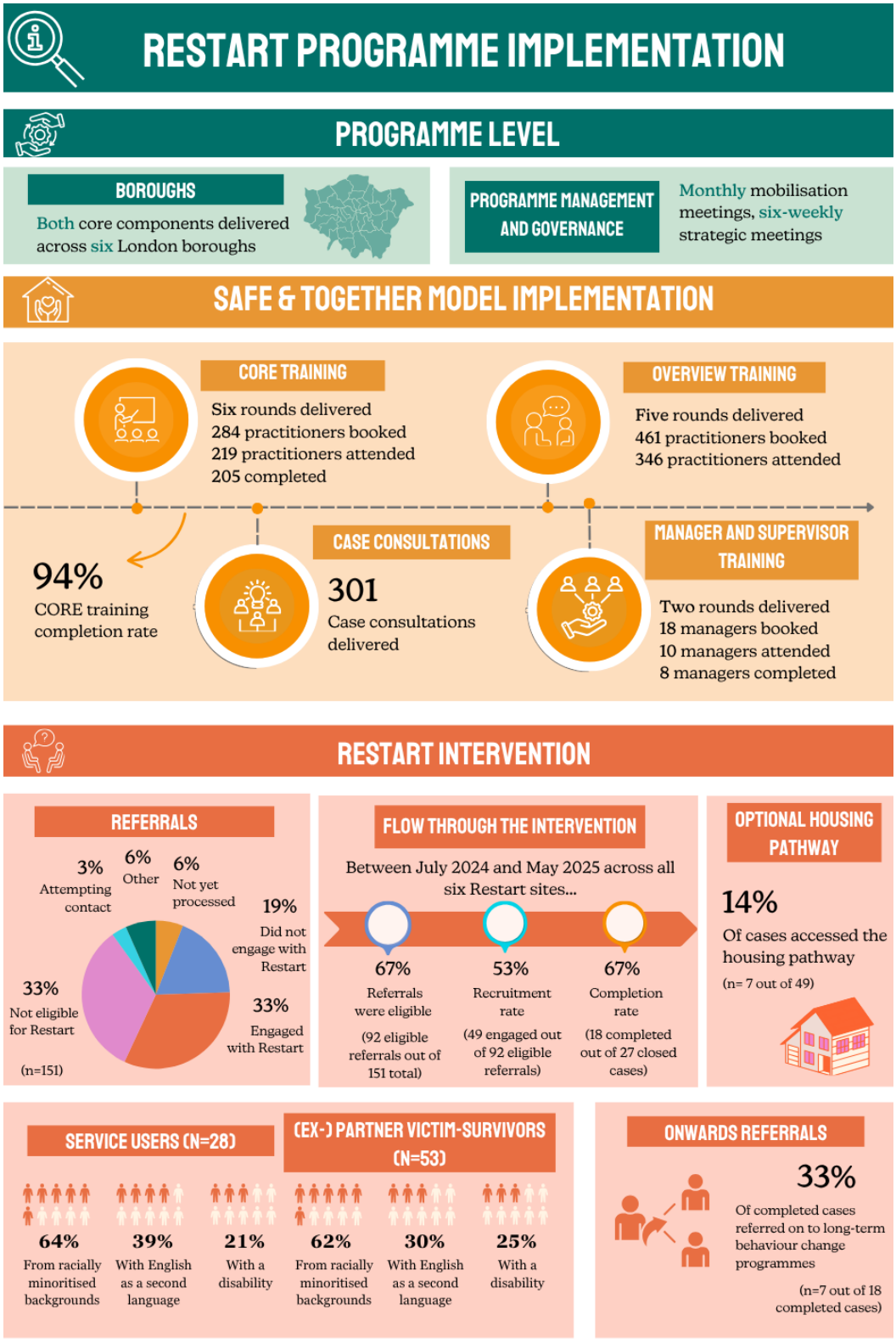
strategic priorities to tackle domestic abuse perpetration, operational capacity, complementary DAPP provision, and creative and innovative housing teams, were all associated with more effective implementation at the area level.

- Programme-level infrastructure enabled implementation. Regular operational and strategic meetings, along with opportunities to share learning, supported coordination and consistency, although engagement from local area leads varied. Interviewed local area leads praised the commitment and adaptability of programme managers and frontline delivery teams.
- Looking ahead**, strengthening area selection processes** to account for local system readiness and **further developing spaces for cross-strand learning** may enhance programme coherence and influence on local systems.

Future impact evaluation feasibility

A full-scale impact evaluation of Restart as a single programme is not currently feasible due to differences in maturity, design, and delivery across components, and the absence of a shared overarching aim or set of objectives. The study recommends evaluating each component independently, using appropriate methods for each component. Combined findings could support a broader understanding of the Restart programme's effectiveness. In addition, involving experts by experience enriched the feasibility study by grounding findings in lived experience, improving accessibility, and enhancing credibility. Future evaluations should ensure that co-production is embedded from the outset to maximise relevance and impact.

Figure 1: Summary of Restart programme's intervention implementation findings (go to accessibility text)



Safe & Together model implementation and evaluability

Intervention feasibility

The Safe & Together model implementation was delivered as intended across all six sites, with strong practitioner engagement and early signs of practice change. The model shows emerging promise.

Table 1: Safe & Together model implementation key findings

Research question	Summary of findings relating to Safe & Together model implementation
Programme theory	• Safe & Together is an internationally recognised, manualised model focused on improving system responses to domestic abuse. It aligns with child-centred, perpetrator-focused practice. Further UK-specific evaluation is needed.
Reach and responsiveness	• Training uptake and completion rates were high across both CORE and Overview training. • Safe & Together implementation leads played a key role in promoting visibility and providing ongoing support. • Low managerial buy-in was a key challenge.
Dosage and fidelity	• Training was delivered with fidelity. While individual-level data on dosage is not currently collected for training, engagement and completion rates suggest most practitioners received the training as planned.
Quality and acceptability	• The model was widely endorsed for its clarity and emphasis on perpetrator accountability. • While some stakeholders reported that the model is too rigid for the UK context, adaptation work is under way and should be prioritised and continued.

Research question	Summary of findings relating to Safe & Together model implementation
Evidence of promise	• CSC and Early Help practitioners reported greater confidence in identifying coercive control, holding perpetrators accountable and reducing victim-blaming. • Restart practitioners reported improvements in referral form quality from CSC following CORE training.

Future impact evaluation feasibility

Safe & Together model implementation is potentially well positioned for experimental evaluation. Its structured, replicable training model lends itself to area-level or team-level randomisation within local areas. Further preparatory scoping work is recommended, including embedding validated outcome tools and exploring additional data sources, such as structured case audits and administrative data, and collaborating with programme stakeholders to co-develop an ethical and acceptable evaluation design.

Restart intervention implementation and evaluability

Intervention feasibility

The Restart intervention addresses a critical service gap and draws on promising approaches for working with domestic abuse perpetrators. This component is at an **earlier level of intervention maturity**. Implementation was affected by the intervention's early development stage and lower-than-expected referral volumes.

Table 2: Restart intervention key findings

Research question	Summary of findings relating to Safe & Together model implementation
Programme theory	• The Restart intervention draws on promising approaches such as motivational interviewing, Cognitive Behavioural Therapy (CBT), and the Duluth model (Eckhardt et al., 2013).

Research question	Summary of findings relating to Safe & Together model implementation
Reach and responsiveness	• **Referral volumes were lower than anticipated,** in part due to limited referrer understanding around low-to-medium-risk domestic abuse, the purpose of the intervention, and low confidence and competence to initiate referral conversations with domestic abuse perpetrators. • **Around half of eligible service users engaged** with the intervention, supported by practitioner persistence and coordination with referrers. • **The intervention reached marginalised groups.** A significant proportion of service users were from racialised backgrounds, had additional language needs, and/or disabilities. • Two-thirds of service users completed the intervention.
Dosage and fidelity	• The average length of support was 23 weeks**.** • The average number of support sessions was six.
Quality and acceptability	• Interviewees viewed the intervention as a **flexible, tailored method** of building motivation for behaviour change, but noted the short length may limit potential. • Parallel support for (ex-) partner victim-survivors was viewed as **empowering and respectful**. Relationships with partner support workers were highlighted as a key mechanism of change. • The optional housing pathway was recognised as a **distinctive feature** of Restart, though **uptake was low**.
Evidence of promise	• Practitioners reported[11] motivation for behaviour change and accountability improved for service users. • Practitioners reported improved safety and wellbeing of nearly three-quarters of (ex-) partner victim-survivors.

[11] This data is based on a subjective assessment made by practitioners, using a five-point Likert scale.

Future impact evaluation

The Restart intervention **is not yet ready for robust impact evaluation** and programme stakeholders raised ethical concerns around the acceptability of randomised designs. No participants were recruited to the feasibility study, and further capacity-building work is recommended to strengthen evaluability. However, the programme team showed strong commitment to learning, embedding new fidelity tools and data monitoring processes during the study.

To improve evaluability, we recommend:

1. Clarifying and codifying the core delivery model, including eligibility and referral criteria
2. Strengthening routine data systems, and embedding validated, short, trauma-informed outcome tools into routine case management
3. Improving training and resources for practitioners on introducing research and obtaining informed consent, or explore other legal bases for sharing data with evaluators
4. Co-designing ethically robust, low-burden methods of capturing service user and (ex-) partner victim-survivor feedback.

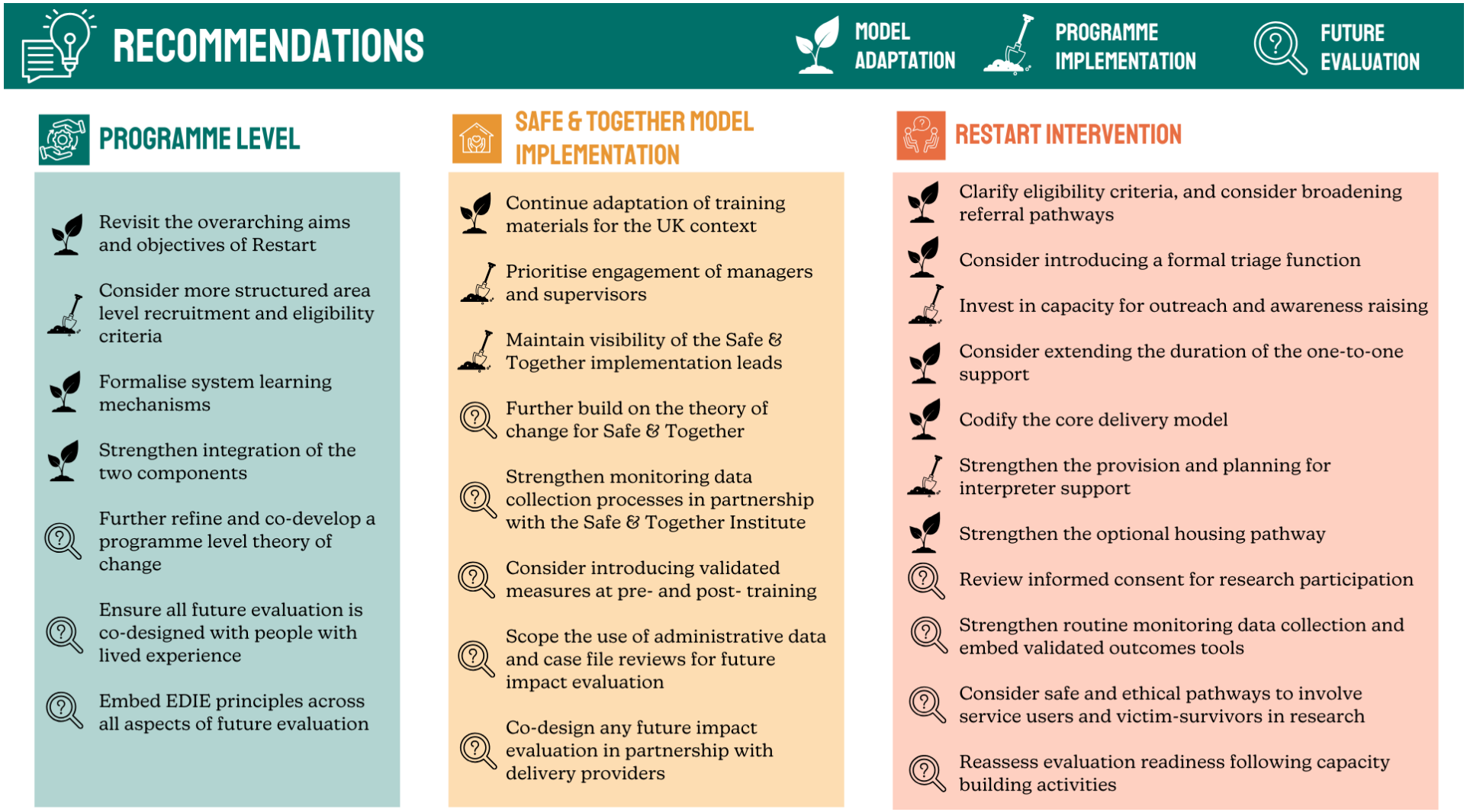
While experimental designs are not yet appropriate, a pre- and post-cohort study may offer a pragmatic and proportionate option, once the model is more established.

Conclusions and recommendations

This feasibility study provides early insights into delivering a combined approach to domestic abuse perpetrator intervention and system-wide change across multiple local authorities. Restart is one of the few UK programmes aiming to strengthen professional responses through Safe & Together model implementation while directly engaging low-to-medium-risk perpetrators.

Though not yet ready for full impact evaluation, Restart shows promise and warrants continued development, targeted adaptation, and investment. Further capacity building and infrastructure improvements are needed before evaluating either component robustly. The report offers recommendations (Figure 2) to **support continuous improvement and shared learning**. These are intended to spark constructive dialogue and reflection among those delivering, commissioning, and shaping the Restart programme.

Figure 2: Recommendations from the Restart feasibility study (go to accessibility text)



INTRODUCTION

Overview

This is the final report for the feasibility study of The Drive Partnership's Restart programme. The partnership was established in 2015 by Respect, SafeLives and Social Finance, and aims to change how agencies respond to high-harm, high-risk domestic abuse cases. The study aimed to understand the programme theory behind the Restart programme, and whether future impact evaluation is feasible and acceptable using either Randomised Controlled Trial (RCT) or Quasi-experimental Designs (QEDs). The study was commissioned by Foundations – the What Works Centre for Children and Families and conducted by Cordis Bright between April 2024 and September 2025.

Background

Study rationale and problem statement

Domestic abuse affects one in five children in the UK, with significant emotional, behavioural, social and physical consequences (Molloy & Waddell, 2021). The Domestic Abuse Act 2021 recognises children who witness or experience domestic abuse as victims.[12] While domestic abuse is the most frequently identified factor in Children in Need (CiN) assessments, only 7% of victim-survivors who wanted their abusers to receive support had been successful (Department for Education, 2024; Domestic Abuse Commissioner, 2022).

Restart was developed to improve local responses to domestic abuse, building on the evaluation of the Domestic Abuse Early Intervention and Accommodation Trial (Taylor et al., 2022). Delivered during the Covid-19 pandemic by Cranstoun – a charity supporting people with substance misuse, domestic abuse, housing insecurity, and criminal justice, with Children's Social Care (CSC) and Housing teams across 10 London boroughs, this emergency response addressed a surge in domestic abuse helpline calls. Restart targets key systemic gaps:

a. Gaps in CSC responses to domestic abuse, and a need for workforce development in skills and confidence in identifying, and responding to, domestic abuse perpetrators
b. Lack of early intervention and behaviour change programmes for low-to-medium-risk domestic abuse perpetrators
c. Few options for adult and child victim-survivors to remain safe at home or source alternative accommodation
d. Gaps in Housing teams' responses to domestic abuse.

12 See: https://www.legislation.gov.uk/ukpga/2021/17/contents

Each of these factors is explored further below.

Gaps in CSC responses to domestic abuse

CSC can play a crucial role in identifying perpetrators of domestic abuse and in intervening earlier to ensure families' safety, preventing situations escalating to high risk (Ferguson et al., 2020). However, studies show a need to ensure that CSC practitioners have the skills and confidence to manage domestic abuse (Asmussen et al., 2022). The Child Safeguarding Practice Review Panel (2022) highlighted the need for domestic abuse informed training for CSC practitioners, which aims to improve competences, knowledge, and awareness recognising signs of abuse, intervening earlier, and responding to instances of harm. Supporting this, the UK Government's Tackling Domestic Abuse Plan (2022, p. 58) identifies that 'professionals who often encounter domestic abuse need support and training to improve their ability to identify and appropriately refer cases'.

Research also shows a need for cultural shifts within CSC, to place the onus for action onto domestic abuse perpetrators and not the adult and child victim-survivors (Wild, 2023; Holt, 2017). Removing the child from both parents continues to be deployed as the main approach to child protection, despite long-standing arguments that risk to children increases post-separation from their non-abusive parent (Ferguson et al., 2020; Holt, 2017). There is a need to challenge gendered 'failure to protect' narratives, whereby the non-abusive parent, most often the mother, is held solely accountable for ensuring children's safety (Wild, 2023; Olszowy et al., 2020). This includes improving recognition of adult victim-survivors' protective strategies in managing their relationship with the perpetrator to minimise harm to their child(ren) (Wendt et al., 2015). This demonstrates the need for improved knowledge and understanding across the CSC workforce, and improved responses which hold perpetrators to account for their actions to halt the cycle of harmful behaviour (Wild, 2023).

Lack of early intervention and behaviour change programmes for low-to-medium-risk domestic abuse perpetrators

Complementary to a system response which places the onus of responsibility with the domestic abuse perpetrator, is support at the individual level to improve motivation for change. There is emerging evidence that the effectiveness of long-term domestic abuse perpetrator programmes (DAPPs) is enhanced when it is accompanied by support which aims to intervene early and improve motivation for change (Cordis Bright, 2023; Eckhardt et al., 2013; Stewart et al., 2013; Vigurs et al., 2016). A systematic review of DAPPs found that programmes incorporating techniques to address motivation, accountability, and readiness to change had a positive impact on change-relevant attitudes, treatment engagement, and abusive behaviour (Eckhardt et al., 2013).

Despite this, in the UK there is limited provision which aims to intervene with low-to-medium-risk domestic abuse perpetrators to improve motivation for change before risk escalates (Domestic Abuse Commissioner, 2022). Many existing programmes are either court or child protection mandated, and those that are not, may be inaccessible, either requiring a fee or travelling large distances to attend (Callaghan et al., 2020).

In addition, physical and financial barriers to accessing DAPPs are compounded by the fact that people may not always view their behaviours as domestic abuse, and naming and owning harmful behaviours can take specialist support and early intervention. This further provides barriers to access of domestic abuse perpetrator interventions (Make a Change, 2023), and highlights the need for increased interventions which aim to intervene early with domestic abuse perpetrators to improve insights into abusive behaviour and increase motivation for behaviour change (Asmussen et al., 2022)

A lack of options for adult and children victim-survivors to remain safe at home or find alternative accommodation

Domestic abuse is a common cause for adult and child victim-survivor homelessness (Kendrick, 2024). Housing needs are often used to exert control over victim-survivors, with the perpetrator using housing issues to manipulate the victim-survivors economically, or to justify their return to the home (Domestic Abuse Housing Alliance (DAHA), 2021). In addition, perpetrators may block access to housing and support completely for adult and child victim-survivors. In England, government figures show that for 2022 to 2023 domestic abuse is the second most frequently cited reason for loss of households last settled home (MHCLG, 2025). Many women who are forced to flee their homes due to domestic abuse end up homeless, and nearly one-third of women experiencing homelessness cited domestic abuse as a significant factor (Domestic Abuse Housing Alliance, 2021). These figures are also likely to be an underestimate, as domestic abuse is significantly under-reported, and victim-survivors are more likely to experience 'hidden' or 'concealed' homelessness (Bretherton & Pleace, 2018; Bretherton, 2017).

The Domestic Abuse Act 2021 mandated the statutory requirement for local authorities to provide refuge services and safe accommodation to victim-survivors.[13] Despite this, many areas do not have the resources or training to execute this requirement, with more than 10,000 women turned away from refuge in 2022 (Jayanetti & Savage, 2023). Implementation gaps persist, with local authority capacity constraints and proof of priority requirements impacting the ability of adult and child victim-survivors to access support services (Kendrick, 2024). Those who are offered alternative accommodation are often housed away from their local neighbourhood, leaving them isolated from support networks and their children's schools, colleges, workplaces, or childcare (Bimpson et al., 2021).

For many victim-survivors, remaining in the home is not possible or desirable. But for others, it is their preferred option, which requires making the home a safe space for both the adult and child victim-survivor by removing the perpetrator from the home (Kendrick, 2024). This approach is in line with the UK government's perpetrator strategy, which places the onus of response to domestic abuse with the domestic abuse perpetrator (Home Office, 2024). It also reflects DAHA's recommendation that perpetrators should be diverted into alternative accommodation to prevent abuse and serious harm (Domestic Abuse Housing Alliance, 2018). This allows the adult and child

[13] See: https://www.legislation.gov.uk/ukpga/2021/17/contents

victim-survivors to remain close to their existing support networks, minimises disruption to children's schooling, friendships and stability, and reduces the economic and mental burdens of relocating on the adult and child victim-survivor (Domestic Abuse Housing Alliance, 2021).

However, there are a lack of alternative accommodation options for perpetrators to enable adult and child victim-survivors to remain safe at home. High demand for social housing across the UK means there is a high threshold for single perpetrators to access housing, and without sufficient understanding of domestic abuse, housing teams may try to negotiate with families to keep them together due to high demand (Domestic Abuse Housing Alliance, 2021). Service mapping reveals limited long-term funding and pathways for individual perpetrators seeking accommodation in the UK, which would enable adult and child victim-survivors to remain safe and together at home if they choose to (Domestic Abuse Commissioner, 2022). This highlights the need for further provision and understanding of what works to keep adult and child victim-survivors safe at home.

Gaps in Housing teams' responses to domestic abuse

Given this context, the Housing workforce is pivotal in early domestic abuse identification and intervention, and in preventing the rise of family homelessness caused by domestic abuse. While not domestic abuse experts, it is important that Housing strategic and operational stakeholders have a sufficient confidence, awareness, and understanding of domestic abuse and the impact that a lack of accommodation options can have on adult and child victim-survivors. Research from the Centre for Homelessness Impact (CHI) found a limited understanding across Housing of the impact of domestic abuse on victim-survivor mental health and wellbeing, including the misinterpretation of coping strategies such as drugs and alcohol (Bimpson et al., 2021). This further deters victim-survivors from seeking support and prevents access to alternative accommodation. Reflecting this, research undertaken by SafeLives and Gentoo (2018) concluded that the housing workforce should be equipped with the skills and confidence to recognise signs of domestic abuse and effectively collaborate with external organisations to safeguard and support residents.

About Restart

Restart is a dual-component programme designed to improve responses to domestic abuse in low-to-medium-risk families known to Children's Social Care (CSC) or Early Help. It combines: (1) implementation of the Safe & Together model to build system-wide capacity for domestic abuse-informed practice; and (2) the Restart intervention which includes support for perpetrators, (ex-) partner victim-survivors, and an optional housing pathway.

Restart's aims and objectives

Restart was developed in response to the context outlined in the section About the Restart programme. It aims to achieve the following objectives:

1. **To catalyse cultural and systems change across CSC, Early Help, and Housing.** To do this, Restart aims to build workforce knowledge and confidence in responding to domestic abuse, ensuring that accountability is placed with the perpetrator, that children are centred as victim-survivors, and that practitioners partner with victim-survivors.
2. **To build motivation for change and facilitate access to long-term behaviour change interventions for domestic abuse perpetrators.**
3. To ensure that (ex-) partner and child victim-survivors are **kept safe, together, free from harm**, and can remain in their homes if they choose to.
4. To **facilitate access to alternative accommodation** for perpetrators where required, building space for action and ensuring that (ex-) partner and child victim-survivors do not need to flee their homes.

Ultimately, Restart aims to reduce the frequency and severity of domestic abuse and achieve the long-term safety and wellbeing of (ex-) partner and children victim-survivors.

Restart's core components

To achieve these aims and objectives, Restart operates across the **system level** and the **family level**. It does this through the following components, also shown in Figure 3 below:

1. Safe & Together model implementation. This is a system-level approach aimed at improving responses to domestic abuse, by focusing on improving awareness, knowledge, and understanding of CSC, Early Help, and Housing workforces. The model was developed and validated in the US, and has not been adapted for UK context.[14] The model implementation work focuses on ensuring that system level responses to domestic abuse place the accountability with the perpetrator, that children are centred as victim-survivors of domestic abuse, and that that the (ex-) partner and child victim-survivor have the option of remaining safe and together at home. It consists of (1) a four-day CORE training course aimed at CSC and Early Help, (2) a one-day Overview training aimed at multi-agency stakeholders, (3) case consultations and audits to support embedding the model in practice.
2. The Restart intervention. This is a family-level intervention aimed at low-to-medium-risk domestic abuse perpetrators in families known to CSC or Early Help. It consists of three strands:
    - **One-to-one domestic abuse perpetrator intervention:** This is a four-to-eight-week domestic abuse perpetrator intervention delivered on a one-to-one basis, across one to two hour-long weekly sessions. It aims to improve motivation, accountability, and readiness for behaviour change, and to facilitate onwards referral to a longer-term behaviour change programme. The intervention also aims to meet unmet needs through facilitating referrals to wider support services.

[14] Safe & Together has previously been evaluated in both the US and London contexts. Further information from these evaluations is presented in the section Safe & Together model implementation evaluation design.

- **Parallel support for (ex-) partner victim-survivors.** While the perpetrator (service user) engages in the one-to-one domestic abuse perpetrator intervention, Restart provides parallel support and risk monitoring for victim-survivors. This is tailored based on the wishes of the (ex-) partner victim-survivor, but typically includes a series of weekly check-ins, and ongoing risk management and identification of needs.
- **An optional housing pathway.** This is available to all service users who are engaging with support. It facilitates access to temporary, diversionary accommodation for the service user (typically access to a hotel for up to four weeks), with support to secure longer-term housing. Accommodation support workers also provide advice to service users, (ex-) partner victim-survivors, and referrers around accomodation. It aims to remove the service user from the home to provide space for action and reflection, while also ensuring the adult and child victim-survivor have the option to remain safe and together at home.

Programme stakeholders described the programme as a systems change model, with the Restart intervention providing "tools in the toolbox" for CSC, Early Help, and Housing to refer to as part of embedding the Safe & Together model into their everyday practice. The two components are intended to complement each other, with referrals for the Restart intervention generated through the Safe & Together model implementation work, and referrals to ad hoc case consultation and Safe & Together training prompted through conversations with the Cranstoun team as part of delivery of the Restart intervention.

Further information about Restart, including the underlying theory and description according to the TIDieR checklist (Hoffmann et al., 2014), is set out in the chapter Validating Restart's programme theory and delivery model.

About the feasibility study

Research objectives and questions

The primary objectives of the feasibility study of the Restart programme were:

- To investigate the Restart programme in more detail, including the underpinning programme theory and evidence base, intended activities and outcomes, and implementation in practice.
- To consider whether and how future impact evaluation of Restart can be conducted using experimental or quasi-experimental designs.

The high-level research questions of the feasibility study of the Restart programme are set out below. The study also had a number of sub questions, which are set out in Appendix A.

Feasibility study research question(s)

1. Programme theory validation: To what extent is the Restart programme's theory of change rooted in evidence?

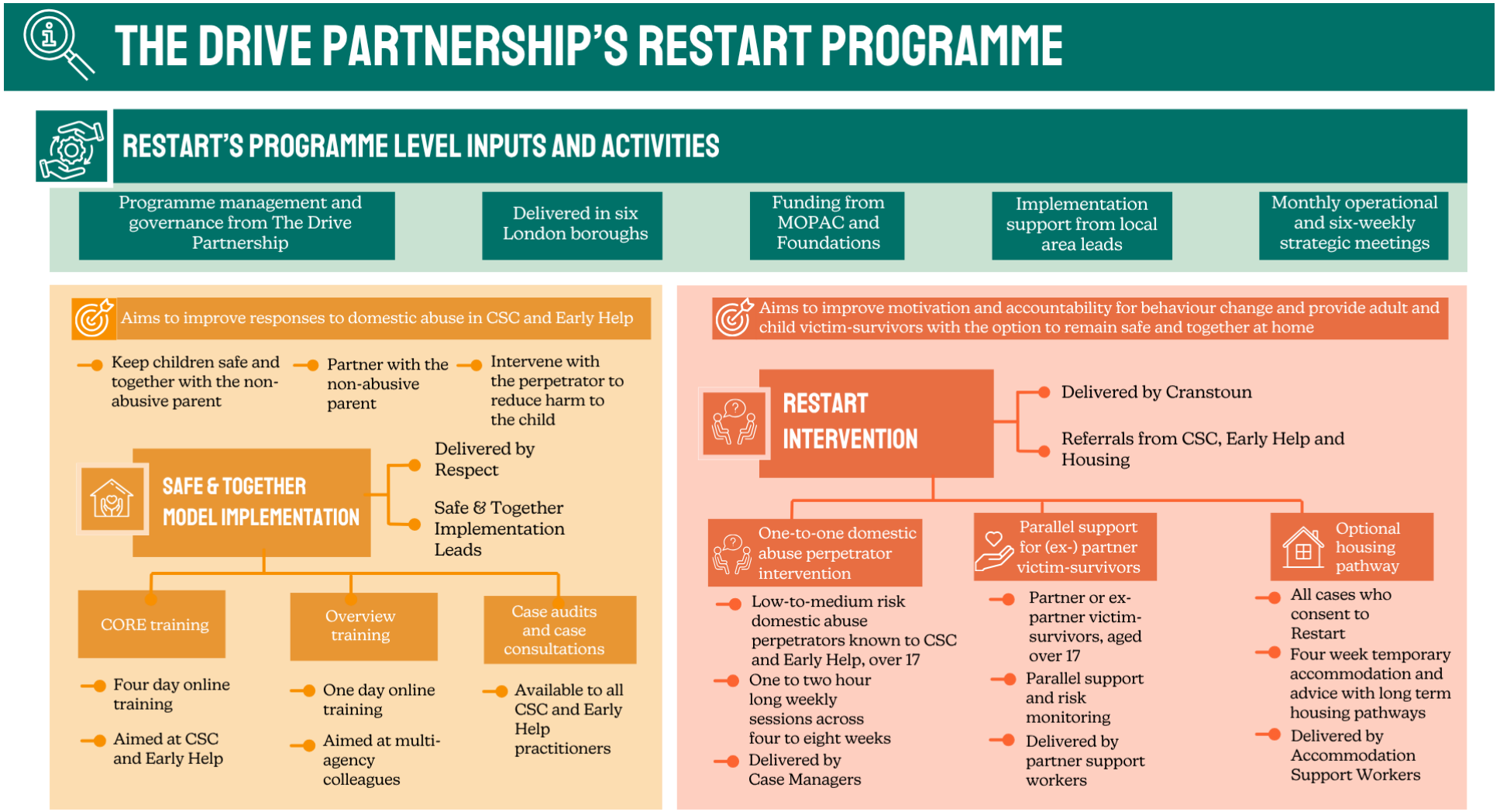
2. Intervention feasibility: To what extent was the Restart programme implemented and delivered as intended?

3. Evidence of promise: To what extent does the Restart programme show evidence of promise?

4. Impact evaluation feasibility: To what extent would an experimental or quasi-experimental methodology be feasible and acceptable?

5. Equality, Diversity, Inclusion, and Equity (EDIE): To what extent do these findings vary based on EDIE?

Figure 3: Restart programme summary (go to accessibility text)



About the scope of the feasibility study

The feasibility study primarily focused on exploring our core research questions related to the one-to-one domestic abuse perpetrator intervention. This included an in-depth examination of delivery, engagement, outcomes, and data collection processes for that component.

While the Safe & Together model implementation forms a key part of the wider Restart programme, our analysis of this component was more limited in scope. This was due to time and resource constraints, and because this element of Restart was not directly funded by Foundations. As such, the study undertook a lighter-touch analysis of Safe & Together model implementation across local areas, and these findings should be interpreted more cautiously.

However, findings related to the Safe & Together model implementation, where relevant, are presented throughout the report. In addition, we provide early reflections and recommendations to inform the design of future research and evaluation focused on this component of Restart.

Progression criteria

As part of the study, we worked with The Drive Partnership and Foundations colleagues to agree progression criteria, which were Specific, Measurable, Achievable, Relevant, and Timebound (SMART). These are set out in the Conclusion and are intended to guide recommendations about whether the Restart intervention should progress to a future impact evaluation using either experimental or quasi-experimental designs. These do not include criteria for the Safe & Together model implementation component of Restart, as this was being funded separately and was not the primary focus of the feasibility study.

Ethical review

Independent ethical approval was sought through Foundations' internal ethics committee, verifying our feasibility study plan as safe, ethical, and considering all key safeguarding and ethical considerations, and awarded on 14 August 2024. For more information on the ethics of the feasibility study, please see the feasibility study protocol (Andersen et al., 2024).

Data protection

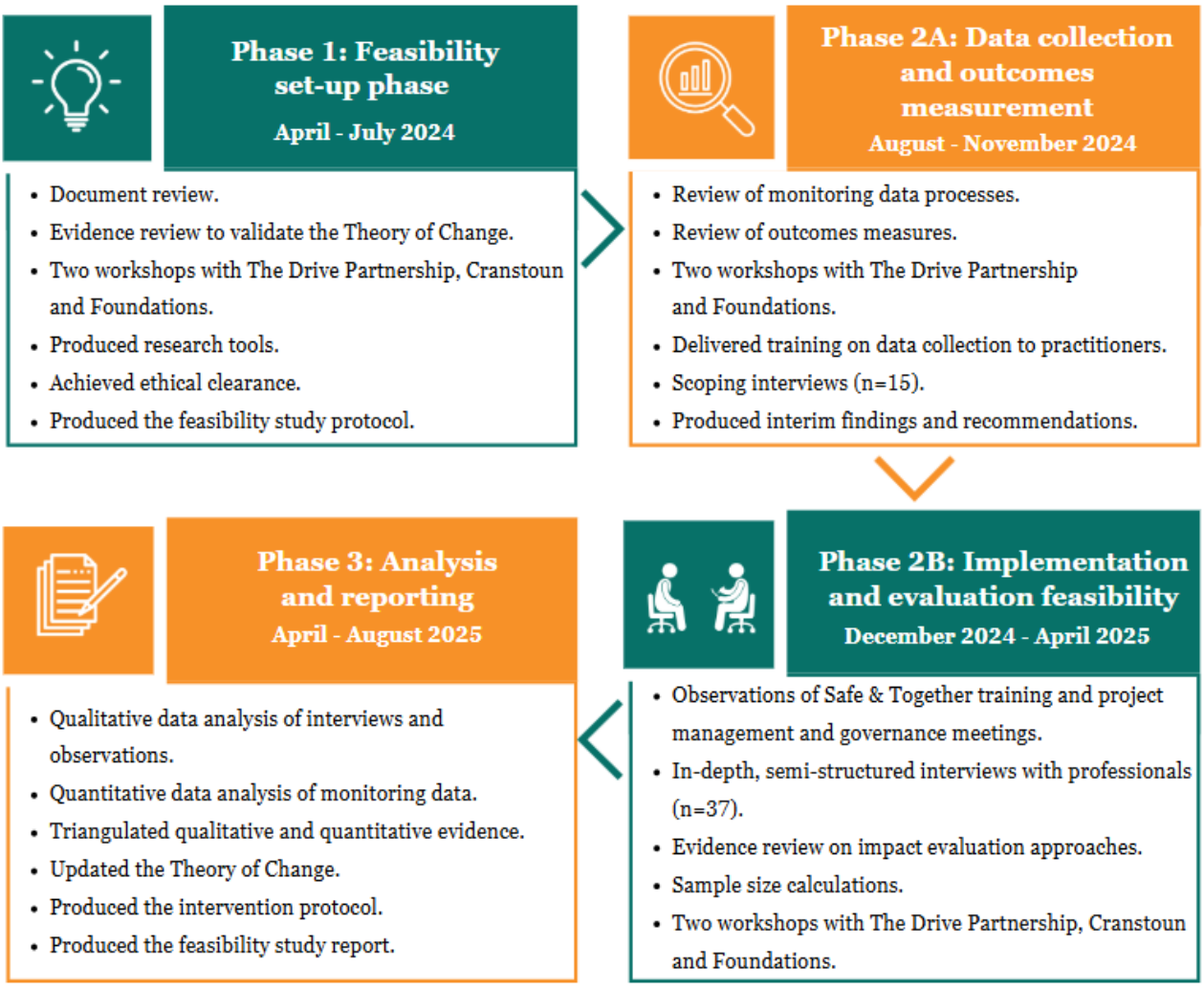
Cordis Bright delivered the feasibility study in line with our full Data Protection and Information Governance Framework for storing and handling personal data. Cordis Bright is registered under the Data Protection Act, has Cyber Essentials Plus accreditation and is registered under the NHS Data Security and Protection Toolkit. Cordis Bright developed a Data Sharing Agreement with SafeLives (on behalf of The Drive Partnership), Cranstoun, and Respect for the feasibility study (see Appendix C). For this study, Cordis Bright was a recipient and data processor of personal data. Further information about ethics and data protection is available in the feasibility study protocol (Andersen et al., 2024).

METHODS

Overview

The feasibility study took an exploratory approach, with a focus on building capacity for future impact evaluation. Figure 4 summarises the methods applied across the different phases of the study, and the rest of this section outlines these methods in more detail.

Figure 4: Summary of methods used in the Restart feasibility study (go to accessibility text)



Phase 1: Feasibility set-up phase (April to June 2024)

Phase 1 focused on understanding and validating Restart's programme theory. This involved:

- A review of programme documentation, to clarify Restart's referral, eligibility, informed consent, and data collection processes
- An evidence review to validate the theory of change, focusing on the evidence behind Restart's intended activities, mechanisms, and outcomes
- Two workshops with programme stakeholders, to further clarify programme theory, participant pathways and agree the feasibility study design
- Producing research tools, including participant information sheets, informed consent materials, topic guides for semi-structured interviews, and data protection documentation (listed in Appendix B)
- Achieving ethical clearance from Foundations' internal ethics committee
- Producing the feasibility study protocol and registering the study on the Open Science Framework.

Phase 2A: Data collection and outcomes measurement (August to November 2024)

Phase 2A focused on capacity building for data collection and outcomes measurement. In this phase, we conducted the following research activities:

- **A review of monitoring data processes for the Restart intervention, including suggestions for improvements to existing processes, and support implementing changes and newly developed fidelity checklists into case management systems and routine delivery.**
- **An evidence review of outcome measures** for service users, (ex-) partner victim-survivors, and CSC practitioners who engage with the Safe & Together model implementation work.
- **Two workshops with programme stakeholders to discuss any changes to data collection processes, outcome measures to trial throughout the remaining feasibility study period and generating buy-in for RCT/QED evaluation approaches.**
- **Training on feasibility study processes for Restart practitioners. The evaluation team delivered two training sessions, one online and one in-person, with Restart practitioners.** These focused on collecting informed consent for study participation from service users and (ex-) partner victim-survivors and supporting completion of validated tools. We produced a practitioner handbook to support the training and provided ongoing guidance with implementing feasibility study processes.
- **Fifteen scoping interviews were conducted** with programme stakeholders (n=7) and Restart practitioners (n=8) to build further understanding of implementation in practice.

- **Interim findings and recommendations were produced in an internal interim report, reflecting on study progress to date.** The report included outlined initial recommendations for intervention adaptations and amendments to feasibility study methods.

Phase 2B: Implementation and evaluation feasibility (December 24 to April 25)

Phase 2B planned to understand: (a) how well Restart has been implemented, and (b) the feasibility of future impact evaluation. These planned activities included:

- **Participant recruitment to the feasibility study**, including the completion of validated outcome measures at pre- and post-support, an optional semi-structured interview about their experience of support, and, for service users, potentially taking part in an observed support session.
- **Semi-structured interviews with professionals**, including programme stakeholders, Restart practitioners, local area leads, and CSC and Early Help stakeholders.
- **Programme observations**, including of programme governance and mobilisation meetings, Community of Practice sessions, and Safe & Together training observations.
- **Analysis of monitoring data** for both the Restart intervention and Safe & Together model implementation.
- **Future impact evaluation deep dive**, to explore the feasibility of future impact evaluation methods.

The subsequent sections provide more detail on each strand of activity.

Participant recruitment to the feasibility study

Despite continued efforts from both the delivery team and the evaluation team, no participants were recruited to the Restart feasibility study across this period. This meant that the evaluation team were unable to analyse pre- and post-outcome measures, conduct semi-structured interviews with service users and (ex-) partner victim-survivors, or conduct observations of the one-to-one domestic abuse perpetrator intervention. The reasons for this, along with implications for future research and study design, are explored in detail in the chapter Findings: Impact evaluation feasibility. The rest of this section outlines the research activities we planned to conduct, but were unable to due to recruitment challenges.

Recruiting service users and (ex-) partner victim-survivors

The feasibility study planned to recruit both service users and (ex-) partner victim-survivors to a feasibility study. The planned recruitment pathways were that, after attending an introductory meeting and providing informed consent to receive support from Restart, all service users and (ex-) partner victim-survivors would then be asked by their Restart practitioner whether they would be

interested in taking part in a research study. If they indicated that they would be, they would then take part in a separate meeting with another practitioner (called Evaluation meeting 1). The purpose of this meeting would be to gain informed consent and collect baseline measures. Evaluation practitioners would be a different Restart practitioner to an individual's case manager or partner support worker, i.e. a different practitioner to the person delivering support.

Obtaining informed consent for the Restart feasibility study

Informed consent would then be obtained by service user or victim-survivor evaluation practitioners during Evaluation meeting 1 (T1). For both service users and (ex-) partner victim-survivors, this would take place after their first one-to-one session with their Restart practitioner. These meetings would typically take place virtually, via video call or phone call. Service users and (ex-) partner victim-survivors would be provided with an information sheet and a consent form which set out more information about the feasibility study in advance of the meeting, which would then be explained verbally. A copy of these information sheets is provided in Appendix B. Consent could be achieved either verbally or returned via the online form.

Completing validated outcome measures

If consent was obtained from service users or (ex-) partner victim-survivors, baseline measures would then also be collected in Evaluation meeting 1. For service users, this included a measure of motivation and readiness for behaviour change, and for (ex-) partner victim-survivors, a measure of wellbeing. The same measures would be completed in Evaluation meeting 2 (T2), which would take place with the same service user or victim-survivor evaluation practitioner either within five working days of the case closure meeting (for service users), or within four weeks of the service user's case closing (for (ex-) partner victim-survivors). In addition, a measure of therapeutic alliance was intended to be captured in Evaluation meeting 2 for service users, and a measure of the quality of the relationship with partner support workers was introduced at the same timepoint for (ex-) partner victim-survivors.

All measures were reviewed to ensure that they were in line with Early Intervention Foundation evidence standards, i.e. that they were not amended, that they were standardised and validated, and that they captured the project's outcomes. In addition, we selected measures which were brief, used clear language in plain English, and had evidence of confirmatory or exploratory factor analysis. The outcomes measured planned for use in this study are shown in Tables 3 and 4.

Table 3: Outcome measures for service users

Outcome	Measure
Motivation and readiness for behaviour change (T1 and T2)	The University of Rhode Island Change Assessment (URICA) scale (32 items) (McConnaughy et al., 1983)

Outcome	Measure
Relationship with case manager (T2 only)	The Working Alliance Inventory (Short-Revised) (12 items) (Horvath, 1981)

Table 4: Outcome measures for (ex-) partner victim-survivors

Outcome	Measure
Wellbeing (T1 and T2)	Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) (7 items) (Stewart-Brown et al., 2009)
Quality of relationship with partner support worker (T2 only)	Survivor-defined Practice Scale (SDPS) (nine items) (Cattaneo et al., 2014)

Outcome measures were intended to be administered via an online survey, hosted by Cordis Bright to ensure differentiation between evaluation and practice. Given the range of contexts likely to be experienced by each participant, several options were provided: (1) a survey link could be sent to participants to fill out while on a phone or video call with a Restart practitioner, who would be on hand in case they had any questions or needed further support; (2) if the participant did not have access to technology or preferred not to have a link sent to them due to safety concerns, the Restart practitioner would open the survey and share their screen via video call with the participant, completing the survey together; or (3) the survey would be completed via phone call with the participant. These options were designed to promote accessibility and safety, mitigate any issues relating to digital exclusion or low literacy, and to accommodate the full range of potential contexts to enable participation.

Semi-structured interviews with service users and (ex-) partner victim-survivors

We planned to conduct in-depth, semi-structured interviews with a subset of 12 service users and 12 (ex-) partner victim-survivors who had consented to take part in the feasibility study. To manage risks associated with perpetrator consultation, the interviews would have been sampled separately and would not have included linked dyads. Participants were to be evenly distributed across Restart local areas, with input from the Restart programme manager ensuring the sample reflected a range of ages, ethnicities, and levels of engagement. The interviews were intended to explore participants' experiences of support and early signs of promise, while recognising the limitations of a small sample limitations. Topic guides had been developed in collaboration with The Drive Partnership and Foundations. Interviews were expected to last 45 to 60 minutes and be conducted

online or in person, depending on individual preference. We had prepared a detailed information sheet outlining the aims of the feasibility study, what participation involved, and the voluntary nature of the interviews. Written and verbal consent would have been obtained from all participants. Restart practitioners were to support with logistics, offer pre- and post-interview support, and handle arising safeguarding concerns. Each participant would have received a £20 high street voucher in recognition of their time.

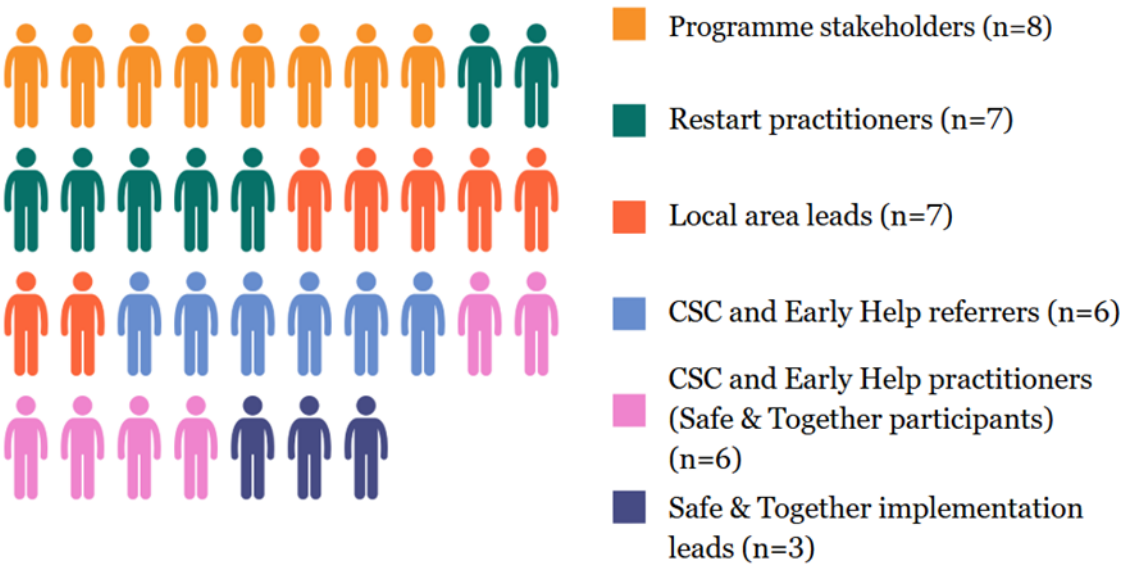
One-to-one domestic abuse perpetrator intervention observations

The evaluation team planned to conduct four and a half days of observation of one-to-one domestic abuse perpetrator intervention sessions, for those who consented to take part in the feasibility study. The aim of these observations was to deepen our understanding of how the intervention was delivered in practice and to assess fidelity to the programme model. We developed an observation guide in collaboration with The Drive Partnership and Foundations, which included capturing general observations on core components of the intervention (e.g. content, format, and adaptation), alongside any emerging evidence of promise related to mechanisms of change. Observations were to be carried out by a member of the Cordis Bright team using recordings of sessions shared securely by Cranstoun. Consent would have been obtained during initial recruitment to the study, and at the start of each session. Observers would have excluded any personal or identifiable information from their notes.

In-depth, semi-structured interviews with professionals

The evaluation team conducted 37 interviews with a range of stakeholder groups, shown in Figure 5.

Figure 5: Number of stakeholders interviewed (go to accessibility text)



These interviews explored implementation (i.e. fidelity and adherence to programme theory), evidence of promise across Restart's components, EDIE considerations for all components of Restart, and future impact evaluation feasibility. The latter topic included views on feasibility study activities so far, including views on the introduction of monitoring and outcomes data collection, the acceptability and practicality of potential randomisation, and considerations for evaluating each component of the programme in the future.

Topic guides were developed by Cordis Bright and agreed in collaboration with The Drive Partnership and Foundations colleagues in Phase 2A. This ensured learnings from Phase 2A informed key areas of interest in Phase 2B (e.g. relating to data collection processes and core components of delivery).

Informed consent was achieved from interviewees verbally at the beginning of each interview. All interviews took between 45 minutes to an hour and were conducted virtually over Microsoft Teams.

Involvement of experts by experience

The evaluation team worked closely with five experts by experience during the feasibility study to co-facilitate interviews with professionals: three young people from the SafeLives Changemakers group, and two adults from the SafeLives Pioneers group.

The evaluation team ran a series of training sessions with both groups, which focused on introducing the Restart programme, feasibility studies and RCTs, and training them on approaches to conducting and co-facilitating semi-structured interviews. All interviews were offered for co-facilitation, and with coordination support from SafeLives' Authentic Voice Coordinator (AVC) and Young People's Authentic Voice Coordinator (YPAVC), the evaluation team co-facilitated 20 semi-structured interviews with professionals (out of the total 37). The Changemakers and Pioneers were supported closely throughout the process through pre- and post-interview meetings with the evaluation team and YPAVC, where we discussed their preferred way of dividing up topic guides, answered any questions, and afterwards explored the key findings from the interview.

Following the completion of interviews, we held analysis meetings with both groups to explore and discuss key themes, triangulate against other data sources, and discuss our final recommendations. Changemakers and Pioneers then reviewed the feasibility study report, providing suggestions for accessibility and additional formats to support dissemination. All Changemakers and Pioneers were given the opportunity to write a foreword for the final report, which was taken forward by one Changemaker with time and interest to draft this with support from the YPAVC.

Programme observations

The evaluation team conducted four days of observation of a range of additional programme activities. These included site specific monthly mobilisation meetings, cross-site Strategic Steering Committee (SSC) meetings, observations of Safe & Together CORE and Overview training, Community of Practice meetings, and ad hoc learning events held by the programme team. These

observations were conducted between November 2024 to May 2025, and informed our understanding of implementation of the programme.

The evaluation team developed observation guides for each activity, which included capturing general observations on key components of the programme and its implementation (e.g. setting, engagement, content), as well as implications for the theory of change.

In addition, we also planned to observe multi-agency Housing Panel meetings. However, we were unable to as these were not held during our observation window due to low take-up of the housing pathway (further information about this is provided in the chapter Findings: Impact evaluation feasibility).

Future impact evaluation deep dive

Phase 2B also aimed to understanding the feasibility of future impact evaluations of Restart via a 'deep dive'. This included:

- **An evidence review on impact evaluation approaches.** We conducted an internal evidence review scoping different impact evaluation approaches for each programme component. The review also explored the feasibility of accessing administrative datasets such as CSC and Housing data.
- **Delivering two workshops with programme stakeholders.** These workshops planned to focus on randomisation approaches and recruitment and retention rates for an impact evaluation. Due to recruitment difficulties, the scope of these workshops shifted to focus on enablers and barriers to generating Restart referrals, possible approaches for scaling Restart, and key reasons service users and (ex-) partner victim-survivors were not engaging with the feasibility study.
- **Completing sample size calculations.** We conducted desk-based power calculations to assess the sample size required for a future pilot RCT of the one-to-one domestic abuse perpetrator intervention to be sufficiently powered.

Phase 3: Analysis and reporting (April to August 2025)

This section outlines our high-level approach to both quantitative and qualitative data analysis.

Quantitative data analysis

We analysed a range of monitoring data sources for this report, due to constraints around data availability and consent constraints.

For the Safe & Together model implementation work, we received aggregate activity data for training and case consultations. This included the number of individuals by Restart site who had booked, attended, and completed CORE training, and the number of individuals who had booked

and attended Overview training and Supervisor training, broken down by borough. We also received information on the agencies of those who attended Overview training, and their agencies. Individual-level data for those who have received the training is not currently collected or available to the evaluation team. Aggregate data analysis was conducted by Respect's Safe & Together Training and Resources Manager, and shared securely with Cordis Bright.

For the Restart intervention, consent to share individual-level data with third-party evaluators is given separately to consent to receiving support for Restart. This meant that individual-level data was only available for a subset of the total cohort who have received Restart across the feasibility period. To enable a comprehensive assessment, the evaluation team analysed:

- **Aggregate data for the entire cohort**, i.e. on referral, engagement, and case closure status for every service user and (ex-) partner victim-survivors who consented to receiving support from Restart across all six local areas between July 2024 and May 2025. This data was analysed by The Drive Partnership's Research, Evaluation, and Analysis (REA) team, and aggregate data tables were shared with the evaluation team.
- **Individual-level monitoring data** for a subset of 28 service users and 53 (ex)- partner victim-survivors who received support from Restart across all six local areas between July 2024 and May 2025, who also consented to sharing their data with third-party evaluators. This included demographic data, needs data, activity data, risk assessments, and evaluation assessments. This data was analysed by Cordis Bright.

All individual-level monitoring data was shared securely with Cordis Bright via encrypted email. All data was shared in line with GDPR, using pseudonyms and processed via the legal basis of consent. Quantitative analysis was conducted in Excel, and included an assessment of data quality (i.e. completeness and appropriateness of categories), and descriptive statistics (i.e. means and proportions) for each variable of interest. Activity data analysis was used to inform understanding around the dimensions of implementation, including fidelity, dosage, reach, recruitment, and attrition. Analysis of demographic and socioeconomic data was used to address key research questions around EDIE, including differences in access and experience of the intervention. This data was used to address quantitative progression criteria around reach, retention, fidelity, data completion, and fidelity.

Qualitative data analysis

Qualitative data from in-depth interviews, observations and open-text case management data were analysed using framework analysis (Ritchie & Lewis, 2003). Following familiarisation with the data, a thematic framework was developed based on the key evaluation questions agreed with programme partners during the set-up phase and themes emerging from the data. Data was indexed against this framework and charted into a matrix to identify key themes across (1) implementation and fidelity; (2) evidence of promise, including whether experiences of support have differed by group; and (3) the feasibility and acceptability of future impact evaluation. This iterative process of coding and constant comparison enabled the team to identify recurring themes

and outliers, ensuring findings were grounded in the data while responsive to the evaluation questions.

Triangulation and reporting

The evaluation team took a robust approach to triangulating qualitative and quantitative evidence to ensure that findings with high relevance and strong consistency were prioritised. The analysis drew on evidence reviews, document reviews, interviews, observations, and monitoring data analysis, allowing datasets to be integrated rather than treated as isolated silos. This enabled the team to identify both commonalities and outliers across sources. The datasets were then mapped against the research questions, with emerging sub-themes iteratively reviewed and discussed to ensure the final analysis was rigorous and reflective of the collective evidence on how well both the feasibility study and the Restart programme have been implemented.

VALIDATING RESTART'S PROGRAMME THEORY AND DELIVERY MODEL

Overview

This chapter sets out findings relating to Restart's programme theory (see Figure 3 above for more information). This includes:

- Restart's theory of change, including the underlying evidence base and areas for further development.
- A description of Restart using the TIDieR framework (Hoffmann et al., 2014).

Research question(s) answered in this chapter

1. Programme theory validation: To what extent is the Restart programme's theory of change rooted in evidence?

This chapter draws on a review of programme documentation, evidence on 'what works' with this cohort, and findings from semi-structured interviews. It outlines the rationale for Restart's components, their intended sequencing and interdependencies, and the anticipated pathways to change.

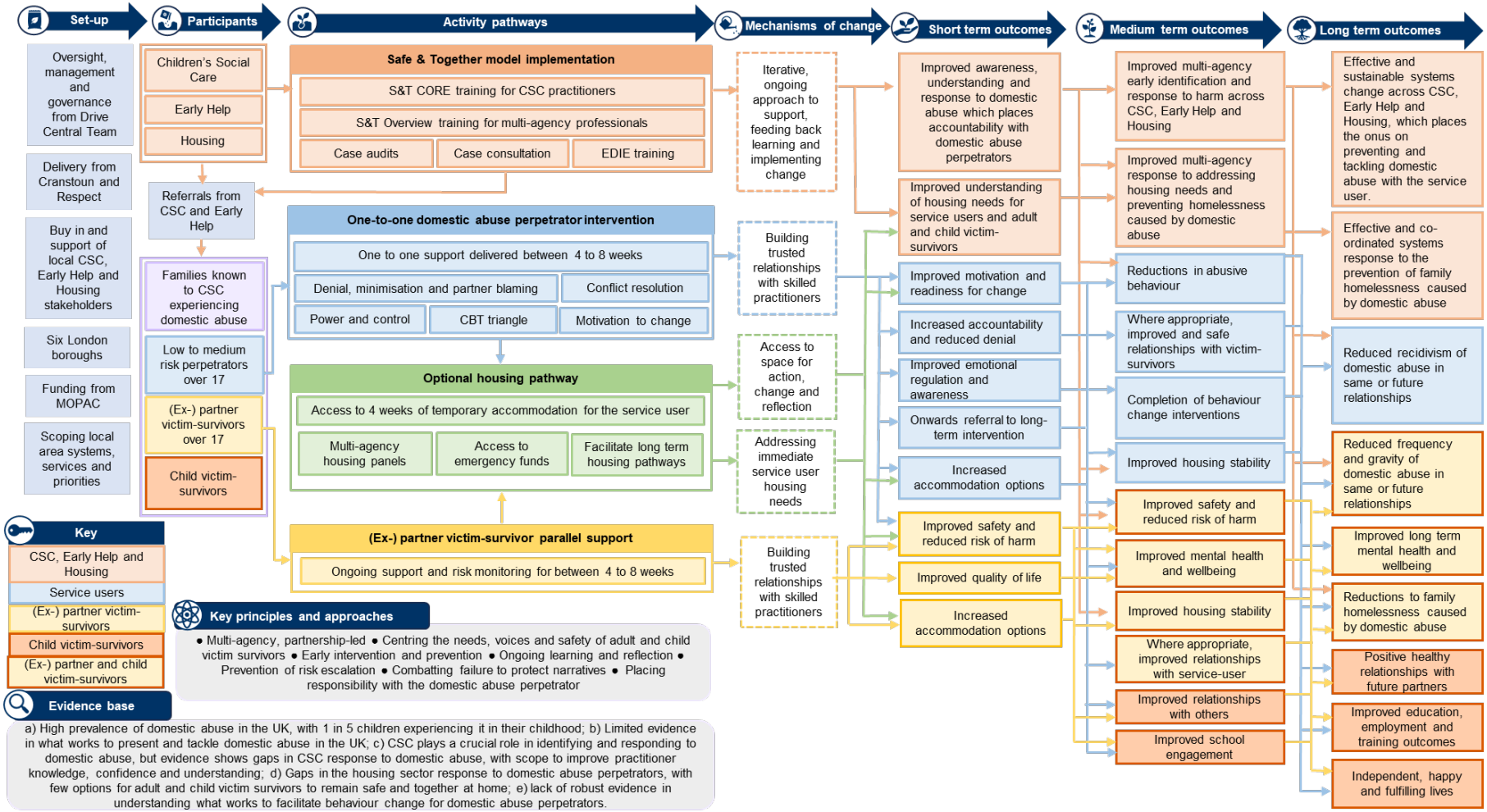
Restart's theory of change

Figure 6 sets out Restart's theory of change. This was developed collaboratively by Cordis Bright and The Drive Partnership as part of the theory building element of the feasibility study and has been validated through interviews and workshops with programme stakeholders and Restart practitioners. A full narrative – including risks and assumptions, more detail about each component, and mechanisms of change – is provided in the feasibility study protocol.

Evidence and assumptions underpinning the theory of change

Restart's programme theory rests on the premise that it is possible to intervene earlier and more effectively with low-to-medium-risk domestic abuse perpetrators and improve outcomes for children and (ex-) partner victim-survivors. This section summarises the assumptions underpinning each component and the available evidence to support them, drawing on the intervention's documentation and logic, as well as external evidence reviewed by the evaluation team.

Figure 6: Restart's theory of change (go to accessibility text)



Safe & Together model implementation work

Assumptions from the theory of change

- Embedding Safe & Together principles in CSC, Early Help, and Housing will drive systemic change, shifting practitioner responses to be more domestic abuse-informed and perpetrator-focused.
- Iterative support from implementation leads will sustain these changes beyond initial training inputs.

Safe & Together is a trademarked, internationally recognised systems-change model, adopted in multiple jurisdictions across the US, Australia, and the UK. According to the Safe & Together Institute, implementation has been associated with reductions in domestic abuse-related child removals (by 44% to 66%) and lower re-referral rates to children's services. UK-based evaluations suggest the model can reframe harmful 'failure to protect' narratives and reduce escalation into formal child protection procedures (Humphreys & Campo, 2017).

Respect's use of **Safe & Together implementation leads**, which are a central feature of Restart's approach to embedding the Safe & Together model, is also a key mechanism for change. Emerging findings from other London boroughs suggest that this iterative, relationship-based approach is effective in sustaining culture change (Garner & Kelly, 2023).

The overall evidence base remains **emergent**, largely consisting of internal evaluations and descriptive practice reports. Independent, comparative studies validating effectiveness at scale are still needed.

One-to-one domestic abuse perpetrator intervention

Assumptions from the theory of change

- One-to-one work builds trust and supports motivation for change, particularly in individuals who would not engage in group settings.
- Incorporating elements of Motivational Interviewing, CBT, and the Duluth model can support behaviour change, especially when tailored to individual needs and experiences.

The overall evidence base for perpetrator behaviour change interventions remains **mixed and inconclusive** (e.g. Almeida et al., 2024; Vigurs et al., 2016). However, several strands of evidence support the specific design choices made in Restart:

- Evidence suggests that **motivational interviewing techniques** are associated with reduced dropout, increased session attendance, and stronger emotional engagement with longer-term behaviour change programmes (Gilchrist et al., 2020; Eisenstadt et al., 2017).

- **CBT-based approaches** that address distorted thinking patterns and integrate stress reduction show modest reductions in domestic abuse perpetrator recidivism and longer time to reoffending (Bloomfield & Dixon, 2015; Birch & Boxhall, 2022).
- **Elements of the Duluth model**, including use of the power and control wheel, help service users conceptualise their behaviour and responsibility (Bender et al., 2018; McCausland et al., 2019).

In Restart, the emphasis on **practitioner-service user relationships** is particularly well supported. Evidence suggests that trusted, individualised work can reduce resistance, support disclosure and reflection, and reduce abusive behaviour over time (Bell et al., 2019; Hughes, 2017). However, there remain several limitations:

- Much of the evidence is based on small-scale, non-randomised studies with short follow-up periods.
- There are high attrition rates and reliance on self-reported outcomes (Akoensi et al., 2013).
- Tailored one-to-one interventions require practitioner skill and adaptability, which may affect fidelity and scalability.

Parallel support for (ex-) partner victim-survivors

Assumptions from the theory of change

- Independent, trauma-informed support enhances victim-survivor safety and wellbeing.
- Regular risk assessment and case coordination improve whole-family planning and system accountability.

Several features of Restart's partner support offer are consistent with promising practice:

- **Keyworker models** help build trust and continuity of care, valued by survivors for their nonjudgemental and validating approach (Anderson et al., 2020; Chung et al., 2017).
- **Regular risk assessments**, conducted with specialist staff, can improve survivor perceptions of safety (Eggins et al., 2022).
- **Interventions that centre both adult and child victim-survivors' needs** are associated with stronger engagement and improved safety planning (Anderson et al., 2020).

However, variation in length and scope of support across contexts makes comparative analysis difficult. Research is scarce for specific groups, particularly for minoritised or disable survivor groups, and few studies include robust control conditions.

Optional housing pathway

Assumptions from the theory of change

- Providing temporary alternative accommodation for perpetrators can create the "space for action" needed to facilitate engagement, reflection, and behaviour change.
- Removing perpetrators (rather than victims) can reduce disruption for children and families and enhance victim-survivor safety and stability.

Evidence indicates that this component addresses a gap in current service provision. There is **minimal UK-based evidence**, but several sources highlight the rationale for developing and evaluating perpetrator housing pathways:

- Without the option to rehouse perpetrators, victims face homelessness or entrapment (Bretherton, 2017; Bimpson et al., 2021).
- Housing instability for perpetrators may increase stress and reduce engagement; addressing this may improve readiness for change (DAHA, 2021).

Restart's approach aligns with emerging calls for **piloting alternative models** that reduce pressure on survivors and support whole-family recovery. However, the evidence base is currently descriptive, with no large-scale evaluations and little understanding of long-term impact or unintended consequences. Evaluating Restart's optional housing pathway is therefore an important opportunity to build the field.

Summary

Restart's theory of change draws on a carefully selected evidence-base and reflects real-world practitioner and system knowledge. While several components are supported by promising evidence, much of the literature remains emergent and mixed in quality. The design choices embedded in Restart, particularly its emphasis on practitioner relationships, coordinated system responses, and early-stage intervention, are grounded in available learning and represent a thoughtful, if not yet fully validated, attempt to address long-standing service gaps. The subsequent chapters in this study explore the extent to which these mechanisms are being delivered in practice, and how future evaluation can best test their effectiveness.

Proposed changes to Restart's theory of change

Several opportunities to continue refining Restart's theory of change were generated during the feasibility study, through workshops, interviews, and observations. These should be considered in any future iteration of Restart's theory of change. They include:

- **Additional activities.** Ensuring that the new Safe & Together training for managers and supervisors, introduced part-way through the study, is reflected in future versions.

- **Additional mechanisms of change**. Restart practitioners and local area leads suggested multiple additions to mechanisms of change within the theory of change:
    - The four-day Safe & Together training provides time and space for social workers to reflect on current practice and approaches, which is particularly valuable in the context of high caseloads.
    - An important aspect of the parallel support for (ex-) partner victim-survivors is that the partner support worker role is centred around their needs and wishes, which may be different from interactions they have had with other services prior to Restart.
    - Restart offers (ex-) partner victim-survivors space for reflection, both through the time spent receiving direct support, and the physical space provided if the service user accesses the optional housing pathway.
- **Adding further medium-term outcomes for (ex-) partner victim-survivors.** Restart practitioners and programme stakeholders suggested some additional short- and medium-term outcomes for (ex-) partner victim-survivors. These included:
    - From the optional housing pathway, (ex-) partner and child victim-survivors have the option to remain safe and together at home in the short term.
    - From the Safe & Together model implementation work, (ex-) partner and child victim-survivors develop trusting relationships with CSC and Early Help in the medium term.
- **Framing 'improved quality of life' for (ex-) partner and child victim-survivors as a medium-term outcome.** Interviewees noted that improved quality of life for (ex-) partner victim-survivors is unlikely to be achieved in the short term. This is due to the short duration of the Restart programme and the transitions required at the end of support. These may involve referral into, and completion of, longer-term behaviour change programmes for the service user, or securing sustainable housing if they have accessed the optional housing pathway.

In addition, **mechanisms and outcomes for children and young people require further refinement**. Restart is underpinned by a child-centred ethos, and programme stakeholders, Restart practitioners and CSC and Early Help referrers consistently emphasised that children are the intended long-term beneficiaries of the programme. While the intervention works directly with adults, it seeks to influence outcomes for children indirectly. Evidence from workshops, interviews, and case management data suggests that Restart may improve children's safety, stability, and wellbeing through three main pathways:

1. Creating more stable and safer home environments **via the optional housing pathway**, by supporting the removal of the perpetrator from the household and providing (ex-) partner and child victim-survivors with the option to remain safe and together at home.
2. Reducing the severity and frequency of domestic abuse experienced by children **via the one-to-one domestic abuse perpetrator intervention**, by increasing perpetrator motivation and accountability for behaviour change, resulting in appropriate onward

referrals to and – crucially – the successful completion of effective longer-term behaviour change programmes.

3. Enhancing the quality of support for children and families **via Safe & Together model implementation**, by improving professional practice and multi-agency responses to children and families experiencing domestic abuse.

Given the complexity of the context and short-term nature of the intervention, it is likely that all outcomes for children are achieved, and should therefore be measured, in the medium to long term (further discussion on outcome measurement is provided in the chapter Findings: Impact evaluation feasibility). Future theory development should make these pathways more explicit and consider how Restart operates as a stepping stone within a broader, coordinated system response, contributing to a service landscape which ultimately improves outcomes for children experiencing domestic abuse.

In future versions of Restart's theory of change, greater clarity is needed about how and when child-level outcomes are expected to occur, what conditions are necessary to support these changes, and which elements of the programme (direct or indirect) are most critical. This would support a clearer evaluation framework and help communicate the programme's purpose to partners and commissioners.

What is Restart?

This section describes and analyses Restart according to the TIDieR checklist – a standardised framework used to explain interventions (Hoffmann et al., 2014).

For whom?

Restart's participants are:

- **Safe & Together model implementation work:** primary stakeholders are CSC, Early Help, and Housing workforces. Stakeholders from a range of wider agencies engage with the Overview training.
- **Restart intervention:**
  - Low-to-medium-risk domestic abuse perpetrators, aged over 17, who have involvement with at least one child known to CSC or Early Help.[15]
  - Victim-survivors aged over 17, who are the partner or ex-partner of the referred domestic abuse perpetrator ('(ex-) partner victim-survivor' throughout).

To be referred into the Restart intervention, there is no criteria for age range of the children. Though they do not participate directly in the intervention, the primary intended beneficiaries of

[15] Having involvement with a child could mean having parental responsibility for the child or being the partner or ex-partner of their parent.

the programme include the children of perpetrators and (ex-) partner victim-survivors, who should be able to live safely at home.

Why?

Restart was developed in response to the following context:

- Gaps in CSC responses to domestic abuse
- Lack of early intervention and behaviour change programmes for low-to-medium-risk domestic abuse perpetrators
- Gaps in Housing teams' responses to domestic abuse
- A lack of options for adult and children victim-survivors to stay safe and together at home.

Who delivers?

Restart's strategic partners are:

- **The Drive Partnership:** Restart was designed by The Drive Partnership and developed by The Drive Partnership in collaboration with Cranstoun, Respect, DAHA, and MOPAC (see below).
- DAHA**:** is the leading specialist domestic abuse organisation supporting housing providers to improve their response to domestic abuse.[16] DAHA was not involved in Restart during the feasibility study period.
- **The Mayor's Office for Policing and Crime (MOPAC):** MOPAC is the strategic partner and commissioner of the five Restart local areas in which delivery was already under way as of April 2024, providing strategic oversight and support to the project development.[17]

Restart's delivery partners are:

- **Cranstoun:** Cranstoun is a national provider of specialist domestic abuse services and is the delivery provider for the one-to-one domestic abuse perpetrator intervention. Cranstoun also provides managerial and strategic oversight for Restart.
- **Respect:** Respect is an accredited provider of specialist domestic abuse services. As well as contributing to strategic oversight to Restart via The Drive Partnership, Respect is also the service provider for the Safe & Together model implementation strand.

Practitioner roles and responsibilities are:

- **Safe & Together Implementation Leads**, provided by Respect, deliver the Safe & Together model implementation work.

[16] See: https://www.dahalliance.org.uk/
[17] Existing sites funded by MOPAC are Camden, City of Westminster, Croydon, Havering, and Sutton. The sixth site, Barking & Dagenham, was introduced for the feasibility study with delivery starting in July 2024.

- **Case managers,** provided by Cranstoun, deliver the one-to-one domestic abuse perpetrator intervention with service users.
- **Partner support workers,** provided by Cranstoun, provide parallel support to (ex-) partner victim-survivors.
- **Accommodation support workers,** provided by Cranstoun, deliver the optional housing pathway.

What? (Programme)

Restart is a partnership-led, multi-agency approach to keeping families safe at home through earlier engagement with those causing harm through domestic abuse. It can be broken down into two core components:

1. **Safe & Together model implementation work.** This is a system-level programme which consists of: (1) a four-day CORE training aimed at CSC and Early Help; (2) a one-day Overview training aimed at multi-agency stakeholders; and (3) case consultations and audits to support embedding the model in practice. These case consultations can also function as a mechanism to prompt referrals into the one-to-one intervention.
2. **The Restart intervention.** This is aimed at low-to-medium-risk domestic abuse perpetrators in families known to CSC or Early Help. It consists of three strands:
    a. **One-to-one domestic abuse perpetrator intervention** with low-to-medium-risk perpetrators. This involves one or two sessions per week which last 60 minutes, across a four-to-eight-week period (excluding the assessment period), and is delivered either face-to-face or online via phone or video call. The intervention follows a workbook which contains eight core activities: the Judgement Box; Ladder of Change; The Feelings Wheel; Cognitive Behavioural Therapy Triangle; Signs; Signals and Time-Out; Power and Control Wheel; and the Equality Wheel. However, the exact activities and order in which they are conducted with each service user is tailored based on individual need.
    b. **Parallel support for (ex-) partner victim-survivors**. Once the perpetrator (once accessing Restart, known as the 'service user') is referred, a partner support worker is allocated to the (ex-) partner victim-survivor to provide parallel support and risk monitoring, which includes ongoing risk management and identification of needs. This is often delivered remotely (via text message or phone calls), and typically occurs weekly or bi-weekly but can be increased to multiple times a week depending on individual need. Support is generally delivered over four to eight weeks, with potential extensions lasting up to 12 weeks in total. The length of support is not contingent on the length of support delivered to service users, and (ex-) partner victim-survivors may access an additional four weeks of support after the service user has disengaged with or completed support if they require it. The frequency of support is led by the wishes of (ex-) partner victim-survivors, who do not have to engage with this component of support if they do not wish to.

c. **An optional housing pathway for service users.** Restart provides an optional housing pathway which facilitates access to temporary, diversionary accommodation for the service user, guided by the wishes of the victim-survivor. The optional housing pathway consists of a temporary diversionary accommodation offer, which hosts service users for up to four weeks in a hotel (contingent on their ongoing engagement with the one-to-one domestic abuse perpetrator intervention), as well as identifying longer-term housing placements through local authority housing services. Accommodation support workers may also advise service users, (ex-) partner victim-survivors, and referrers on accommodation and longer-term housing options. The optional housing pathway has two core functions: first, to reduce the risk of homelessness and meet service users' basic needs; and second, to create space for action and reflection, i.e. for those who may live with the (ex-) partner victim-survivor but are not currently at risk of homelessness.

Where? (Local areas)

Restart is delivered in six London Boroughs. Of these, Restart has been delivering in five since 2021: Camden, City of Westminster, Croydon, Havering, and Sutton. As part of the feasibility study funded by Foundations, Restart was also delivered in a sixth borough: Barking & Dagenham.

Where? (Settings)

Both the Safe & Together CORE and Overview training courses are delivered virtually by trainers (i.e. they are live). Safe & Together implementation leads are co-located in social care offices, and consultation and advice can be delivered either in person or virtually.

The Restart intervention is delivered on a one-to-one basis, and this can be either virtual or in person. In-person sessions can be delivered in settings including the local borough's CSC buildings, and Cranstoun offices. Other local settings can be used as agreed between the service user, CSC, and the Restart team.

When?

Restart delivery period for the purpose of the feasibility study ran as follows:

- Existing five local areas: July 2024 to March 2025.
- Barking & Dagenham: July 2024 to May 2025.

Tailoring?

As Restart is delivered in local authorities, there are elements which are tailored based on local contexts and systems. Local variations at the borough level include:

- **Referral pathways.** While referrals are currently received to the one-to-one domestic abuse perpetrator intervention by CSC, Early Help, and Housing across all local areas,

programme stakeholders note that this will be monitored and can be adapted based on local needs.

- **The exact optional housing pathway that is available to service users.** This depends on the local area's housing stock and available pathways. While all local areas include the provision of temporary housing accommodation, the location and pathways of longer-term housing will differ.
- The **availability of non-statutory onwards referral pathways** to long-term Domestic Abuse Perpetrator Programmes (DAPPs). This will vary based on existing provision for low-to-medium-risk domestic abuse perpetrators.

Given the fluid nature of risk and need in the context of domestic abuse, a key approach to delivering the Restart intervention is that delivery is bespoke and tailored based on the individual's need. Tailoring takes the following form across the main components:

- The one-to-one domestic abuse perpetrator intervention includes several 'core' activities and sessions which are completed with all service users. However, the exact order that these sessions are completed in varies. In addition, format (virtual or in person) and dosage (between one or two sessions of support for four to eight weeks) varies, and these decisions are made using the case manager's judgement, guided by the needs, wishes, and accessibility requirements of the service user.
- The tailored nature of the Restart intervention prioritises inclusivity across various cultural, racial, ethnic, and socioeconomic backgrounds. Programme documentation states that one-to-one support allows tailored assistance and delivery of the programme, supported by staff upskilling to ensure culturally competent and inclusive approach to support. This includes tailoring outreach strategies, culturally sensitive messaging, and accessible recruitment materials to reach families from a range of backgrounds.
- The parallel support delivered to (ex-) partner victim-survivors varies in length and is typically provided between four to eight weeks. This is not linked to the length of support provided to the service user but is dependent on the (ex-) partner victim-survivor's wishes and safeguarding requirement.

How well?

Fidelity to Restart throughout the feasibility study has been assessed against the programme's theory of change, manual, and workbook. This was done through the use of monitoring data, the implementation of fidelity checklists which the practitioner team completed following each completed session of support, observations of training sessions, and semi-structured interviews with practitioners.

FINDINGS: RESTART'S IMPLEMENTATION AND EVIDENCE OF PROMISE

Overview

This chapter sets out key findings relating to Restart's implementation and evidence of promise. It is structured in the following way:

- Reach and responsiveness.
- Dosage and fidelity.
- Quality, acceptability, and inclusivity.
- Evidence of promise.
- Future programme adaptations.

Research question(s) answered in this chapter

2. Intervention feasibility: To what extent was the Restart programme implemented and delivered as intended?

3. Evidence of promise: To what extent does the Restart programme show evidence of promise?

5. Equality, Diversity, Inclusion, and Equity (EDIE): To what extent do these findings vary based on EDIE?

Each section presents findings at the programme level, followed by Safe & Together model implementation work and the Restart intervention.

Participant flow through Restart

Figures 7 and 8 below summarise participant flow across the two core components of Restart during the feasibility study period, which are then discussed in more detail throughout the rest of this chapter. Figure 7 shows the flow through the Safe & Together model implementation, including through the CORE training, Overview Training, Supervisor Training and the number of case consultations. Figure 8 shows the flow through the Restart intervention, including the number of referrals, recruited service users, and case closure rates. Please note that sample sizes are much smaller for this component, and findings should therefore be interpreted with caution.

Figure 7: Participant flow through Restart's Safe & Together model implementation (go to accessibility text)

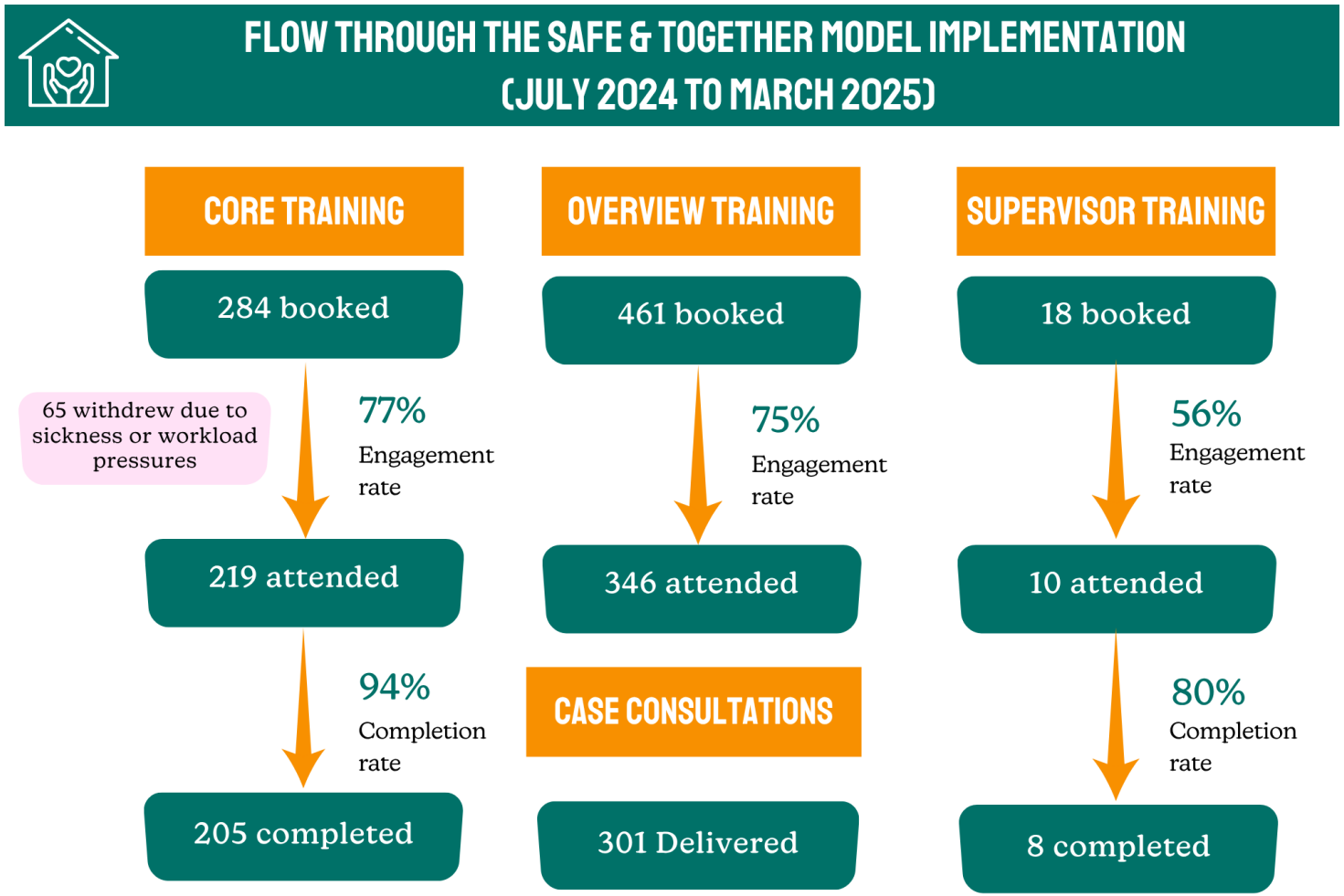
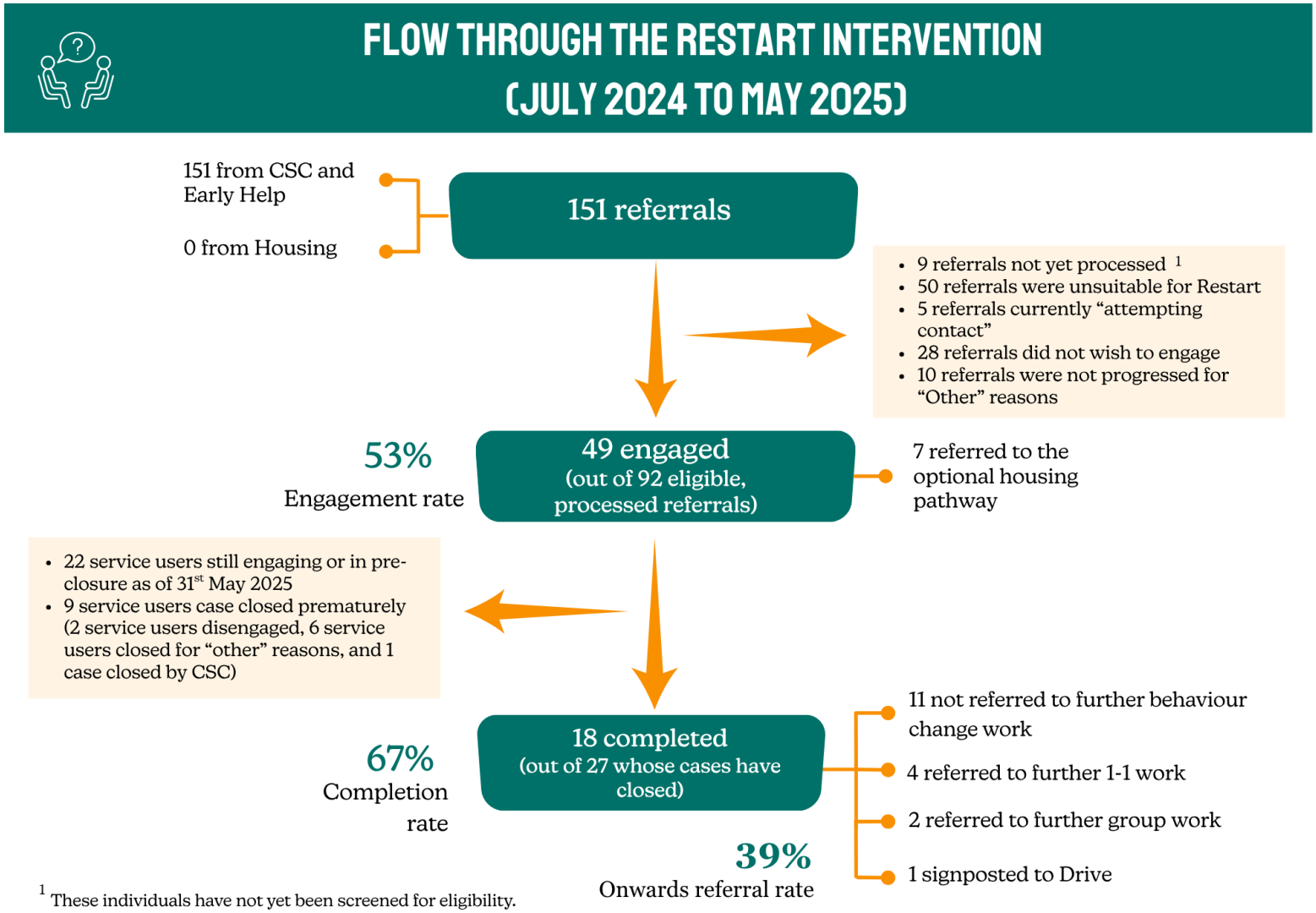


Figure 8: Participant flow through the Restart intervention (go to accessibility text)



[1] These individuals have not yet been screened for eligibility.

Reach and responsiveness

Key messages

Programme level

- Restart was delivered across six London boroughs. Programme stakeholders and local area leads suggest **local area responsiveness** to Restart is shaped by strategic buy-in and recognition of local need across CSC and Early Help, alignment with local strategic priorities to tackle domestic abuse perpetration, operational capacity to support implementation, and complementary DAPP provision for Restart to refer into.
- While all local authorities are currently eligible for Restart, **effective implementation depends on local system readiness for Restart**. Future site selection may wish to incorporate the above factors more strategically into recruitment processes.

Safe & Together model implementation

- There was **strong demand for Safe & Together CORE training**: Between April 2024 and March 2025, 284 CSC practitioners booked onto Safe & Together CORE training across five local areas, with 219 attending (a 77% engagement rate). Six rounds of CORE training were delivered between April 2024 and March 2025 with a **94% completion rate** (205 practitioners completed).
- **There was also strong demand for the Overview training:** 461 multi-agency professionals booked onto the Overview training across six local areas, with 346 attending (75% engagement rate). Five rounds of Overview training **were delivered to a wide multi-agency audience**, with participants attending from a wide range of sectors including education, health, and housing.
- **301 case consultations** were delivered across all six local areas during this period.
- **Low manager take-up** of the CORE training was reported to negatively impact practitioner ability to embed the model into practice. Additional training aimed at managers has started to be delivered, and it may be beneficial to require managers to attend both CORE and Supervisor training alongside rollout to frontline practitioners.
- **Safe & Together implementation leads played a key role** in promoting the Safe & Together model, by attending team meetings, and supporting referrals across local areas, according to interviewees. Despite high engagement rates, levels of CSC staff turnover and CSC workload pressures also posed challenges to reach and recruitment.

Restart intervention

- Across all local areas, referral volumes to the Restart intervention were **lower than anticipated** (151 between July 2024 and May 2025 compared with a target of 360), with 33% of referrals (n=50) assessed as ineligible or inappropriate, predominantly due to being too high risk. Interviews suggest this is due to **poor referrer understanding**

of eligibility criteria, and **low confidence and competence** to initiate referral conversations.

- **Potential solutions** suggested by Restart practitioners include revisiting the eligibility criteria, broadening referral pathways, increasing capacity within the Restart delivery team for awareness raising activities, and developing resources for referrers.
- Individual-level data for of a subset of service users (28 people) and (ex-) partner victim-survivors (53 people) suggest that a **substantial proportion** of the cohort were from **marginalised or minoritised backgrounds**, including being from racially minoritised backgrounds (64% of service users and 62% of (ex-) partner victim-survivors), having additional language needs (39% and 30% respectively), or disclosing disabilities (21% and 25%). This suggests Restart has the **potential to reach marginalised groups**, but further aggregate-level data on the demographic profile of the full cohort of people supported by Restart, including how this compares to local population data, is needed to understand this in more detail.
- 49 service users engaged with Restart across all six sites between July 2024 and May 2025, i.e. **a 53% recruitment rate** from eligible referrals. Case notes suggest motivation for engagement includes wanting to become better parents, and wanting to improve relationships with their partners or ex-partners.
- 27 service users had their cases closed between July 2024 and May 2025. Of these people, **67% completed the intervention** (n=18), with the remaining **33% disengaging part-way through support** (n=9). Of those that completed (n=18), a minority were referred to longer-term behaviour change programmes (n=7). These patterns highlight the **programme's potential to facilitate sustained engagement**, and also the **need for tailored strategies to address barriers to retention** with the programme.

Programme level

From July 2024 to May 2025, Restart was delivered across six London boroughs: Barking & Dagenham, Camden, City of Westminster, Croydon, Havering, and Sutton. This section sets out findings relating to reach and responsiveness at the area level.

Local area recruitment and eligibility

Programme stakeholders reported that area-level recruitment and eligibility for Restart has so far been led by local interest, and a commitment to tackling domestic abuse perpetration. Eligibility for Restart is not restricted by geography; in principle, any local authority would be eligible to implement the programme, granted they commission the programme.

Local area responsiveness to Restart

The degree to which the six local areas engaged with Restart varied, shaped by a range of contextual and structural factors. Factors reported by programme stakeholders included:

- **Recognition of local need and gaps in provision.** Programme stakeholders and local area leads identified that engagement with Restart was stronger in areas where both key strategic leads (such as CSC directors) and stakeholders who would interact with the programme (such as CSC and Early Help practitioners and housing officers) had a clear understanding of the domestic abuse landscape, and recognised gaps in provision targeting low-to-medium-risk perpetrators. For example, where areas had undertaken recent needs assessments or were actively seeking to address gaps in perpetrator provision, they reported greater urgency and receptivity to the programme.

> "Boroughs have to recognise their need and be willing to respond to it."
> Programme stakeholder

- **Alignment with local strategic priorities.** Programme stakeholders stated that engagement tends to be stronger when Restart's aims align with existing local strategies, particularly those focused on domestic abuse prevention and systems change. In Camden, for example, domestic abuse perpetration is recognised as a strategic priority, and dedicated perpetrator leads are in place within the local authority. Programme stakeholders reflected that this alignment provided a clear strategic anchor for Restart's implementation, ensuring it was not seen as a standalone initiative, but as a core component of the borough's broader safeguarding and VAWG response.
- **Strategic leadership across key agencies involved with Restart.** The presence of active, visible support from senior leaders within CSC, Early Help, Housing, and VAWG teams also enabled local responsiveness to Restart. Programme stakeholders reported that Restart was more likely to be understood, prioritised, and integrated into day-to-day practice when these stakeholders attended mobilisation meetings and SSCs or championed the programme within their teams. Conversely, in areas with more limited leadership engagement, there were greater challenges in maintaining programme visibility, sustaining referrals, and building momentum.
- **Capacity to support implementation.** Programme stakeholders emphasised that local areas with more limited capacity to support day-to-day implementation, whether due to financial constraints, staffing shortages, or competing priorities, were less able to take up and champion Restart. Limited capacity among team managers and service leads meant that opportunities to promote the programme, support referrals, and attend implementation meetings were sometimes missed. In contrast, named points of contact with more capacity to engage with the programme were able to play a vital role in raising awareness and troubleshooting operational issues.
- **Complementary DAPP provision.** The presence of complementary local DAPP provision also shaped how effectively Restart could be operationalised. Restart practitioners and local area leads noted that the availability of behaviour change programmes for onward

referral, particularly for low-to-medium-risk perpetrators, was a key enabler. In areas where these services were limited or inconsistent, Restart's potential to support sustained change and offer a clear pathway for service users was reduced. In contrast, areas that had appropriate referral routes for both low- and high-risk individuals were better equipped to integrate Restart as part of a coherent local response.

These findings suggest that while all local authorities are technically eligible to implement Restart, certain enabling conditions are critical for successful uptake and delivery. Recognition of local need, alignment with strategic priorities, visible leadership buy-in, operational capacity, and access to complementary DAPP provision all emerged as important indicators of system readiness for Restart. In areas where these foundations were in place, Restart was more likely to be embedded meaningfully across services, with greater reach, consistency, and impact. Conversely, in boroughs where these conditions were less developed, the programme faced greater implementation challenges and risked being perceived as peripheral. Future site selection may wish to incorporate the above factors more strategically into recruitment processes.

Safe & Together model implementation work

Analysis of monitoring data suggests that **recruitment processes** for both CORE and Overview training are **working as intended**, indicating **high demand** across Restart boroughs.

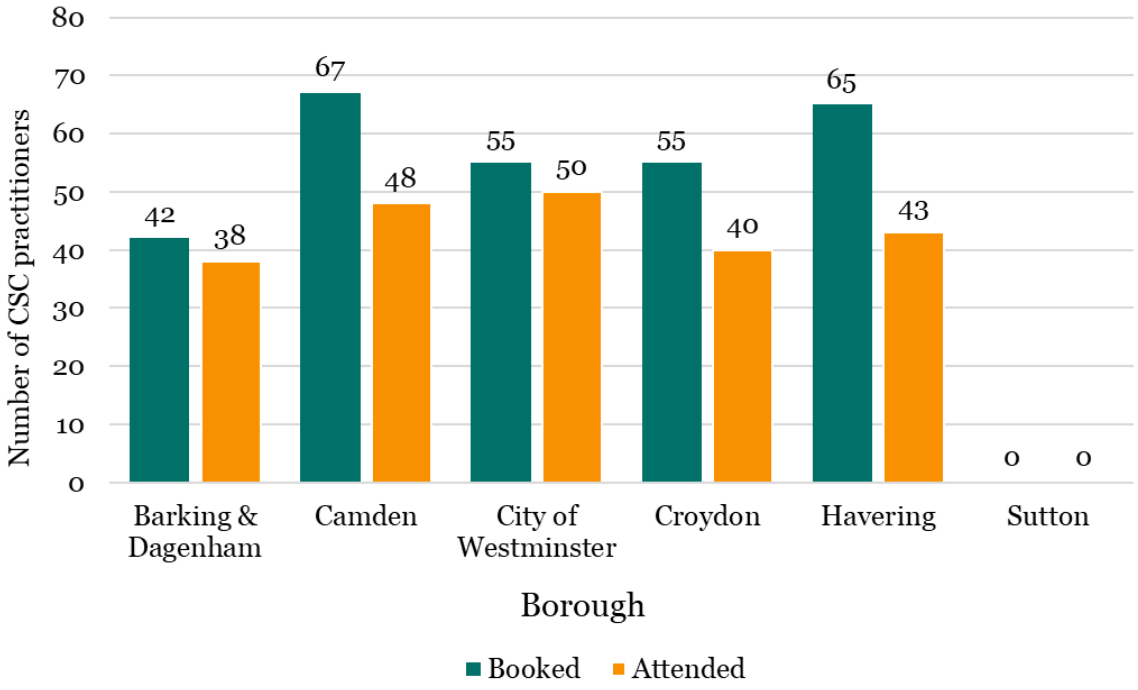
CORE training

Recruitment

Aggregate-level monitoring data suggests that **recruitment into the Safe & Together CORE training works well**. Between April 2024 and March 2025, 284 CSC practitioners booked on to receive the four-day CORE training across five local areas, ranging from between 55 to 67 CSC practitioners per site (Figure 9). Of these practitioners, 219 went on to attend the CORE training, resulting in an overall engagement rate of 75%.

Despite this fairly strong conversion from booking to attendance, engagement with Safe & Together varied by borough. Westminster achieved the highest engagement rate (91%) followed by Barking & Dagenham (90%), while Camden, Croydon, and Havering showed similar engagement levels (72%, 72%, and 66% respectively) (Figure 9). Sutton did not provide matched funding for Restart in 2024–25 and was therefore not offered Safe & Together CORE training.

Figure 9: Number of CSC practitioners who booked onto and attended CORE training across Restart boroughs between July 2024 and March 2025 (link to raw data)



Reasons provided for non-attendance suggest that most of those who did not attend found it hard to fit the training in alongside their day-to-day role (for a more detailed breakdown of withdrawal reasons, see Table E2, Appendix E). Programme stakeholders explained that this conversion rate is built into their recruitment planning, and that they typically invite around 25% more people than they have capacity for to account for withdrawals and ensure that they deliver each session at full capacity.

Programme stakeholders and Restart practitioners reported that recruitment to the CORE training was highly enabled by **Safe & Together implementation leads,** who played a central role in **promoting and embedding the model** across CSC, Early Help, and multi-agency teams. They stated that Safe & Together implementation leads consistently raised awareness of CORE training courses and encouraged take-up of the training offer. In particular, allocating individual implementation leads to each local area was reported to be particularly effective, as CSC and Early Help practitioners understood who to approach about the model. In one example, interviewees shared that all places on a CORE training course were filled within four days, highlighting that where communication was timely and clear, and staff responded quickly and positively. Implementation leads were described as taking an active role in engaging CSC practitioners, including attending team meetings and embedding themselves in local networks, and using case consultations as a platform to promote the training. Interviewees said this visibility and relational work helped strengthen trust and boosted confidence in using the model.

"When the implementation lead has really strong working relationships – you can see it." Programme stakeholder

Despite this strong uptake in some areas, interviewees also reported several barriers to recruitment to the CORE training:

- **Frequent staff turnover in CSC and Early Help.** Most programme stakeholders, Restart practitioners, local area leads, and CSC and Early Help practitioners described high turnover rates within CSC and Early Help teams posing challenges to recruitment to the Safe & Together training. Safe & Together implementation leads reported that this required repeated efforts to promote training opportunities and track uptake across local areas. Interviewees noted that this made it harder to ensure consistent exposure to the model and undermined long-term sustainability.
- **Limited workforce capacity.** Some CSC and Early Help practitioners appreciated the length of the CORE training course, stating the dedicated time allowed them to focus solely on exploring Safe & Together concepts. However, they also stated that some CSC and Early Help practitioners struggled to attend the CORE training course, either due to high workloads or emergency safeguarding issues arising during the training, which led individuals to drop out.

"The challenge was taking four days off from work and balancing work commitments alongside it." CSC practitioner

These findings suggest that there is strong interest in Safe & Together training from CSC and Early Help and the implementation lead model appears effective in driving uptake. However, sustaining engagement across boroughs will require continued efforts to mitigate practical barriers such as staffing pressures, communication gaps, and workforce turnover.

Engagement and completion

Across April 2024 to March 2025, six rounds of four-day CORE trainings were delivered. Table E1 (Appendix E) shows that an average of approximately 36 individuals attended each round. Most rounds included representation from all five boroughs, typically with six to eight participants from each borough.

Of the 219 individuals who attended CORE training across the five boroughs, 205 (93.6%) successfully completed and passed the training (Table 5). Completion rates were high across all boroughs and ranged from 91% to 97%, indicating strong levels of engagement with the training. Only 14 attendees (6.3%) did not meet the full learning requirements, likely due to incomplete post-training surveys.

Table 5: Number of individuals who attended and completed CORE training across six Restart boroughs

Borough	Attended	Completed	Completion rates[18]
Barking & Dagenham	38	37	**97.3%**
Camden	48	44	**91.7%**
City of Westminster	50	47	**94.0%**
Croydon	40	38	**95.0%**
Havering	43	39	**90.7%**
Sutton	0	0	**N/A**
Total	**219**	**205**	**93.6%**

Overview training

Recruitment

Aggregate-level data suggests that **recruitment to the one-day, multi-agency Overview training also works well**.

Figure 10 shows that, across the same period, 461 individuals booked onto the training across six local areas, of which 346 attended.[19] It also shows that bookings and attendance were highest in Camden and Havering, and lowest in Croydon, with engagement rates averaging 75%, ranging from 72% in City of Westminster to 79% in Camden.

[18] Completion rates were calculated as the proportion of individuals who completed the training out of those who attended it.
[19] Completion data was only available for CORE training sessions, which required the completion of a post-training survey to gain CPD credit.

Figure 10: Number of multi-agency professionals who booked and attended Overview training across six sites between July 2024 and March 2025[20] (link to raw data)

Engagement and completion

Five rounds of one-day, multi-agency Overview training were delivered to a total of **346 multi-agency professional**s across six boroughs during the feasibility study period. Aggregate attendance data shows that an average of approximately 58 participants attended each round (Table E3, Appendix E). Most sessions included representation from all six boroughs, with attendance per borough ranging between 8 and 17 participants for each round. City of Westminster, Camden, and Havering generally reported higher attendance compared to Croydon, Sutton, and Barking & Dagenham, where turnout was lower during one or two rounds.

Available aggregate activity data shows that Overview training was **attended by professionals from a wide range of agencies** (Table E4, Appendix E). Most participants came from family/child services (15%), followed by education (14%), NHS/health services (12%), and housing/accommodation services (10%). Other participants included staff from probation, social work teams,[21] domestic abuse advocacy services, substance use services, law enforcement, and other specialist organisations. Smaller numbers of participants came from mental health services, children and young people services, as well as religious and therapeutic services.

[20] Engagement rates were calculated as a proportion of the number of individuals who attended the training out of those who booked onto it. Data on the number of people who were initially invited to the training was not available.
[21] Please note that more granular data on attendance across different social work teams was not collected.

Data on completion is not currently collected for the Overview training.

Case consultations

A total of **301 case consultations were delivered by Safe & Together implementation leads** across the six Restart boroughs between July 2024 and March 2025, suggesting that this element of the model is being actively used (Table 6). The volume of consultations varied across boroughs, with Havering accounting for nearly one-third of all consultations (32.9%), followed by Camden (22.5%) and Barking & Dagenham (19.6%). These patterns may reflect higher levels of practitioner engagement or awareness in these areas. In contrast, uptake in Croydon (7.3%) and Sutton (1.3%) were notably lower.

Table 6: Number of case consultations delivered across each of the six Restart boroughs between July 2024 and March 2025

Borough	Number of case consultations	Percentage of consultations
Barking & Dagenham	59	19.6%
Camden	68	22.5%
City of Westminster	49	16.2%
Croydon	22	7.3%
Havering	99	32.9%
Sutton	4	1.3%
Total	**301**	**100%**

Qualitative feedback offers some insight into this variation. While most interviewees did not reflect directly on the intended scale or targets for case consultations, some CSC and Early Help practitioners reported barriers to accessing them. A few described confusion about how to request a consultation, or uncertainty about what to expect. One practitioner recalled needing to contact multiple colleagues to identify the right access point, which led to uncertainty about engaging.

Taken together, these findings suggest that while delivery of case consultations is progressing well in some areas, there is still scope to strengthen communication and accessibility. Continued efforts to promote awareness, clarify referral pathways, and set expectations may help increase consistency of reach and practitioner confidence in using the offer across all boroughs.

Supervisor training

Some CSC and Early Help practitioners who attended the training highlighted **low buy-in from managers negatively affected their ability to embed the Safe & Together model** into practice. This challenge was compounded when managers had not attended the CORE training themselves. Without managerial support, CSC and Early Help practitioners reported feeling unsupported in their approach, making it challenging to sustain changes in practice and encourage wider cultural shifts.

> "I might get conflicting advice from managers on how to approach a case – this can be tricky to navigate." Early Help practitioner

Recognising this, programme stakeholders reported that **additional training aimed at Supervisors and Managers was introduced** across the feasibility study period. This is a two-day course delivered virtually, and is aimed at Supervisors and Managers who have already completed the Safe & Together CORE training. It is organised around the following supervisory skills:

- Assessing and supporting the quality of worker's practice
- Decision making and worker guidance
- Managing worker safety.

Two training rounds were delivered across the period, and Table 7 shows that across both rounds, 18 bookings were recorded across five boroughs, of which 10 supervisors attended, and eight supervisors fully completed the training.

Table 7: Number of people who booked, attended, and completed supervisor training across five Restart boroughs between July 2024 and March 2025[22]

Borough	Booked	Attended	Completed and passed	Attended but did not meet learning hours
Camden	1	1	1	0
City of Westminster	0	0	0	0
Croydon	2	0	0	0
Havering	6	4	3	1
Sutton	9	5	4	1
Total	18	10	8	2

This supervisor training represents a valuable step in supporting implementation, particularly where low confidence or lack of supervisory tools may be a barrier. However, it does not fully address the broader issue of managerial buy-in. If supervisors have not completed the CORE training or do not feel aligned with the principles of Safe & Together, they are unlikely to champion or reinforce the model in everyday practice. Future delivery may wish to consider **requiring managers to attend both the CORE and the supervisor training prior to or alongside rollout** to frontline practitioners. This may help ensure a more coherent and supported implementation environment, where staff receive consistent guidance and oversight aligned with the Safe & Together approach.

Restart intervention

Referrals and eligibility criteria

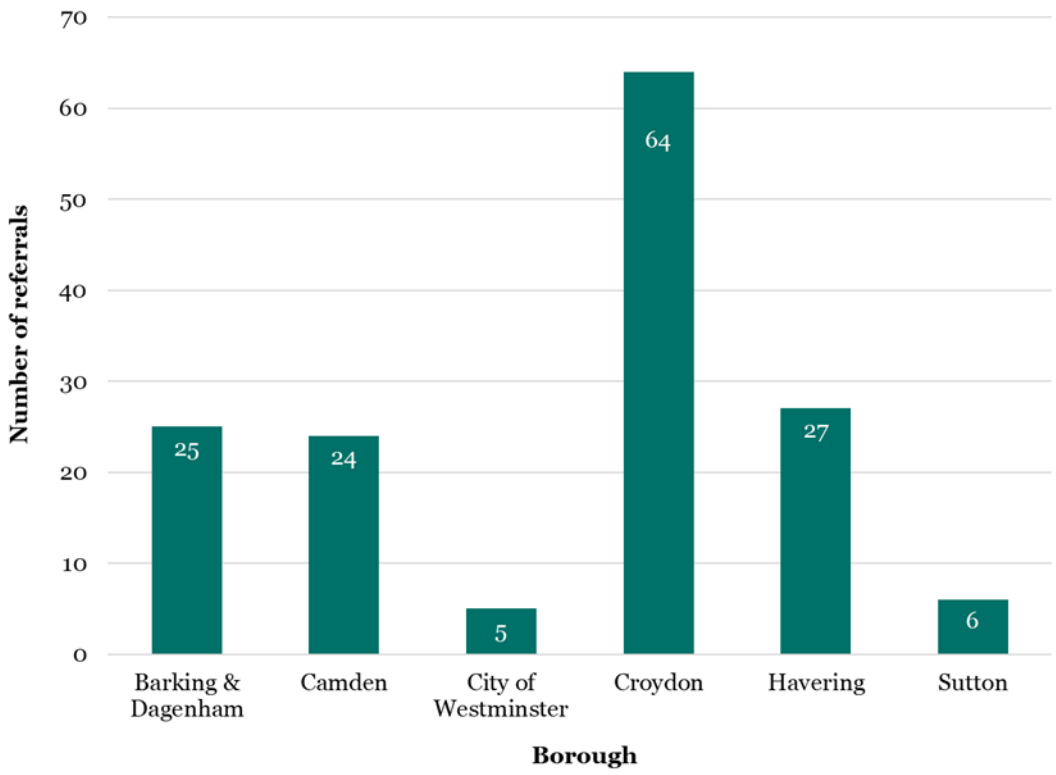
CSC and Early Help referrers across all local areas reported that the **referral process into Restart is generally straightforward**. Referrers described the referral form as clear and non-onerous compared with other interventions they might refer into, and said they valued the Restart

[22] Please note that data on supervisor training for Barking & Dagenham was not available.

team's responsiveness. Most referrers noted that they typically received a response within a few days, allowing them to progress referrals efficiently.

However, **fewer referrals were made** to the Restart intervention across the feasibility study period (July 2024 to May 2025) **than initially planned**. Aggregate-level case management data shows that, across the period, 151 referrals were made across the six participating boroughs, compared to an initial target of 360 referrals (i.e. 60 per site). This target incorporated buffer for an anticipated 68% conversion rate from referral to engagement. This was intended to ensure that targets of delivery to 244 families across all six sites could be met. Figure 11 shows how referral volumes were distributed across the six Restart sites.

Figure 11: Referral numbers to the Restart intervention across the six Restart sites (link to raw data)



All referrals came from either Children's Social Care or Early Help, and no referrals were received from Housing.[23]

In addition, case management data shows that of 151 referrals, more than half (58%, n=88) were not progressed. Of these:

- 50 referrals (33%) were an "unsuitable case for Restart". Of these, 19 referrals were judged to be too high risk for the Restart intervention, and recommended for The Drive Project instead.
- 28 referrals (19%) progressed to "attempting contact" but were closed after service users did not engage or consent to receive support.
- 10 referrals (6%) did not progress to engaging with support for "Other" reasons.

Implementing new interventions is time and resource intensive, so initially slow referral rates for the Restart intervention (particularly in Barking & Dagenham) were to be expected. However, referral rates remained slower than anticipated across all boroughs over the duration of the feasibility study apart from in Croydon, and awareness raising efforts in Barking & Dagenham did not translate into an up-tick in referrals after an initial mobilisation period. Original referral rate estimates were based on delivery data from the previous 12 months, with Barking & Dagenham using the same benchmark as more established areas. Interviews with programme stakeholders, practitioners, local area leads, and referrers highlighted the following key themes expanding on low referral thresholds.

Eligibility criteria

The Restart intervention aims to work with low-to-medium-risk families who are experiencing domestic abuse and are known to CSC or Early Help. However, programme stakeholders identified **a range of challenges with referrers' understanding of low-to-medium-risk domestic abuse**, reflected by the fact that 33% of referrals are ineligible. While the referral form provides several indicators of low-to-medium-risk to help with this, referrals into the intervention are often too high-risk, and need to be recommended for The Drive Project by Restart practitioners instead. This suggests that there is scope to improve referrer understanding of the risk levels associated with domestic abuse.

> "We routinely come up against social workers who are just grateful we're working with perpetrators." Programme stakeholder

That said, programme stakeholders also highlighted that social workers are often too busy to ensure that referrals are directed to the most appropriate services. Some suggested that specialist domestic abuse practitioners may be better placed to triage cases to the right intervention instead. This suggests that a beneficial programme adaptation may be building in more focused capacity to triage referrals to other services.

[23] Please note that Restart does not currently collect closed text information distinguishing referrals from Children's Social Care and Early Help. Future changes to monitoring data may wish to introduce this distinction.

Interviews also indicated scope for further clarity around eligibility for those on bail. While individuals on bail are eligible for the intervention, considered on a case-by-case basis, both practitioners and referrers expressed some confusion around this, suggesting that greater clarity and guidance is needed.

Data on eligibility was only available at the individual-level for a small sample of seven service users. Given the limited size and variability of this subset, no meaningful conclusions can be drawn about overall patterns. However, the small number of complete records highlights the need to strengthen how eligibility data is captured. Currently, information is recorded through open-text fields on the referral form, which may hinder consistent interpretation or internal monitoring. Future iterations of the referral process could include clearer guidance and closed-question thresholds to support referrer understanding of the target cohort and improve internal screening processes.

Referral pathways

The Restart intervention is currently open to referrals from CSC, Early Help, and Housing. In practice, referrals were received from CSC and Early Help, with none from Housing.[24] Several local area leads questioned whether CSC is the right place to target for referrals, stating that the level of risk in families who are referred to CSC for domestic abuse has often escalated beyond low-to-medium-risk. Some local area leads suggested a greater focus could be placed on eliciting referrals from Early Help instead, while others suggested potentially widening referral pathways, including to universal services or to self-referrals. While programme stakeholders reiterated that they do work with eligible families in the CSC caseload, they agreed that there is scope **to continue focus on Early Help**, and that **seeking referrals from a wider range of sources**, such as universal services and self-referrals, may increase the numbers of eligible referrals into the intervention.

It is likely that low-to-medium-risk domestic abuse cases do exist within the CSC caseload, particularly among families referred for other primary concerns such as parental mental ill health or neglect. However, this creates additional challenges in identifying appropriate referrals, as domestic abuse may not be the presenting issue and may go unrecognised or unrecorded by CSC referrers. In such cases, social workers may require further support, tools, and reflective space to identify patterns of abuse, assess suitability for intervention, and make confident referrals to the programme.

Confidence and competence to initiate referral conversations

In the current model, referrers must gain consent for a referral into the Restart intervention from service users and (ex-) partner victim-survivors. However, programme stakeholders and local area leads stated that initiating conversations around domestic abuse can be challenging, and that some referrers may lack the confidence to do so with the families they work with. This speaks to a

[24] Please note that we were unable to speak with Housing representatives, which should be noted as a limitation to the findings in this section.

system-wide challenge in building practitioner capability and confidence to identify and respond to domestic abuse, which can present further challenges to gaining appropriate referrals.

Understanding of the intervention

Some Restart practitioners reported that there is scope to improve referrer understanding of the Restart intervention. They provided examples of referred families being misinformed about its purpose, such as the intervention being incorrectly described by referrers as parenting support or couples counselling. This confusion can undermine trust and negatively affect service users' engagement with Restart practitioners.

Awareness-raising activities

To address the above challenges, programme stakeholders have been conducting a range of awareness-raising activities to try and elicit a greater number of appropriate referrals over the course of the feasibility study. These have included:

- **Co-location** between Restart delivery team leads and Safe & Together implementation leads in multi-agency safeguarding hubs (MASHs), CSC, and Early Help offices
- **Regular presentations** about the Restart intervention at Early Help and CSC team meetings
- **Offering referral consultations** for those considering making a referral into the Restart intervention, and using Safe & Together case consultations as an opportunity to prompt for referrals
- **Developing scripts and information sheets for referrers**, to support understanding of what the intervention is and who it targets, and how to raise this in conversation with families in order to gain consent for a referral. These materials were developed and circulated to all boroughs in January 2025.

Local area leads and CSC and Early Help referrers across all boroughs highlighted how **valuable the awareness-raising activities** conducted by the Cranstoun and Safe & Together teams has been. They stated that this supports increased awareness of the intervention, relationship building, and better understanding around eligibility. In addition, informal pre-referral consultations held between Restart practitioners and CSC and Early Help referrers were viewed positively by referrers for their ability to enhance understanding around eligibility.

However, while there have been promising examples of awareness-raising activities across the study, programme stakeholders highlighted the **time and resource** this takes and stated that they would like to increase the scale of these activities to reduce the reliance on pockets of repeat referrers. In addition, they said that high rates of staff turnover in CSC and Early Help teams can undermine momentum and knowledge about the programme, highlighting the need for ongoing awareness-raising activities.

> "[We are] doing everything we can to get the word out about the programme … but it's hard as there always seems to be someone new, even in the same borough." Restart practitioner

Given the spread of Restart across London boroughs, they suggested that ideally there would be **capacity to do this work on a full-time basis** to support effective implementation.

Recruitment to the one-to-one perpetrator intervention

Aggregate monitoring data suggests that, of the 92 eligible referrals received between July 2024 and May 2025, 49 service users (53.2%) had moved to engaging with the Restart intervention as of 31 May 2025. Of the remaining 43 eligible referrals (46.7%):

- Five referrals were in "attempting contact", where Restart practitioners were trying to establish contact with the service user at the time of data collection.
- 28 referrals were closed after the service user chose not to engage with the Restart intervention.
- 10 referrals were closed for "Other" reasons.

Restart practitioners aim to contact all service users within five working days of a referral being received. Data on the date the first contact was made with each service user following referral was not available. However, for the subset of 28 service users with individual-level monitoring data, 21% (n=6) of service users with available data moved from the case status "referred" to "engaged" in less than a week, and 36% (n=10) were engaged in one to three weeks. The average time between referral and engagement was five weeks, with referral to engagement times ranging from less than one week (n=6), to 19 weeks (n=1).

Programme stakeholders, Restart practitioners, local area leads, and CSC and Early Help referrers provided some insight into this variation, highlighting the amount of work that is required to recruit to the intervention (i.e. convert referrals into cases where both the service user and (ex-) partner-victim survivor consent to receiving support). Referrers and practitioners highlighted the following aspects as working well:

- **Restart practitioners' responsiveness.** CSC and Early Help referrers explained that Restart practitioners' efficient referral processing, which includes prompt confirmation of receipt and regular updates, helps sustain initial engagement. They described the importance of making the most of the 'window of opportunity' when service users consent to receiving a referral for support, so timely response rates from Restart practitioners were welcomed.

> "The support from the Restart practitioner was really positive; they were so eager to try and meet with him and help to get things done." Referrer (CSC)

- **Restart practitioners' persistence in engaging service users.** Restart practitioners and CSC and Early Help referrers stated comprehensive, sustained efforts are made to engage service users in the one-to-one domestic abuse perpetrator intervention.

> "We try really hard to try to engage them … we don't really operate on a 'three phone calls and then we close your case' basis. We won't just give up at the first hurdle." Restart practitioner

- **Coordinated approaches between Restart practitioners and CSC and Early Help referrers.** In some cases, Restart practitioners may liaise with referrers to coordinate the onboarding process, including a three-way meeting between CSC or Early Help, the service user, and the Restart practitioner. While practitioners stated that this does not always happen due to CSC and Early Help availability, this approach promotes continuity, transparency, and collaborative working, helping to build trust with Restart practitioners and providing a more stable handover to support. It also reduces the risk of being unable to engage service users due to practicalities such as contact details changing.

However, Restart practitioners also reported the following challenges to gaining timely engagement with the programme:

- **Lack of detail in referral forms.** Restart practitioners emphasised that when referral forms lack sufficient detail, support can be delayed for service users. Restart practitioners are then required to contact referrers for additional detail on a service user prior to the intervention assessment, to build a clearer picture of the family situation and confirm suitability for the intervention.
- **Supporting wider needs as part of the referral and assessment process.** Restart practitioners noted that service users are sometimes referred without a clear understanding of their broader needs reflected in the referral form, such as mental health challenges or substance use. These needs do not make individuals ineligible for the Restart intervention – the one-to-one domestic abuse perpetrator intervention is designed to help stabilise participants' situations as a foundation for behaviour change. However, when these needs only emerge during the assessment process, it can lead to uncertainty about how best to sequence or coordinate support, particularly if immediate needs require attention before sustained engagement with the Restart intervention is possible. This reflects the reality that many referrers, particularly in CSC, may not have worked directly with the perpetrating parent and may have limited insight into their circumstances. This reinforces the importance of ensuring that the Restart intervention has clear pathways for onward referral or parallel support, as well as clarity about when and how the intervention can work alongside other services. If particular needs are found to consistently prevent engagement, this may indicate a need to revisit eligibility criteria or consider layered models of support.

While CSC and Early Help referrers reported welcoming how straightforward the referral reform is, this suggests there may be scope to improve the format of the form, to ensure that relevant information is clearly recorded to enable efficient onboarding to the programme.

Demographic characteristics

This section summarises key characteristics of the 28 service users and 53 (ex-) partner victim-survivors who consented to share individual-level demographic data with evaluators. While the sample is limited, the findings provide useful insight into the profile of a subset of those engaging with Restart between July 2024 and March 2025. Full data tables are included in Appendix D.

Gender and sexual orientation

All service users (100%, n=28) identified as both male and heterosexual. Nearly all (ex-) partner victim-survivors (98%, n=52) identified as both female and heterosexual; one identified as male.

Age

Service users were predominantly in their 30s, with 13 aged between 31 and 40. The average age was 40, ranging from 22 to 57.

In contrast, most (ex-) partner victim-survivors were slightly younger: 15 were aged 25–30, and only two were over 50. The average age was 35, ranging from 20 to 62.

Race and ethnicity

Just over a third of both service users (36%, n=10) and (ex-) partner victim-survivors (38%, n=20) identified as White British. The rest reflected a mix of ethnic backgrounds:

- **Among service users:** 29% were from Asian backgrounds (including Other Asian, Bangladeshi, Indian), 21% from Black backgrounds (including Black African, Black Caribbean, and Black Other), with smaller numbers identifying as Arab, White Irish, and Pakistani.
- **Among (ex-) partner victim-survivors:** 30% were from Black backgrounds, 19% were from Asian backgrounds, with smaller proportions from Mixed, White Roma, or multiple ethnic heritages.

Disability and health

Six of the 28 service users (21.4%) disclosed a disability. Their needs were varied and, in some cases, overlapping. These included:

- Physical disabilities such as mobility issues and chronic back pain
- Mental health conditions including depression, anxiety, bipolar disorder, and trauma
- Neurodiversity such as Attention Deficit Hyperactive Disorder (ADHD)
- Alcohol or drug use, with two service users currently engaged in recovery support.

Among (ex-) partner victim-survivors, nearly a quarter (24.5%, n=13) reported a disability. Most disclosures related to mental health, including Post-Traumatic Stress Disorder (PTSD), depression, anxiety, Obsessive Compulsive Disorder (OCD), Borderline Personality Disorder (BPD), and bipolar disorder. A few individuals also reported physical injuries (including those linked to abuse), long-term health conditions, or recovery from cancer or substance use. Most needs were overlapping or long-standing conditions.

Language and interpreter need

A significant proportion of both groups spoke English as an additional language, including 39% (n=11) of service users and 30% (n=16) of (ex-) partner victim-survivors. A smaller proportion reported requiring interpreter support (six service users, 21.4%, and three (ex-) partner victim-

survivors, 5.6%). All six service users who required an interpreter spoke different languages, including Urdu, Pashto, Tamil, Punjabi, Sylheti, and Arabic. This indicates that a substantial proportion of service users require interpreter support to access the Restart intervention, with over one in five of this smaller subset requiring it.

Parenthood

Of the 27 service users with individual-level data, all (100%) were parents, with an average of two children each. In total, 58 children's ages were reported, with ages ranging from less than 1 year to over 18. The average age was 7, distributed in the following way:

- 1.7% (n=1) of children were less than 1 year old
- 37.9% (n=22) of children were between 1 to 4 years old
- 29.3% (n=17) were between five to 10 years old
- 29.3% (n=17) of children were between 11 and 17 years old
- 1.7% (n=1) of children were 18+.

This indicates that many families engaging with the Restart intervention are supporting very young children, with around 40% under the age of 4, and a further 30% under the age of 10.

This data offers valuable insight into the demographic profile of a subset of service users and (ex-) partner victim-survivors who engaged with the Restart intervention and consented to share information. The findings suggest that the intervention is reaching a diverse group of families, including those who may experience multiple forms of marginalisation, such as racially minoritised communities, individuals with mental health needs or disabilities, and those facing language barriers.

Notably, a large share of participants spoke English as an additional language, disclosed a disability, or were parenting very young children. These characteristics suggest that the Restart intervention is reaching and engaging families who may otherwise face barriers to accessing support, and highlight the importance of ensuring that support is delivered in an accessible and inclusive way to achieve change.

However, this analysis reflects only a subset of the wider cohort. As such, while the findings are encouraging, they should be **interpreted with caution** and cannot be assumed to represent the full diversity of the programme's reach. Further analysis on a larger proportion of the cohort, including benchmarking against local population demographic data, would support a fuller understanding of who is engaging and who may still be missing.

Engagement with the one-to-one domestic abuse perpetrator intervention

Of the 49 service users who consented to receive support from the one-to-one domestic abuse perpetrator intervention, 22 (44.8%) were still engaging or in pre-closure[25] as of May 2025, and 27 (55.1%) had their cases closed (see Case closure section below).

For service users who remained engaged throughout the duration of the one-to-one domestic abuse perpetrator intervention, open-text case notes detailed different motivations that supported their sustained participation. These included:

- Wanting to become better parents and improve their relationships with their children
- Wanting to improve their relationships with partners or ex-partners – for example, by becoming a more supportive partner, or learning to communicate more calmly
- Recognising a need to stop using violence and abusive behaviours, including managing anger or alcohol use.

However, not all service users engaged voluntarily or had intrinsic motivation to participate. Some told case managers they were taking part because children's services or other professionals had told them to. A few said the one-to-one domestic abuse perpetrator intervention was not something they needed, or that they did not want services involved in their lives at all. While this is to be expected given the target cohort, this lack of internal motivation helps explain why some people disengaged or exited before completing the intervention. It may be useful for future research to benchmark these engagement rates with the Restart intervention against other programmes aimed at a similar target cohort, such as Cranstoun's Men and Masculinities Programme, to provide further context around these figures.

Case closure

Aggregate monitoring data shows that 27 people had their cases closed between July 2024 and May 2025 across all six local areas. Of these, 18 completed the one-to-one domestic abuse perpetrator intervention, while the remaining nine disengaged from support part-way through.

Among those who completed the one-to-one domestic abuser perpetrator intervention, 11 were not referred onward to further support, while seven were successfully referred into longer-term behaviour change support. This included four service users who were referred to further one-to-one work, two into group work, and one who was recommended for The Drive Project.

The nine people who disengaged had their cases closed for the following reasons:

- Six had their cases closed for "Other" reasons.

[25] These cases are still open and may receive additional support, but exit processes and outcomes assessments are starting to be collected.

- Two stated they no longer wanted to engage in the one-to-one domestic abuse perpetrator intervention.
- One exited after their case was closed by CSC.

Case notes for a subset of people with individual-level monitoring data indicate that "Other" reasons for disengagement included service users being relocated outside a Restart borough, staff being unable to establish contact with the service user, or the service user being on bail, remanded, or serving a custodial sentence at the time of case closure. Interviewees also noted other reasons that led to service users disengaging part-way through the one-to-one domestic abuse perpetrator intervention. These included the service user experiencing an acute period of mental health or substance abuse issues, or becoming uncomfortable with the nature of the intervention as it progressed.

These patterns highlight both the intervention's potential to facilitate sustained engagement with behaviour change services, but also the importance of addressing barriers to retention to support engagement through to completion, and referrals into longer-term behaviour change programmes. Future research may wish to benchmark these figures against other behaviour change programmes, and should seek to consult with service users to understand effective strategies to enable engagement, as well as areas for improvement.

Dosage and fidelity

Key messages

Programme level

- Both core components of Restart (Safe & Together model implementation and the Restart intervention) were delivered across all six local areas during the feasibility study. Implementation was supported by programme-wide structures such as monthly mobilisation meetings, SSC meetings and Community of Practice meetings.
- These cross-site structures provided a strong foundation for implementation and sharing knowledge, learning, and reflection, though their effectiveness depended on local engagement and follow-through.

Safe & Together model implementation

- Individual-level data on dosage is not currently collected for the CORE or Overview trainings. However, high engagement and completion rates suggest that the majority of practitioners received the training as planned.
- Observations of the Overview training suggested that training sessions are delivered to high quality by engaging trainers, with fidelity to the planned delivery model.

Restart intervention

- Comprehensive data on dosage and fidelity was not available for this evaluation due to lack of consent to share data with evaluators. Fidelity checklists have been embedded into everyday practice, and future research should aim to collect and analyse a larger number of fidelity checklists over an extended time period to better understand dosage, fidelity, and adherence in practice.
- For the 12 service users who completed the one-to-one domestic abuse perpetrator intervention with individual-level data, the average length of support was 23 weeks, and the average number of sessions received was 6.2, ranging from one to 13 sessions. While eight service users received the intended range of sessions, the length of support indicates that there is scope to clarify definitions of 'completion', considering number of sessions, length of engagement, and/or the achievement of specific outcomes.
- Restart practitioners reported that parallel support for (ex-) partner victim-survivors is flexible and responsive, typically offered remotely and focused on emotional support, safety planning, and advocacy. However, no quantitative monitoring data is currently collected which limits understanding of dosage received.
- Low uptake limits opportunities for learning around the optional housing pathway: Between July 2024 and May 2025, seven service users were referred into the optional housing pathway and received hotel accommodation for up to four weeks, as intended. This suggests the temporary accommodation offer of the optional housing pathway can be delivered as planned, but low uptake points to a need to better understand and address barriers to engagement.

Programme level

Both core components of Restart (i.e. the Safe & Together model implementation work and the Restart intervention) were delivered and implemented during the feasibility period across all six local areas. While the dosage and fidelity of Safe & Together and the Restart intervention varied across local areas, all six took active steps to mobilise both strands of the programme.

To support consistent implementation, several cross-site and local structures were delivered across the study period:

- Monthly mobilisation meetings were held in each site to monitor progress, share operational updates, and troubleshoot emerging challenges. While attendance at these meetings varied, they provided an important forum for connecting local delivery with national programme oversight.
- At the programme level, the programme team convened quarterly SSC meetings, which brought together delivery partners, commissioners, and local area leads to reflect on progress and ensure alignment across local areas.
- In addition, quarterly Community of Practice meetings created space for Restart practitioners and practice advisors to share learning, build relationships, and strengthen the consistency of practice and address case specific challenges with local area leads.

While this infrastructure provided a strong foundation for implementation, the extent to which programme-level fidelity was maintained in practice is shaped by how each component was experienced and embedded locally. The following two sections explore dosage and fidelity in more detail at the component level, considering both Safe & Together and the Restart intervention.

Safe & Together model implementation

CORE training

Individual-level data on dosage (i.e. the number of sessions received by each individual practitioner) is not currently collected. However, the high completion rates set out in the section Engagement and completion indicate that this is being delivered as intended. Each training round was delivered as planned (i.e. across four full days), and the available data suggests that the majority of practitioners who completed the programme received the full amount of training.

Overview training

Similarly, individual-level data on dosage was not available for the Overview training. However, observation of an Overview Safe & Together training confirmed training sessions were delivered with fidelity to the planned delivery model. The two half-day sessions were delivered as intended, with clear structure, appropriate pacing, and coverage of all core content. The trainer was engaging and knowledgeable, using real-life examples to bring the material to life. Attendance was high, and participants appeared engaged throughout, contributing actively to discussions and showing genuine interest in the content. Overall, the session demonstrated high-quality delivery aligned with programme expectations.

Case consultations

Data on the number of case consultations received per practitioner (i.e. the individual-level 'dosage' of support) was not recorded as part of this feasibility study. As a result, it is not possible to assess the intensity or distribution of support. In addition, there was no clearly defined benchmark for how many consultations were expected per borough or practitioner, limiting the ability to interpret dosage against intended targets. Future monitoring work may wish to capture both individual-level consultation data and anticipated delivery volumes to support more robust assessment of uptake and responsiveness.

Restart intervention

One-to-one domestic abuse perpetrator intervention

The one-to-one domestic abuse perpetrator intervention is designed to be delivered across four to eight weeks, across one or two hour-long weekly sessions. While there is substantial flexibility already built into this design (which could range from 4 to 16 sessions), monitoring data suggests that even greater flexibility is applied in practice.

Of the 12 people with individual-level monitoring data who completed the intervention, 11 received support beyond the intended four-to-eight-week period (Table 8). **On average, people accessed support for 23 weeks**, with durations ranging from 5 to 46 weeks.

Table 8: Duration of support accessed by service users who completed the one-to-one domestic abuse perpetrator intervention (n=12)

Duration of support (in weeks)	Number of service users
Less than 4 weeks	0
4–8 weeks	1
9–13 weeks	2
14–18 weeks	1
19–23 weeks	3
More than 23 weeks	5
Grand total	**12**

Table 9 sets out the total number of sessions received by the 12 service users with individual-level monitoring data who completed the intervention. This shows that eight received between 4 and 16 sessions, with four receiving fewer than four sessions. The **average number of sessions received was 6.2**, ranging from 1 to 13 sessions. While this shows that the majority of service users who 'complete' the one-to-one domestic abuse perpetrator intervention receive the intended number of sessions, it also suggests that further consideration should be given to definitions of completion, to ensure that this reflects meaningful engagement with the intervention.

Table 9: Total number of sessions received by the service users who completed the one-to-one domestic abuser perpetrator intervention (n=12)

Duration of support (in weeks)	Number of service users
0–3 sessions	4
4–7 sessions	3
8–11 sessions	2

Duration of support (in weeks)	Number of service users
12–16 sessions	3
Grand total	**12**

Fidelity checklists were introduced to case management processes as part of capacity-building support delivered by the evaluation team in November 2024. These capture the number of completed sessions, the length of the sessions, and which of the eight workbook activities were completed. Due to the low proportion of service users who consented to individual-level data being shared, only seven completed fidelity checklists were shared with the evaluation team covering five service users. These checklists were completed to high standard, and suggest that the tool is being used and embedded into everyday delivery. However, the small number of shared checklists limits the ability to draw meaningful conclusions about implementation quality. Clearer explanations of how the data will be used may help to increase service users' willingness to consent to data sharing, and this is discussed further in the next chapter (Findings: Impact evaluation feasibility). Future research should aim to analyse a larger number of checklists collected over an extended period to provide a more robust understanding of dosage and fidelity in practice.

Given that these findings relate to such small sample sizes they should be **interpreted with caution**. However, taken together with the monitoring data on session duration, these findings illustrate the high degree of flexibility with which the one-to-one domestic abuse perpetrator intervention is delivered and the significant variation in support received by service users. While this flexibility aligns with stakeholder views and is supported by wider literature on effective work with domestic abuse perpetrators (see the chapter Validating Restart's programme theory and delivery model), it also highlights the need for greater clarity and consistency in programme delivery. This will be essential if future evaluation efforts are to use experimental or quasi-experimental methods to assess Restart's impact. Future research should aim to collect and analyse a larger number of fidelity checklists over an extended time period to better understand dosage, fidelity, and adherence in practice.

Parallel support for (ex-) partner victim-survivors

Restart practitioners reported that the parallel support for (ex-) partner victim-survivors typically involves providing emotional support, risk monitoring, safety planning, and signposting to more specialist services if needed. This may also involve partner support workers advocating for the (ex-) partner victim-survivor with other services, such as CSC, as needed.

> "Sometimes they [(ex-) partner victim-survivors] may make heavy disclosures, talk about recent incidences with the service user or discuss extra needs they want me to advocate for them with CSC." Restart practitioner

The Restart team does not currently collect quantitative data on the number or type of sessions and support delivered to (ex-) partner victim-survivors. Information on what has been delivered is

captured through in-depth qualitative case notes, which have not been analysed by the evaluation team.

Optional housing pathway

Between 1 July 2024 and 31 May 2025, **seven service users were referred to the optional housing pathway**, from the total cohort of 49 (14.2%). This is slightly lower than the programme's anticipated up-take of 20% of all cases. However, interviewees did not describe any individual-level patterns to explain this low uptake.

> "Unfortunately, there have also been limited learnings due to the low number of cases involving a housing intervention." Local area lead

Available individual-level monitoring data for a subset of service users (n=28) suggests that all service users were asked whether they would like to access the optional housing pathway, of which four service users (also around 14%) chose to access it. All four service users were placed in hotel accommodation funded by Restart. For three service users, this followed prior stays in emergency accommodation. Of the four that accessed support:

- Two service users accessed a hotel for three weeks each
- One service user accessed a hotel for four weeks
- One service user was offered a placement but subsequently disengaged from the programme.

This suggests that this element of the optional housing pathway is being delivered as intended to the few service users who choose to access it. However, this should be interpreted with caution given the small sample sizes.

Quality, acceptability, and inclusivity

Key messages

Programme level

- Interviews indicate a strong perceived relevance and acceptability of Restart, particularly in contexts where local areas struggle to respond to low-to-medium-risk domestic abuse. Programme stakeholders, local area leads, and CSC and Early Help referrers consistently viewed Restart as a valuable and much-needed programme, filling key gaps in early perpetrator intervention and housing provision.
- High-quality programme management, expert practice guidance, passionate practitioners, and structured opportunities for cross-site learning were reported as key enablers of implementation. However, lack of clarity on Restart's aims and objectives, funding stability, and workforce capacity were reported to be challenging.

Safe & Together model implementation

- The Safe & Together model's core aims were widely endorsed by interviewees, reflecting the demand for the model. Implementation leads and engaging trainers were central to delivering high-quality support through accessible case consultations and relationship-based engagement.
- However, uptake and application of the model were somewhat limited by perceived rigidity, model fatigue (i.e. scepticism towards new approaches which may be short-lived), and gaps in post-training support, indicating scope for adaptation of the model for the UK context and further investment in implementation support capacity.

Restart intervention

- The Restart intervention was reported by interviewees to be a flexible response that may build motivation for change, but Restart practitioners raised concerns about the short duration limiting its potential for impact, especially where motivation for change requires longer engagement.
- Parallel support for (ex-) partner victim-survivors was viewed as empowering and respectful, but its duration and dependency on service-user engagement raised some concerns for Restart practitioners about equity of access.
- The optional housing pathway was recognised as a unique and innovative feature of Restart, particularly in addressing immediate risk. However, uptake was low and implementation was hampered by cultural resistance by housing teams, system-level misalignments, and lack of clarity on how systemic housing change would be achieved.

Programme-level reflections

Overall, programme stakeholders, local area leads, and CSC and Early Help referrers felt that Restart is an **acceptable and needed programme**. Interviewees highlighted that Restart addresses important gaps in existing services, particularly the provision of accommodation options for domestic abuse perpetrators and early intervention for individuals displaying low-to-medium-risk behaviours. Additionally, interviewees emphasised that Restart promotes a cultural shift, especially regarding the practice of CSC, Early Help, and Housing practitioners in domestic abuse cases. Across local areas, the programme was seen to offer a practical and innovative response to systemic challenges in working with domestic abuse, with the overall aim of preventing the escalation of domestic abuse risk and harm and improving the safety and wellbeing of both adult and child victim-survivors.

However, the quality and consistency of Restart's implementation was reported to vary across areas, shaped by a number of enabling and constraining factors at the programme level. Key enablers included:

- **Strong programme management and nationally recognised expertise.** The role of the dedicated programme manager and a nationally respected programme team was consistently highlighted as a strength. Interviewees valued the clear oversight, expert

guidance, and consistent coordination this brought to the programme, which supported local implementation efforts and helped maintain a focus on safe, ethical, and high-quality practice across local areas.

- **Structured opportunities for cross-site learning and reflective practice.** SSC meetings, Communities of Practice, and access to a knowledgeable practice advisor were seen as vital mechanisms for sharing learning and sharing challenges and solutions. Local area leads stated that they valued these opportunities to learn from other local areas, which helped to strengthen the quality and consistency of delivery over time.
- **Joint implementation efforts between components** were also seen as a clear strength. Collaborative work between Restart practitioners and Safe & Together implementation leads, including co-facilitated outreach sessions and shared presentations to CSC and Early Help teams, were reported to build cross-agency understanding and a sense of collective ownership. While practitioners from Cranstoun and Respect were initially viewed as distinct teams, over time Restart practitioners reported an increased focus on using Safe & Together case consultations as opportunities to prompt CSC practitioners to make referrals into the Restart intervention helped shift perceptions and build a more integrated identity for Restart as a cohesive programme.

Programme stakeholders, Restart practitioners, local area leads, and CSC and Early Help referrers also identified key factors that influence the quality and acceptability of Restart implemented at the area level. These include:

- **Clarity of scope and purpose.** Some interviewees expressed uncertainty about Restart's scope and purpose. While the aims and objectives of both components were well understood, many interviewees lacked clarity on what Restart aims to achieve as an overall programme.
- **Workforce capacity constraints** across CSC, Early Help, and Housing were pointed to as a significant barrier. High caseloads, frequent safeguarding emergencies, and staff turnover were reported to limit practitioners' capacity to engage consistently with Restart, including engaging with Safe & Together model implementation work, embedding new models into everyday practice, or making referrals into the Restart intervention.
- **Uncertain funding durations.** Short-term funding arrangements, both internally for Restart and externally across participating boroughs, were also reported by programme stakeholders to impact programme stability and planning.

Safe & Together model implementation work

Acceptability

There was consensus among interviewees that the Safe & Together implementation work is acceptable and addresses a critical need in child safeguarding practice. Programme stakeholders and Restart practitioners consistently endorsed the model's three core aims:

- **Partnering with the non-abusive parent.** Interviewees emphasised the importance of shifting accountability away from (ex-) partner victim-survivors and recognising their protective efforts, which are often underappreciated in traditional child protection approaches.

> "The person that's best placed at managing risk and protecting their children is the victim-survivor." Programme stakeholder.

- **Intervening with perpetrators to reduce harm.** The model was seen by interviewees to enhance practitioners' confidence in engaging with perpetrators, addressing a long-standing gap in safeguarding responses where fathers can become 'invisible' in casework.
- **Keeping children safe and together with the non-abusive parent.** The child-centred, trauma-informed nature of the model was welcomed by local area leads and CSC and Early Help practitioners, who accepted that there is scope to improve the consistency of this approach, particularly as it does not always align with the prevailing culture or typical course of action within CSC, where responses may prioritise immediate risk management or removal rather than family preservation.

However, several barriers impacted the acceptability of Safe & Together model implementation:

- The **rigidity of the model** was cited as a key challenge. As the model was developed in the US, programme stakeholders and local area leads noted that the training content is not all applicable to UK legal, cultural, and social work contexts.

> "There isn't any flexibility with the model – it's quite prescribed … makes it difficult to deliver." Programme stakeholder

- **Model fatigue** was also reported to be an issue by programme stakeholders, who stated that public sector workers can often experience scepticism about embedding new models and ways of working which may be short-lived, which limits engagement and buy-in to Safe & Together.
- **Perceived disconnect between training and the case consultation/follow-up offers of support.** Multiple CSC and Early Help practitioners stated that there is scope to improve the current post-training support offer, and they would welcome further support with embedding the Safe & Together model in practice. For example, interviewees suggested that regular updates or newsletters following the training which set out examples of learning and best practice, or a working group around the model could be beneficial.

Quality

Despite these challenges, multiple enablers supported high-quality implementation. Interviewees highlighted the central role played by the Safe & Together implementation leads, whose contributions included:

- **Flexible, accessible case consultations.** Local area leads, and CSC and Early Help practitioners valued the range of formats available (in person, phone, email), the depth of guidance provided, and the focus on supporting structured case planning.
- **Relationship-based engagement.** Implementation leads were praised for building trust and rapport with CSC and Early Help teams, which was seen as vital in embedding the Safe & Together implementation model into daily practice.
- **Confidence building.** Several CSC and Early Help practitioners reported that consultations directly enhanced their ability to assess risk, understand perpetrator patterns, and deliver child-centred support.

> "[Case consultations] give me a place to go and think about what this family need and the steps to take to improve outcomes for everybody. I've found these consultations incredibly helpful since I'm relatively new to the role and haven't done much work in domestic abuse." Early Help practitioner

However, a key challenge to quality was **burnout and high workloads**. CSC and Early Help practitioners under significant emotional strain reported struggling to engage with the model's more challenging concepts, particularly in high-pressure environments.

> "Social workers are under an inordinate amount of pressure, and it's easier to work with what's in front of you, which is often [(ex-) partner] victim-survivors. Making that extra effort to talk to perpetrators can often feel intimidating." Programme stakeholder

Inclusivity

While the Safe & Together model includes a focus on equality, diversity, inclusion, and equity (EDIE), and training on these areas is delivered as part of implementation, most programme stakeholders and Restart practitioners did not raise EDIE-related themes during interviews. Future research should explore this further, including how EDIE principles are understood, applied, and experienced in the context of Safe & Together model implementation.

Restart intervention

One-to-one domestic abuse perpetrator intervention

Acceptability

The one-to-one domestic abuse perpetrator intervention was viewed as an innovative strand of Restart. Interviewees reported that the intervention **meets a key gap in the system** by offering a short, tailored approach to service users at low-to-medium-risk, with some interviewees describing it as a stepping stone to longer-term behaviour change.

Restart practitioners also **valued the flexibility** of the one-to-one domestic abuse perpetrator intervention, including the ability to select activities from the workbook based on the individuals'

needs, stating that this helps to sustain service-user engagement and promote motivation for behaviour change. This is because practitioners can prioritise activities that are the most relevant, interesting and accessible to service users.

In addition, Restart practitioners and programme stakeholders described the **practitioner and client relationship** as a **central lever for change**. Sustained, nonjudgemental engagement, cultural sensitivity, and a strong rapport were seen as essential in overcoming resistance. In some cases, shared lived experience or cultural alignment between practitioner and client enhanced trust and willingness to participate in the programme.

However, Restart practitioners and programme stakeholders raised concerns that the **short length** of the one-to-one domestic abuse perpetrator intervention may limit the extent to which service can develop motivation for behaviour change.

Quality

A key enabler of high-quality delivery reported by Restart practitioners was **strong internal culture of reflective and collaborative practice**. Interviewees reported feeling well supported by their team, with organisational leadership encouraging reflective, collaborative best practice. For example, interviewees highlighted that team discussions are held to support individual CSC and Early Help referrers engaging with service users who may present with a wider range of needs.

Inclusivity

Programme stakeholders and Restart practitioners stated that they are committed to delivering an inclusive and accessible service, and that their practice aims to accommodate diversity, ensuring efforts are neuroinclusive and support service users', (ex-) partner victim-survivors', and referrers' cultural, religious, or linguistic backgrounds.

> "I think Restart is quite conscious about being inclusive and thinks about things that could be a barrier for service users." Referrer (CSC)

The one-to-one domestic abuse perpetrator intervention's flexibility in delivery, cultural sensitivity, and person-centred approach were consistently described as key strengths by practitioners and stakeholders. While there is still work to do to ensure consistent reach and equity across all local areas, these findings indicate that the Restart intervention has a strong foundation for delivering inclusive, accessible support that meets the diverse needs of families affected by domestic abuse.

However, multiple challenges to inclusive and accessible delivery of the one-to-one domestic abuse perpetrator intervention were identified, including:

- **Interpreter provision.** To enable access to support for those with English as an Additional Language, the one-to-one domestic abuse perpetrator intervention offers support via the use of interpreters, provided by CSC. Some Restart practitioners reported quick, straightforward access to interpreters with knowledge of a wide range of languages

(including British Sign Language). However, others raised concerns about limited or inconsistent access to interpreters in some local areas, causing potential delays in support.

> "If English isn't their first language, that can cause delays." Restart practitioner

> "If we need interpreters, we have to ask social services. But in the whole 14 months I've worked on this project, I've only been successful once." Restart practitioner

Given the findings indicating that 21.4% of service users require an interpreter to access support, this indicates that a substantial proportion of the cohort may experience delays, or not be able to access support altogether, due to language needs and constraints around interpreter provision.

- **Practitioner–service user dynamics.** While Restart practitioners acknowledged the diversity of Restart teams as a strength, some delivery practitioners reflected on challenges in engagement when gender and cultural dynamics intersected. In particular, a few Restart practitioners noted that some service users occasionally expressed reluctance to engage with female case managers or preferred culturally matched services (with limited availability), which could negatively impact intervention delivery.
- **Adapting intervention materials.** Restart aims to work with all families experiencing domestic abuse, regardless of their sexuality or gender identity, and the programme makes use of the Respect toolkit for same-sex couples or women service users. However, some Restart practitioners highlighted that the one-to-one domestic abuse perpetrator workbook assumes cisgender, heterosexual relationships and focuses on traditional gender dynamics. This may make the intervention content less relevant for same-sex couples or women service users. They suggested that there is scope to adapt the intervention materials to use more inclusive language for use in these cases.

These challenges highlight the importance of continued investment in inclusive practice, ensuring that all aspects of the Restart intervention, from referral pathways to intervention materials, are responsive to the diverse identities, needs, and experiences of the families it aims to support.

Parallel support for (ex-) partner victim-survivors

Acceptability

The parallel support provided to (ex-) partner victim-survivors was widely viewed as acceptable and empowering. Restart practitioners highlighted the following as key strengths:

- **The person-centred and flexible nature of the support**, which respects (ex-) partner victim-survivors' autonomy in choosing whether to engage, and which outcomes they wish to pursue.

> "[We] make engagement their choice, as so many choices have previously been taken away from them." Restart practitioner.

- The emphasis on **individual definitions of success** and a correspondingly nonjudgemental approach, whether remaining with or separating from the service user, was seen to promote dignity and choice.

However, several challenges affected acceptability, including **support being contingent on service-user engagement**. If the service user disengages from the one-to-one domestic abuse perpetrator intervention part way through, the (ex-) partner victim-survivor can continue accessing support from their partner support worker, typically for up to an additional four weeks. However, Restart practitioners noted that, while operationally necessary, these requirements can play into the ongoing dynamics of power and control and can set (ex-) partner victim-survivors up for disappointment.

> "That's really difficult because the [(ex-) partner] victim-survivor thinks: 'I've been given the gift of this person to advocate for me but now it's taken away because the service user isn't engaging'. Another loss, through no fault of their own." Restart practitioner

This suggests that the expectations around the length of support could be made clearer from the outset. In addition, locating parallel support for (ex-) partner victim-survivors within existing local domestic abuse services, or linking in with longer-term community support pathways, may provide a solution to this and support a more sustainable and consistent offer. However, this would likely require more additional staffing and resourcing than is currently allocated, and may therefore need to be considered in the context of any future scaling of the model.

In addition, short support timescales were reported to impact relationship building. Building trust is essential for (ex-) partner victim-survivors to feel safe to open up and engage meaningfully, according to Restart practitioners. However, Restart practitioners stated that limited support timescales can make it challenging to establish the strong, trusting relationships needed to provide support.

Quality

Restart practitioners reported that high-quality delivery of the parallel support for (ex-) partner victim-survivors was supported by:

- **Positive working relationships between Restart practitioners.** Interviewees described strong internal relationships have proved crucial in delivering coordinated parallel support for (ex-) partner victim-survivors. Regular communication with case managers enables ongoing risk assessment, as updates on service users' engagement and motivation for behaviour change are shared, allowing timely decisions such as referrals to Multi-Agency Risk Assessment Conferences (MARAC) if risk escalates.
- **High-quality training.** Interviewees stated that they have attended – and would have managerial support to access in the future, as needed - a broad range of high-quality training courses, such as Independent Domestic Violence Advisor (IDVA) training and specific resources related to domestic abuse homicides, financial abuse, female genital mutilation, and stalking. Such training helps to improve the quality of their practice by

ensuring they understand the dynamics and risks relating to specific types of abuse and stay up to date on developments in this sector.

Optional housing pathway

Acceptability

The optional housing pathway was viewed by programme stakeholders, Restart practitioners, local area leads, Safe & Together implementation leads, and CSC and Early Help referrers as a **unique, innovative and valuable component of Restart**. Interviewees noted that traditional services rarely offer accommodation support to perpetrators, and that this pathway seeks to address a significant gap in existing services.

> "I think it's a positive and unique aspect of the programme. There's a limited amount that we can do regarding housing for the service user … if he didn't find somewhere else to live, he would just return home, so this support option seemed valuable." Referrer (CSC)

Nonetheless, **cultural barriers within housing teams** were reported to impact acceptability. Some programme stakeholders, Restart practitioners, and local area leads described resistance to the idea of housing perpetrators within housing teams, with concerns about "rewarding" abusive behaviour. In some cases, housing staff felt service users should receive criminal justice responses rather than accommodation. Given the wider housing crisis, housing services may also fear that choosing to accommodate service users could be interpreted as diverting limited resources away from others with urgent needs. This was reported to limit buy-in among housing teams by programme stakeholders, who suggested the need for broader sector-wide training on domestic abuse across housing.

Quality

Restart practitioners highlighted the **speed and flexibility of the temporary accommodation support**, emphasising it can be organised within four hours. Programme stakeholders and Restart practitioners highlighted that obtaining buy-in from housing officers in some local areas and multi-agency housing panels has led to faster processing of cases, providing service users with accommodation support as quickly as possible.

> "The thing that makes or breaks this pathway is the people and relationships." Restart practitioner

However, significant implementation barriers for the optional housing pathway, specifically in relation to identifying longer-term housing placements, were identified by interviewees. These findings build on a recent report on the housing pathway published by Henderson et al. (2024), and include:

- **Limited housing stock within the context of a housing crisis.** Restart practitioners noted the shortage of suitable long-term accommodation options as a persistent barrier to

supporting service users. This challenge is especially acute given that Restart is delivered across six London boroughs, where housing affordability, availability, and demand are uniquely constrained. These challenges are compounded by London's exceptionally competitive rental market, high Local Housing Allowance (LHA) shortfalls, and long social housing waiting lists, estimated to be up to seven years in some areas. These dynamics may play out differently in other parts of the country, where housing supply and affordability constraints may differ.

- **Legislative misalignment.** Restart's aims are sometimes at odds with current housing policies. Restart practitioners reported that service users often do not meet statutory 'priority need' thresholds under homelessness legislation, or they are considered to have made themselves 'intentionally homeless', particularly where domestic abuse, substance use, or rent arrears are involved. Additionally, Restart practitioners highlighted that policy frameworks often fail to recognise the strategic value of housing service users as a route to safeguarding adult and child victim-survivors, despite legislative provisions under Part 4 of the Domestic Abuse Act 2021.[26] This policy–practice gap limits system buy-in and reduces the perceived legitimacy of the service user housing pathway.
- **Complex tenancy and joint housing arrangements.** Restart practitioners also discussed the complexity of tenancy arrangements involving joint tenancies, social housing allocations, and household compositions. For example, some service users may remain legally tethered to a shared tenancy, which creates additional control or risk for (ex-) partner victim-survivors. In other cases, transferring a tenancy from a perpetrator to a victim-survivor may be at the discretion of the housing provider, which can be challenging if they do not have the full context or have not bought-in to the model. This further limits the extent to which Restart can support sustainable longer-term housing pathways.
- **Constraints linked to LHA and the PRS (private rented sector).** A further reported barrier involves restrictions on LHA for younger adults. Many single perpetrators under the age of 35 are only eligible for the shared accommodation rate, which is unsuitable in cases involving parenting responsibilities or heightened risk. This policy limits engagement and reduces the suitability of PRS placements, which are often the only viable long-term housing option in the absence of social housing.
- **Sequencing of support across support strands.** Some Restart practitioners questioned whether the optional housing pathway and one-to-one domestic abuse perpetrator intervention need to be delivered concurrently, or whether there may be greater value in staggering the support. In particular, some interviewees suggested that addressing housing needs first may be essential to enable meaningful engagement in behaviour change work. They suggested that service users facing housing insecurity may struggle to engage consistently with one-to-one sessions, and practitioners noted that stabilising accommodation could provide the foundation for sustained reflection and change.
- **Scope to improve systems learning and strategic influence.** Although Restart aims to inform wider systems change, particularly in housing, there is scope to further develop

[26] See: https://www.legislation.gov.uk/ukpga/2021/17/contents

current mechanisms to translate case-level learning into strategic action. While early versions of the programme benefited from support from DAHA, interviewees reported that feedback loops currently rely heavily on individual practitioner relationships, with scope to improve infrastructure for structured reflection, cross-site learning, or policy advocacy.

While recognised as a unique, innovative, and needed aspect of the programme, the optional housing pathway illustrates both the potential and complexity of integrating housing into a whole-system response to domestic abuse. However, for this pathway to operate consistently, further work is needed to align operational delivery with policy levers, remove systemic eligibility barriers, and embed strategic feedback mechanisms. Developing these elements will be critical for achieving Restart's dual aims of improving individual safety and driving broader systems change.

Inclusivity

In addition to the structural and process-related challenges impacting the optional housing pathway, stakeholders raised concerns about the further **barriers in responding to disabled service users' housing needs**.

> "We're really up against it with what housing can offer." Restart practitioner.

For example, a ground-floor flat may be needed due to a service user's physical accessibility needs, which is unlikely to be available in an already scarce pool of housing stock.

In addition, No Recourse to Public Funds (NRPF) status should be noted as a significant inclusivity barrier for service users accessing accommodation, with local authorities restricted from housing those with NRPF directly, as individuals' immigration status and their 'Right to Rent' must be confirmed (Henderson et al., 2024). In practice, this means that service users with NRPF can only be housed in charitable accommodation or with social landlords (Henderson et al., 2024). While this is an important issue, it was not raised as a concern during interviews.

Evidence of promise

Key messages

Interpreting the findings in this section

The study did not seek to provide evidence of outcomes and impact. We also were unable to engage service users or (ex-) partner victim-survivors directly, which means we are unable to report on either evidence of promise from pre- and post-questionnaires, or from in-depth interviews. The findings in this section should therefore be interpreted with caution, and any future study should seek to understand experiences of support from service users and victim-survivors.

CSC and Early Help practitioners

- Early evidence from a small sample of CSC and Early Help practitioners suggests Safe & Together model implementation may improve practitioners' perceived confidence, understanding of coercive control, and ability to place accountability on perpetrators. This reflects progress against key outcomes in Restart's theory of change.
- CSC and Early Help practitioners also reported reduced use of victim-blaming language, supported by Restart practitioners who reported improvements to referral forms to the Restart intervention after Safe & Together training had been received.

Service users

- A minority of the 18 service users who completed the one-to-one domestic abuse perpetrator intervention across all sites, seven were referred to either one-to-one or group based longer-term behaviour change programmes.
- Practitioner-reported assessments in individual-level case management data for a subset of 12 service users with case notes indicated that motivation for change had improved "greatly" or "slightly" for all 12 service users, and that accountability had improved "greatly" or "slightly" for all 12 service users.
- Case notes indicated that the four service users who accessed the optional housing pathway valued the short-term accommodation was valued, but longer-term outcomes were constrained by factors like immigration status and housing shortages.

(Ex-) partner victim-survivors

- Practitioner reported assessments in individual-level case management data shows improved safety and improved wellbeing for 71% and 75% of (ex-) partner victim-survivors respectively (out of a total of 35 and 36).
- Open-text case notes and interviews with Restart practitioners also suggest that a key mechanism of change is the emotional and practical support provided by partner support workers.

Children and young people

- Case notes highlighted the emotional and behavioural impacts of domestic abuse on children, with some early signs of parent-reported improvement where perpetrators left the home or parents engaged more fully with services. This suggests some potential for indirect benefit, particularly via stabilising the home environment, although effects were varied and context-specific.
- Programme stakeholders and Restart practitioners consistently emphasised that Restart does not work directly with children, making it difficult to evidence or attribute specific child-level outcomes to the intervention. Further work is needed to clarify which child outcomes are theoretically viable within the current model and how they could be measured.

This section sets out findings from individual-level case management data analysis and interviews with professionals against the outcomes in Restart's theory of change for CSC and Early Help practitioners, service users, (ex-) partner victim-survivors, and children and young people.

CSC and Early Help practitioners

Assessing outcomes and impact from Safe & Together model implementation work was beyond the remit of this study. However, early and emerging evidence from interviews with programme stakeholders, local area leads, and CSC and Early Help practitioners suggests areas of promise. These preliminary indications align with several intended outcomes set out in Restart's theory of change. These include:

- **Improved awareness and understanding of domestic abuse which places accountability on perpetrators.** Some local area leads, and CSC and Early Help practitioners highlighted Safe & Together model implementation work has encouraged CSC and Early Help staff to shift accountability for domestic abuse from (ex-) partner victim-survivors to service users.

  > "[Safe & Together] has led to effective partnership with [(ex-) partner] victim-survivors, rather than a more punitive, safeguarding approach." Local area lead

  Some CSC and Early Help practitioners reported this approach **provided them with confidence** to approach domestic abuse cases with intent to engage service users, and build positive, productive relationships with families.

  > "It gave me more confidence around having conversations about domestic abuse with both service users and [(ex-) partner] victim-survivors." Early Help practitioner

- **Improved identification and response to harm.** Several CSC and Early Help practitioners stated Safe & Together model implementation work helped them recognise domestic abuse as a **pattern of behaviour**, rather than as isolated incidents. This has led to some CSC and Early Help practitioners describing abusive behaviour more clearly and descriptively in case management documents and referrals, better contextualising (ex-) partner victim-survivors' actions within broader patterns of abuse, and having greater awareness of service-user manipulation when engaging with CSC and Early Help practitioners.

  > "Before [Safe & Together], I'd have meetings with service users and [(ex-) partner] victim-survivors but realised they [service users] can use the professional to aid their control. I learned through Safe & Together model to meet them separately." Early Help practitioner

  > "Safe & Together looks at how we record domestic abuse on case management systems, so we can really unpick specific behaviours." Programme stakeholder

In addition, multiple areas of promise not currently included in Restart's theory of change were highlighted by Restart practitioners and CSC and Early Help referrers. These included:

- **Reduced use of victim-blaming language.** Some CSC and Early Help referrers reported a reduced use of victim-blaming language in and case documentation following their participation in Safe & Together CORE training.

> "[Safe & Together] changed the way I think, write, and focus on the voice of the child and the impact of abuse." Referrer (CSC)

This was supported by Restart practitioners, who noted improvements in referrals made into Restart after referrers had received the Safe & Together training, including the use of language, level of detail, and placing more attention on children in case documentation.

- **Improved understanding of victim-survivors' circumstances.** Some programme stakeholders and Restart practitioners reported that CSC and Early Help referrers have developed a better understanding of the complexities of victim-survivors' circumstances, and the protective efforts they may take. This enhanced understanding can lead to more appropriate and supportive responses from CSC and Early Help referrers, resulting in better support provided for the victim-survivor, and greater accountability placed on the service user. For example, one (ex-) partner victim-survivor's history of experiencing coercive control had previously been overlooked by CSC due to their substance misuse. After receiving parallel support and risk monitoring, a Restart practitioner communicated the risk posed by their (ex-) partner to CSC, ultimately preventing custody from being awarded to the service user.

> "She had someone who believed her for the first time. By the time Restart had finished, we'd make it clear with social care about the danger he posed to their child. That was really important, as she was facing a situation where children's services would place the child with him, so we changed that dynamic." Programme stakeholder.

- **Perceived increase in complaints due to CSC and Early Help staff placing greater accountability on service users.** Some Restart practitioners highlighted that they believed complaints against CSC and Early Help practitioners had increased, stating that this was an unintended outcome reflecting greater system accountability for service users. This perception echoes findings from a separate evaluation of Safe & Together model implementation work, and suggests that considerations around the implications of this for practitioner wellbeing and safety should be given as part of future model implementation work.[27]

> "I get the sense that, anecdotally, in cases where social workers are focusing on perpetrator accountability, this has led to pushback from some service users,

[27] See: https://www.respect.org.uk/pages/evaluation

such as attempts to manipulate and undermine practitioners or complain about the service." Restart practitioner

Some outcomes in Restart's theory of change for CSC and Early Help practitioners were not raised by interviewees. These were:

- Improved understanding of housing needs for service users, (ex-) partner victim-survivors and children
- Improved multi-agency response to addressing housing needs and preventing homelessness caused by domestic abuse.

The theorised mechanism for achieving these outcomes was via the Restart intervention. If a family accesses the optional housing pathway via the Restart intervention, it is intended that the Cranstoun team feed this back to CSC and Early Help practitioners, building their knowledge and understanding of housing needs relating to domestic abuse. However, in practice, there have been limited opportunities for practitioners to initiate and test housing referrals through the intervention. This has likely contributed to reduced housing-related outcomes for wider practitioners, and constrained opportunities for multi-agency collaboration around housing needs. Future implementation should explore ways to strengthen the integration of the housing pathway within the core intervention, to ensure housing-related outcomes are meaningfully addressed and embedded in practice.

Service users

An in-depth assessment of outcomes was beyond the scope of this feasibility study. However, this section sets out **preliminary** indications of promise aligned with short-term outcomes in Restart's theory of change. It is based on the following sources of evidence:

- Aggregate case closure data for 18 service users who completed Restart between July 2024 and May 2025
- Practitioner assessments in individual-level case management data, completed by case managers – these were available for a subset of 12 service users who (a) completed Restart, and (b) consented to share individual-level data with evaluators
- Open-text case notes in individual-level case management data for the same 12 service users, also completed by case managers.
- Interviews with programme stakeholders, Restart practitioners and referrers, which explored evidence of promise for the families they work with.

These findings should be interpreted with caution due to small sample sizes, a lack of validated outcome measures, and the absence of direct consultation with service users.

Improved motivation and readiness for behaviour change

For the 12 service users with available individual-level data, practitioner assessments indicate that motivation and readiness for behaviour change:

- “Increased greatly” for seven service users
- “Increased slightly” for five service users.

These findings were echoed in open-text case notes and interviews with practitioners, where Restart practitioners described the importance of using early sessions to introduce key concepts and tools aimed at supporting reflection and building motivation. These included accessible, structured activities from the Restart workbook, such as the Ladder of Change, Power and Control Wheel, and Judgement Box. Practitioners described how these activities encourage insight into behaviour in a nonconfrontational way, particularly when delivered through skilled, trauma-informed facilitation.

Increased accountability and reduced denial

Practitioner assessments indicated the following changes to accountability and denial for the 12 service users with available individual-level data:

- “Great improvement” for five service users
- “Slight improvement” for seven service users.

Supporting this, both referrers and programme stakeholders gave examples in interviews of cases where the one-to-one domestic abuse perpetrator intervention raised awareness of abusive patterns and provided an opportunity for service users to acknowledge harm. One referrer described how the intervention prompted a turning point for a service user, stating:

> “It introduced the idea to the service user that their behaviours are bad, it made it real for him. And he said it was the beginning of that process for him. We saw changes quite quickly as a result.” Referrer

These findings suggest early indications of the one-to-one domestic abuse perpetrator intervention’s ability to challenge denial and improve accountability for those that complete it successfully.

Improved emotional regulation and awareness

Qualitative evidence provided some evidence of the one-to-one domestic abuser perpetrator intervention resulting in improved emotional regulation and awareness. Open-text case notes and interviewees provided some examples of some service users experiencing improvements in communication and anger management. One practitioner described in an interview a service user who had started to connect his behaviour with harm caused to his children. Others described how activities such as the CBT Triangle and Feelings Wheel had helped to introduce new language around emotions, promoting greater regulation and awareness.

Onwards referral to long-term intervention

Of the 18 service users with aggregate level monitoring data, seven were referred into longer-term DAPPs at the end of the programme. Case management data shows that:

- Four service users were referred to one-to-one behaviour change programmes.
- Two service users were referred to group work behaviour change programmes.
- One service user was recommended for The Drive Project.

Referrals were made into services such as Cranstoun's Men and Masculinities programme[28] and Rise Mutual CIC's Culturally Integrated Family Approach (CIFA) programme.[29] Where onward referrals were made, open-text case notes described how sessions focused on challenging minimisation and build motivation for continued support and enabled consent for an onwards referral.

Programme stakeholders explained that onward referral may not be suitable for some cases and should therefore not be applied as a universal definition of success – particularly where risk is lower or alternative goals are prioritised. Interviews with Restart practitioners and local area leads also highlighted some variability of DAPP provision within and across local areas, suggesting that this may limit the extent to which this outcome can be achieved. While onwards referrals are still facilitated through Restart even where a local DAPP is not available, if service users need to travel outside of their borough to take part then this will limit uptake. Clarifying the intended pathway and strengthening referral mechanisms will be important for future implementation and evaluation.

Increased accommodation options

Four service users (14% of the 28 service users with individual-level activity data) accessed the offer of temporary accommodation during the study period, so evidence on this outcome is limited. Three expressed appreciation for the accommodation provided and remained in contact with practitioners throughout, according to case notes.

However, longer-term housing outcomes were more variable. One service user was supported into a private sector leased property via their local authority, while two others were unable to secure further support due to having no recourse to public funds (NRPF). One of these received temporary emergency accommodation; the other disengaged from the Restart intervention and received no further support. These cases suggest that while short-term emergency accommodation was valued, systemic barriers such as immigration status and limited housing stock constrain the optional housing pathway's longer-term impact. This highlights the need to clarify the aims, scope, and resourcing of this pathway if it is to offer meaningful, equitable support.

(Ex-) partner victim-survivors

This section presents early, indicative insights into outcomes for (ex-) partner victim-survivors. It draws from the following sources of evidence:

[28] See: https://cranstoun.org/help-and-advice/domestic-abuse/men-and-masculinities/
[29] See: https://enfieldparentingdirectory.co.uk/course/culturally-integrated-family-approach-cifa-programme-to-domestic-abuse-2/

- Practitioner assessments in individual-level case management data for 36 (ex-) partner victim-survivors, completed by partner support workers
- Open-text case notes for 36 (ex-) partner victim-survivors, also completed by partner support workers – some case notes provided quotes and direct feedback from (ex-) partner victim-survivors on their own outcomes and outcomes for their children
- Interviews with programme stakeholders, Restart practitioners, and referrers, which explored evidence of promise for the families they work with.

As consent for case management data to be shared with the evaluation team was given separately by service users and (ex-) partner victim-survivors, we are not able to link this data for most cases. This means we are unable to analyse differences in outcomes for (ex-) partner victim-survivors based on whether their partner or ex-partner completed Restart or disengaged from support.

These **findings should be interpreted with caution** due to small sample sizes, a lack of validated outcome measures, and the absence of direct consultation with (ex-) partner victim-survivors. In addition, they rely on practitioner assessments, so the findings are subjective and should be interpreted accordingly.

Increased safety and reduced risk of harm

For 35 (ex-) partner victim-survivors with individual-level data on safety, practitioner assessments indicated that feelings of safety had:

- "Greatly increased" for 17 (ex-) partner victim-survivors (48.5%)
- "Slightly increased" for eight (ex-) partner victim-survivors (22.8%)
- "No change" for seven (ex-) partner victim-survivors (20.0%)
- "Slightly worsened" for one (ex-) partner victim-survivor (2.8%)
- "Greatly worsened" for two (ex-) partner victim-survivors (5.8%).

For those who felt safer, open-text case notes described reasons such as the service user being removed from the home due to the optional housing pathway, safety planning provided by practitioners, and support with practical safety measures like doorbell cameras. Some also linked this to the service user's calmer communication and reduced conflict, which they attributed to the support from case managers.

Where feelings of safety hadn't changed, open-text case notes said that this was because (ex-) partner victim-survivors felt safe to begin with, or because, despite support from their partner support worker, their sense of risk had not changed. In a few cases where feelings of safety decreased, this was due to the service user making threats, continuing their abusive behaviour, or being released on bail, which increased feelings of fear and anxiety.

Improved wellbeing and feelings of empowerment

For the 36 (ex-) partner victim-survivors with individual-level data on wellbeing, practitioner assessments indicated the following changes:

- “Improved greatly” for 14 (ex-) partner victim-survivors (38.8%)
- “Improved slightly” for 13 (ex-) partner victim-survivors (36.2%)
- “No change” for six (ex-) partner victim-survivors (16.6%)
- “Worsened slightly” for two (ex-) partner victim-survivors (5.5%)
- “Worsened greatly” for one (ex-) partner victim-survivor (2.7%).

For those who had experienced improvements to wellbeing, open-text case notes described that contributing factors included access to grief support, support with boundary-setting, managing sobriety, and parenting support. Case notes for (ex-) partner victim-survivors who did not experience improvements or experienced declines in wellbeing often linked this to ongoing health problems, housing insecurity, or court-related stress.

Open-text case notes also highlighted improvements to empowerment, stating that (ex-) partner victim-survivors had started to better understand the impact of abuse on their mental health and substance use, and several felt more confident in seeking counselling or disclosing abuse. Restart practitioners also described increases in empowerment through interviews, describing improved confidence and decision making. This included support for one person to engage with the Clare’s Law process, for example.[30]

Trusting relationships with Restart practitioners

Open-text case notes suggest that the emotional and practical support provided by partner support workers was an important driver of positive change. According to case notes, (ex-) partner victim-survivors valued the safe, nonjudgemental space created by partner support workers, which helped them feel more confident and better able to voice their fears and experiences. Several case notes described improvements in self-belief and a clearer understanding of how to disclose domestic abuse and seek help. Some case notes highlighted that (ex-) partner victim-survivors now have a better understanding of how abuse had affected their mental health and substance use and felt more equipped to manage these issues. Case notes also stated that the partner support worker role had supported (ex-) partner victim-survivors navigate difficult relationships and interactions with service users, and other services such as counselling.

In a few cases, positive feedback from (ex-) partner victim-survivors on the support they had received was directly recorded in case notes, for example:

> “Restart is great opportunity to learn and grow during a hard time you have not been through before and do not know where to turn.” Feedback given by a (ex-) partner victim-survivor to their practitioner

[30] Clare’s Law, officially known as the Domestic Violence Disclosure Scheme (DVDS), allows people to ask the police whether a current or former partner has a history of domestic abuse. It also enables police to proactively disclose such information if they believe someone is at risk.

In a handful of cases, case notes described that (ex-) partner victim-survivors had limited contact with their partner support worker either because the service user was not engaging with Restart, or due to further incidents of abuse, which made them reluctant to stay involved.

Improved relationships with the service user

Evidence on improved relationships with service users was more limited. However, a few interviewed Restart practitioners reported feedback from (ex-) partner victim-survivors that their (ex-) partner was now communicating more constructively and clearly.

> "We've had positive feedback from [(ex-) partner] victim-survivors that they [service users] communicate better and navigate arguments better." Restart practitioner

They explained that this had resulted in more positive interactions and fewer arguments, improving their relationship with the service user.

Increased accommodation options

Three (ex-) partner victim-survivors had accessed direct support from the optional housing pathway in individual-level case management data. For example, one (ex-) partner victim-survivor at risk of homelessness was placed in emergency accommodation (a self-contained flat) for two weeks, after the local authority accepted a duty to support their housing needs. Open-text case notes reported feedback from the (ex-) partner victim-survivor that this process was very quick, and that they now felt less stressed and happier that the service user no longer knows where they live, and cannot continue being verbally abusive.

These early findings suggest that parallel support for (ex-) partner victim-survivors may have the potential to positively influence (ex-) partner victim-survivors' safety, stability, and wellbeing. However, the sample size is small and the evidence is preliminary. Further research and more systematic engagement with (ex-) partner victim-survivors will be essential to better understand these effects and assess the programme's wider impact.

Children and young people

Although Restart does not directly deliver support to children, several early anecdotal observations of positive change during the intervention period were given by practitioners in interviews and open-text case notes, most commonly linked to the housing pathway.

In some cases, Restart practitioners reported that the safe removal of the service user had created a more stable and safe home environment for children. This was described as contributing to immediate improvements in children's mood and behaviour.

> "We did hear in a court meeting that the perpetrator's two girls were relieved he had left the home. Children can run around and be themselves when the perpetrator has left." Restart practitioner

A few case notes referenced statements from (ex-) partner victim-survivors describing improvements in their children's wellbeing, particularly where there had been reductions in violence, substance use, or controlling behaviours.

These examples support the theoretical rationale for focusing on children as the long-term beneficiaries of Restart. However, they were noted in a limited number of cases, and the study did not systematically assess outcomes for children. Where information was captured, it was indirectly via verbal, anecdotal reports to practitioners, rather than through validated tools or direct engagement from the research team with either (ex-) partner or child victim-survivors themselves.

To strengthen understanding of Restart's impact on children, future evaluations should incorporate more direct assessment of child-level outcomes. These might include:

- Emotional wellbeing
- Home stability
- School attendance
- Reduced re-referrals to CSC
- Improved relationships with the non-abusive parent.

It may also be useful to align measurement with the Domestic Violence and Abuse Core Outcome Set (DVA-COS) (Foundations, 2025), which identifies core domains such as:

- Child emotional health and wellbeing
- Feelings of safety
- Caregiver emotional health and wellbeing
- Family relationships
- Freedom to go about daily life.

Capturing these outcomes will require a carefully designed, trauma-informed approach, using tools and indicators developed in partnership with children, families, and professionals. It will also be important to acknowledge timescales: many of these changes are likely to emerge in the medium to longer term, particularly where they rely on sustained perpetrator behaviour change and broader system support.

Ultimately, robust assessment of these outcomes will be essential to establish whether and how Restart contributes to sustained improvements in the safety, stability, and wellbeing of children affected by domestic abuse.

FINDINGS: IMPACT EVALUATION FEASIBILITY

Key messages

• **Evaluating Restart as a single programme is unlikely to be feasible or desirable using experimental or quasi-experimental designs**, due to differences in design, delivery, and maturity across components. Future impact evaluation should use a tailored design for each component of Restart to be more robust and insightful.

• **Safe & Together model implementation is well placed for a future experimental evaluation**, with potential for CSC team-level randomisation stratified within boroughs, potentially supported by administrative data. Embedding validated tools and considering other data sources will be key next steps, as well as exploring acceptability and feasibility with programme stakeholders and practitioners.

• **The Restart intervention is not yet ready for impact evaluation using experimental designs**, due to challenges with informed consent and data collection experienced during the feasibility study, ethical acceptability relating to randomised controlled trials, and challenges relating to intervention feasibility set out in the previous Findings chapter.

• **A cohort pre- and post-study is likely to be the most feasible option** for a future impact evaluation of the one-to-one domestic abuse perpetrator intervention, using short, trauma-informed tools integrated into routine delivery.

• **Future evaluability depends on further capacity building and model adaptations**, including clearer programme design, strengthened implementation consistency, improvements to consent processes, and improved data collection processes, including the embedding of validated tools.

Overview

This chapter sets out key findings relating to the feasibility of a future impact evaluation of the Restart programme.

Research question(s) answered in this chapter

4. Impact evaluation feasibility: To what extent would an experimental or quasi-experimental methodology be feasible and acceptable?

5. Equality, Diversity, Inclusion, and Equity (EDIE): To what extent do these findings vary based on EDIE?

This section is structured in the following way:

- Programme-level impact evaluation design.
- Safe & Together model implementation evaluation design
- Restart intervention evaluation design.

Key considerations relating to EDIE are highlighted throughout each section.

Programme-level impact evaluation design

This section outlines reflections on the feasibility and appropriateness of a future impact evaluation focused on Restart as a whole programme, based on findings from the feasibility study.

Evaluation focus and scope

Restart is a multi-component intervention comprising several distinct strands of activity, including Safe & Together model implementation and the Restart intervention that incorporates a one-to-one domestic abuse perpetrator intervention for perpetrators, parallel support for (ex-) partner victim-survivors, and an optional housing pathway. Findings from this feasibility study suggest that these components are relatively disparate in practice. Some strands are more clearly defined and amenable to consistent delivery, while others are implemented in more flexible and adaptive ways.

This variation poses a challenge to identifying a coherent and evaluable primary research question that could be meaningfully applied to Restart as a single, unified programme. While it may be possible to evaluate Restart at a programme level by focusing on improved responses to domestic abuse perpetrators, this is unlikely to be suitable for experimental or quasi-experimental designs, due to the non-linear, adaptive nature of the intervention and the interdependencies across sectors and services.

Systems thinking-informed approaches may offer a more appropriate framework for exploring programme-level change. These approaches could capture the complexity, iteration, and context-specific dynamics underpinning Restart's intended outcomes. Potential methods include:

- Mapping pathways of change using contribution analysis or ripple effects mapping
- Gathering practitioner and stakeholder insights through qualitative interviews and reflective practice tools

- Embedding learning cycles to enable adaptive development and continuous improvement.

However, given that the components of Restart are relatively disparate, a more robust and insightful evaluation is likely to come from assessing the individual components independently. These component-level evaluations, such as those for Safe & Together model implementation or the Restart intervention, may be more suitable for evaluation using experimental or quasi-experimental methods. These focused evaluations could be developed with clearly defined research questions, outcome measures, and comparator groups, and their findings synthesised to inform a broader understanding of Restart's overall effectiveness. The next two sections explore each in turn.

Safe & Together model implementation evaluation design

The Safe & Together model is a well-established, manualised framework developed in the United States, which has been introduced across all six local areas delivering Restart, to support workforce development across CSC and Early Help. While this feasibility study did not focus in detail on future impact evaluation of the Safe & Together model, several findings provide a useful foundation for considering future impact evaluation design.

Evaluation questions and outcomes

Interviews and monitoring data suggest that the Safe & Together model implementation work is valued by practitioners and is feasible to deliver at scale with fidelity. Programme stakeholders, Restart practitioners, Safe & Together implementation leads, local area leads, and CSC and Early Help practitioners highlighted positive outcomes including increased practitioner confidence, structured case thinking, and improved engagement with perpetrators of domestic abuse. These outcomes align with the model's aims and suggest that a future impact evaluation could explore:

- To what extent does the Safe & Together model implementation improve CSC and Early Help practitioners' competence and confidence in identifying, engaging with, and managing risk posed by domestic abuse perpetrators?
- To what extent does the Safe & Together model implementation improve practice in CSC and Early Help in supporting and safeguarding children affected by domestic abuse and their families?
- To what extent does the Safe & Together model implementation improve outcomes for children known to CSC or Early Help and their families experiencing domestic abuse?
- To what extent does the Safe & Together model implementation contribute to wider system change in relation to responses to domestic abuse perpetrators?

Given the manualised and replicable nature of Safe & Together training delivery, these evaluation questions are theoretically well suited to an experimental or quasi-experimental evaluation design.

A primary outcome of such an evaluation could be self-reported confidence and competence in engaging with domestic abuse perpetrators, using pre- and post-training surveys, with a potential follow-up point to assess durability of change, and the extent to which this translates to changes in practice.

Secondary outcomes to consider may include:

- Improvements to CSC and Early Help practice and decision making for families experiencing domestic abuse
- Improvements to CSC and Early Help team culture and attitudes relating to domestic abuse
- Improvements to child/family safeguarding outcomes
- Decreases in escalation/increases in de-escalation of case status for families experiencing domestic abuse.
- Improvements to language used in case notes and assessment.
- Improvements to how well supported adult victim-survivors feel by CSC and Early Help practitioners in safety planning, advocacy, and day-to-day parenting
- Improvements in child victim-survivor safety and wellbeing.

These suggestions and appropriate data collection methods should be explored further and collaboratively agreed with Safe & Together programme stakeholders before use in any future trial.

Randomisation designs

A key consideration for experimental designs would be the most appropriate unit of randomisation, and we present two potential options below.

Option 1: Area-level randomisation

Area-level randomisation would involve assigning local authorities to either receive Safe & Together model implementation (treatment group) or continue with standard continuous professional development (CPD) offers (business as usual (BAU) group), with the possibility of incorporating a waitlist or crossover design. This approach brings several advantages:

- **Reduces contamination:** Assigning whole areas minimises the risk that trained staff inadvertently influence or support colleagues in the control condition.
- **Better fit with system-wide model:** This design aligns with the Safe & Together model implementation's ethos of culture change across the system, making it more coherent with the intervention's theory of change.
- **Simpler operational management:** From a training delivery perspective, planning sessions across whole boroughs may be more logistically efficient.

However, there are also disadvantages to consider:

- **Variable area engagement:** The feasibility study highlighted differing levels of engagement across local areas, and this design may risk inconsistent implementation

fidelity between boroughs. It may also be challenging to secure buy-in from local authorities who are allocated to the control group.

- **Sample size and power:** Randomising at the area level will reduce statistical power, requiring substantially larger sample sizes and a higher number of bought-in local authorities than currently receive Restart.
- **Data collection complexity:** Managing and coordinating data collection is likely to pose logistical challenges, with a high risk of attrition from control group areas, particularly if the study relies on self-reported data from participants.

Option 2: Team-level randomisation

An alternative approach would involve randomising **CSC or Early Help teams** to receive Safe & Together training or continue with BAU CPD, stratified within participating boroughs. This model would require a focus on outcomes at the practitioner level while maintaining some level of local operational consistency.

Team-level randomisation would present the following advantages:

- **Increases statistical power:** Assuming that all teams within a borough can be recruited to the trial, this design could allow for more units of allocation, boosting statistical power and reducing the number of areas that need to be recruited.
- **Controls for area-level variation:** Randomising within boroughs reduces the risk that local authority context alone drives differences in outcomes.
- **Efficient use of existing structures:** Some boroughs may already manage CPD delivery at the team level, potentially making team-level rollouts easier to align with current practice and approaches.

However, it would also have the following disadvantages to consider:

- **Implementation and the risk of contamination:** Teams within the same local authority often collaborate, share practices, or have crossover in management, which may raise the possibility of trained staff influencing nontrained colleagues. Additionally, staff movement across teams during the trial period is likely, which could lead to individuals initially assigned to the intervention condition transferring into control teams, or vice versa. This would need to be managed via robust trial design and implementation protocols, and highlights the importance of careful planning, ongoing tracking of team and individual assignments, and analytic strategies to account for crossover, such as intention-to-treat principles, compliance analysis, and sensitivity analyses.
- **Focuses on the training component rather than the broader model:** A team-level RCT is best placed to assess the direct effect of Safe & Together training and coaching on practice, but it does not capture the full system-change ambition of the model. Even where only some teams are randomised, implementation activity at borough level (e.g. leadership engagement, revised forms and processes, integration into VAWG strategies) is likely to influence all teams. This means the trial estimates the incremental impact of training for those receiving it, rather than the wider systemic effects that Safe & Together seeks to

achieve. These broader impacts would therefore need to be assessed through complementary methods such as qualitative research, action learning sets, or quasi-experimental analysis of CSC administrative data.
- **Ethical and equity concerns:** Delivering training to some teams and not others within the same borough could raise questions about fairness, particularly if Safe & Together training is perceived as highly beneficial.
- **Requires substantial buy-in:** Local authorities, Respect, and practitioners would need to support a within-site randomisation approach, and clear messaging would be required to manage practitioner expectations and morale.

Given the above trade-offs, **a cluster randomised trial with randomisation at the team level** may offer the most feasible and robust solution, potentially incorporating a stepped-wedge or waitlist design, and complemented with wider methods to capture the systems change ambitions of the model. In these designs, all local areas or teams eventually receive the Safe & Together training, but in a staggered sequence. This may reduce resistance to withholding training and enhance buy-in, align with logistical delivery considerations in rolling out the training across a new area, while still allowing for a controlled comparison of outcomes.

Systems thinking informed approach to Implementation and Process Evaluation (IPE)

In addition to testing impact on defined outcomes, future evaluation should explore how the Safe & Together model implementation component is implemented and embedded across different contexts. A mixed-methods IPE would be essential to understand mechanisms of change, fidelity, local adaptations, and barriers to implementation. Systems-informed approaches, such as action learning sets, reflective practice groups, or ripple-effects mapping, could be used to explore changes in team culture and inter-agency collaboration. This would enrich understanding of broader system transformation beyond individual-level changes.

Where feasible, the evaluation could also include multi-level theory testing to understand variation in outcomes across teams and local authorities, as well as to examine the influence of contextual factors such as leadership, organisational readiness, or existing domestic abuse pathways.

Data collection and outcome measurement

Self-report outcome measures

Validated, reliable outcome tools for **assessing practitioner confidence and competence** in engaging with domestic abuse perpetrators are currently limited. While Safe & Together training is typically accompanied by pre- and post-training surveys (administered by the Safe & Together Institute), these do not currently include validated measures, and would need adaptation or supplementation in collaboration with the Safe & Together Institute.

Outcome measures could assess:

- Practitioner competence and confidence in engaging with domestic abuse perpetrators
- Perceptions of team culture, supervision quality, and case decision making
- Confidence in working with the concepts of identifying perpetrator patterns of behaviour, protective parenting, and coercive control dynamics.

Suggesting specific outcome measures is beyond the scope of this study, and any future study would need to conduct a full measures review, before deciding which tools are the most practical and appropriate in collaboration with programme stakeholders and practitioners.

Follow-up surveys at three and six months post-training would be recommended to assess the extent to which the model has been embedded into practice, and any changes to confidence and competence have been sustained. However, **the risk of attrition** in any future trial relying on self-report data is likely to be high, given findings from this study about social worker capacity and turnover. High turnover could reduce the number of follow-up responses, particularly if trained practitioners leave the team or local authority before completing post-training surveys. It may also weaken the embeddedness of Safe & Together principles in practice, especially if untrained or newly recruited staff replace trained colleagues. These risks would need to be mitigated through:

- Close monitoring of staff movement across teams
- Maintaining an up-to-date sample frame for survey follow-up
- Possibly offering repeat or catch-up training for new staff
- Considering retention strategies (e.g. incentives, reminder systems) to minimise attrition at follow-up points
- Communicating the purpose and benefits of evaluation clearly and consistently
- Gaining team leader buy-in to encourage completion for team members
- Flexibility in the time/date and mode of survey completion.

Analytic strategies that can account for attrition may also need to be deployed, such as intention-to-treat or mixed-effects models that accommodate unbalanced data. These logistical challenges would need to be considered further as part of any future RCT scoping of Safe & Together.

CSC case files

CSC case files may provide opportunities to measure the extent to which Safe & Together training translates to **improvements to domestic abuse-related practice**. This could be done by building on the **structured case audit rubric** currently in use, which would offer a practice-based indicator of whether core Safe & Together principles, such as partnering with the non-offending parent and focusing accountability on the perpetrator's pattern of behaviour, are being embedded into case recording, assessment, and planning.

The case audit rubric would build on the existing rubric used by the practice team, and any changes would be co-developed in partnership with Safe & Together experts, drawing on existing fidelity and auditing tools and aligned to the model's core components. Domains might include: (i) evidence of perpetrator pattern identification; (ii) use of non-blaming, strengths-based language

towards the victim-survivor; (iii) evidence of partnering in planning and safety strategies; and (iv) child-centred assessment of harm from coercive control.

Case files would be purposively sampled across teams and timepoints to reflect a mix of risk levels, teams, and characteristics. Audits would be conducted by trained scorers (ideally Safe & Together-accredited practitioners or researchers), following inter-rater reliability calibration and, where feasible, blinded to intervention allocation and timing. Each domain would be scored against predefined criteria using a Likert scale or rubric-based assessment.

It is the view of the evaluation team that it would not be possible to fully blind Safe & Together experts through this process, and that it would be evident when a practitioner has received Safe & Together training, even if the principles have not been implemented fully. This has implications for introducing scoring bias which would need to be fully considered and addressed.

Another key consideration for this approach is the time and resource required to conduct this activity, relative to the value this analysis may add to a future evaluation. However, this approach may provide a unique opportunity to assess observable changes in how professionals document and respond to domestic abuse in everyday practice. This data would be analysed at the team level using mixed-effects models and triangulated alongside practitioner surveys and administrative indicators to explore practice change as a potential mediator of improved outcomes for families.

CSC case management data

Routinely collected administrative data held within local authority CSC systems may serve as a valuable secondary data source in a future impact evaluation of the Safe & Together model. This data can offer a longitudinal perspective on child and family outcomes and may be less prone to attrition compared to survey-based measures.

Potential indicators aligned with Safe & Together principles include:

- Escalation or de-escalation of case status (for example, from Child in Need to Child Protection and vice versa) for domestic abuse-related cases, as a proxy for the appropriateness of risk assessment and system involvement
- Number and quality of actions or interventions recorded in relation to the domestic abuse perpetrator, as documented in assessments, plans, or case notes[31]
- Re-referral rates for families where domestic abuse has been identified, as a proxy for the effectiveness and sustainability of earlier intervention and planning
- Case closure reasons, including whether cases are closed due to risks being resolved, family disengagement, or other operational criteria

[31] Please note that previous evaluations of Safe & Together delivered as part of the London Partnership has found that CSC data systems do not consistently capture or record the number of actions or interventions for domestic abuse perpetrators, and has begun work to design and implement this into existing Safe & Together sites' case management systems. Future research should build on and complement this work to avoid duplication of effort.

- Qualitative assessment of case note language (such as the use of victim-blaming or survivor-supportive framing), through structured coding or the use of natural language processing (NLP), to assess shifts in practitioner orientation over time.

These indicators can help identify system-level change and provide evidence of whether practitioner behaviour and decision making (both of which are key targets of the Safe & Together model) are translating into observable patterns within case management. They may also support exploratory analysis of associations between implementation strength and outcomes for children and families.

However, the feasibility of using CSC data depends on several factors:

- Variation in data quality and completeness between local authorities, particularly for unstructured or underused fields such as free-text case notes or perpetrator-specific entries
- Information governance requirements and data access agreements, especially in relation to identifiable or sensitive records
- Resource implications associated with data extraction and analysis, particularly where manual coding or NLP methods are required to interpret open-text fields and map them to the evaluation framework.

Evaluability of these indicators should be explored through further scoping work with local authority data leads. This may include feasibility audits, small-scale data extraction exercises, and co-development of shared data dictionaries to support harmonisation across local areas in a future full trial.

Outcomes for children and adult victim-survivors

Future evaluation designs should also consider how best to capture the voices and perspectives of children and families who are supported by practitioners trained in the Safe & Together model. This is important both for understanding the impact of the model on its ultimate intended beneficiaries, and for informing improvements to practice.

Potential approaches to explore in the future include:

- **Feedback tools for non-abusive parents**, exploring how supported and safe they feel, their experiences of practitioner interactions, and perceived changes in the family dynamic
- **Optional, age-appropriate child feedback mechanisms**, co-developed with safeguarding experts and children's rights organisations, to explore how children feel about practitioner involvement and whether they feel heard, safe, and supported
- **Involvement of specialist support workers**, such as domestic abuse advocates or family support staff, to facilitate feedback ethically and safely
- **In-depth qualitative case studies**, incorporating parent and child perspectives, that can illuminate the ways in which practice change affects families in real-life contexts.

Careful consideration must be given to consent processes, safeguarding, and emotional safety when designing child- or family-facing research. In some cases, proxy reporting or observational tools

(e.g. based on practitioner or support worker insights) may be more appropriate than direct data collection. Future research should explore the feasibility, acceptability, and ethical considerations of different approaches to capturing these perspectives, with a view to ensuring that children's and families' voices are meaningfully and safely embedded in evaluation design.

Sample size

Estimating the required sample size for an experimental evaluation of Safe & Together model implementation was beyond the scope of this study. Future impact evaluation scoping should seek to estimate this informed by robust power calculations, which draw from available evidence (where available) on pre-test/post-test correlations of the selected primary outcome measure, and intra-cluster correlation estimates for attitudes and behaviours within CSC and Early Help teams.

Acceptability and appetite for experimental evaluation

Safe & Together stakeholders demonstrated interest in undertaking further impact evaluation of Safe & Together, highlighting the importance of long-term evaluation that can assess not only immediate outcomes but also the model's contribution to practice and culture. They emphasised that any future evaluation should reflect the model's iterative implementation, including the embedded role of the implementation lead, and should be positioned as part of a broader learning and improvement strategy rather than a narrow assessment of training delivery and effectiveness.

As Safe & Together is widely recognised internationally as evidence-based, some programme stakeholders expressed some reservations about the need for further evaluation, stating a stronger interest in applying robust evaluation methods to other components of the Restart programme. It is important to note, however, that to our knowledge the evidence base for Safe & Together in the UK context using experimental or quasi-experimental designs is still relatively scarce, and no explicit effort was made to gauge Safe & Together colleagues' appetite for a randomised controlled trial (RCT) or similar evaluation design as part of this work.

Looking ahead, further engagement is needed to explore whether and how randomisation could be introduced in a way that is both ethically sound and acceptable to stakeholders. This would give Safe & Together strategic and practitioner colleagues time to consider the implications of different trial designs, including their feasibility and alignment with the programme's systems change ambitions.

Embedding EDIE in evaluation design

Embedding equality, diversity, inclusion, and equity (EDIE) principles in any future evaluation will be essential. Future work could therefore:

- Explore how the Safe & Together model implementation supports inclusive practice, particularly in relation to practitioners working with families from a range of minoritised and marginalised backgrounds. This may include understanding how the model is

interpreted and applied in different community contexts, and how it intersects with practitioners' own identities, experiences, and other cultural competence training.
- Examine how the model is received and adapted in boroughs with differing population demographics, and where relevant, identify enablers and barriers to equitable practice across these settings.
- Ensure recruitment and data collection tools used in evaluation are inclusive, accessible, and sensitive to cultural and linguistic needs.
- Include marginalised voices (e.g. LGBTQ+ victim-survivors, disabled or racially minoritised practitioners) in qualitative or reflective components such as action learning sets, to surface diverse experiences and perspectives.

These elements should be co-developed with Safe & Together programme stakeholders, implementation leads and the Safe & Together Institute to ensure they are contextually grounded, meaningful, and feasible to implement within the realities of CSC and Early Help practice.

Quasi-experimental designs

If experimental designs are not feasible, quasi-experimental approaches using matched comparator local areas or pre/post designs with statistical adjustment could be explored.

The use of administrative data would be central to the feasibility of any quasi-experimental design. However, as described above, feasibility is contingent on several factors: the completeness and granularity of local datasets; the consistency of recording practices across local areas; the extent to which relevant fields (e.g. perpetrator engagement or coercive control) are captured in structured formats versus open text; and the accessibility of this data for research purposes.

This study has not sought to understand the most feasible way of conducting this, and further work understanding which administrative data sources may be appropriate to enable this would need to be completed in collaboration with local authorities and the Safe & Together Institute.

Restart intervention evaluation design

This section explores the feasibility of a future impact evaluation of the Restart intervention. It reflects on the feasibility study processes which were introduced as part of this study, and assesses implications and next steps for a future impact evaluation, including potential designs, data requirements, outcome measures, sample sizes, and acceptability considerations.

Reflections on feasibility study processes

Gaining informed consent to the research study

Obtaining informed consent from Restart service users and (ex-) partner victim-survivors emerged as a key challenge during the feasibility study. **No service users or (ex-) partner victim-survivors were recruited to the feasibility study.** Across project management meetings,

practitioner workshops, and stakeholder interviews, several barriers to consent and participation in a research study were identified:

- **Challenges collecting consent before rapport has been built.** Restart practitioners reported difficulties obtaining consent from service users at the start of support, before trust and rapport has been built with their case managers. Given that the Restart intervention is not mandatory, practitioners worried that asking for consent to a research study will result in service users also disengaging from support.
- **Effect of separate evaluation points of contact on participant experience.** To ensure separation between practice and evaluation, the study suggested that participants have a separate evaluation point of contact to their Restart practitioner, i.e. somebody who does not deliver support but is responsible for conducting research activities relating to the feasibility study. Practitioners understood and accepted the rationale for this and were willing to pilot it. However, they raised concerns about its potential impact on participant experience of engaging with the Restart intervention. In particular, they highlighted the risk that (ex-) partner victim-survivors, may experience fatigue from engaging with multiple professionals. Many of these individuals report feeling overwhelmed by repeated assessments and the need to repeatedly share their experiences with different practitioners.
- **Restart practitioner capacity for managing evaluation activities.** Challenges around implementing feasibility study activities should be understood in the context of capacity, with the practitioner team working flexibly to accommodate this around existing delivery commitments. Any future impact evaluation would need to account for the capacity and resource required to conduct evaluation activities, e.g. by factoring this into the intervention team's workload planning and required team size, or considering a separate role to support data collection.
- **Low motivation to take part in research.** Local area leads, Restart practitioners and CSC and Early Help referrers highlighted service users generally tend to show little interest in research, potentially viewing it as futile and not seeing participation as a valuable exercise. Restart practitioners reflected that this is a challenge of the cohort, who may not view themselves as requiring support, meaning that motivation to take part in research to improve the support is low. This may have been further heightened by the fact that the feasibility study activities were optional, and support was not dependent on participation in the one-to-one domestic abuse perpetrator intervention.

> "It's really hard to get service users on board with this process. Many just say they're not keen, it's a waste of time." Restart practitioner

  In addition, local area leads and Restart practitioners emphasised some service users and (ex-) partner victim-survivors may decline participation in research generally, due to fear of judgement, especially by researchers or CSC and Early Help referrers who may lack specialist domestic abuse knowledge.
- **Data sharing concerns.** Multiple Restart practitioners highlighted that concerns around data sharing, in combination with the early introduction of feasibility study processes, caused some service users and (ex-) partner victim-survivors to decline participation in the

feasibility study due to a lack of trust in the programme. Service users also declined data-sharing due to fears the information could be later used against them.

> "When it comes to collecting anonymised information … that's when I find service users and (ex-) partner victim-survivors get quite hesitant, especially when we're building up that trust in the early stage." Restart practitioner

- **Accommodating language requirements.** Funding for interpreters and translators for delivering the Restart intervention is managed by CSC. However, it was unclear whether this funding would also cover translation and interpretation for evaluation activities. As well as practical considerations with funding, the context posed additional challenges in ensuring translators and interpreters receive guidance and training on:

  - Translating terms and concepts relating to domestic abuse
  - Explaining the research study to collect informed consent
  - Explaining items in outcome measures (if these measures are not validated in the required language)
  - Ensuring the same translator does not end up working with both the service user and (ex-) partner victim-survivor, in line with best practice around safety and risk management.

Potential solutions to gain consent for a future research study to consider were identified in collaboration with The Drive Partnership and Cranstoun, including:

- **Developing explanatory materials**, such as a video to clearly communicate the purpose and value of the feasibility study. These would need to be made available in key languages, and/or produced with the option for subtitles. Rewording consent and information forms with more motivating and engaging language could also support this, and ideally these would be co-produced with service users and (ex-) partner victim-survivors who have been through the Restart intervention.
- **Changing who collects informed consent.** Restart practitioner, local area lead, and CSC and Early Help referrer views on who should lead informed consent and data collection processes with service users and (ex-) partner victim-survivors were mixed. Some felt referrers were best placed to introduce research activities at the referral stage to gauge interest early and to avoid disrupting trust with Restart practitioners.

  > "[Restart practitioners] don't want to badger them to engage with research at that point and then have them not engage with Restart." Local area lead

  However, concerns were also raised by programme stakeholders about adding consent and data collection responsibilities to already stretched CSC teams. There are also questions about whether CSC would have stronger relationships with the service user than Restart practitioners. An alternative approach would be to embed external researchers to lead informed consent and data collection processes. While this could reduce the burden on Restart practitioners and referrers, it would increase the number of professionals service

users and (ex-) partner victim-survivors interact with, potentially impacting trust in the Restart intervention. On balance, programme stakeholders agreed that Restart practitioners' specialist domestic abuse knowledge makes them best placed to conduct these processes, if the capacity and resource required to do this is factored into planning.

Given the above limitations, it is possible that redesigning a future study to **rely more heavily on routine monitoring data and case notes**, rather than requiring standalone consent processes for each aspect of the research, could reduce burden and improve feasibility. If consent remains the legal basis for data use, additional capacity-building work would be needed with practitioners to improve the proportion of participants who provide informed consent for sharing data with research. This should include training and scripts in the study handbook to support Restart practitioners in explaining the purpose and value of data sharing in research to potential participants. Improving data collection on reasons for non-consent would also support identification and resolution of barriers to participation. Alternatively, given that the Restart programme is funded by a public authority (MOPAC) and a What Works Centre, it may be appropriate to **consider other lawful bases for sharing data with researchers**, such as public task or legitimate interests. Further work is needed to explore and develop a legally and ethically robust model for data sharing with future evaluation.

Data collection processes for service users and (ex-) partner victim-survivors

Current monitoring data collection processes used for the Restart intervention is comprehensive. A large volume of information is collected across all aspects of delivery, including a range of open-text boxes, often resulting in a broad but fragmented dataset. The current scale and complexity of data capture can create challenges for both analysis and day-to-day use in practice. This study has identified several recommendations for improvements to monitoring data, which are set out in in the concluding chapter.

At present, pre- and post-intervention evaluation assessments are completed for both service users and (ex-) partner victim-survivors as part of routine delivery. These include practitioner-led subjective assessments of motivation for behaviour change, levels of denial and accountability, and, on the (ex-) partner victim-survivor side, perceptions of safety, wellbeing, and empowerment. However, these assessments do not currently draw on validated measurement tools, which limits their potential to support robust monitoring or impact evaluation. Some open-text case notes also include quotes and direct feedback on support from participants, but this feedback is not currently captured routinely.

There was strong interest among practitioners and delivery partners in strengthening the quality of case management data by embedding validated, structured tools. Stakeholders were particularly keen to use outcome measures that are meaningful to families and practitioners, feasible to administer in routine delivery, and reflective of both individual progress and broader system change. Any future decisions around embedding tools into everyday practice should be taken holistically, and include an assessment of the existing data collected across Restart. This means

carefully considering the overall ask of practitioners, ensuring that new tools do not duplicate existing measures, and that the combined requirements remain proportionate to delivery. Decisions should weigh up the potential benefits of additional tools for monitoring and evaluation against the practical realities of routine practice, safeguarding time for meaningful engagement with service users and (ex-) partner victim-survivors.

A key challenge in this area is the lack of validated outcome measures that are suitable for use in domestic abuse perpetrator programmes in the UK. A review conducted by the evaluation team identified several limitations in existing tools. Most focus narrowly on domestic abuse recidivism and do not adequately assess motivation for behaviour change or victim-survivor safety and wellbeing. Additionally, many tools suffer from design limitations, including:

- A narrow focus on physical or sexual abuse
- The use of gendered language that assumes male perpetrators and female (ex-) partner victim-survivors
- A heteronormative framing of relationships
- Language that may retraumatise or disempower (ex-) partner victim-survivors
- A tendency to place responsibility for child wellbeing on the (ex-) partner victim-survivor
- Limited accessibility for people with SEND or low literacy levels.

Despite these challenges, the review identified two promising tools that may be appropriate for use in Restart: the **University of Rhode Island Change Assessment (URICA)** (McConnaughy et al., 1983) to measure changes in motivation for behaviour change, and the **Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)** (Stewart-Brown et al., 2009) to measure changes in wellbeing for (ex-) partner victim-survivors. Both tools have potential to offer meaningful, trauma-informed insight into participant journeys and could be embedded into case management systems if found to be acceptable and feasible.

Future work should therefore prioritise the piloting and validation of these tools within the Restart intervention's context, including determining whether it is appropriate to interpret or translate an outcomes measure into a language in which it has not already been used and validated. If successful, they could be integrated into routine data collection, helping to reduce the burden of unstructured assessments while improving the quality and utility of monitoring data across the programme. We understand that Foundations is currently in the process of developing an outcomes framework and outcome measures database for domestic abuse, and this work, including the development and validation of additional measures in the UK context, should be continued and prioritised.

Data collection processes for children and young people

The feasibility study also explored the possibility of measuring outcomes for children and young people. All stakeholder groups highlighted the importance of capturing the voice of the child, or child outcomes, to understand Restart's impact. However, Restart practitioners were less clear on how these measures could be implemented in practice, citing concerns such as:

- **Service users or (ex-) partner victim-survivors not wanting to discuss children.** While valuable information about children's wellbeing can be obtained from Restart service users and (ex-) partner victim-survivors, individuals are sometimes reluctant to discuss their children due to fears of repercussions from CSC. This is compounded by the brief nature of the Restart intervention which can limit the time available for service users and (ex-) partner victim-survivors to build the trust needed for disclosures about their children.
- **CSC may not foreground the child's experience of domestic abuse.** Although the child is typically the subject of the case in CSC, domestic abuse procedures and referral narratives often centre on the dynamics between the service user and the (ex-) partner victim-survivor. Interviewees noted that this can result in the child's specific experience or risk being described vaguely or indirectly. In some cases, this lack of child-focused detail has led to Restart intervention referrals being returned for further clarification.
- **Lack of CSC capacity.** While CSC staff are well placed to capture the voice of the child or child outcomes given their existing relationships with families, this responsibility would place an additional time burden on an overstretched workforce, potentially impacting the quality of collected data.

These challenges are further compounded by the findings in the section Children and young people, where it is still unclear which outcomes for children and young people may be theoretically achieved and measured within the Restart intervention's timescales. Additionally, the **broad age range of children in families referred to the intervention**, spanning from infants to adolescents, introduces further complexity; as what constitutes meaningful change or appropriate indicators, and the appropriate tools with which to measure them, will vary widely depending on developmental stage, context, and needs.

Nevertheless, interviewees raised multiple suggested methods for capturing the voice of the child or child outcomes in the future. These included:

- **Using narrative case notes.** Routinely recorded in CSC's case management system, narrative case notes may be a promising source of information on child outcomes that can be accessed through local authorities. However, these notes are primarily designed to support case management rather than evaluation, meaning the quality and consistency of detail about children's experiences may vary significantly across practitioners, teams, and local authorities. In addition, case notes can be subjective and shaped by the recording practitioner's perspective, potentially leading to incomplete or biased accounts.
- **Extrapolating data from risk assessments.** Some local area leads highlighted completing risk assessments, such as the Domestic Abuse Risk Assessment for Children (DARAC) tool, requires CSC staff to have direct conversations with children and capture their experiences. Similarly, the Support to Safety rapid risk assessment includes elements focused on the child, which may provide insights that can be extrapolated. However, such tools are often used for safeguarding and risk management rather than outcomes monitoring, and their use may not be standardised across boroughs. Additionally, they rely on professional judgement and on children feeling safe and able to disclose sensitive information, which may not always be the case.

These reflections underscore the complexity of capturing outcomes for children and young people within an evaluation of the Restart intervention. While there is strong consensus that the voices and experiences of children are essential to understanding the full impact of the intervention, current systems, capacities, and delivery structures offer limited means of doing so in a consistent or ethically robust way.

As such, any future effort to measure child outcomes must be grounded in a realistic appraisal of what can be meaningfully and safely captured within the scope of a brief, adult-facing intervention. Developing a clearer theory of change in relation to children, co-designed with partners in children's services, would be an important step. In parallel, exploratory work to test the feasibility and acceptability of using narrative case notes or risk assessments as proxy indicators may offer a practical route forward, particularly if embedded within routine case management processes.

Future impact evaluation using experimental designs

The above findings on feasibility study processes suggest a range of barriers and challenges to experimental research in this context. Until these barriers are addressed, piloting an RCT is unlikely to be feasible or desirable. The ethical, relational, and operational risks associated with RCTs, particularly those involving withholding support or relying on early-stage self-report measures, pose significant challenges to acceptability, recruitment, and internal validity. As such, any RCT should be considered a longer-term aspiration rather than an immediate next step.

Nevertheless, two potential RCT designs are presented here to illustrate possible future directions for evaluation, contingent on substantial programme development and capacity-building.

Option 1: Individual-level RCT comparing Restart to business as usual (BAU)

One possible design would randomise eligible service users to receive the one-to-one domestic abuse perpetrator intervention, compared with BAU. This would be an individual-level, two-arm RCT with one-to-one allocation, focused on a primary outcome of motivation for behaviour change. While theoretically capable of producing a robust estimate of Restart's impact, this model faces critical feasibility concerns:

- **Outcome measure:** Motivation for behaviour change could theoretically be measured through a validated self-report tool such as URICA. However, the feasibility study highlighted a number of limitations with self-report methods in this context. Practitioners reported that introducing surveys before trust is established risks disengagement, and that participants may be wary of sharing personal reflections, particularly in the early stages of support. As a result, reliance on survey tools may result in high levels of missing data or selective response bias.
- **Comparator group variability:** BAU provision for low-to-medium-risk domestic abuse perpetrators is highly variable between the current local areas. In some areas, the one-to-one domestic abuse perpetrator intervention may represent the only available support; in others, families may be referred to other DAPPs such as Men and Masculinities or CIFA.

This variability introduces challenges in defining a consistent comparator condition and raises questions about the fairness of allocating participants to different levels of support.

- **Acceptability and ethics:** Programme stakeholders, Restart practitioners, referrers, and local area leads expressed a range of concerns about randomisation in this model. The notion of withholding the Restart intervention from families who wish to engage was seen as particularly problematic given the challenges of securing participation in voluntary services. Referrers were especially mindful of the risk of missing rare moments when individuals are willing to accept support. There was also some scepticism about whether service users would understand the principles of random allocation or feel comfortable engaging with an unfamiliar evaluation process.

On balance, the risks and limitations of this design, both practical and ethical, suggest it is not appropriate at this stage in the Restart intervention's development.

Option 2: RCT comparing behaviour change programme vs the one-to-one domestic abuse perpetrator intervention + behaviour change programme

An alternative design would test whether Restart increases motivation for behaviour change by randomising participants to either:

- A standalone behaviour change programme (e.g. a local DAPP); or
- The one-to-one domestic abuse perpetrator intervention followed by the behaviour change programme.

This would be an individual-level, two-arm RCT with 1:1 allocation. While potentially more acceptable and focused on a measurable behavioural proxy (e.g. programme attendance), this model also presents challenges:

- **Outcome measure:** The primary outcome in this design would be take-up and attendance at a longer-term behaviour change programme, with engagement used as a proxy for motivation. This approach addresses some challenges of self-report data and is therefore less susceptible to the introduction of non-response bias. However, attendance is not a perfect proxy for internal change, and may be influenced by external factors such as court mandates or practical constraints.
- **Operational challenges:** Findings from the feasibility study suggest that a minority (38.8%) of service users who complete the one-to-one domestic abuse perpetrator intervention are currently referred onto longer-term behaviour change support. Ensuring that DAPP delivery is consistent would need to be a key focus for this design, both in terms of availability and eligibility criteria. Access to DAPPs is often constrained by waiting lists, geographical disparities, and capacity limitations, which could introduce delays or variability in delivery. As such, adopting this evaluation model would require groundwork to strengthen local partnerships, clarify referral protocols, and ensure timely and equitable access to follow-on support. Without these structural adjustments, any comparison of

outcomes between the one-to-one domestic abuse perpetrator intervention plus DAPP and DAPP alone risks conflating programme effectiveness with external delivery constraints.

- **Ethical considerations:** Programme stakeholders expressed greater comfort with this model. As all participants would receive a recognised intervention, concerns about withholding support were less pronounced. Practitioners noted that this design better aligns with Restart's model, as it does not require denying access altogether. However, they also expressed concern that this design would place pressure onto Restart practitioners to achieve consent for onwards referral to longer-term behaviour change programmes, and would risk not recognising any changes that had been achieved via the programme.

As with the previous model, this design requires strengthened delivery partnerships, more consistent referral protocols, and clearer theories of change linking the Restart intervention with follow-on engagement. While both designs are theoretically viable, they are not feasible or appropriate at present. Substantial investment in evaluation readiness, stakeholder engagement, and delivery development would be required to support these designs in future.

Further engagement with programme stakeholders, Restart practitioners, and participants is essential to ensure any future evaluation is both ethical and methodologically robust. Strengthening delivery fidelity, increasing referral volumes, and embedding simple outcome measures in routine practice should be prioritised as foundational steps to build future evaluability.

Sample size calculations

For demonstrative purposes, we present three different power calculations for a potential impact evaluation of the one-to-one domestic abuse perpetrator intervention using experimental designs, with URICA as the primary outcome measure (Table F1, Appendix F). These scenarios are based on different estimates of the pre-test/post-test correlation, ranging from 0.4 to 0.6. Given that little is known about this parameter for URICA when used with domestic abuse perpetrators, the sample size for any future efficacy study should be informed by estimates from a well-designed pilot study, and take a conservative approach.

For demonstrative purposes, power calculations suggest that a future impact evaluation aiming to achieve a minimum detectable effect size (MDES) of 0.2 (alpha = 0.05, power = 0.8) would require:

- Between 1,145 and 1,502 eligible referrals (assuming a 55% conversation rate from referral to engagement, in line with the findings from this feasibility study)
- A target participant recruitment sample of between 630 to 828 service users (assuming a 20% attrition rate from recruitment to case completion)
- A final analytical sample size of between 504 to 661 service users.

These projections highlight the significant scale required for a robust impact evaluation using an experimental design. When compared to the current delivery model (through which the intervention received 92 eligible referrals across six local areas between July 2024 and May 2025,

resulting in 49 individuals engaging and 28 completing) the gap between existing reach and required scale becomes clear. Scaling up 151 referrals from 11 months to 164 referrals across 12 months, this implies that between seven and nine years would be required to reach this sample size at the current scale – far longer than is typically required for a study of this size.

Another potential route to achieving the required scale would be to increase the number of delivery sites. However, the evaluation team considers that simply expanding into new areas does not guarantee a sufficient increase in sample size. Additional work is needed to strengthen implementation in existing sites to ensure consistent delivery, improve recruitment and retention, and establish reliable monitoring mechanisms. As such, it is the team's view that further development within current delivery areas should be prioritised before expansion to new sites is pursued.

This underscores the need for considerable expansion in both referral volume and engagement rates before a future impact evaluation would be feasible or desirable. As such, the design of a full-scale impact evaluation would likely be beyond the scope of the intervention in its current form. This finding strengthens the case for future capacity-building work which explicitly focuses on optimising recruitment and retention processes, validating measurement tools, and refining implementation fidelity, all of which are critical precursors to generating credible and generalisable evidence of effectiveness.

Future impact evaluation using quasi-experimental designs (QEDs)

The feasibility of a QED is constrained by a lack of suitable data sources. To the knowledge of the evaluation team, no existing datasets currently capture outcomes that directly reflect motivation, accountability, or readiness for behaviour change.

It is possible that linked CSC case management records may provide some insight into referral pathways, service engagement, safeguarding outcomes, or case escalation/de-escalation for families referred to Restart. However, these administrative data systems do not reliably measure the internal or relational shifts that Restart targets, such as motivation, accountability, or reflective capacity. There are also significant challenges in using CSC administrative data **to assess eligibility for the Restart intervention**, as many relevant variables, such as domestic abuse risk levels or perpetrator willingness to engage, will be captured inconsistently or recorded only in free-text fields. This makes it difficult to define and construct a comparator group that is meaningfully matched on need and context.

In addition, **data systems are unlikely to routinely capture individual characteristics** that are likely to influence engagement and outcomes, such as prior experience with statutory services, mental health status, or attitudes towards behaviour change. This undermines the ability of quasi-experimental approaches to adjust for key confounders or to interpret observed effects in a meaningful way.

There are also **theoretical concerns with relying on proxy outcome measures** commonly used in administrative data. For example, changes in case status (e.g. escalation or de-escalation) are influenced by a range of factors beyond the intervention, including professional judgement, staffing levels, thresholds, and wider contextual dynamics. As such, they may not provide a reliable or valid signal of whether meaningful change has occurred. Relying on these indicators without complementary qualitative or perceptual data risks over-interpreting outcomes that are not robustly linked to the intervention's theory of change.

Further scoping work is needed in collaboration with local authorities and Restart practitioners to:

- Identify potential administrative indicators that could be embedded in routine systems
- Test the feasibility and consistency of these indicators across local areas
- Develop or adapt simple outcome tools that reflect meaningful change and can be integrated into delivery.

Until this foundational work is completed, QEDs should not be considered a primary evaluation strategy.

Cohort pre- and post-study

In light of the feasibility challenges identified throughout this chapter, particularly those relating to recruitment, informed consent, attrition, data collection, and ethical acceptability, a **cohort pre- and post-study** currently represents the most practicable and proportionate option for evaluating the impact of the Restart intervention.

This design would involve following a single cohort of service users over time, collecting data at two or more points (e.g. intake and exit), using validated outcome measures embedded into routine practice. Where feasible, follow-up with (ex-) partner victim-survivors could also be included, alongside analysis of routine case notes and service engagement data. The design would prioritise:

- **Trauma-informed, low-burden data collection**, embedded within the Restart case management process
- **Validated tools** focused on meaningful and feasible outcomes such as motivation for behaviour change, emotional regulation, and practitioner-assessed readiness
- **Use of narrative case notes and monitoring data** to complement self-report surveys and reduce reliance on high-effort evaluation contact
- **A focus on feasibility and learning**, rather than causal attribution, to generate useful insights into who benefits, in what ways, and under what conditions.

Importantly, this design avoids the ethical and operational risks associated with withholding support or attempting to implement randomisation in a context where risk must be carefully managed, trust is often low, and the services face capacity constraints. It also supports early implementation learning and continuous improvement while laying the groundwork for more robust evaluation designs in future.

This approach would also allow for incremental strengthening of evaluation readiness, including:

- Piloting and validating outcome measures
- Testing methods to integrate these tools into practice
- Exploring the feasibility of longer-term follow-up through case file review or routine data linkages
- Building practitioner and participant trust in the evaluation process.

Additional considerations

When considering potential future impact evaluation designs for each component, it is important to recognise that in practice the different components of Restart are interconnected. Safe & Together model implementation seeks to create the system conditions necessary for successful implementation of the Restart intervention, and the Restart intervention acts as a "tool in the toolbox" for CSC and Early Help to refer into, as part of embedding the Safe & Together model into everyday practice and improving outcomes for the families they support. While this chapter has set out evaluation considerations for each component, there is therefore merit in retaining the implementation of each component within the broader Restart programme when thinking about how to build the evidence base.

There are different ways in which the evaluation designs described above could be brought together under a single study, offering complementary insights into both Safe & Together and the one-to-one intervention. However, the most appropriate approach, and the precise balance between programme-level, component-level, and systems-focused evaluation, will ultimately depend on the outcomes from future scoping work, and capacity-building, and require significant investment in both delivery and evaluation.

Any such evaluation would need to be carefully co-designed with delivery partners, local authorities, and people with lived experience, to ensure that it is feasible, proportionate, and aligned with the ethos of Restart. At this stage, the designs presented here should therefore be seen as illustrative options and thought exercises, rather than firm proposals.

CONCLUSION

Evaluator judgement

Based on the feasibility study findings, our overall judgement is that **Restart demonstrates sufficient promise to proceed to further capacity-building work, alongside several model adaptations and changes to strengthen programme implementation.**

Scope and remit

It is important to note that the progression criteria presented in this chapter relate specifically to the Restart intervention. However, the discussion that follows also includes key findings and insights relating to the Safe & Together model implementation component, although this was not the primary focus of this study.

The study has found that Safe & Together model implementation **is well placed for robust impact evaluation**. Training was delivered with high fidelity, uptake was strong, and early signs of practice change were reported by CSC and Early Help practitioners. These findings suggest that Safe & Together model implementation work may be suitable for future impact evaluation using experimental designs, subject to further work to strengthen data systems and outcome measurement tools.

In parallel, the Restart intervention is **not yet ready for robust impact evaluation**, however the study has generated a clear roadmap for future development which aims to address some of the barriers and challenges encountered. While referral and retention rates fell below target thresholds, they provide a workable foundation from which to strengthen implementation. Importantly, the Restart team has demonstrated commitment to learning, adaptation, and improvement, evidenced by the consistent embedding of new monitoring tools, responsiveness to fidelity guidance, and strong programme stakeholder engagement with the study.

In line with this, we judge overall evaluation readiness to be **Amber**. The Restart programme shows meaningful promise and is on a viable trajectory towards impact evaluation, provided the recommendations in this report are addressed and the foundations for evaluability continue to be strengthened.

Interpretation

Discussion

Restart was developed in response to a persistent and well-documented gap in the domestic abuse system: the lack of coordinated, early, and meaningful responses to perpetrators, particularly those assessed as low-to-medium-risk who often fall outside the remit of statutory interventions. This group, while frequently visible to services such as CSC, Early Help, and housing, has historically been underserved by behaviour change programmes or multi-agency responses. Restart seeks to address this gap through a multi-component model that combines system-wide workforce development, targeted perpetrator intervention, support for (ex-) partner victim-survivors, and, where possible, stabilising housing support.

Safe & Together model implementation

The Safe & Together model implementation component was the most consistently delivered element across all six local areas and demonstrated strong feasibility. The fidelity of CORE and Overview training delivery was high, with strong attendance and completion rates, and evidence of practitioner engagement and reflection. Interviewees reported that Safe & Together had begun to shift cultures and practices within CSC and Early Help services, encouraging more confident, child-centred approaches to domestic abuse which hold the perpetrator to account.

Sustaining these shifts will likely depend on continued follow-on support, such as reflective consultations and leadership buy-in, which varied across local areas. In addition, the model's current form, developed in the US, poses challenges in application to UK-specific statutory, legal, and social contexts. Ongoing efforts to adapt the model for the UK are welcomed and should continue.

While this study did not assess evidence of outcomes for Safe & Together model implementation work directly, early implementation evidence suggests promise in improvements to workforce confidence, competence, and practice. These features, alongside the high implementation fidelity and practitioner endorsement, suggest that Safe & Together model implementation work is well positioned for future formal evaluation, particularly if complemented by validated tools, improved data systems, and a standalone theory of change.

Restart intervention

Implementation of the Restart intervention was more varied, shaped in large part by the challenging context in which Restart operates. Within this environment, Restart practitioners demonstrated significant skill, persistence, and compassion, working flexibly and relationally to engage both service users with differing levels of readiness for change and (ex-) partner victim-survivors.

The flexibility of the one-to-one domestic abuse perpetrator intervention was reported by programme stakeholders and Restart practitioners as a strength, enabling engagement with service users who may not respond to more rigid interventions. However, challenges with referrals, the absence of a codified delivery framework, and variation in fidelity made it difficult to assess dosage or replicate delivery at scale. The short formal duration (four to eight weeks) was also widely seen as insufficient to establish trust, embed tools, or create meaningful change.

Parallel support for (ex-) partner victim-survivors is an essential safety mechanism and source of emotional and practical support, according to programme stakeholders and Restart practitioners. Case data indicates potential ripple effects in improving victim-survivors' safety, housing, wellbeing, and empowerment – though evidence remains preliminary and limited by lack of direct participant feedback.

The optional housing pathway, while valued as an innovative and stand-out offer, was used infrequently during the feasibility study. Where delivered, it offered short-term safety and stability, but systemic issues – including limited housing stock, local authority thresholds, and NRPF status – constrained long-term impact. While the pathway remains a promising component of a coordinated systems response to domestic abuse, it requires clearer aims, dedicated resourcing, and closer integration with wider housing systems to be viable as part of a scalable offer. This study builds on the recent work by Henderson et al. (2024) to suggest that The Drive Partnership should focus on producing guidance for Housing teams on navigating local systems, accessing alternative funding pots, and supporting prioritisation of perpetrators for housing interventions. At a strategic level, The Drive Partnership should continue its lobbying efforts with MHCLG to secure additional provision for housing responses to domestic abuse as part of a more rounded systemic solution.

Children and young people

The feasibility study highlighted a strong, shared commitment across partners to improving outcomes for children and young people affected by domestic abuse. However, there remains a lack of clarity around which child-level outcomes are realistically achievable within the scope of Restart, and by which mechanisms. As the programme does not work directly with children, and given the short duration of formal engagement, capturing meaningful change for children is inherently challenging. Any positive impact on children is likely to be indirect and the result of three potential longer-term mechanisms: (1) the service user is able to achieve and sustain longer-term behaviour change, due to an onwards referral from the Restart intervention; (2) the (ex-) partner and child victim-survivors have the option to remain safe and together at home due to the optional housing pathway; and (3) they are better supported by CSC due to the Safe & Together model implementation work.

Children's experiences and responses to change in their home environment can vary significantly, influenced by a range of factors including age, developmental stage, previous trauma, and existing protective relationships. The wide age range of children associated with programme participants adds a further layer of complexity, making it difficult to identify outcome indicators or measurement tools that are both appropriate and meaningful across different contexts. These factors highlight the need to co-develop a clear and realistic theory of change for children and

young people, supported by practical, ethical, and developmentally sensitive tools and processes for data collection that align with Restart's indirect model of impact and its relatively short delivery timeframe.

Future evaluation

Evaluating Restart as a single, unified programme is unlikely to be feasible or desirable at this stage. The feasibility study has shown that Restart's two core components differ significantly in terms of maturity, delivery consistency, and readiness for future impact evaluation. Future impact evaluation efforts should treat each component as distinct, enabling more tailored, proportionate, and methodologically robust approaches.

Safe & Together model implementation is the more developed of the two components and is well positioned for experimental evaluation. Evidence from this study suggests Safe & Together training is being delivered with consistency and fidelity across local areas, and is beginning to embed shifts in professional practice. Team-level randomisation within boroughs could offer a viable evaluation design, particularly if supported by administrative data and complemented by validated tools capturing changes in casework, language, and practitioner confidence. Acceptability and feasibility of different evaluation designs will need to be explored with programme stakeholders and local sites, particularly given ongoing workforce pressures and resource constraints.

The **Restart intervention** is at an earlier level of intervention maturity. The feasibility study encountered challenges in securing informed consent and capturing participant-level data. These were compounded by ongoing questions around fidelity, delivery duration, and referral pathways, as well as ethical concerns about applying randomised controlled trials to a voluntary, safety-critical service. However, practitioner assessments and open-text case note evidence indicates early promise in areas such as motivation, accountability, and emotional regulation. This suggests that a **cohort pre- and post-study** may represent the most feasible design for impact evaluation of the one-to-one domestic abuse perpetrator intervention.

Across both components, future evaluability will depend on investment in programme infrastructure, including: clearer articulation of delivery models and target outcomes; improvements to data collection and consent processes; and greater consistency in implementation. With these foundations in place, Restart will be better positioned to generate robust and meaningful evidence of impact.

Involving experts by experience in this feasibility study added significant value, grounding the research in lived experience. Their contributions helped validate emerging interview themes during analysis, strengthening the credibility and relevance of findings and recommendations. Reflections from experts by experience also prompted the evaluation team to reconsider the use of language, particularly in relation to the use of acronyms and framing, resulting in findings that were more inclusive and accessible to a wider audience. Looking ahead, future evaluations should seek to embed co-production from the outset to further enhance the quality and impact of research in this area.

More broadly, this study contributes valuable insights to a complex and evolving field. Evaluating domestic abuse perpetrator interventions, particularly those delivered outside statutory or criminal justice settings, continues to pose significant methodological and ethical challenges. There remains limited consensus on appropriate outcomes, persistent concerns around re-traumatisation and harm, and insufficient infrastructure to support consistent data collection. Nonetheless, Restart and this feasibility study offer early indications of how a proportionate, ethical evaluation approach can begin to take shape which centres practitioner and participant perspectives, builds evaluability over time, and supports more effective responses to a group that has historically been underserved.

Table 10: Progression criteria summary: Restart intervention

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Intervention implementation				
Referrals Can the Restart intervention receive X% of the target number of referrals?	75%+	50% to 74%	Under 50%	**Amber: 58%** Across July 2024 to April 2025, Restart aimed to receive a total of 180 referrals across Croydon, Camden, and Barking & Dagenham. 104 referrals were received across the period in total: 60 in Croydon, 23 in Camden, and 21 in Barking & Dagenham. This is 58% of the total target of 180.
Recruitment to support Can X% of referred service users be recruited to the one-to-one domestic abuse perpetrator intervention?	75%+	50% to 74%	Under 50%	**Amber: 50%** 52 service users were recruited to the one-to-one domestic abuse perpetrator programme across the period: 31 in Croydon, 15 in Camden, and 6 in Barking & Dagenham. This is 50% of the 104 referrals received.

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Retention Can X% of recruited service users be retained by the one-to-one domestic abuse perpetrator intervention until case closure?	75%+	50% to 74%	Under 50%	**Red: 44%** 23 service users were retained until case closure (i.e. they completed the intervention) in Camden, Croydon, and Barking & Dagenham. This is 44% of the 52 service users who were recruited by the one-to-one domestic abuse perpetrator intervention.
Experiences of implementation and support *Are there significant barriers to implementation of the intervention, as identified by programme stakeholders or participants?*	3 or fewer barriers. Those barriers which are identified are likely to be surmountable.	4 or more barriers. Those barriers which are identified are likely to be surmountable.	1 or more of the identified barriers appears unlikely to be surmountable.	**Amber** Findings from the feasibility study show that implementation of the Restart intervention faced several barriers. These included low and inconsistent referral volumes, high rates of ineligible referrals, limited understanding of eligibility criteria among referrers, low confidence to introduce the intervention, and challenges linked to short intervention duration and inconsistent delivery. However, these issues appear surmountable, and the study has suggested several solutions to pilot in future capacity-building work, including clearer referral guidance, broader referral pathways, improved training and outreach, increased duration, and codification of the delivery model.

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Feasibility study implementation				
Recruitment to the feasibility study Can X% of service users and (ex-) partner victim-survivors who are asked to take part in the feasibility study consent to take part?	75%+	50% to 74%	Under 50%	**Red: 0%** No service users or (ex-) partner victim-survivors were recruited to the feasibility study, and therefore the progression criterion for recruitment was not met. Despite significant efforts, Restart practitioners encountered substantial challenges in introducing the research. These included concerns about timing, safety, privacy, and perceived burden on participants, particularly given the sensitive nature of the intervention and context. This meant that no participants gave consent for research activities during the study period. However, the study generated valuable learning on how to improve consent processes for future research, including the importance of practitioner training, co-designed scripts, and embedding data collection into routine delivery.

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Retention: Baseline measures Can X% of recruited study participants complete baseline measures?	90%+	70% to 89%	Under 70%	**Red: N/A** No study participants were recruited to the feasibility study, and therefore no baseline measures were completed. The study had originally planned to collect baseline measures using short surveys, but due to the lack of participant recruitment, this was not possible. However, this challenge offered important insight: in future, embedding validated baseline measures into routine delivery (e.g. as part of case management systems) may offer a more practical and trauma-informed approach to data collection, reduce reliance on separate research processes, and improve feasibility and uptake.
Retention: Endpoint measures Can X% of recruited study participants complete endpoint measures?	75%+	50% to 74%	Under 50%	**Red: N/A** No study participants were recruited to the feasibility study, and therefore no endpoint measures were completed. As a result, no data on endpoint completion rates is available. Moving forward, embedding endpoint measurement into routine delivery processes, using short, proportionate, and trauma-informed tools, may offer a more feasible and sustainable route to capturing change over time, especially for sensitive or hard-to-reach groups.

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Data completion: Baselines Can baseline measures be completed with an average of X% of items complete?	90%+	70% to 89%	Under 70%	**Red: N/A** As above, no study participants were recruited to the feasibility study, and, as such, no baseline measures were completed.
Data completion: Endpoint Can endpoint measures be completed with an average of X% of items complete?	90%+	70% to 89%	Under 70%	**Red: N/A** As above, no study participants were recruited to the feasibility study, and, as such, no endpoint measures were completed.

Progression criteria	Green: Proceed to pilot trial	Amber: Proceed with changes	Red: Do not proceed unless changes are possible	Explanation
Barriers and challenges to future impact evaluation *Are there significant barriers to the proposed impact evaluation approach, as identified by programme stakeholders or participants?*	3 or fewer barriers. Those barriers which are identified are likely to be surmountable.	4 or more barriers. Those barriers which are identified are likely to be surmountable.	1 or more of the identified barriers appears unlikely to be surmountable.	**Amber** There are multiple barriers to a future impact evaluation of the Restart intervention, but these are likely to be surmountable with targeted adaptations. Stakeholders identified challenges relating to: (1) ethical and practical difficulties in securing informed consent from service users and (ex-) partner victim-survivors; (2) short intervention duration, limiting scope for observable impact; (3) inconsistent implementation and fidelity; (4) unclear eligibility criteria and low referral numbers; and (5) limited use of validated outcome measures. Nonetheless, these barriers are not insurmountable. The feasibility study identifies concrete opportunities for resolution, including refining the delivery model, strengthening consent processes, embedding proportionate outcome tools into routine delivery, and considering a non-randomised cohort design as a first step.

Limitations

While the feasibility study offers valuable learning about the Restart programme's implementation and potential, several important limitations should be taken into account when interpreting its findings:

1. **Relative limited focus on Safe & Together model implementation:** The Safe & Together model implementation work was not the primary focus of this feasibility study. As such, the evaluation offers relatively limited insight into its standalone implementation, effectiveness, or role in contributing to broader systems change. Further work is needed to understand how Safe & Together model implementation work interacts with and supports other components of the programme.
2. **Challenges with consent and research participation:** The study encountered significant barriers to engaging programme participants in research activities. These included ethical concerns around informed consent, safeguarding considerations, capacity constraints among delivery staff, and hesitancy or mistrust from potential participants. These challenges limited the extent to which research tools and processes could be piloted and tested in full.
3. **Lack of direct perspectives from service users and (ex-) partner victim-survivors:** Direct feedback from programme participants was not captured during the feasibility phase. This limits the study's ability to assess how the programme was experienced by those it aims to support and restricts understanding of its acceptability, relevance, and impact from a participant perspective.
4. **Lack of validated outcome measures:** As no participants consented to the feasibility study, these findings are based on practitioner-reported assessments and routine case data, none of which were based on validated outcome measures. This constrains the robustness of findings related to change over time, and highlights the need for future evaluation efforts to incorporate reliable and trauma-informed tools that can be embedded in case management systems.
5. **Limited individual-level monitoring data:** The availability and quality of individual-level monitoring data across the entire cohort of service users was limited to a subset who gave consent for this data to be shared. This restricted the ability to undertake comparative or cohort-level analysis, and limited insight into individual journeys and outcomes.
6. **Short study timescale relative to site set-up and delivery:** The feasibility study took place over a relatively short timeframe, compared with the time that programme stakeholders reported was needed to launch and mobilise a new delivery site. Much of the study period was therefore focused on establishing infrastructure, and raising awareness of the intervention. As a result, the study was not able to assess whether delivery would have become embedded or fully operational over time, nor whether the intended model could be sustained beyond initial mobilisation.

Acknowledging these limitations is essential in situating the study's findings within a realistic frame. It ensures that early learning from Restart is interpreted appropriately and helps to shape proportionate expectations for future research and programme development.

RECOMMENDATIONS

Several opportunities to strengthen the design, delivery, and sustainability of Restart in future phases or wider rollout were identified throughout the feasibility study. This section suggests recommendations for model adaptation, programme implementation, and future evaluation, broken down by the programme level, Safe & Together model implementation work, and the Restart intervention.

Table 11: Recommendations key

Recommendations key		
Model adaptation	**Programme implementation**	**Future evaluation**

These recommendations are offered in the **spirit of continuous improvement and shared learning**. We recognise that not all recommendations will be universally agreed upon; however, they are intended as starting points for further constructive dialogue, adaptation, and reflection among the experts involved in delivering, commissioning, and shaping Restart.

Importantly, these recommendations are not solely for The Drive Partnership to take forward. They should be developed and implemented collaboratively, with active partnership between the Drive Partnership, Cranstoun, MOPAC, Foundations, and experts in evaluation, systems change, and behaviour science, to ensure they are both feasible and impactful.

Table 12: Recommendations

Recommendations and why they matter	Type
Programme-level recommendations	
1. Revisit the overarching aims and objectives of Restart • Refine the overarching aims and objectives of Restart as a cohesive programme, considering how each component complements and works towards these aims and objectives. • A clearer programme vision would support shared ownership, integrated delivery, and clearer pathways into support, while also enhancing the ability of future evaluations to assess system-wide impact.	**Model adaptation**
2. Consider more structured area-level recruitment and eligibility criteria • Introduce a more formalised approach to area-level recruitment based on system readiness, strategic engagement and buy-in, implementation capacity, and the availability of complementary DAPP services. • Site selection processes structured by these factors would support sustainability and ensure resources are targeted to where they can have greatest impact.	**Programme implementation**

Recommendations and why they matter	Type
3. Formalise systems learning components • Strengthen structured mechanisms for systems learning through thematic learning sets or regular cross-borough reflection sessions. • These sessions should focus on underdeveloped components (e.g. the optional housing pathway) and support alignment with local systems. • Formalising thematic learning sets would promote shared learning, address implementation gaps, and generate local solutions to systemic barriers.	**Model adaptation**
4. Strengthen the integration between the two components • Continue reflective learning sessions for CSC that focus on both Safe & Together model implementation and referral pathways into the Restart intervention. • Build on the workforce development component of Safe & Together delivery by supporting practitioners to identify and introduce the Restart intervention appropriately. This includes providing tools, language, and supervision to increase practitioner confidence in making timely, appropriate referrals.	**Model adaptation**

Recommendations and why they matter	Type
5. Further refine and co-develop a programme-wide theory of change • Clarify the overarching programme aims and objectives and outcomes for each component and how these contribute to shared goals. • Make explicit Restart's role within a broader, coordinated system response to domestic abuse, avoiding assumptions about linear or attributable change in isolation from wider services. • Ensure the theory of change includes short-, medium-, and long-term outcomes and addresses systems change explicitly. • Revisit the mechanisms and timescales through which Restart contributes to outcomes for children and young people – such as increased safety, improved emotional wellbeing, and greater family stability – through both direct and indirect means. • Align child outcome measurement with the Domestic Violence and Abuse Core Outcome Set (DVA-COS), covering domains such as child and caregiver wellbeing, feelings of safety, family relationships, and freedom to go about daily life. Acknowledge that many of these outcomes are likely to manifest over the medium to longer term, and that appropriate tools and ethical, trauma-informed approaches will be required to assess them robustly.	**Future evaluation**
6. Ensure all future research is co-produced with people with lived experience • Prioritise ethical, inclusive research approaches that centre lived experience, including through co-design, peer research, and adapted qualitative methods. • Co-production will ensure evaluations are meaningful, inclusive, and capable of capturing the relational and emotional dimensions of support.	**Future evaluation**

Recommendations and why they matter	Type
7. Embed EDIE principles across all aspects of future evaluation • Design evaluation tools and processes that are inclusive, culturally sensitive, and accessible to people from diverse backgrounds, including those with language needs, disabilities, or different literacy levels. • Explore differential impacts of Restart components for families from minoritised and marginalised communities. • Ensure that voices of underrepresented groups (e.g. LGBTQ+ victim-survivors, racially minoritised practitioners) are included in qualitative and participatory elements. • Embed inclusive, culturally sensitive approaches and ensure marginalised voices are centred to strengthen both ethical rigour and analytical depth.	**Future evaluation**
Safe & Together model implementation recommendations	
8. Continue adaptation of Safe & Together CORE and Overview training materials for the UK context • Build on current efforts to tailor Safe & Together content to the UK policy and practice context. Adaptations should preserve fidelity to core principles while enhancing local relevance and practitioner engagement.	**Model adaptation**

Recommendations and why they matter	Type
9. Prioritise engagement of managers and supervisors • Continue efforts to engage managers in Safe & Together training and model implementation to better support CSC and Early Help staff in embedding new approaches. • Consider mandating manager attendance at CORE training as a condition for any future rollout of the model. • Continue to build on and deliver Safe & Together training aimed at managers and supervisors.	**Programme implementation**
10. Maintain visibility of the Safe & Together implementation lead • Continue investing in skilled, accessible implementation leads. Their presence helps sustain momentum, model trauma-informed practice, and troubleshoot barriers in real time.	**Programme implementation**
11. Refine a distinct theory of change for Safe & Together model implementation • Clarify the specific mechanisms through which Safe & Together model implementation contributes to short-, medium-, and long-term outcomes, such as improved safeguarding, practitioner confidence, and coordinated multi-agency responses. This will support the foundations for a future long-term impact evaluation. • Align this with the broader Restart programme theory of change and systems change ambitions.	**Future evaluation**

Recommendations and why they matter	Type
12. Strengthen monitoring data collection processes, in collaboration with the Safe & Together Institute • Monitoring data processes at the individual level would need to be strengthened, to enable assessment of dosage, uptake, or practitioner engagement beyond attendance. • Include fidelity measures, implementation indicators, and practitioner experience in future evaluations to understand how Safe & Together model implementation is applied and sustained in practice. • Explore potential for longitudinal methods to assess Safe & Together's contribution to culture and practice change over time.	**Future evaluation**
13. Consider implementing validated measures pre- and post-training • Identify or develop short, validated tools that align with the core aims of Safe & Together, such as practitioner confidence in engaging with domestic abuse perpetrators, understanding of coercive control, and ability to partner with non-offending parents. • Work with the Safe & Together Institute and local partners to embed these tools into existing training workflows, ideally using digital platforms to support efficient data capture and analysis.	**Future evaluation**

Recommendations and why they matter	Type
14. Scope the use of administrative data and case file reviews for future impact evaluation • Conduct feasibility work with local authorities to understand the availability, quality, and consistency of administrative CSC data relevant to Safe & Together outcomes. • Explore the potential to use case status (e.g. Child in Need, Child Protection, case closure) and re-referral rates as proxy indicators, while recognising the limitations of these measures in capturing cultural and relational change. • Co-develop and pilot a structured case note audit rubric in partnership with Safe & Together experts and the Safe & Together Institute.	**Future evaluation**
15. Co-design any future impact evaluation in partnership with delivery providers • Engage delivery partners, commissioners, and local authorities early in the evaluation planning process to ensure that designs are realistic, acceptable, and aligned with delivery contexts. This includes jointly exploring design options such as RCTs, stepped wedge, or quasi-experimental models; modelling sample size and power requirements; and planning for adequate lead-in time to adapt data systems, consent processes, and staff training.	**Future evaluation**
Restart intervention recommendations	

Recommendations and why they matter	Type
16. Clarify and communicate eligibility criteria, and consider broadening referral pathways • Develop clear and consistent guidance on risk thresholds and suitability for the intervention to reduce ambiguity and support timely, appropriate referrals, with a particular focus on increasing referrals from Early Help and Housing. • Clearer, co-developed eligibility guidance, especially on suitable risk levels, could streamline referrals, reduce the time required to screen cases, and improve access for appropriate service users. • Consider expanding referral routes beyond CSC, Early Help and Housing, including health and community partners. • Broadening referral pathways could support earlier identification of risk, widen access to the intervention, strengthen multi-agency working, and ensure the intervention is embedded within a wider system of support. It would also require revisiting requirements for active involvement from social workers, and considering alternative pathways for safeguarding and risk management.	**Model adaptation**
17. Consider introducing a formal triage function • Consider introducing a 'one-stop shop' triage model to manage inappropriate referrals, allocate cases efficiently, and reduce the burden on practitioners who screen cases for eligibility. This would require investment in triage capacity, agreed protocols across boroughs, and referral routes into other existing specialist services.	**Model adaptation**

Recommendations and why they matter	Type
18. Invest in capacity for outreach and awareness-raising • Invest in additional capacity for continuous outreach and awareness raising activities, to improve the intervention's visibility through sustained relationship-building, briefings, and awareness activities across agencies and boroughs.	**Programme implementation**
19. Extend the duration of the one-to-one domestic abuse perpetrator intervention • Increase the timeframe to a minimum of eight weeks. This would provide a longer timeframe to build trust, introduce tools, and support meaningful reflection or progress, while recognising that Restart is not a long-term behaviour change intervention that would require a longer duration.	**Model adaptation**
20. Codify the core delivery model • Preserve the relational, flexible ethos of the one-to-one domestic abuse perpetrator intervention while providing a clearer structure for core content, session sequencing, and workbook usage. This will support fidelity, quality assurance, and evaluation.	**Model adaptation**
21. Strengthen provision and planning for interpreter use • Ensure consistent access to high-quality interpreters by clarifying procedures for booking and using interpretation services across all sites. This includes training practitioners on working effectively with interpreters, planning for additional time in sessions, and ensuring materials are accessible for non-English-speaking service users. This will help promote inclusion, equity, and engagement across diverse communities.	**Programme implementation**

Recommendations and why they matter	Type
22. Strengthen the optional housing pathway Consider the following actions to strengthen the optional housing pathway: • Appoint named housing champions in each borough. • Clarify the alignment between Restart's aims and existing housing legislation, and provide clearer guidance on the routes to support that are available for Housing teams. • Invest in cultural change work across housing partners. • Explore alternative uses for available funding, such as rent deposits. • Develop clearer guidance on the sequencing of accessing housing support and the Restart intervention. • Re-establish structured feedback loops with strategic partners such as DAHA to ensure case-based learning translates into housing system reform and advocacy. These adaptations aim to shift the housing pathway from a promising but inconsistently implemented element into a strategically integrated strand of Restart's whole-systems model. Doing so would improve practitioner experience, support ethical and sustainable practice, and lay stronger foundations for future evaluation and policy influence.	**Model adaptation**
23. Review and strengthen informed consent processes for research participation • Revisit the legal basis for sharing monitoring data with evaluators. • Continue to work collaboratively with delivery partners to design consent processes that are clear, trauma-informed, and sensitive to the context of domestic abuse. • Ensure that practitioners are supported to introduce research ethically and confidently, with scripts or guidance that address common concerns around safety, privacy, and data use.	**Future evaluation**

Recommendations and why they matter	Type
24. Strengthen routine monitoring data collection, and embed consistent and validated measurement tools • Further strengthen routine data collection systems to be more streamlined, and ensure key indicators are consistently completed. Continued refinement of data systems will also reduce the burden on practitioners, and support them to focus on high-quality delivery. • This should include quantitative data around: (1) eligibility thresholds, (2) referral sources, (3) location of sessions, (4) ensuring it is clear what is a planned/completed session vs other contact, (5) number of check-ins completed with (ex-) partner victim-survivors, and (6) revisiting the number of open-text boxes. • Pilot and test trauma-informed proportionate tools that can be embedded into routine delivery in collaboration with programme stakeholders and practitioners, such as SWEMWBS (for wellbeing) and adapted URICA (for motivation and change readiness) for future evaluation. • Ensure tools are appropriate for the Restart context, feasible to use in practice, and aligned with each component's theory of change to ensure consistent use and meaningful insight into change over time.	**Future evaluation**

Recommendations and why they matter	Type
25. Consider safe and ethical pathways to involve service users and (ex-) partner victim-survivors in research • Co-design research participation approaches with (ex-) partner victim-survivors, practitioners, and specialist services to ensure they are empowering, optional, and trauma-informed. • Explore flexible and low-burden methods of participation, such as anonymous feedback tools, phone interviews with (ex-) partner victim-survivor support workers, or creative methods for expressing impact and safety. • Prioritise (ex-) partner victim-survivor voice in understanding the relational, emotional, and safety dimensions of the intervention's impact, beyond case-level metrics.	**Future evaluation**
26. Reassess evaluation readiness following model refinement and capacity-building activities • Once key adaptations have been made (e.g. refining the delivery model, embedding validated tools, and strengthening consent and data collection processes), a formal reassessment of evaluation readiness should be undertaken. • This review should explore the feasibility of different evaluation designs, taking into account ethical considerations, delivery maturity, and stakeholder confidence. • A pre/post cohort study may be an appropriate next step, offering a pragmatic approach to assessing early outcomes while continuing to build the evidence base for more robust future evaluation designs, such as randomised or quasi-experimental trials.	**Future evaluation**

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APPENDICES

Appendix A: Full list of research questions

Research questions
1. Programme theory validation: To what extent is the Restart programme's theory of change rooted in evidence?
1a. To what extent is Restart's theory of change supported by the evidence base and theory?
1b. To what extent is Restart's theory of change validated by the views and experiences of referrers, practitioners, service users, and programme stakeholders?
1c. Are further changes needed to Restart's theory of change to clearly outline intended outcomes from each component for different groups?
2. Implementation feasibility: To what extent has Restart been implemented and delivered in line with the following dimensions of implementation?
2a. Fidelity/adherence: Is Restart being implemented with fidelity to the theory of change and logic model? If not, in what ways does it differ and why?
2b. Dosage: How much of each of Restart's components have been delivered? Does this match the dosage agreed?

Research questions
2c. Quality and acceptability: How well is Restart delivered? Is Restart acceptable to key stakeholder groups, such as referrers, commissioners, and system stakeholders?
2d. Reach: How well has Restart reached its intended cohort?
2e. Responsiveness: How well is Restart able to engage service users, (ex-) partner victim-survivors and training recipients? If people do not engage, why is this? Does this vary based on people's backgrounds and experiences?
2f. Adaptation: Are further adaptations to the Restart model or its implementation needed to accommodate context and need, improve delivery, or further promote EDIE?
3. Evidence of promise: To what extent does Restart show evidence of promise?
3a. To what extent does Restart show evidence of promise with regards to its intended causal mechanisms and outcomes for perpetrators, (ex-) partner victim-survivors, practitioners, and the local system?
3b. Are there any potential harms or unexpected consequences of implementation or participation?
4. Impact evaluation feasibility: To what extent would an experimental or quasi-experimental methodology be feasible and acceptable?
4a. What evaluation questions should be asked in any impact evaluation?
4b. Are these questions suited to exploration by experimental and/or quasi-experimental methods?

Research questions
4c. To what extent have data collection processes, including the use of validated and appropriate outcome measures, been established and embedded effectively?
4d. Which component(s) of Restart, if any, would be most appropriate for an experimental or quasi-experimental design? Which methodologies would be most appropriate for other components?
4e. What is the most appropriate primary outcome for an impact evaluation? What do we know about its distribution in the Restart population?
4f. How many eligible participants need to be referred to, be onboarded, and complete the programme to achieve a sample size which would enable a pilot or full-scale evaluation?
4g. How many sites would need to be included in a pilot or full-scale evaluation to achieve the required sample size?
4h. What does 'business as usual' look like for families who are not supported by Restart?
4i. To what extent would experimental or quasi-experimental methodologies (including randomisation) be acceptable to key stakeholder groups (such as intervention delivery staff, perpetrators, (ex-) partner and child victim-survivors, and commissioners/referrers)? Do referrers accept and understand the uncertainty associated with randomisation?
4j. Apart from randomisation, what are the other main operational/ethical and logistical risks associated with an impact evaluation? Can these be avoided or mitigated through evaluation design? If not, how can they be mitigated during implementation?
4k. Which data sources and methods could feasibly be used to understand value for money?

Research questions
4l. Which comparator groups and/or administrative datasets may be feasible for use in a quasi-experimental approach, should experimental designs not be feasible?
5. Equality, diversity, inclusion, and equity: To what extent do key findings vary by EDIE characteristics?
5a. Reach and retention: To what extent does Restart's reach, recruitment, and retention rates vary based on EDIE characteristics?
5b. Dosage and fidelity: To what extent does dosage and fidelity vary based on EDIE characteristics?
5c. Experience of support and responsiveness: Have experiences of receiving support differed by background? Does the extent to which service users engage with support vary by background?
5d. Adaptation: Are further adaptations to the Restart model or its implementation needed to further accommodate EDIE?
5e. Evidence of promise: To what extent does Restart show evidence of promise in achieving outcomes, and does this vary by EDIE characteristic?
5f. Future impact evaluation feasibility: What are the key considerations for a future impact evaluation to embed EDIE in its design, delivery, and analysis? To what extent are these considerations feasible and acceptable to Restart's key stakeholders?

Appendix B: Research tools

Research tool type	Document
Study information sheet and consent forms	
Study information sheet – (ex-) partner victim-survivors	Link to document
Study information sheet – service users	Link to document
Interview information sheet and consent forms	
Interview information sheet – (ex-) partner victim-survivors	Link to document
Interview information sheet – service users	Link to document
Scoping interviews information sheet	Link to document
Restart feasibility study research interviews information sheet	Link to document
Interview topic guides	
Restart local area leads – Phase 2A topic guide	Link to document
Restart practitioners – Phase 2A topic guide	Link to document
Programme stakeholders – Phase 2A topic guide	Link to document
CSC and Early Help referrers & Housing stakeholders topic guide	Link to document
(Ex-) partner victim-survivors topic guide	Link to document
Restart local area leads – Phase 2B topic guide	Link to document

Research tool type	Document
Restart practitioners – Phase 2B topic guide	Link to document
Programme stakeholders – Phase 2B topic guide	Link to document
Safe & Together implementation leads topic guide	Link to document
Service users topic guide	Link to document
Observation guides	
Monthly project management and quarterly governance meetings	Link to document
Multi-agency housing panel meetings	Link to document
Safe & Together model implementation	Link to document
One-to-one domestic abuse perpetrator intervention sessions	Link to document

Appendix C: Data sharing agreement

Link to document

Appendix D: Participant characteristics

This Appendix sets out various demographic characteristics for the 28 service users and 53 (ex-) partner victim-survivors who consented to sharing their data with third-party evaluators. The data includes information on age, ethnicity, nationality, and number and ages of children. It provides useful context on the profile of participants whose experiences have informed this study.

Borough

Table D1: Number (%) of service users and (ex-) partner victim-survivors who consented to share their data with evaluators between July 2024 and April 2025 broken down by borough (n=28)

Borough	Number (%) of consenting service users	Number (%) of consenting (ex-) partner victim-survivors
Barking & Dagenham	1 (4%)	3 (6%)
Camden	7 (25%)	10 (19%)
City of Westminster	4 (14%)	1 (2%)
Croydon	8 (29%)	22 (42%)
Havering	5 (18%)	12 (23%)
Sutton	3 (11%)	5 (9%)
Total	**28 (100%)**	**53 (100%)**

Age

Table D2: Age categories of consenting service users (n=27)

Age category (in years)	Number of service users	Percentage of service users
Below 25	1	3.7%
25–30	3	11.1%
31–35	6	22.2%
36–40	7	25.9%
41–45	3	11.1%
46–50	5	18.5%
51–55	0	0.0%
Above 55	2	7.4%
Valid total	**27**	**100%**
Not available	1	-
Grand total	28	-

Table D3: Age categories of (ex-) partner victim-survivors (n=52)

Age category (in years)	Number of (ex-) partner victim-survivors	Percentage of (ex-) partner victim-survivors
Below 25	4	7.5%
25–30	15	28.3%
31–35	11	20.8%
36–40	6	11.3%
41–45	9	17.0%
46–50	5	9.4%
51–55	1	1.9%
Above 55	1	1.9%
Valid total	**52**	**100%**
Not available	1	-
Grand total	53	-

Ethnicity

Table D4: Ethnic backgrounds of service users (n=28)

Ethnicity[32]	Number of service users	Percentage of service users
Asian, Asian British ,or Asian Welsh: Bangladeshi	2	7.1%
Asian, Asian British, or Asian Welsh: Chinese	0	0%
Asian, Asian British, or Asian Welsh: Indian	2	7.1%
Asian, Asian British, or Asian Welsh: Pakistani	1	3.6%
Asian, Asian British, or Asian Welsh: Other Asian	3	10.7%
Black, Black British, Black Welsh, Caribbean, or African: African	3	10.7%
Black, Black British, Black Welsh, Caribbean, or African: Caribbean	3	10.7%
Black, Black British, Black Welsh, Caribbean, or African: Other Black	1	3.6%
Mixed or Multiple ethnic groups: White and Asian	0	0%
Mixed or Multiple ethnic groups: White and Black African	0	0%
Mixed or Multiple ethnic groups: White and Black Caribbean	0	0%
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	0	0%
White: English, Welsh, Scottish, Northern Irish, or British	10	35.7%
White: Irish	1	3.6%

[32] These are based on ONS categories and can be found here.

Ethnicity[32]	Number of service users	Percentage of service users
White: Gypsy or Irish Traveller	0	0%
White: Roma	0	0%
White: Other White	1	3.6%
Other ethnic group: Arab	1	3.6%
Other ethnic group: Any other ethnic group	0	0%
Total	**28**	**100%**

Table D5: Ethnic backgrounds of (ex-) partner victim-survivors (n=53)

Ethnicity[33]	Number of (ex-) partner victim-survivors	Percentage of (ex-) partner victim-survivors
Asian, Asian British, or Asian Welsh: Bangladeshi	5	9.4%
Asian, Asian British, or Asian Welsh: Chinese	0	0%
Asian, Asian British, or Asian Welsh: Indian	2	3.8%
Asian, Asian British, or Asian Welsh: Pakistani	0	0%
Asian, Asian British, or Asian Welsh: Other Asian	3	5.7%
Black, Black British, Black Welsh, Caribbean, or African: African	9	17.0%

[33] These are based on ONS categories and can be found here.

Ethnicity[33]	Number of (ex-) partner victim-survivors	Percentage of (ex-) partner victim-survivors
Black, Black British, Black Welsh, Caribbean, or African: Caribbean	4	7.5%
Black, Black British, Black Welsh, Caribbean, or African: Other Black	3	5.7%
Mixed or Multiple ethnic groups: White and Asian	1	1.9%
Mixed or Multiple ethnic groups: White and Black African	0	0%
Mixed or Multiple ethnic groups: White and Black Caribbean	1	1.9%
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	1	1.9%
White: English, Welsh, Scottish, Northern Irish, or British	20	37.7%
White: Irish	0	0%
White: Gypsy or Irish Traveller	0	0%
White: Roma	1	1.9%
White: Other White	3	5.7%
Other ethnic group: Arab	0	0%
Other ethnic group: Any other ethnic group	0	0%
Total	**53**	**100%**

Nationality

Table D6: Nationalities of service users (n=27)

Nationality	Number of service users	Percentage of service users
Afghan	1	3.7%
Bangladeshi	2	7.4%
English	14	51.8%
Ghanaian	1	3.7%
Indian	1	3.7%
Irish	1	3.7%
Pakistani	2	7.4%
Sri Lankan	1	3.7%
Turkish	1	3.7%
Any other nationality	3	11.1%
Valid total	**27**	**100%**
Not available	1	-
Grand total	28	-

Table D7: Nationalities of (ex-) partner victim-survivors (n=52)

Nationality	Number of (ex-) partner victim-survivors	Percentage of (ex-) partner victim-survivors
Afghan	1	1.9%
Bangladeshi	6	11.5%
English	28	53.8%
Ghanaian	1	1.9%
India	2	3.8%
Italy	1	1.9%
Jamaica	1	1.9%
Lithuania	1	1.9%
Nigerian	4	7.6%
Polish	1	1.9%
Romania	1	1.9%
Sierra Leone	1	1.9%
South Africa	1	1.9%
Sri Lanka	1	1.9%
Zimbabwe	1	1.9%
Any other nationality	1	1.9%
Valid total	**52**	**100%**
Not available	1	-
Grand total	53	-

Children

Table D8: Number of children per service user (n=28)

Number of children	Number of service users	Percentage of service users
0	2	7.1%
1	7	25.0%
2	9	32.1%
3	8	28.6%
4	2	7.1%
Total	**28**	**100%**

Table D9: Age distribution of children (n=58)

Age bracket of the child (in years)	Number of children	Percentage of children
Below 1 year	1	1.7%
1–3 years	17	29.3%
4–6 years	14	24.1%
7–9 years	5	8.6%
10–12 years	9	15.5%
13–17 years	11	19.0%
18 years+	1	1.7%

Valid total	**58**	**100%**
Not available	1	-
Grand total	59	-

Appendix E: Safe & Together training

Table E1: Number of individuals who booked, attended, and completed each CORE training round

Training round	Booked	Attended	Completed and passed	Attended but did not meet learning hours
Round 1	34	27	24	3
Round 2	53	37	33	4
Round 3	54	42	40	2
Round 4	49	37	37	0
Round 5	50	36	36	0
Round 6	44	40	35	5
Total	**284**	**219**	**205**	**14**

Table E2: Reported reasons for withdrawal for CORE training by borough

Reason for withdrawal	Camden	Croydon	Havering	City of Westminster	Total
No reason provided	4	10	4	2	**20**

Reason for withdrawal	Camden	Croydon	Havering	City of Westminster	Total
Workload pressures	4	0	5	1	**10**
Manager withdrawal	2	0	7	0	**9**
Urgent casework	2	1	1	0	**4**
Court attendance	1	1	1	1	**4**
Sickness within teams	3	0	0	1	**4**
Left service	0	0	3	0	**3**
Staff shortages	1	1	0	0	**2**
Ofsted inspections	0	1	0	1	**2**
Personal reasons	1	1	0	0	**2**
Already completed	0	0	2	0	**2**
Annual leave	1	0	0	0	**1**
Total	**19**	**15**	**23**	**6**	—

Table E3: Number of individuals who booked and attended each Overview training round

Training round	Booked	Attended
Round 1	109	79
Round 2	95	67
Round 3	111	77
Round 4	54	48
Round 5	92	75
Total	**461**	**346**

Table E4: Number of participants from different partner agencies that attended Safe & Together Overview training (n=327)[34]

Partner agency	Number of participants attended	Percentage of participants who attended (n=284)[35]
Family/child services	48	16.9%
Education	44	15.5%
NHS – health services	39	13.7%
Housing/accommodation	34	12.0%
Parole/probation	31	10.9%
Social worker	26	9.2%
Domestic violence advocacy/Women's sector	24	8.5%

[34] Some participants selected multiple agency categories (e.g. both 'Social worker' and 'Children and young people's service), so counts exceed the total unique number of individual attendees.
[35] Percentages in this column are calculated out of the total number of unique individuals who attended the Overview training, i.e. out of 284.

Partner agency	Number of participants attended	Percentage of participants who attended (n=284)[35]
Substance abuse treatment/addiction services	17	6.0%
Other	13	4.6%
Law enforcement	11	3.9%
Specialist organisation	8	2.8%
Mental health	7	2.5%
Children and young people's service	6	2.1%
Domestic violence	5	1.8%
Therapist/clinical psychologist	5	1.8%
Religious service	3	1.1%
Adult social care	2	0.7%
Practice and development	1	0.4%
Quality assurance	1	0.4%
Men's behaviour change/perpetrator intervention services	1	0.4%
Sexual health services	1	0.4%
Total	**327**	**100.0%**

Appendix F: Sample size calculations

Table F1: Power calculations for the Restart intervention

	Scenario 1	Scenario 2	Scenario 3
Minimum Detectable Effect Size (MDES)	0.2	0.2	0.2
Pre-test post-test correlation (participant level)	0.4	0.5	0.6
Alpha	0.05	0.05	0.05
Power	0.8	0.8	0.8
One sided or two sided?	Two-sided	Two-sided	Two-sided
Required final analytical sample	661	591	504
Number of recruited participants (assumes 20% attrition from engagement to programme completion)	828	740	630
Number of eligible referrals (assumes 55% conversion rate from referral to engagement)	1,502	1,343	1,145

Appendix G: Accessibility text

Figure 1: Summary of Restart programme's intervention implementation findings

This figure summarises key implementation findings across three levels: **programme-level**, **Safe & Together model implementation**, and the **Restart intervention**. It uses a structured layout with icons and short text boxes to visually represent progress, challenges, and outcomes.

Programme-Level Implementation

- Delivery across six London boroughs: Both core components of the Restart programme—Safe & Together model implementation and the Restart intervention—were delivered across all six participating sites.
- Programme management and governance: via monthly mobilisation meetings and six weekly strategic meetings.

Safe & Together Model Implementation

- Training delivery: Six rounds of four-day CORE training were delivered across the sites. 284 CSC practitioners booked, 219 attended, 205 completed the training, with a 94% CORE training completion rate.
- Overview training:
  Five rounds of one-day Overview training were delivered to multi-agency professionals. 461 professionals booked, 346 attended, Participants came from sectors including education, health, and housing.
- Manager training: A two-day training course for managers and supervisors was introduced to support embedding the model in practice. 18 managers booked, 10 managers attended, 8 managers completed.
- Case consultation: 301 case consultations delivered.

Restart Intervention

- **Referrals:** Between July 2024 and May 2025, 151 referrals were received across the six boroughs. Of these, 67% (92 out of 151) were eligible for Restart, 33% were not. 33% engaged, 19% did not engage, 6% had not yet been processes, 3% were attempted to being contacted, and 6% were categorised as other.
- **Engagement and completion:** 53% of eligible referrals were recruited (49 of the 92 eligible), out of the 27 closed cases, 18 were completes (67%**).**
- **Optional housing pathway:** 14% of the eligible and engaged service users accessed the housing pathway (7 out of 49).
- Onwards referrals: 33% of completed cases referred on to long-term behaviour change programmes (7 of 18 completed cases).

- **Parallel support for (ex-)partner victim-survivors:** 53 took up support, of these, 62% wre from racially minoritised backgrounds, 30% had english as a second language, 25% had a disability.
- **Service users:** of the 28 the study has data on, 64% were from racially minoritised backgrounds, 39% had English as a second language, 21% had a disability.

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Figure 2: Recommendations from the Restart feasibility study

A visual diagram summarising the key recommendations from the feasibility study.

Programme level recommendations include:

1. Revisit the overarching aims and objectives of Restart
2. Consider more structured area-level recruitment and eligibility criteria
3. Formalise system learning mechanisms
4. Strengthen integration of the two components
5. Further refine and co-develop a programme-level theory of change
6. Ensure all future evaluation is co-designed with people with lived experience
7. Embed Equity, Diversity, Inclusion, and Equity principles across all aspects of future evaluation

Safe & Together Model Implementation recommendations include:

1. Continue adaptation of training materials for the UK context
2. Prioritise engagement of managers and supervisors
3. Maintain visibility of the Safe & Together implementation leads
4. Further build on the theory of change for Safe & Together
5. Strengthen monitoring data collection processes in partnership with the Safe & Together Institute
6. Consider introducing validated measures at pre- and post-training
7. Scope the use of administrative data and case file reviews for future impact evaluation
8. Co-design any future impact evaluation in partnership with delivery providers

Restart Intervention recommendations include:

1. Clarify eligibility criteria, and consider broadening referral pathways
2. Consider introducing a formal triage function
3. Invest in capacity for outreach and awareness raising
4. Consider extending the duration of the one-to-one support
5. Codify the core delivery model
6. Strengthen provision and planning for interpreter support
7. Strengthen optional housing pathway
8. Review informed consent for research participation

9. Strengthen routine monitoring data collection and embed validated outcomes tools
10. Consider safe and ethical pathways to involve service users and victim-survivors in research
11. Reassess evaluation readiness following capacity-building activities

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Figure 3: Restart programme summary

A partnership diagram showing the structure of the Restart model.

1. Restart Programme Level Inputs and Activities

- Programme management and governance from The Drive Partnership
- Delivered in six London boroughs
- Funding from MOPAC and Foundations
- Implementation support from local area leads
- Monthly operational and six-weekly strategic meetings

2. Safe & Together Model Implementation

- Delivered by the Respect organisation and the Safe & Together Implementation Leads.
- Aims to improve responses to domestic abuse in CSC and Early Help:
  - Keep children safe and together with the non-abusive parent
  - Partner with the non-abusive parent to keep the child safe
  - Intervene with the perpetrator to reduce risk to the child
- The Safe & Together mode implementation is broken into three areas:
  - Core training: Four days online training which is aimed at Children's Social care and Early Help
  - Overview training: one day online training aimed at multi-agency colleagues
  - Case audits and case consultations: available to all Children's Social care and Early Help practitioners.

3. Restart Intervention

Delivered by Cranstoun. It aims to improve motivation and accountability for behaviour change and provide adult and child victim-survivors with the option to remain safe and together at home. Referrals from: Children's Social Care, Early Help, Housing. It includes three strands made up a one-to-one domestic abuse perpetrator intervention, parallel support for (ex)partner victim-survivors, and an optional housing pathway.

1. One-to-one domestic abuse perpetrator intervention: For low-to-medium risk domestic abuse perpetrators known to CSC who are over 17 years old. One to two hour long weekly sessions across four to eight weeks. Delivered by Case Managers.

2. Parallel support for (ex-) partner victim-survivors: For partners or ex-partners of those referred into Restart who are over 17 years old. Parallel support and risk monitoring is delivered by Partner Support Workers
3. Optional housing pathways: All cases who consent to restart can access a four-week temporary accommodation and advice, with long term housing pathways. Delivered by Accommodation and Support Workers.

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Figure 4: Summary of methods used in the Restart feasibility study

A timeline diagram showing the four phases of the feasibility study from April 2024 to August 2025. Each phase is represented as a horizontal segment with a title and list of activities that occured during the phase. The timeline includes icons and colour-coded segments to distinguish phases and activities.

Phase 1: Feasibility Set-Up Phase (April – July 2024)

- Document review
- Evidence review to validate the Theory of Change
- Two workshops with The Drive Partnership, Cranstoun, and Foundations
- Produced research tools
- Achieved ethical clearance
- Produced the feasibility study protocol

Phase 2A: Data Collection and Outcomes Measurement (August – November 2024)

- Review of monitoring data processes
- Review of outcomes measures
- Two workshops with The Drive Partnership and Foundations
- Delivered training on data collection to practitioners
- Scoping interviews (n=15)
- Produced interim findings and recommendations

Phase 2B: Implementation and Evaluation Feasibility (December 2024 – April 2025)

- Observations of Safe & Together training and project management and governance meetings
- In-depth, semi-structured interviews with professionals (n=37)
- Evidence review on impact evaluation approaches
- Sample size calculations
- Two workshops with The Drive Partnership, Cranstoun, and Foundations

Phase 3: Analysis and Reporting (April – August 2025)

- Qualitative data analysis of interviews and observations
- Quantitative data analysis of monitoring data
- Triangulated qualitative and quantitative evidence to update the Theory of Change
- Produced the intervention protocol
- Produced the feasibility study report

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Figure 5: Number of stakeholders interviewed

An infographic showing the number of stakeholders interviewed during the feasibility study. It uses icons of people to represent different stakeholder groups (e.g. practitioners, programme managers, local leads). Each group is labelled with the number of interviews conducted.

- Programme stakeholders (n = 8)
- Restart practitioners (n = 7)
- Local area leads (n = 7)
- Children's Social Care and Early Help referrers (n = 6)
- Children's Social Care and Early Help practitioners (Safe & Together participants) (n = 6)
- Safe & Together implementation leads (n = 3)

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Figure 6: Restart's theory of change

This figure is a detailed theory of change model diagram. The diagram is structured under the categories of: set-up, participants, activities, mechanisms of change, short-term outcomes, medium-term outcomes, long-term outcomes.

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Figure 7: Participant flow through Restart's Safe & Together model implementation

A flowchart showing participant progression through Safe & Together model implementation from July 2024 to March 2025. Each stage is represented by a box with numbers and brief notes. Arrows connect the boxes to show progression. The layout is vertical and linear.

- **CORE Training:** 284 booked, 219 attended, 205 completed. 65 withdrew to sickness or workload.
- **Overview Training:** 461 booked, 346 attended
- **Manager Training:** 18 booked, 10 attended, 8 completed
- **Case Consultations:** 301 delivered

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Figure 8: Participant flow through the Restart intervention

A flowchart showing participant progression through the Restart intervention.

Referrals: There were 151 referrals (151 from Children's Social Care and Early Help, 0 from Housing). Of these referrals:

- 9 referrals not yet processed (these individuals have not yet been screened for eligibility)
- 50 referrals were unsuitable for Restart
- 5 referrals currently marked as "attempting contact"
- 28 referrals did not wish to engage
- 10 referrals were not progressed for "Other" reasons

Engagement: There was a 53% engagement rate (49 of the 92 eligible processed referrals).

- 22 service users still engaging in pre-assessment or first assessment
- 9 service users had their case closed prematurely:
- 2 service users disengaged
- 6 service users closed for "other" reasons
- 1 case closed by CSC
- 7 service users referred to the optional housing pathway

Completion: 67% Completion rate (18 service users completed out of 27 whose cases have closed)

- 11 not referred to further behaviour change work
- 4 referred to further one-to-one work
- 2 referred to further group work
- 1 signposted to Drive
- 22 service users still engaging or in pre-closure as of 31st May 2025
- 8 Service users case close prematurely (2 service users disengaged, 6 service users closed for "other" reasons, and 1 case closed by Children's Social Care).

39% onwards referral rate.

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