Adaptation report

FATHERS FOR CHANGE (F4C)

Foundations
What Works Centre for Children & Families

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Authors

Lilli Wagstaff, Lisa Mueller, Jack Martin, Tom McBride

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Funding and competing interests

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About Foundations, the national What Works Centre for Children & Families

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 Behavioural Insights Team (BIT)

The Behavioural Insights Team is a global social research and innovation consultancy that combines a deep understanding of human behavior with rigorous evaluation methods to improve people's lives. We partner with governments, charities, and service providers to design and test frontline interventions, generating the high-quality, actionable evidence needed to tackle complex social challenges and scale what works.

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GLOSSARY OF TERMS / ABBREVIATIONS & ACRONYMS

Abbreviation / acronym / terms	Description
BIT	Behavioural Insights Team
DA	Domestic abuse
F4C	Fathers for Change
RCT	Randomised controlled trial
TIDieR	Template for intervention description and replication
ToC	Theory of Change

EXECUTIVE SUMMARY

Domestic abuse has wide reaching and long-lasting impacts on the lives of children and families, whilst imposing huge financial and social costs on society. Many different approaches to supporting victim-survivors and children who have been impacted by domestic abuse exist, but only a small number evidence-based interventions are targeted at perpetrators of domestic abuse and changing their behaviours. As far as we know, no perpetrator programme that is underpinned by a robust evaluation (such as a randomised controlled trial, RCT) is available in the UK. Therefore, adapting evidence-based perpetrator programmes which have been developed and tested overseas and transporting them to the UK is a promising route to increase the availability of evidence-based and effective provision in this area. To do this successfully, adaptations to programmes need to be based on an in-depth understanding of how they have been developed and delivered to date as well as the new context and target population that they will operate in and for, to ensure that they are safe and have a good chance of being impactful in their new setting.

This document reports on the adaptation work undertaken to transport the Fathers for Change (F4C) programme from the US to the UK. F4C is a therapeutic programme for fathers who have been violent towards their partner which aims to prevent future domestic abuse. The programme is a strengths-based approach using fatherhood as a motivator for change. Through increasing father's parenting competence and understanding of the impact of domestic abuse on children, fathers gain motivation to change maladaptive patterns linked to abuse (Stover, 2013). The adaptation project was funded by Foundations, managed by their UK delivery partner The Fatherhood Institute and executed by the Behavioural Insights Team (BIT) in collaboration with The Fatherhood Institute's local implementation partner St. Michael's Fellowship.

In this report we describe the programme as delivered in the US, the differences identified between the US and the UK context, the adaptations made to the F4C programme to make it suitable for UK delivery, and the rationale and process behind making those adaptations. To conduct this work, an evidence-based approach was undertaken over a 7-month period to adapt the F4C protocol and implementation process, including a rapid review of research, a desk review of F4C programme materials and related research papers, a site-visit, expert interviews, a survivor interview, a focus group with perpetrators who had received the group-based perpetrator intervention Caring Dads, and multiple adaptation workshops with the adaptation team[1].

Based on these research activities the project team created a number of outputs including:

1. A detailed theory of change (ToC) and logic model, a 'template for intervention description and replication' (TIDieR) checklist, and an implementation logic model representing delivery in the US.

[1] The adaptation team included the intervention developer, The Fatherhood Institute, St. Michael's Fellowship, domestic abuse research experts, adaptation experts, clinical experts and Behavioural Insights Team researchers.

2. A list of mismatches between the US and UK context and suggested adaptations
3. A detailed theory of change (ToC) and logic model, a 'template for intervention description and replication' (TIDieR) checklist, and an implementation logic model representing delivery in the UK.

The group agreed on eight adaptations to the F4C programme and its implementation in the UK. Whilst overall there were no serious reservations about the suitability of the adapted programme in the UK, some of the most challenging issues we identified were around addressing the different workforces available to deliver F4C in the US versus the UK, addressing the different levels of wraparound support available to families eligible for F4C in the US versus the UK, and compliance with UK-based standards for perpetrator programmes (including the need for integrated support for victim-survivors).

The strengths of the work included the highly structured process and tools used to support the adaptation, the diversity of stakeholders we were able to draw on (including fathers representing those who would be eligible for F4C in the UK), and the expertise of the adaptation team. Limitations included limited involvement of victim-survivors.

INTRODUCTION

Background

Domestic abuse is both prevalent and impactful on children's lives, increasing the risk of a range of negative outcomes (Juliette et al., 2023). This includes behavioural and social-emotional outcomes, as well as physical health outcomes (Kitzmann et al., 2003; Dong et al., 2004; Herrenkohl et al., 2008; Chan & Yeung 2009).

A recent review funded by Foundations (Barlow et al., 2023) identified four broad approaches of working to support children who have witnessed and been impacted by domestic abuse:

1. Approaches for parents who have been victims of domestic abuse (and their children)
2. Approaches working with children alone.
3. Approaches working with the whole family.
4. Approaches for parents who have used violence towards their partner.

Of this fourth category, only one of three identified interventions – Fathers for Change, or F4C - was found to have evidence of effectiveness from small-scale RCTs in terms of reducing domestic abuse incidents and reducing young people's exposure to them (Stover, 2015; Stover et al., 2019; Stover et al., 2025).

As part of Foundations' commitment to building a pipeline of high-quality interventions to support children and families in the UK (Juliette et al., 2023), the What Works Centre has undertaken - with delivery partners the Fatherhood Institute and St Michael's Fellowship - a project to transport and deliver this promising intervention in the UK for the first time. To support this endeavour, the Behavioural Insights Team will be conducting a pre-implementation adaptation exercise to promote feasibility, acceptability, and impact within the UK context.

Intervention overview

F4C is a USA-based 18-topic, one-to-one therapeutic programme aimed at preventing repeat perpetration of domestic abuse (DA) by fathers. In particular, it supports fathers involved in abusive behaviours to change their understanding of emotions, thinking and behaviour. It positions fatherhood as a key motivator, and provides a safe space to explore, in-depth, men's individual histories and challenges; build key skills to enable healthy co-parent/couple and father-child relationships; and improve parenting (Stover, 2023).

Study rationale

Adaptation refers to a process of thoughtful and deliberate alteration of the design and/or delivery of an intervention to improve its fit or effectiveness in a new context (Wiltsey Stirman et al., 2019).

Whereas strict fidelity to intervention blueprints was once deemed essential to replication effectiveness, it is now recognised that reality is more complex and some adaptation of the intervention to the new context is likely to be needed (Green et al., 2023).

Transporting programmes that have been found to be impactful overseas to a new country is commonplace. However, programmes often fail to generate impact (or fail to generate it to the same extent) in their new settings. Examples of replication failure of US interventions trialled in Europe include flagship violence and offending prevention interventions such as Functional Family Therapy (Humayun et al. 2017) and Multisystemic Therapy (Fonagy et al., 2018), as well as more upstream interventions such as the school-based social-emotional learning programme PATHS (Berry et al., 2016).

Plausible theories explaining this include failure to sufficiently adapt an intervention for its new context, or to adapt it well. In other words, unplanned, excessive, or insufficient changes could undermine the effectiveness of the programme, and it is fit with the local context (Green et al., 2023). For instance, some changes to the intervention may undermine the underlying theory of change (e.g., removing core components - features in the design and delivery of the intervention which are hypothesised to be responsible for its effectiveness), while a failure to fully appreciate important contextual differences (e.g., culture, practitioner skill levels) may mean that necessary adjustments are not made.

OUR APPROACH

Overall, the aim of our work was to ensure that F4C is ready for delivery in the UK and has the best chance to demonstrate its:

- Deliverability (i.e., that F4C can be delivered well and as intended, embedded effectively within local systems, and that it can recruit and retain the intended population) and
- Acceptability (i.e. that F4C is received well by both UK-based practitioners and fathers) which in turn will maximise the intervention's chances of achieving impact.
- Impact (i.e. that it is likely to be evaluable in the UK and that 'core components' of the intervention hypothesised to drive effectiveness are retained).

Our overall approach involved examining whether: I) the intervention's theory of change/logic model, ii) implementation plan/logic model and iii) the intervention's materials need to be modified in the UK, given contextual differences with the US. We conducted this work in four stages (*see sections below for more detail on the proposed methodology for each stage*):

- **Stage 1 - Understanding the intervention** as it is delivered in the United States, including the content of the intervention as well as aspects of its delivery context (e.g., cultural, geographical, social, and economic, legal, ethical) and implementation.
- **Stage 2 - Understanding the new, UK context**, and **identifying areas where there may be 'mismatches'**, i.e., elements of the programme or the approach to delivering/implementing it that may not work well in the UK or might only work well if aspects of the context are attended to.
- **Stage 3 - Adapting the intervention**, by examining identified mismatches and determining whether they warrant an adaptation to the intervention content or approach to delivering/implementing it, and if so, the nature of the required adaptation. The Fatherhood Institute will take the lead in terms of actually adapting materials for delivery.
- **Stage 4** - Reflecting on and making recommendations around whether to proceed to **delivery of the adapted programme in the UK**.

A range of frameworks for conducting intervention adaptation exist, many of which broadly recommend the same steps (Movsisyan et al., 2019; Moore et al., 2021). Our approach to adaptation is based on our team's experience delivering adaptation studies, in particular the work of the Ending Youth Violence Lab (EYV Lab) at BIT, as well as our collaborator Dr Nick Axford's work transporting and adapting Becoming a Man (an evidence-based youth development programme) from the US to the UK. We applied a similar approach to that used in adapting Becoming a Man (Green et al., 2023).

It is important to note that while we think a pre-implementation adaptation exercise is important, adaptation is likely to be ongoing and continue beyond this report. While some necessary adaptations have been identified as part of this process, others will only become clear once the programme has been delivered in the UK for the first time, by learning from the experiences of those delivering the programme in its new context.

Stage 1: Understanding the intervention

Objectives

The primary objective of this stage of the work was to lay the groundwork for future adaptation by developing a strong understanding of the intervention, including its content and aspects of its delivery/implementation in the US.

Methods

To achieve these objectives, we conducted four main research activities. Each contributed to producing: i) A TIDieR framework description of F4C, ii) a ToC and logic model for F4C, and iii) an implementation logic model for F4C. Please see the following section on Findings for more detail.

Review of programme documents

We requested key materials from the programme developer, including:

- *Programme description and theory* - Theory of change/logic model (and other articulation of programme goals/objectives, rationale).
- *Delivery-focused practitioner materials* - Sessions plans, curriculum (and delivery manuals for practitioners).
- *Participant facing materials* - e.g., workbooks, multimedia materials, homework/take-away materials.

Examining existing research on the F4C programme

We identified existing research (whether quantitative, qualitative, or implementation/ process focused) relating to the F4C programme by:

- Requesting published research from the developer.
- Searching clearinghouses - i.e., websites and resources which attempt to describe programmes and services, describe their evidence, and often rate programmes on the extent to which they have support from methodologically robust evidence. Please see Appendix H for a full list of clearinghouses searched.
- Rapid literature search - i.e., searching Google Scholar for additional publications. We used the search terms “Fathers for change” and “Fathers4Change”, given that the programme is not widely known by any alternative name. We did not include other search-terms to restrict the search as we were potentially interested in any materials that may be identified.
- Snowballing - i.e., looking at relevant papers cited in already identified research.

We captured a range of key information on identified studies including:

- Implementation characteristics - i.e., setting, number, and duration of sessions, who delivers it (qualifications, experience levels etc.), extent to which the intervention is personalised/tailored, nature of training and support offered.
- Study design.
- Characteristics of the sample.
- What was measured.
- Overall findings.
- Differential impact (i.e., results of any analysis that imply or conclude the programme is more feasible/acceptable/effective for certain groups, or when delivered in a certain way, or under certain conditions, versus others).

Rapid review of other research

We conducted a rapid review of research relating to similar programmes (i.e., fatherhood-focused domestic abuse behaviour change programmes) to identify common elements driving outcomes and underlying frameworks of behaviour change.

We identified reviews of studies investigating the effectiveness of fatherhood-focused domestic abuse behaviour changes by:

- Requesting relevant reviews from experts in our project team and the programme developers.
- Examining previous work conducted by the funder, Foundations (and the legacy organisations the Early Intervention Foundation and What Works Children's Social Care).
- Snowballing - i.e., looking at relevant reviews cited in already identified research.
- Searching a small number of bibliographic databases - Google Scholar, the Campbell Library of Systematic Reviews, the Cochrane Library, and PROSPERO. For more details on inclusion/exclusion criteria and the search methodology (i.e., search strings), please see Appendix I.

We captured a range of key information on identified reviews including:

- Type/methodology of review.
- Types of studies included in review.
- Population/s of focus.
- Intervention/s of focus (including information on how they have been implemented, and any information - if reported - relating to what may drive implementation outcomes, i.e., fidelity, reach, acceptability).
- Outcomes investigated (i.e., for families, parents, and children).
- Overall findings.
- Evidence of differential impact (i.e., results of any analysis that imply or conclude the programme is more effective for certain groups, or when delivered in a certain way, or under certain conditions, versus others).
- Any information on the underlying theory of included interventions (if reported).

While evaluations investigating the effectiveness of specific interventions (such as RCTs) often provide limited data on core components or determinants of effectiveness, evidence synthesis studies (such as systematic reviews, and/or meta-analyses) will more often investigate this. Therefore, we examined reviews of interventions similar to F4C to provide useful data on core components for these types of intervention in general.

Interviews

We conducted a series of remote interviews with programme developers (including Professor Stover) and staff at the delivery organisation in the US.

These were semi-structured in-depth interviews with a range of representatives of the US programme. Experienced qualitative researchers from BIT conducted the qualitative research activities. We completed two remote interviews lasting 45 minutes to an hour.

We purposively sampled representatives of the programme in terms of what their area of focus/expertise may be to achieve full coverage of our research questions (for example, some individuals may be closer to implementation of the programme, versus the theoretical background of the programme).

In these interviews we gathered information about the original programme model and its implementation, with a focus on the key questions above, and filling in any gaps in understanding left after the literature review activities.

We employed a light-touch framework approach, summarising the rich qualitative data we generated and charting the data into a number of frameworks (i.e. the ToC and ILM) with a focus on distilling key themes around the 'core components' of the intervention and implementation barriers/facilitators in the US.

Site visit to view implementation in New Haven, CT, US

We conducted a site visit to a US implementation site to see and understand the local implementation context and meet with the developer and other key academics/practitioners in the US. This research expanded and deepened what we learned from the previous four research activities. We conducted a series of interviews using a similar approach to those described above, as well as some elements of naturalistic observation. This included:

- Attending an all-collaborative virtual meeting attended by all the DCF-funded teams implementing F4C across the state
- A visit to the Yale F4C Center
  - A tour of Yale Center where F4C is delivered
  - An in-person interview with Carla Stover
  - A focus group with all the practitioners in the Yale F4C Group
- A visit to Family Centered Services Team (a DCF-funded delivery site)
  - A tour of the centre
  - An interview with the supervisor

A paired interview with two practitioners

Findings

We created three outputs to capture the learnings from the above research activities and gain a full understanding of the intervention and necessary adaptations:

- TIDieR framework description
- ToC and logic model
- Implementation logic model

Relevant content from across these outputs was shared with different stakeholder groups from the UK (in Stage 2) to support identifying mismatches.

A TIDieR framework description of F4C

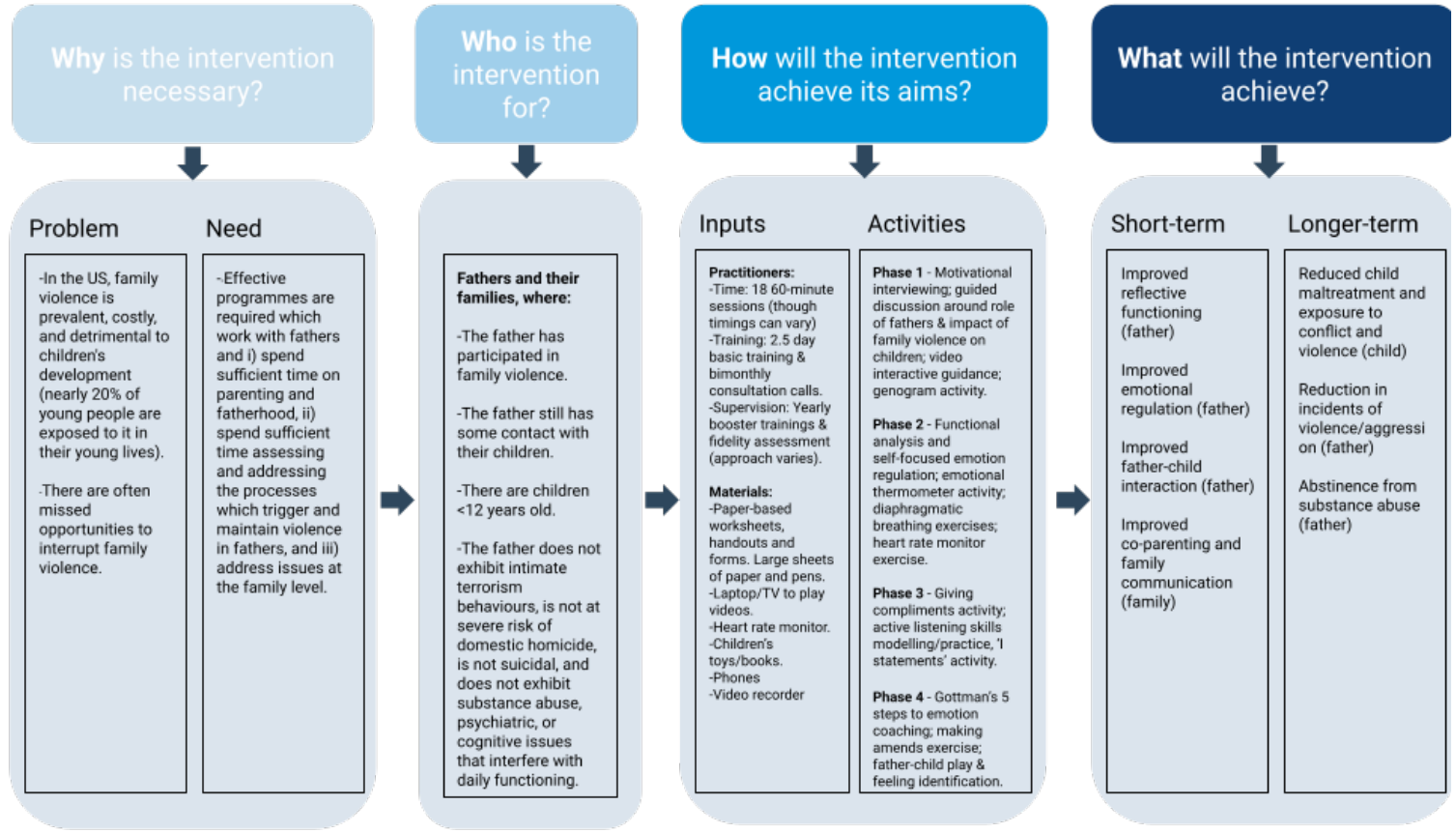
A TIDieR framework is a specific methodological framework for describing interventions in adequate levels of detail, adapted to be more appropriate for psychosocial/behavioural interventions. The F4C TIDieR framework can be found in Appendix A.

A ToC & logic model for F4C

While theories of change and logic models are related and both convey valuable information about a programme or service, they are distinct. The latter tends to be descriptive, laying out what the goals of an intervention are and what the key activities of an intervention are (often in the form of a sequential diagram). A theory of change, on the other hand, tends to be explanatory, providing the connective tissue between the elements of a logic model and explaining why, for example, the programme activities are expected to produce the desired outcomes. We have combined the key questions addressed by each of these methods into a single template, informed by the Early Intervention Foundation's guidance (Asmussen et al., 2019) and have populated this based on the Stage 1 research activity.

Figure 1 shows a simplified overview diagram of the F4C ToC and logic model. Further details can be found in Appendix B.

Figure 1. Simplified overview of the F4C ToC and logic model (pre-adaptation)



A key objective for Stage 1, as part of setting out F4C's theory of change and logic model, was to identify the hypothesised core components of F4C (i.e. features in the design and delivery of the intervention which are hypothesised to be crucial to its effectiveness). It was necessary to identify these early on, to guide future decisions about which elements of the intervention may or may not be amenable to adaptation. We identified seven hypothesised core components, split across a few key groups. Below we summarise the seven core components:

Table 1. Hypothesised core components of Fathers for Change

Core components identified relating to:	
Practitioner skills and qualifications	**Description/justification**
Practitioners should be supported to take an empathic approach towards fathers	The F4C programme requires clinicians to confront and acknowledge their own attitudes. The public and many practitioners will hold strong attitudes towards those who commit family violence. This may result in practitioners closing down any effort to connect empathically with the father (Stover et al., 2020). Part of this is also selecting practitioners who are well-suited to this work in the first place, and providing appropriate training e.g. IPV advance training.
Practitioners should have skill and experience in working with both adults and children	The F4C programme involves helping fathers to develop better reflective functioning related to their children. For practitioners to provide this support, it is important that they have an understanding of child development and the impact of family violence on child development. Otherwise there is a risk that practitioners do not sufficiently focus on supporting fathers to be mindful of their children's experiences and needs (Stover et al., 2020).
Practitioner supervision/support	**Description/justification**
Practitioners should be delivering F4C within a supportive environment	Delivering the F4C programme can be challenging and emotionally taxing for practitioners. Practitioner burnout and turnover have been experienced in settings delivering this sort of

	programme. Important forms of support for practitioners include: i) having more than one person delivering the programme within a given setting, ii) fostering a culture of reflective supervision within a given setting, and iii) practitioners being encouraged to be part of a community through informal peer support networks.
Content of the programme	**Description/justification**
Programme content should utilise fatherhood as the motivator for change	A core component of F4C is its focus on the parenting role (rather than exclusively focusing on the father's violent behaviours). It supports fathers to find the moments when they and their child/ren are positively connected, to give them the opportunity to see times when they are competent, and to naturally incentivise them to have more of these moments. Increasing father's feelings of competence and sense of meaning around their parenting role, as well as concern about the impact of IPV on their children, will provide motivation to change maladaptive patterns which lead to violence/aggression (and use of substances) (Stover 2013). In addition, it is posited that this approach supports engagement with the programme by supporting reach and engagement, supporting the development of a therapeutic alliance, and supporting better learning and understanding.
Programme content should be tailored and not take a 'one-size-fits-all' approach	A core component of F4C is attempting to assess and understand the specifics of a father's and families' case and provide support to help the father individually depending on what is driving his violent behaviour, and help him in relation to his relationships with the co-parent and children (Stover 2023). This includes using an attachment-informed therapeutic approach - by focusing on the fathers' childhood experiences, including his own childhood adversity. Practitioners will assess participants' trauma history and post traumatic stress symptoms and determine participants' ways of processing trauma to tailor emotional regulation

	content appropriately. Practitioners can also vary the degree of structure during sessions, such as whether to use programme materials, and will follow up flexibly to participants' responses. This is important, as it enables responding individually to a specific fathers' and families' needs.
Delivery of the programme	**Description/justification**
The programme should be delivered at the family-level and focus on family systems	F4C has sessions with a focus on family/co-parental communication, and incorporates flexible inclusion of co-parents and children in later sessions of the programme (Stover 2023). Parallel sessions allow clinicians to assess dynamics and risks within the family (Stover 2023). Dynamics can sometimes be best addressed by thinking about the broader family system. For example, if one partner is attempting to use a new skill to manage emotions and the other partner is not receptive, it can undermine repeated use of that skill (Stover 2023). Inclusion of partners has been found to significantly improve treatment outcomes for men in substance use disorder treatment and their children (Kelley & FalsStewart, 2002).
The programme should be delivered at the family-level and focus on family systems	Unlike other perpetrator-focused programmes, F4C is not delivered to groups of fathers but rather to individual families. It is hypothesised that individual sessions are more effective than group-based sessions, as there is evidence that antisocial participants have a 'contagion effect' within the group, which reduces engagement and potential benefit to other participants (Meis 2008; Murphy and Meis 2008).

This is a tool that focuses on implementation strategies of an intervention and the systems and context that support them (unlike a standard theory of change and logic model which focuses on the overall conceptual model of why and how an intervention is intended to produce outcomes for the target population) (Smith et al., 2020). It involves describing:

- **Implementation determinants:** 'context-specific barriers and facilitators' that 'prevent or enable implementation' (Smith et al., 2020). A taxonomy of implementation determinants (the 'CFIR domains') that we have examined can be found here (Damschroder

et al., 2022). This is supplemented by the taxonomy of contextual factors provided by Craig et al. (2018). These are described at multiple levels:

- *Inner setting* - The setting where the intervention is delivered (including its physical, IT, and work/organisational infrastructure, its culture, its available resources, and its incentive systems).
- *Outer setting* - The setting the inner setting exists within (e.g. a community or system), including local economic/ environmental/political conditions, and policies and laws.
- *Characteristics of individuals* - The roles and characteristics of leaders, facilitators/practitioners, implementation support workers, etc.

- **Implementation strategies:** methods or techniques used to enhance the adoption, implementation, and sustainability of a clinical program or practice' (Proctor et al., 2013; Powell et al., 2015). A taxonomy of implementation strategies can be found here (Powell et al., 2015).
- **Mechanisms:** the processes by which implementation strategies are intended to produce implementation outcomes.
- **Implementation outcomes:** the effects of implementation strategies such as delivering the intervention with fidelity, the intervention having the desired reach, the intervention being sustainable etc (Proctor al., 2011; Powell et al., 2015).

Figure 2 shows a simplified version of the implementation logic model for F4C. More details can be found in Appendix C.

Overall, many of the identified determinants (or context-specific barriers and facilitators) to implementing F4C were those that are routine or expected for behavioural interventions (e.g. access to appropriate physical spaces, materials and equipment, sufficient funding, practitioner training etc.). However, determinants that were more specific to perpetrator programmes (and F4C) and were felt to require special attention included:

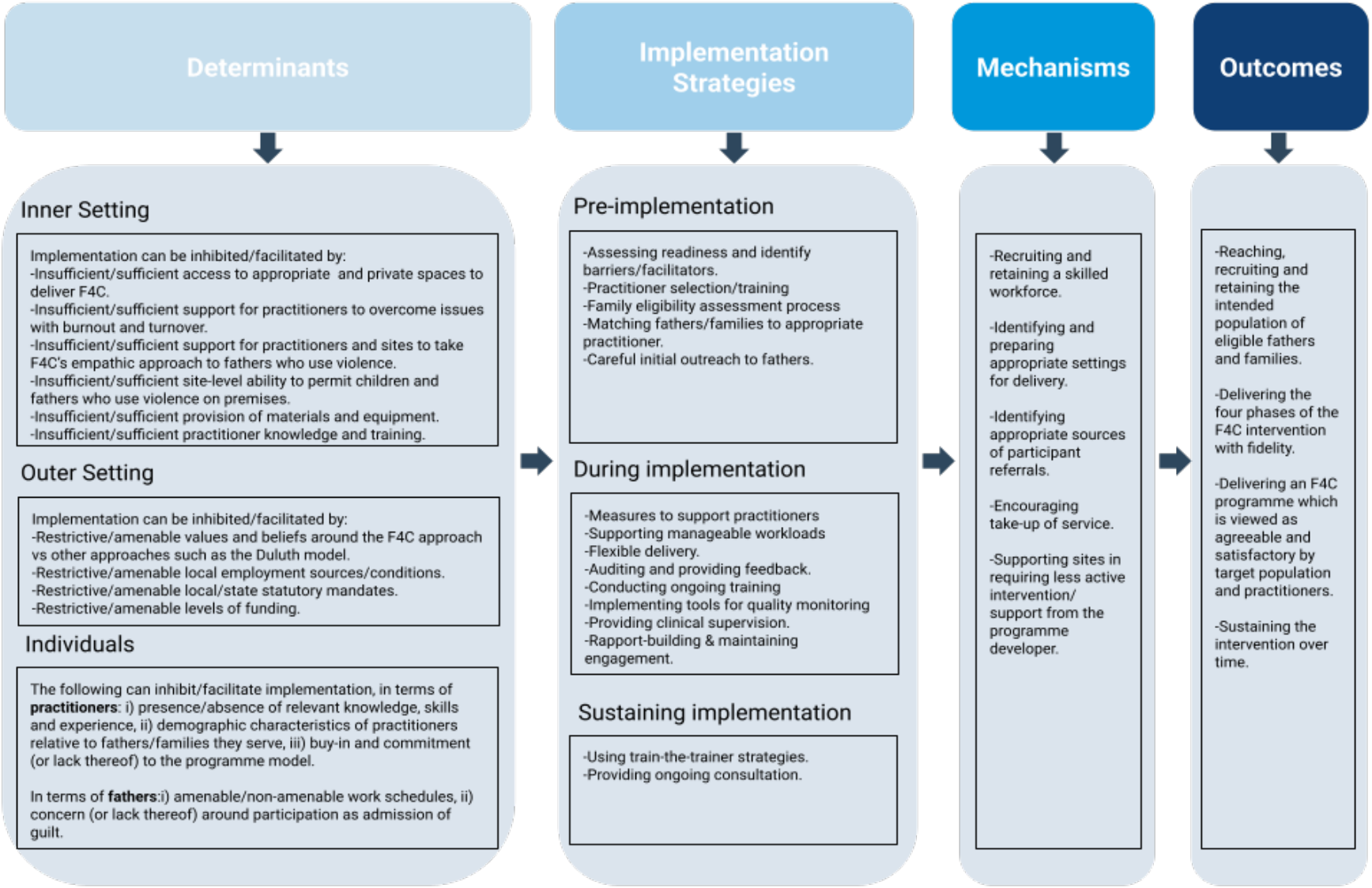
- **Values and beliefs in the broader system**: Views and beliefs around perpetrators may influence successful take-up and implementation of the programme, as it is predicated on taking a person-centered approach. The public and many decision-makers or influential figures may hold strong attitudes towards those who commit family violence. The primary approach to men who use violence in the US - the Duluth model of batterer intervention - focuses on challenging societal influences that perpetuate violence against women, manifestations of power and control, and promote behavioural change through skills for anger management (but typically focus less on parenting/fatherhood, the family dynamic, and the context of a father's violent behaviour). This model may have a cultural hold over service provision, meaning that practitioners, referrers, and other professionals could have some opposition to services based on a different approach and ethos.
- **Policies and laws in the broader system**: In the US, programme developers find that local/state statutory mandates around domestic abuse can inhibit implementation as other programmes (typically batterer intervention programmes) are often court-mandated, which crowds out the opportunity to deliver F4C (or means that F4C can only be delivered after a

batterer intervention programme is received by a father - at which point their motivation for further intervention may be exhausted).

  - Assessing readiness and identifying barriers and facilitators using the F4C organisational readiness form was identified as a key implementation strategy. This can help mitigate risks and barriers around local/state statutory mandates.

- **Motivation of intervention recipients**: The motivation of fathers to participate in a family violence focused programme is a key determinant of implementation success. Some fathers have concerns that participation represents an admission of guilt, and this fear can be exacerbated when child protective services and the criminal justice system are involved.
  - Careful initial outreach to fathers was identified as a relevant key implementation strategy. Practitioners should engage with the participant empathically as a person and focus on slowly building a trusting relationship.
  - Matching fathers/families to appropriate practitioners was identified as another key implementation strategy. The initial F4C eligibility assessment process can inform matching a practitioner to a father based on i) the fathers needs and the expertise of the practitioner, and ii) demographics, including ethnicity.

Figure 2. Simplified implementation logic model for F4C (pre-adaptation)



Stage 2: Understanding the UK content and identifying mismatches

Objectives

The primary objective of this stage of the work was to engage a range of UK stakeholders, to learn more about the UK context in which F4C would be delivered, share what we have learnt about the intervention as delivered in the US in the preceding stage, and identify possible 'mismatches' with the UK context.

Mismatches are defined as any element of the programme which might not work well in the UK (and so having a negative impact on the programme's deliverability, acceptability, evaluability, or ability to improve outcomes), and therefore might warrant an adaptation. The mismatches we identified ranged from the wording of programme materials to deeper contextual factors (such as social and cultural factors, or local practices and aspects of the local implementation context).

Methods

To answer the questions above, we conducted five research activities, where we acquired the perspectives of a range of UK stakeholders on the extent to which the programme is achievable, realistic, and appropriate for the UK context, and to identify where stakeholders have concerns about deliverability, acceptability, and ability to improve outcomes:

Table 2. Stage 2 stakeholder engagement activities

Activity	Approach	Focus (research questions)	Sampling	Data gathering and analysis
Delivery partner workshops: Engaging Fatherhood Institute & St Michael's senior managers and practitioners.	Workshops (2 sessions half-day long). Each with 4-6 staff.	All, but with a particular focus on implementation.	We purposively sampled delivery partner representatives in terms of what their area of focus/expertise may be to achieve full coverage of our research questions.	We used a similar approach to data gathering and analysis as described in preceding sections on qualitative work.
Stakeholder interviews: Engaging UK-based researchers and topic experts in fatherhood-focused	6 Semi-structured depth interviews (45 minutes long).	All.	As above.	

abuse interventions.				
Workshops with fathers: Engaging men who would be eligible for the programme.	Workshop (one session - 2 hours long) 6 participants. In-person.	Activities, Issues and needs of target population, Value-add, Impact, Materials, and already planned adaptations.	Convenience sample of men who are eligible for F4C and have previously participated in Caring Dads, a similar programme delivered by the project delivery partner.	
Victim-survivor interviews: Engaging survivors whose partners would be eligible for the programme.	Semi-structured depth interviews (60 minutes long) 1 participant	Activities, Issues and needs of target population, Value-add, Impact, and already planned adaptations.	Convenience sample of partners of men who have previously participated in Caring Dads, a similar programme delivered by the project delivery partner.	

Findings

To capture all the learning from these research activities and to prepare for the final adaptation stage, we created a mismatch log describing identified mismatches in detail. This covers all mismatches we considered, including those that did not lead to adaptations in the final stage.

We organise identified mismatches within 7 broadly chronological categories, following the stages of implementing a service: i) **Initial due diligence** - looking at the broader system and compliance with standards, ii) **Onboarding workforce** - specifying practitioner backgrounds and qualifications, iii) **Onboarding fathers and families** - specifying eligibility criteria, acquiring referrals, and achieving take-up, iv) **Delivering the programme** - specifying programme content and format, and iv) **Programme materials and branding**.

For each mismatch we provide a description and an explanation of why a given programme element or aspect of implementation may be mismatching. We also describe whether the mismatch concerns one of the seven identified core components of the intervention ('surface' level mismatches do not, 'deep mismatches' do). We describe the risks of addressing or not addressing the mismatch, along with a description of how it was identified.

Table 3. Mismatch log summary and identified mismatches

Potential mismatch	Rationale (why might this be a mismatch)	Level (surface level or deep)	Risks of addressing the mismatch	Risks of not addressing the mismatch	Source
1 - Initial due diligence: looking at the broader system and compliance with standards					
1. Compliance with UK standards for perpetrator interventions: Integrated support for victim-survivors	The UK Home Office Standards stipulate that perpetrator-focused interventions should not take place without integrated support for victim-survivors. The support should be truly victim-focused, there should be parity of provision for the father and victim-survivor, and the same member of staff should not work with both victim and perpetrator. This statutory standard, which doesn't exist in the US, may require modifications to the delivery of the co-parent strand of F4C, or providing additional support above and beyond this.	Surface	The range of options for addressing this do not appear to be likely to impact core components.	Noncompliance with UK standards may result in safety issues, reputational damage, and difficulties in accessing governmental funding in the longer-term for programme delivery.	Stakeholder interviews (academics & experts)
2. Compliance with UK standards for perpetrator	The UK Home Office Standards stipulate that joint work is rarely suitable and sets out a set of conditions that must be met if it is to take place. These conditions	Deep	Some options for addressing this, such as removing conjoint work from the programme,	Noncompliance with UK standards may result in safety issues, reputational damage, and difficulties in	Stakeholder interviews (academics & experts)

interventions: Conjoint support (i.e. fathers and co-parents receiving support in same sessions)	include: i) that the coparent proactively engages with the conjoint work (it isn't coerced), ii) that the joint work occurs subsequent to behaviour change work with the father, and that iii) careful suitability assessments for the conjoint work take place beforehand. This statutory standard, which doesn't exist in the US, may require modifications to the conjoint element of F4C.		would impact core components (i.e. F4C's family-level focus).	accessing governmental funding in the longer-term for programme delivery.	
3. Compliance with UK standards for perpetrator interventions: Addressing power and control	The Home Office Standards stipulate that perpetrator programmes should i) not be seen as a route to maintain or reassert control over an ex-partner and father's motivation should be carefully assessed throughout the intervention, and ii) focus on the forms of power, control and exploitation that research and practice have shown to be part of domestic abuse. This statutory standard, which doesn't exist in the US, may require modifications to the content of F4C.	Deep	Some options for addressing this could potentially impact core components. If the focus of F4C is shifted to power, control and gender for the whole programme, this would deviate from the theoretical basis of F4C.- i.e. taking an empathic approach to fathers and using fatherhood as a motivator for change.	Noncompliance with UK standards may result in safety issues, reputational damage, and difficulties in accessing governmental funding in the longer-term for programme delivery.	Stakeholder interviews (academics & experts)
4. Wraparound or	In some sites in the US, there is a robust package of other services routinely provided alongside F4C, which attend to	Surface	The range of options for addressing this do not appear to be likely	If this wraparound support is a key moderator of F4C's effectiveness (i.e. if it	Delivery partner workshops.

supplementary support	other needs fathers/families may have. We understand this level of supplementary support is unlikely or cannot be guaranteed in the UK.		to impact core components.	'unlocks' F4C's impact), we may find no/limited effect in the UK if F4C is trialled here.	
2 - Onboarding workforce: specifying practitioner backgrounds and qualifications					
5. Practitioner qualifications, background and experience	In the US, practitioners are Master's-level clinicians and trained therapists. It is also strongly recommended that the programme is delivered by practitioners with a background and expertise in delivering interventions to adults and children. We understand that in the UK, the intention is to deliver the programme with practitioners who do not have this level of qualification, and it cannot be guaranteed that it will be delivered by practitioners with the recommended background.	Deep	Some options for addressing this - such as insisting that F4C is delivered by a similar workforce as in the US - may inhibit the feasibility of delivering the programme in the UK (i.e. it may not be possible to recruit a sufficient number of practitioners with the required background).	Proceeding with a workforce which has different levels of training and different backgrounds to that of the US may risk effective delivery of a complex, therapeutic programme. Delivery by practitioners with experience in working with both adults and children is a hypothesised core component.	Stakeholder interviews (local authority, academics & experts); Delivery partner workshops
3 - Onboarding fathers and families: specifying eligibility criteria, acquiring referrals, and achieving take-up					
6. No or limited mandated referrals in the UK	Court mandated referrals are the most successful referral pathway in the US but court mandated referrals to community organisations are no longer common in the UK. This may limit the reach of the programme in the UK.	Surface	The range of options for addressing this do not appear to be likely to impact core components.	It's possible that without this referral mechanism, it may be challenging to achieve the number of referrals required to support a well-powered RCT in the future.	Delivery partner workshops

7. Potential concern about partner and child involvement, particularly from referring practitioners	Approaches that involve the co-parent and child in DA interventions are much more common in the US than in the UK. This may raise concerns on the part of referring practitioners, who may have concerns around safety and referring into a different sort of programme.	Deep	Some options for addressing this (such as removing co-parent and father-child sessions) could potentially impact core components, such as the focus on family systems.	This may limit the reach of the programme in the UK, and there may be risks of reputational damage.	Delivery partner workshops and stakeholder interviews (academics and experts, local authority).
8. Scepticism/ concern about perpetrator programmes in general, and about those not following the Duluth model	Some stakeholders may be wary of support that is targeted at fathers participating in violent behaviours. Others may be wary of the form of support that is offered as part of F4C, and be more supportive of batterer intervention-type programmes based on the Duluth model. Practitioners, referrers and other professionals could have some opposition to services based on a different approach and ethos.	Deep	Some options for addressing this (such as building in elements of the Duluth model) would fundamentally impact F4C's core components.	This may limit the reach of the programme in the UK, and there may be risks of reputational damage.	Delivery partner workshops and stakeholder interviews (academics and experts, local authority).
9. Length, depth and intensity of the assessment process	Some UK fathers expressed concerns that the assessment process is overwhelming and intrusive due to its length and number of questions.	Surface	Reducing the length or depth of the assessment process could increase safety risks. It may limit the effectiveness of the programme by not targeting it at fathers	There are risks around limiting programme take-up and engagement.	Workshops with fathers and victim-survivor interview

			and families who are most likely to benefit.		
10. Drug testing	Urinalysis drugs testing is a standard part of the F4C assessment process in the US, aimed at determining whether the fathers is able to engage with the programme and to route them into alternate support which may be more appropriate if necessary. However, there is limited culture of drugs testing in the UK, it may be logistically/legally difficult to do here, and may result in fathers choosing not to participate in the programme.	Surface	Addressing this mismatch is unlikely to affect core components of the intervention. The aim of drug testing is to i) assess impairment and ability to engage with and benefit from the programme, and ii) refer fathers to alternate support that may be more appropriate. However, these goals can be achieved through alternative means.	Enforcing drug testing as part of the assessment process and programme could result in fathers choosing not to participate in the programme.	Delivery partner workshops and stakeholder interviews (academics and experts)
11. Filming and video interactive guidance	Some UK fathers were concerned about being filmed during play activities with their child at the beginning and end of the programme (particularly around feeling analysed and judged).	Deep	The parenting focused element of the programme relies heavily on the use of this footage, and so removing it could impact on F4C core components.	There are risks around limiting programme take-up and engagement.	Workshops with fathers
12. Risk assessment	In the UK, the DASH (or 'Domestic abuse, stalking and 'honour'-based abuse	Surface	Incorporating the DASH seems unlikely	There are risks around not using the DASH. UK	Delivery partner workshops

tool used during assessment process	checklist) is often used to assess levels of danger and risk. This is how different agencies and settings communicate to each other about cases. This measure is not included in F4C's standard battery of up-front assessment/eligibility measures, which may inhibit compatibility and fit with the UK context.		to impact core components or introduce other risks.	referrers and other agencies might not be familiar with the risk assessment tool typically used in the US and it might make it harder to evaluate and understand levels of risk. This could lead to an over- or underestimation of risk.	
4 - Delivering the programme: specifying programme content and format					
13. Concerns about 1-2-1 intervention	Some fathers who we spoke to raised some concerns about F4C's individual format (versus group-based work). This included a worry that individual-work would lack an element of learning that other people have similar difficulties, sharing struggles, and so helping them to open up. Some fathers were also concerned the programme would be more intense if delivered individually.	Deep	Delivering F4C as a group programme would fundamentally alter the programme and would impact core components.	There are risks around limiting programme take-up and engagement.	
14. Concerns about programme length and intensity	Some UK fathers we spoke to raised concerns about the length of time it takes to be involved in the programme and it feeling too in-depth for their particular needs.	Deep	Shortening the programme would make it difficult to complete the in-depth therapeutic work required for the programme to be effective.	There are risks around limiting programme take-up and engagement.	Workshops with fathers

5 - Programme materials and branding					
15. Language and cultural mismatches relating to handouts and worksheets	A set of potential mismatches around the written/printed programme materials were identified. These are typically around differences in spelling between British English and American English, and around words that are commonly used/understood in the US but not so much here. Some broader suggestions around presentation of content to make it more digestible for participants have also been identified.	Surface	Small adjustments to spellings, language, and cultural references appear to be unlikely to impact core components	There are risks around fathers engaging with and understanding the materials, and so risks to the effectiveness of the programme.	Delivery partner workshops
16. The name 'Fathers for Change'	Some UK stakeholders felt that the prefix 'Fathers for' has connotations in the UK it doesn't in the US, namely an association with controversial, anti-feminist, and men's rights activism groups..	Surface	Small adjustments to the programme name appear to be unlikely to impact core components	Potential referrers or participants may be less likely to engage with the programme if they perceive there to be an association to hostility to women. There may be reputational risks.	Stakeholder interviews (academics & experts)

Stage 3: Adapting the intervention

Objectives

The primary objective of this stage of the work was to make recommendations around whether the identified mismatches warrant adaptations to the programme or aspect of implementation, and the form these should take. For each identified mismatch, key questions include:

- Is there a strong rationale that the identified mismatch would undermine deliverability, acceptability, or impact if unaddressed?
- Is there a way of addressing it without interfering with core programme components hypothesised to be responsible or partly responsible for intervention effectiveness?
- What is the best adaptation to address the mismatch?
- What are the implications of this adaptation for the broader programme?
- Should this adaptation be made?

Methods

We addressed the mismatches over the course of a series of seven workshops. Each workshop focussed on a different element of the programme (e.g. materials used, referral pathways, assessment process).

Recommendations around adaptation were made by:

- The programme developer (with their expertise in the F4C programme and approach)
- The Fatherhood Institute (with their expertise in the UK context).

They were supported in this by:

- The evaluation team's expert advisers[2].
- BIT, through:
    - Organising and facilitating the workshops.
    - Putting a structure around the decision-making process.
    - Acting as a 'critical friend' during the workshops and making sure the discussion is informed by the learning from stages 1 and 2.
    - Documenting the process and results.

Success in adaptation can be seen as achieving a balance between i) making sufficient changes such that a programme is likely to be feasible, acceptable, and impactful in its new context, and ii) not making excessive changes that can disrupt core components and undermine effectiveness.

[2] Including domestic abuse research experts, adaptation experts, clinical experts

The aim of the workshops was to achieve consensus between the F4C developer and the Fatherhood Institute on proposed adaptations. Consensus was sought around the necessity of addressing (or the acceptability of not addressing) each mismatch, and on how to address it. While we were not able to engage every stakeholder consulted over the course of the project in the workshops and consensus building exercise itself, we agreed the following:

- The Fatherhood Institute, as the UK-based delivery partner, was to represent the UK context and the perspectives of stakeholders consulted throughout the process. It was their role to advocate for changes that support feasibility, acceptability, and impact in the UK, and to raise concerns if they believed decisions around whether or not to address a mismatch, and how, are insufficient in achieving this.
- The F4C developer, as the owner of and expert in the US-based programmes, were to represent the original programme model. It was their role to advocate for changes that are consistent with and do not undermine the programme's core components, and to raise concerns if they believe decisions around whether or not to address a mismatch, and how, are insufficient in achieving this.

Consensus was broadly defined as neither party having significant concerns (around whether a mismatch has been resolved or not, and how it has been addressed) and was required for a recommendation to progress to delivery of F4C in the UK and a small-scale feasibility study:

Table 4. Progression criteria for adaptation decision-making

Criteria	Description & target	Next steps
Mismatches considered to satisfaction of Fatherhood Institute	Part of our aim is to achieve consensus around an adapted intervention where **sufficient changes are made to support feasibility, acceptability, and impact of the adapted intervention in the UK**. We consider this criterion met if a series of decisions (around whether to address each mismatch, and how to address it) are made and agreed upon where no serious concerns are raised by the Fatherhood Institute in terms of feasibility, acceptability, and impact in the UK. We consider this criterion not met if serious concerns are raised by the Fatherhood Institute which cannot be resolved.	If this and other criteria are met, then we will proceed to the next step. If this criterion is not met, then we will recommend a pause in the project and further consensus-building discussions until all parties withdraw any serious concerns (and provided no additional serious concerns are surfaced).

Core components maintained to the satisfaction of developer of F4C	Part of our aim is to achieve consensus around an adapted intervention where **the core components of the programme are maintained and not undermined.** We consider this criterion met if a series of decisions (around whether to address each mismatch, and how to address it) are made and agreed upon where no serious concerns are raised by the F4C developer in terms of core components. We consider this criterion not met if serious concerns are raised by F4C which cannot be resolved.	If this and other criteria are met, then we will proceed to the next step. If this criterion is not met, then we will recommend a pause in the project and further consensus-building discussions until all parties withdraw any serious concerns (and provided no additional serious concerns are surfaced).
New intervention consistent with statutory guidance[3] and raises no ethical/ safeguarding concerns	Part of our aim is to achieve consensus around an adapted intervention which **is consistent with best practice and statutory guidance in this area and raises no substantive ethical or safeguarding concerns.** We consider this criterion met if a series of decisions (around whether to address each mismatch, and how to address it) are made and agreed upon where no serious concerns are raised by either F4C developers, the Fatherhood Institute, or the BIT extended project team (including senior practitioners, practice experts, and academics). We consider this criterion not met if serious concerns are raised by any party which cannot be resolved.	If consensus can be reached, then we will proceed to the next step. If consensus cannot be reached, then we will recommend a pause in the project and further consensus-building discussions until all parties withdraw any serious concerns.

Findings

All identified mismatches were discussed and a total of eight adaptations were recommended. These included:

- Changes to the approach to delivering F4C in order to be compliant with the UK perpetrator programme standards - This includes lengthening the initial father-focused part of the programme, having different practitioners deliver the father- and coparent-focused parts of the programme, and having the coparent supported by an IDVA (independent domestic violence advocate). The group agreed that compliance with UK standards was important -

[3] Including Home Office Standards for Domestic Abuse Perpetrator Interventions and Home Office Domestic Abuse Statutory Guidance

given reputational and sustainability risks of not doing so - and that there was a set of adaptations we could make to ensure compliance that would not disrupt F4C's core components.

- Navigating differences in practitioner qualifications and experience - The group concluded that it will be challenging to recruit a team that meets all of the requirements typically met in the US. Ultimately the group recommended that we should identify skills/knowledge gaps (particularly around working with children and knowledge of child development) in the existing and to-be-recruited workforce and then fill these with additional training.
- Adaptations to the eligibility assessment process - Including replacing one risk assessment measure with the DASH (which is used more routinely in the UK) and eliminating urinalysis drugs testing from the initial assessment process.
- Surface-level changes to the written materials - To account for differences in UK and US spelling and terminology.

For the remaining eight mismatches, it was agreed that these did not warrant an adaptation:

- Some of these mismatches were found to be minor and could be addressed without altering the programme itself.
- Other mismatches were found to be potentially concerning, but the group concluded that only limited mitigating action could be taken (without altering the programme itself). For example, the group concluded that it would not be possible to provide the same level of wraparound support available to families participating in F4C in the US. Instead, there is a need for establishing strong referral pathways to external service providers, but also expertise among the practitioner team to be able to identify different levels of need and appropriate support. Establishing a family navigator in the team will be one important way of facilitating access to additional support for F4C families.
- Other mismatches reflected concerns of a small number of stakeholders which were possibly not unique to the UK context, such as concerns about the intensity and length of the programme. Addressing these points would have risked undermining core features and the scope of the F4C programme and therefore the project team decided to not make adaptations based on these suggestions.

We achieved full consensus on these decisions, meeting our progression criteria, with no parties raising serious concerns or reservations.

Table 2 shows an overview of how the mismatches were addressed. For each mismatch we provide a description of the agreed adaptation and why it was recommended (alongside a specification of the nature of the adaptation and the ways it may impact on core components).

Table 5. Overview of adaptations

Potential mismatch	Agreed adaptation and rationale	Rationale	Nature of adaptation	Implications[4]
1 - Initial due diligence: looking at the broader system and compliance with standards				
1. Compliance with UK standards for perpetrator interventions: Integrated support for victim-survivors	**Adaptation required** - We have agreed that: i) We will deliver F4C with entirely separate practitioners delivering the father-focused and coparent-focused strands of the intervention, ii) The co-parent focused practitioner or family navigator should also act as the project's IDVA (Independent Domestic Violence Advocate) - they will provide generalised support, outside of the programme, to the coparent including: acting as someone they can go to with safety concerns, someone who explains and describes the father-focused programme to the coparent, and advocating for them when joint work is considered. The IDVA would provide a baseline of support for coparents, whether or not they decide to take-up the co-parent focused strand of F4C.	To ensure compliance with UK standards.	Adaptation involves addition and substitution, it does not involve altering core components.	This has implications for the cost of delivery, and preparation that would need to take place prior to delivery (i.e. for practitioner recruitment/training).

[4] In our protocol we stated we would also include 'Level of consensus' and 'Timing' as fields in the adaptation log. We exclude these here to simplify the adaptation log (we have not included 'Level of consensus' in particular as we have achieved consensus on each decision/recommendation).

2. Compliance with UK standards for perpetrator interventions: Conjoint support (i.e. fathers and co-parents receiving support in same sessions)	**Adaptation required** - We have agreed that we will: i) Ensure that a minimum of 16 sessions are delivered to the father before conjoint work is considered (we understand that the first 8 topics for fathers are often delivered over more than 8 sessions, and so this does not involve designing new sessions or content, but rather imposing a minimum amount of time before progression is considered), ii) Take great care in terms of the transition to conjoint work. Part of this is addressed by the careful up-front assessment process that filters out high-risk cases. Part of this is addressed by involving the IDVA in assessing appropriateness of transition to conjoint work. Part of this will be addressed by developing written documentation and checklists around progression to joint work, and a protocol for how practitioners should assess the appropriateness of conjoint work on an ongoing basis (after it has started).	To ensure compliance with UK standards.	Adaptation involves addition, it does not involve altering core components.	This has implications for the cost of delivery and preparation that would need to take place prior to delivery (i.e. developing checklists and protocols for conjoint work).
3. Compliance with UK standards for perpetrator interventions: Addressing power and control	**Adaptation required** - We understand that power and control and addressing control tactics are addressed throughout F4C. The group agreed that the gendered aspects of this could be emphasised more in programme content to ensure compliance with standards. A power/control/equity wheel exercise (which addresses male privilege) is sometimes used in the initial phase of F4C, and clinicians can choose to focus on use of control tactics throughout the treatment. We will ensure that this content moves from optional to compulsory content to cover in father-focused sessions to be compliant with the Standards. It is important, however, that the overall focus of F4C is not shifted	To ensure compliance with UK standards.	Adaptation involves addition, it does not involve altering core components.	This has implications for the preparation that would need to take place prior to delivery.

	to power, gender and control (as this deviates from the theoretical basis of F4C). In addition, Fatherhood Institute will provide additional training to practitioners delivered by Dr Tara Dickens, providing practitioners with practical approaches to building rapport with the men and draw out their personal histories via investigative interviewing techniques (developed for use in criminal and military contexts) and will address coercive control, helping them to identify men who use techniques and behaviours designed to control women and children.			
4. Wraparound or supplementary support	**No adaptation required** - The group concluded that this is an unavoidable aspect of the UK context. The delivery team will put extra efforts into establishing signposting pathways and signposting fathers/families to relevant services or connecting them to relevant professionals alongside the programme. This will be bolstered by having a member of staff play the 'family navigator' role, who will liase with the designated social worker for each referred father/family to understand what support they already receive, any gaps and how to address these through hyper-local systems.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations. The developer seems comfortable that F4C has been successful in contexts where there has been a less robust wraparound support offer in the US, so this is reassuring.
2 - Onboarding workforce: specifying practitioner backgrounds and qualifications				

5. Practitioner qualifications, background and experience	**Adaptation required** - The delivery team is producing role descriptions for the key practitioner and supporting practitioner roles. However, we expect that it will be challenging to recruit a team that meets all of the requirements typically met in the US. Ultimately the group recommended that we should identify skills/knowledge gaps (particularly around working with children and knowledge of child development) in the existing and to-be-recruited workforce and then fill these with additional training.	To ensure feasibility of delivery in the UK.	Adaptation involves substitution, and altering core components.	This has implications for the potential quality of delivery and for hypothesised core components (i.e. all practitioners have skill and experience in working with both adults and children). The programme developer seems comfortable with this mismatch and the proposed mitigation action, and feels implementation in the UK on this basis can work.
3 - Onboarding fathers and families: specifying eligibility criteria, acquiring referrals, and achieving take-up				
6. No or limited mandated referrals in the UK	**No adaptation required** - It was decided that limited mandated referrals are not a major concern, as there are other referral pathways available. A mitigating action is to put more resources and capacity into promoting the intervention (i.e. providing training and information for referring social workers & professionals, making the case for the ethos of the intervention, its credibility, and US evidence-base).	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.

7. Potential concern about partner and child involvement, particularly from referring practitioners	**No adaptation required** - It has been agreed that no adaptations to the programme are required. However, to mitigate concerns more resource and capacity should be put into promoting the intervention (i.e. providing training and information for referring social workers & professionals; making the case for the ethos of the intervention, its credibility, and US evidence-base; emphasising the 'prize' of family-level work in terms of impact; and emphasis on robustness of the assessment process and eligibility criteria). This will include demonstrating the safety-informed screening processes which will be used to ensure the security of the mother/co-parent and child is at the heart of the work.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.
8. Scepticism/ concern about perpetrator programmes in general, and about those not following the Duluth model	**No adaptation required** - As above, It has been agreed that no adaptations to the programme are required. However, to mitigate concerns more resource and capacity should be put into promoting the intervention (i.e. providing training and information for referring social workers & professionals; making the case for the ethos of the intervention, its credibility, and US evidence-base; emphasising the 'prize' of family-level work in terms of impact; and emphasis on robustness of the assessment process and eligibility criteria). It was further noted in our discussions that the difference between the Duluth model and programmes such as F4C can be overstated, and modern-day Duluth-based programmes often include elements focusing on parenting/fatherhood, the family dynamic, and the context of a father's violent behaviour.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.

9. Length, depth and intensity of the assessment process	**Adaptation required** - It was decided in workshop that this isn't a 'true' mismatch between the UK and US, and that there are likely to be a diversity of preferences about this on both sides of the Atlantic. It was decided that the UK F4C assessment process should be as similar to the US process as possible. This is because i) replicating the robustness and comprehensiveness of the US process may be helpful in reassuring key UK stakeholders about the safety of potentially more controversial elements of F4C (e.g. conjoint working), and ii) the programme has been shown to be effective in the US when the target population has been selected on the basis of the US process - disrupting this could impact effectiveness. Overall, the cautious and conservative approach is to keep the UK and US processes closely aligned. However, we understand that the standard F4C assessment process offers various *options* for measures assessing particular constructs and some members of the group felt this could be confusing or unhelpful for practitioners. It is consistent with this recommendation to narrow down the set of options (so there is a favoured measure for each key construct), without reducing the number of measures actually used.	To ensure feasibility of delivery in the UK.	Adaptation involves subtraction, it does not involve altering core components.	We think there will be minimal negative implications of addressing this mismatch and making minor adaptations to the assessment process, though this can be monitored as part of potential future evaluations.
10. Drug testing	**Adaptation required** - It has been agreed in the final set of the adaptation workshops that drugs testing should not be part of the F4C approach in the UK, and that other methods should be used to achieve the aims of drugs testing (i.e. relying on reports from referring practitioner, reports from the co-parent and practitioner's observations of working with the father on an	To ensure feasibility of delivery in the UK.	Adaptation involves subtraction, it does not involve	We think there will be minimal negative implications of addressing this mismatch and making minor adaptations to

	ongoing basis). We will use relevant validated measures to assess substance use, collaborating with Carla Stover to select validated measures appropriate for a UK context (for example the ASSIST-Lite screening tool).		altering core components.	the assessment process, though this can be monitored as part of potential future evaluations.
11. Filming and video interactive guidance	**No adaptation required** - It was decided in workshop that this isn't a 'true' mismatch between the UK and US, and that there are a diversity of preferences about this on both sides of the Atlantic. This type of exercise is well-established in parenting programmes.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.
12. Risk assessment tool used during assessment process	**Adaptation required** - It was decided in workshop that one of the standard F4C risk assessment measures would be replaced with the DASH.	To ensure feasibility of delivery in the UK.	Adaptation involves substitution, it does not involve altering core components.	We think there will be minimal negative implications of addressing this mismatch and making minor adaptations to the assessment process, though this can be monitored as part of potential future evaluations.
4 - Delivering the programme: specifying programme content and format				

13. Concerns about 1-2-1 intervention	**No adaptation required** - It was decided in workshop that this isn't a 'true' mismatch between the UK and US, and that there are a diversity of preferences about intervention formats on both sides of the Atlantic. The individual format of F4C is a 'core component' which should be protected. Other programmes are available for those who prefer group work.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.
14. Concerns about programme length and intensity	**No adaptation required** - It was decided in workshop that this isn't a 'true' mismatch between the UK and US, and that there are a diversity of preferences about intervention length on both sides of the Atlantic.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.
5 - Programme materials and branding				
15. Language and cultural mismatches relating to handouts and worksheets	**Adaptation required** - Changes to language and grammar in written materials were agreed upon. Please see more detail on amendments to programme materials in Appendix D.	To ensure feasibility of delivery in the UK.	Adaptation involves substitution, it does not involve altering core components.	We think there will be minimal negative implications of addressing this mismatch and making minor adaptations to the programme's handouts and worksheets, though

				this can be monitored as part of potential future evaluations.
16. The name 'Fathers for Change'	**No adaptation required** - The adaptation group, overall, felt that there was value in retaining the intervention name, retaining the focus on fatherhood, and in a sense reclaiming the name 'Fathers' from these other groups. It is worth registering that while no member raised serious reservations around progressing to the next stage in terms of this issue, some members did anticipate that retaining the original name may be a major problem for referrals in the UK.	-	-	We think there will be minimal implications to not addressing this mismatch, though this can be monitored as part of potential future evaluations.

Following the workshops, the ToC/logic model, TIDieR framework descriptions of the intervention and implementation logic model (see Stage 1 findings) were updated to reflect the new, adapted version of F4C. These can be viewed in Appendix E (adapted ToC/logic model), Appendix F (adapted TIDieR framework) and Appendix G (adapted implementation logic model).

Stage 4: Decision-making on proceeding to UK delivery, reflections on the project, and next steps

Decision-making

The primary objective of this stage of the work was to inform decisions by the funder around whether to proceed to delivering the adapted intervention in the UK. To support this decision, we shared a version of this report with the funder laying out the findings of the adaptation process, summarising the extent to which the progression criteria were met, and making a recommendation on whether to proceed to delivery or pause while issues are resolved. We then held a roundtable (with the funder, programme developer, and delivery team) to present the work and review the key outputs from it.

As noted in the section above, we were able to report that our progression criteria were met, and ultimately to recommend that the UK F4C project proceed to the next stage, on the basis that we achieved consensus on the adaptations that would be required for UK delivery (whilst protecting and preserving core components) with the programme developer, the delivery partners, and our experts in the broader adaptation team. We concluded that F4C is a well-evidenced and successful programme in the US, distinct from other UK interventions in the field due to its 1:1, therapeutic approach, and that there was good reason to want to proceed to delivery in the UK and to establish its deliverability, acceptability, and impact in the UK context through evaluation. Following the roundtable, the decision was made to **progress to the next stage of the project.** The key recommendations arising from the roundtable were consistent with the adaptations recommended in Stage 3.

Reflections on the project

The main strengths of the work we conducted were:

- Drawing on adaptation processes conducted in the past, we designed a **highly structured process which involved populating tools such as the Implementation Logic Model**. This approach was felt to be highly comprehensive, providing a strong framework and set of prompts that methodically surfaced potential issues and mismatches. This was useful and the project team felt that many of the identified issues may have been missed in the context of a lighter-touch adaptation approach.
- The **diversity of stakeholders** we were able to draw on as we identified mismatches was absolutely crucial. By drawing on local authority, academic, practitioner expertise, as well as the views and perceptions of fathers and victim-survivors, we were able to build a comprehensive picture of possible mismatches and broader challenges that may be encountered when delivering in the UK.

- The **expertise and pragmatism that the adaptation group brought to the work** and to the decision-making around whether and how to address mismatches, was invaluable. Again, the diversity of different perspectives and professional backgrounds present in the adaptation group ensured that each issue was considered holistically and that a range of potential solutions surfaced.

The main limitation of this work was that we were not able to achieve as much victim-survivor input into the process as we would have liked. Despite best efforts, it was challenging for our delivery partners to recruit victim-survivors for interviews. Although the interview with one coparent we were able to conduct was valuable and insightful, we wanted to incorporate a broader spectrum of survivor voices into our considerations. Furthermore, we did not plan to conduct interviews with children affected by domestic violence, and in retrospect this would have been a useful exercise. This means that the perspectives of victim-survivors are likely to be underrepresented in this adaptation project. Our hope is that the presence of academic experts and social workers who advocate for the rights and safety of victim-survivors in a professional capacity has represented the voice of domestic abuse victims indirectly in the adaptation process.

Next steps

After a set-up phase, UK delivery will begin on a small scale as part of a feasibility study. This will be a mixed-methods study using surveys, qualitative work, and administrative data to gauge whether the intervention can be delivered as intended, recruit and retain its intended population, is acceptable to fathers and to practitioners, and is evaluable in this context. The feasibility study's design will draw on the approach established by the Ending Youth Violence Lab (for example, the adaptation and feasibility study of GenPMTO). Based on this work, further adaptations may be made to the intervention.

BIBLIOGRAPHY

Asmussen, K., Brims, L., & McBride, T. (2019). 10 steps for evaluation success. London: Early Intervention Foundation.

Barlow, J., Schrader-McMillan, A., & Bowen, E. (2023). Improving outcomes for children with child protection concerns who have been exposed to domestic abuse.

Beebe, R., Fish, M. C., Grasso, D., Bernstein, B., DiVietro, S., & Stover, C. S. (2023). Reducing family violence through child welfare intervention: a propensity score-matched study of fathers for change. Journal of interpersonal violence, 38(21-22), 11666-11691.

Berry, V., Axford, N., Blower, S., Taylor, R. S., Edwards, R. T., Tobin, K., et al. (2016). The effectiveness and micro-costing analysis of a universal, school-based, social-emotional learning programme in the UK: a cluster-randomised controlled trial. School Mental Health, 8(2), 238-256.

Chan, Y., and Yeung, J.W. (2009). Children living with violence within the family and its sequel: A meta-analysis from 1995–2006. Aggression and Violent Behaviour, 14(5), 313–322.

Craig, P., Di Ruggiero, E., Frolich, K. L., Mykhalovskiy, E., White, M., Campbell, R., ... & Poland, B. (2018). Taking account of context in population health intervention research: guidance for producers, users, and funders of research.

Damschroder, L. J., Reardon, C. M., Widerquist, M. A. O., & Lowery, J. (2022). The updated Consolidated Framework for Implementation Research based on user feedback. Implementation science, 17(1), 75.

Dong, M., Anda, R.F. et al. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household disfunction. Child Abuse and Neglect 28 (7): 771–84.

Feldman, R. (2012). Parenting behavior as the environment where children grow. In L. C. Mayes & M. Lewis (Eds.), *The Cambridge Handbook of Environment in Human Development* (pp. 535–567). Cambridge University Press.

Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I. et al. (2018). Multisystemic therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): a pragmatic, randomised controlled, superiority trial. The Lancet Psychiatry, 5(2), 119-133.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41–54.

Green, F., Axford, N., Eastmond, N., Berry, V., Mannes, J., Allen, K., et al. (2023). Transporting an evidence-based youth development program to a new country: a narrative description and analysis of pre-implementation adaptation. Journal of Prevention, 44(6), 729-747.

Herrenkohl, T.I., Sousa, C., Tajima, E. A., Herrenkohl, R.C. and Moylan, C.A. (2008). Intersection of child abuse and children's exposure to domestic violence. Trauma, violence & abuse, 9(2), 84–99.

Home Office (2022). Domestic abuse: statutory guidance (accessible here).

Home Office (2023). Standards for domestic abuse perpetrator interventions (accessible here).

Humayun, S., Herlitz, L. Chesnokov, M., Doolan, M., Landau, S., & Scott, S. (2017). Randomized controlled trial of Functional Family Therapy for offending and antisocial behavior in UK youth. Journal of Child Psychology and Psychiatry, 58(9), 1023-1032.

Juliette, C., Rodriguez, D., Walker, E., Arnott, B., Moore, I., Clarkson, M., Goujon, C., Blackburn J., O'Higgins, A. (2023). Domestic abuse programmes for children & families: Programme promise & evaluation feasibility.

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: a meta-analytic review. Journal of consulting and clinical psychology, 71(2), 339.

Levendosky, A.A., Huth-Bocks, A.C., Shapiro, D.L., and Semel, M.A. (2003). The impact of domestic violence on the maternal-child relationship and preschool-age children's functioning. Journal of Family Psychology, 17(3), 275–287.

Luyten, P., Mayes, L. C., Nijssens, L., & Fonagy, P. (2017). The parental reflective functioning questionnaire: Development and preliminary validation. *PLoS ONE, 12*(5), e0176218.

Moore, G., Campbell, M., Copeland, L., Craig, P., Movsisyan, A., Hoddinott, P., ... & Evans, R. (2021). Adapting interventions to new contexts—the ADAPT guidance. bmj, 374.

Movsisyan, A., Arnold, L., Evans, R., Hallingberg, B., Moore, G., O'Cathain, A., ... & Rehfuess, E. (2019). Adapting evidence-informed complex population health interventions for new contexts: a systematic review of guidance. Implementation Science, 14(1), 1-20

Powell, B. J., Waltz, T. J., Chinman, M. J., Damschroder, L. J., Smith, J. L., Matthieu, M. M., ... & Kirchner, J. E. (2015). A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project. Implementation science, 10, 1-14.

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., ... & Hensley, M. (2011). Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Administration and policy in mental health and mental health services research, 38, 65-76.

Proctor, E. K., Powell, B. J., & McMillen, J. C. (2013). Implementation strategies: recommendations for specifying and reporting. Implementation science, 8, 1-11.

Siegel, J. M. (1986). The multidimensional anger inventory. *Journal of Personality and Social Psychology, 51*(1), 191–200.

Smith, J. D., Li, D. H., & Rafferty, M. R. (2020). The implementation research logic model: a method for planning, executing, reporting, and synthesizing implementation projects. Implementation Science, 15, 1-12.

Stover, C. S. (2015). Fathers for change for substance use and intimate partner violence: Initial community pilot. *Family process*, *54*(4), 600-609.

Stover, C. S., McMahon, T. J., & Moore, K. (2019). A randomized pilot trial of two parenting interventions for fathers in residential substance use disorder treatment. *Journal of substance abuse treatment*, *104*, 116-127.

Stover, C. S., Beebe, R., Clough, M., DiVietro, S., Madigan, L., & Grasso, D. J. (2020). Evaluation of a statewide implementation of fathers for change: A fathering intervention for families impacted by partner violence. Journal of family violence, 1-11.

Stover, C. S. (2023). Fathers and Violence. Guilford Publications.

Stover, C. S., Shayani, D. R., Ramos, K. L., Sullivan, T. P., & Hayes, A. (2025). Comparing Fathers for Change Individual Therapy for IPV Use to the Duluth Model Intervention in Individual and Group Formats. *Journal of Interpersonal Violence*, 08862605251372568.

Wiltsey Stirman, S., Baumann, A. A., & Miller, C. J. (2019). The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. Implementation Science, 14, 1-10.

APPENDICES

Appendix A: TIDieR framework (pre-adaptation)

TIDieR field	Guidance	Content
Name	Provide a name or phrase that describes the intervention	Fathers for Change (F4C)
Why	Describe any rationale, theory, or goal of the elements essential to the intervention	• Children's exposure to IPV is prevalent, with nearly 20% of a U.S. national sample of 4,000 children and adolescents exposed to IPV in their young lives (Finkelhor et al., 2015). - *Developmental impact* - IPV-exposed children face serious risk of developmental and emotional-behavioral repercussions (Briggs-Gowan et al., 2019; Gilbert et al., 2013; Grasso et al., 2016a, 2016b; Lee et al., 2022; Weir et al., 2021). Exposure to adversity and trauma can accumulate across childhood to impose detrimental effects on development and functioning that can persist into adolescence and adulthood (Casaneuva et al. 2009; Colletti et al. 2008; Grasso et al. 2019; O'Dea et al. 2020; Stover et al. 2017; Grasso et al. 2016; Kitzmann et al. 2003). - *Child maltreatment* - These children often experience other forms of victimization or neglect that co-occur with IPV (Browne et al., 2020; Grasso et al., 2016b, 2021). • There are often missed opportunities to interrupt family violence. One contributing factor is the tendency to focus exclusively on mothers in interventions for safety and treatment of family violence. Alternatively, fathers are mandated to 'Batterer intervention programmes' which challenge societal influences that perpetuate violence against women and teach skills for anger management. These do not: i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes that trigger and maintain violence in fathers, and iii) they ignore the family dynamic (see core components).

		• Effective programmes are required which work with fathers and i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes which trigger and maintain violence in fathers, and iii) address issues at the family level. • F4C, unlike other more traditional approaches, incorporates a focus on fatherhood and on the father-child relationship - F4C's central premise is that a focus on men's roles as fathers provides motivation to change maladaptive patterns of communication and aggressive or unhealthy interactions in relationships. (Stover et al., 2020). It also uses an individualised assessment of families using an attachment-informed therapeutic approach, investigates what is triggering violent behaviour, and aims for cessation of this through supporting improved emotion regulation and reflective functioning (Stover et al., 2020). Finally, it focuses on family systems through parallel and conjoint sessions with co-parents and children, and programme content focusing on family/co-parental communication.
What - Materials	Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed.	Materials used in training for practitioners: • Standardised manual Materials used in family assessments: • Phones, ability to record video for assessments, toys appropriate for child for interaction assessments Materials required for delivery of sessions: • Paper-based worksheets, handouts, and forms; large sheets of paper and pens; laptop/TV to play videos and potentially to draw genogram; heart rate monitor; children's books and games.
What - Procedures	Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.	There are 18 topics overall: nine father-focused, four coparent focused and 5 father-child focused (Stover, 2023). These are delivered across four phases which can compromise a variable number of sessions. There is no 'set number of sessions', although around 18 is often considered complete for a court-ordered diversion in the US. Activities include: **Activities for phase 1 - Engagement and motivational enhancement (4 topics)** • Motivational interviewing. • Guided discussions and educational content. • Genogram (pictorial display of family relationships and patterns of behaviour)

		• Fatherhood models/meaning. • Video interactive guidance. **Activities for phase 2 - Reflective functioning and skills building (4 topics)** • Guided discussions relating to incidents of family violence in the past. • 'Functional analysis' • Diaphragmatic controlled breathing exercise. • Heart rate monitor exercise to observe influence of triggers and coping strategies. • Positive or guided imagery. • Urge surfing. • Taking space. • Mindfulness techniques. • Exercise/physical activities. **Activities for phase 3 - Co-parenting communication (4 topics)** • Giving compliments activity. • Teaching active listening skills. • Practising use of 'I' statements. • Co-parent problem solving **Activities for phase 4 - Restorative parenting (5 topics)** • Fathers' learning John Gottman's 5 steps to emotion coaching and applying to their children. • Making amends exercise. • Unstructured, child-guided play time. • Father-child feelings identification and expression exercise. **Activities for ending treatment (1 session)** • Referral to other services if needed.
Who	For each category of intervention provider (such as psychologist, nursing	• Masters' level clinicians (Stover, 2023) • Trained by model developer using 2-day didactic and experiential training curriculum followed by twice monthly consultation calls to ensure fidelity to the model. (Stover et al., 2020)

	assistant), describe their expertise, background, and any specific training given.	
How	Describe the modes of delivery (such as face to face or by some other mechanism such as internet or telephone) of the intervention and whether it was provided individually or in a group.	Sessions are delivered face-to-face. They are delivered to individual families: • Some sessions are delivered individually to the father, • Other 'parallel' sessions can be delivered individually to the coparent, • Some sessions can be conjointly delivered to both the father and the coparent. • Some sessions can be conjointly delivered to both the father and to the child.
Where	Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	Can be delivered in and by a range of settings/agencies. Including residential substance misuse facilities (Stover 2019) and not-for-profit community mental health agencies (Stover 2020).
When and how much	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose.	18 topics delivered in 60-minute sessions delivered over 18-24 weeks (Stover et al., 2020). The number of sessions and duration of treatment may vary depending on the needs and progress of the father/family.
Tailoring (planned)	If the intervention was planned to be personalised, titrated or adapted, then	Number of sessions, and emphasis across the 18 topics, can vary depending on the situation of the family. Conjoint sessions are not always used depending on the situation of the family:

	describe what, why, when and how.	• Co-parent participation: - Conjoint sessions with the mother target communication skills pertinent to coparenting, but only if the clinician determines through ongoing assessment with the mother that doing so would be safe and appropriate, and if mother wishes to participate. - If so, conjoint sessions must follow a minimum of two assessment sessions and nine individual treatment sessions with the father and two assessment sessions and a minimum of three individual sessions with the mother. (Stover, 2023) - Up to six joint coparent sessions with the father (Stover, 2015) - If it is unsafe or not possible to hold conjoint coparent sessions, fathers can work individually with their clinician to improve their coparenting skills; e.g., practice how to give compliments, use active listening, make I statements, and problem solve • Father-child sessions - Father-child sessions focus on reparations that benefit children including: the father taking responsibility for his violence, making an apology and sharing what he is learning in treatment to change his behaviors - Clinicians only go forward with father-child sessions if they feel they will be beneficial to the child and the father is fully prepared to take responsibility for his past behavior, not seek forgiveness during the session and understands this is a first step in facilitating a strong relationship with his child that may take time to build.
How well (planned)	If adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	Fidelity is assessed using either: • A clinician self-complete checklist, or • A review of session videos and coding on session observation rating sheet. Fidelity is maintained via: • Twice monthly consultation calls for 12 months and • Optional yearly booster trainings to uphold fidelity to the model.

Appendix B: Detailed ToC/logic model (pre-adaptation)

Area of focus	Key questions	Characteristics of a strong ToC/logic model	Description

Why is the intervention needed?	What is the problem the intervention seeks to address?
	
	What need does this generate?
		• **Well-specified** - Problem and need are described in detail.
		• **Evidence-based** - The existence and nature of the problem and need are demonstrated by rigorous evidence and grounded in scientific literature.
			Problem
			
			Intimate partner violence (IPV) is prevalent, costly, and detrimental to children's health and development (Beebe et al., 2023).
			
			• Children's exposure to IPV is prevalent, with nearly 20% of a U.S. national sample of 4,000 children and adolescents exposed to IPV in their young lives (Finkelhor et al., 2015).
			  ○ *Developmental impact* - IPV-exposed children face serious risk of developmental and emotional-behavioural repercussions (Briggs-Gowan et al., 2019; Gilbert et al., 2013; Grasso et al., 2016a, 2016b; Lee et al., 2022; Weir et al., 2021). Exposure to adversity and trauma can accumulate across childhood to impose detrimental effects on development and functioning that can persist into adolescence and adulthood. (Casaneuva et al. 2009; Colletti et al. 2008; Grasso et al. 2019; O'Dea et al. 2020; Stover et al. 2017; Grasso et al. 2016; Kitzmann et al. 2003).
			  ○ *Child maltreatment* - These children often experience other forms of victimisation or neglect that co-occur with IPV (Browne et al., 2020; Grasso et al., 2016b, 2021).
			
			Need
			
			• There are often missed opportunities to interrupt family violence. One contributing factor is the tendency to focus exclusively on mothers in interventions for safety and treatment of family violence. Alternatively, fathers are mandated to 'batterer intervention programmes' which challenge societal influences that perpetuate violence against women and teach skills for anger management. These do not: i) spend sufficient time on parenting and fatherhood,

			ii) spend sufficient time assessing and addressing the processes that trigger and maintain violence in fathers, and iii) they ignore the family dynamic (see core components). • Effective programmes are required which work with fathers and i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes which trigger and maintain violence in fathers, and iii) address issues at the family level.
	Who does this apply to?	• **Well-specified -** The target population is clearly defined in terms of recipients' level of need and the target age of the population. Ineligibility/eligibility criteria are clearly specified. Constructs are operationalised and measurable. • **Realistic in light of wider context and external factors -** i.e. there is a plausible approach to recruiting the target population into the intervention in sufficient numbers, seasonal considerations (including school cycles) that may	• **Families where there is a history of family violence** - Reported physical or verbal intimate partner violence history, defined as threatened or actual sexual or physical violence against an intimate partner (in the last 12 months - Stover 2023) - *Importance* - There is evidence of greater IPV in the coparenting relationships of opioid-dependent men compared to non-drug abusing coparenting couples, and fathers with co-occurring IPV and substance abuse have more negative coparenting relationships (e.g., disagreement about how to parent, lack of communication about parenting) than men from the same community without histories of IPV and substance abuse (Stover, 2015; Moore, Easton, & McMahon, 2011; Stover, Easton, & McMahon, 2013) - *Notes* - Can also be used where violence is mutual/bidirectional within the relationship. • **Fathers with some contact with child(ren)** - *Importance* - More than 60% of men entering batterer intervention programmes (BIPs) are fathers. More than half of women who experience IPV continue living or having frequent contact with the male perpetrator due to shared children (Litton Fox, Sayers, & Bruce, 2001; Mbilinyi et al., 2009; Rothman, Mandel, & Silverman, 2007; Salisbury, Henning, & Holdford, 2009; Hunter & Graham-Bermann, 2013; Israel & Stover, 2009) • Fathers of **children under age 12** - - *Importance* - Family violence has differential impacts on children depending on their ages. Earlier exposure has the most detrimental impact on children's developing brains and nervous systems (Stover 2023).

		stand in the way of recruitment are considered, alternative services/offers that may crowd out recruitment for the intervention are considered.	- *Other* - Upper boundary of age limit has shifted previously from implementation to implementation - from 10 years old (Stover 2015) to 14 years old (Beebe et al., 2023). While not an eligibility criteria or a necessary characteristic of the target population, programme literature notes that fathers may have **co-occurring substance misuse problems**. This is on the basis that co-occurrence of substance misuse and family violence are high as they share common causes, i.e. childhood adversity (Stover 2023). Prevalence rates of IPV in men who enrol in substance use disorder treatment are approximately 50% (Easton, Swan, & Sinha, 2000) with acute and heavy alcohol use and acute cocaine use the most associated with violence overall (Chermack et al., 2010). Moreover the integration of interventions to target both IPV and substance abuse has been shown to be effective (Easton et al., 2007; Stover, 2015). F4C was originally developed for delivery in outpatient substance use treatment settings, however it has broadened out from this over time to include community mental health agencies, child protection agencies, domestic violence service agencies (Stover et al., 2019, Stover et al., 2020, Stover, 2023). Exclusion criteria at assessment stage include: • **Intimate terrorism behaviours** - Men who exhibit intimate terrorist behaviours (i.e. stalk their partner frequently, control their access to family, friends or money to control them). • **Severity and dangerousness** - Men who score highly on the Abusive Behaviour Inventory (particularly on items relating to use of weapons or significant injuries experienced, or on the Danger Assessment Scale (9 or higher) suggesting severe risk of domestic homicide, should not be enrolled and other interventions should be considered (and safety planning should take place). • **An active no-contact protective order pertaining to the child is in place**. • **Substance abuse that interferes with daily functioning** - If the severity of a father's substance use is considered high and likely to interfere with full participation in the programme (i.e. in cases where residential substance misuse treatment is required), alternate treatment may be considered more appropriate. • **Psychiatric symptoms** - Fathers with untreated psychotic disorders, bipolar I disorder, or narcissistic personality disorder, are not considered to be a good fit for the programme.

			• **Currently suicidal or homicidal.** • **Cognitive impairment (i.e. intellectual disability)** that would prevent benefitting from F4C. **Core components/moderators relating to target population:** • Evidence on F4C does not appear to investigate moderators in terms of participant characteristics. However, in terms of implementation outcomes, Stover 2023 notes that in the IPV-FAIR implementation, programme completion rates did not differ due to fathers' age, severity of IPV, employment, education, or ethnicity.
	With respect to this problem, need and population, why will the intervention add value over what is currently available for children and families?	• **A specific, plausible & logical** hypothesis (or ideally evidence-based case) that the intervention is likely to have a greater impact than other programmes available in the UK.	In the US, responses to family violence typically take the form of siloed services which target the needs of mothers (predominantly in the form of confidential victim advocacy services), fathers (through court mandated 'batterer intervention programs - or BIPs), or children separately, but do not focus on the family dynamic and the father–child relationship (Beebe et al., 2023). Within the class of interventions for men who have caused harm, BIPs are the most common in the US. They focus on the nature of control, power and abuse in relationships. They have not been found to be effective in RCTs (Babcock et al., 2024). This overall approach (i.e. separate forms of support for fathers, mothers and/or children, and BIP programmes for fathers), lack the following characteristics: **Focus on fatherhood and on father-child relationship:** • Historically, interventions with families generally have been very maternal-centric. Parenting seems to be traditionally associated with mothering and men's experience of parenting often goes unnoticed (Stover 2023). 'Fathers in general are often ignored or minimized in their roles as parents by service providers…' (Stover 2023). • Few alternative interventions provide guidance on 'how to intervene with fathers and their children' (Stover 2023). They do not spend sufficient time focusing on parenting and fatherhood. • F4C ensures that fathers also have equitable access to programmes (Source: CT DCT interview).

			Individualised assessment of families using an attachment-informed therapeutic approach: • Within the traditional responses, there is limited opportunity to tailor intervention topics to the specific needs of fathers (Beebe et al., 2023). This means they do not address the processes that trigger and maintain violence in fathers who are involved in family violence. Unlike F4C they lack a focus on reflective functioning related to self, partner, and children (Stover 2023). **Focus on family systems:** • Few alternative interventions 'provide guidance on work with coparents together' (Stover 2023). • 'The current system of care for FV is often siloed, with those who cause harm and their families being treated separately, without coordination among providers or across systems' (Stover 2023). • F4C treating the family as a whole fills a gap in other service provision (Source: DFT interview)
How will the intervention achieve its outcomes?	What activities (in the context of the intervention) are required to produce its outcomes?	• **Well-specified -** Activities and what they involve are specified in detail. • **Evidence-based -** There is evidence from the scientific literature and robust evaluation that any given activity has improved the desired outcome/s.	Prior to intervention delivery **fathers and families** receive a pre-treatment assessment to determine eligibility and to develop treatment goals (this is described below in Inputs). Activities and techniques involved in sessions with fathers include: **Phase 1 - Engagement and motivational enhancement** • Motivational interviewing - *What it involves* - Using open questions, affirmations (giving compliments or affirming a behaviour of a father) and reflections to validate fathers' feelings, and summarising fathers' points back to them. Broadly the idea is to roll with resistance (not arguing back or confronting) and to navigate defensive responses from fathers (Stover et al., 2020) - *Importance and mechanisms* - Builds rapport with practitioners (Miller & Rollnick, 2023) and aims to gain some commitment to participation (Stover 2023). - *Timing/frequency* - Phase 1 topics 1 and 2

			• Fatherhood models/meaning - *What it involves* - Guided discussion and educational content around role of fathers and the impact of family violence on children (Stover et al., 2020) - *Importance and mechanisms* - A focus on fatherhood is believed to provide motivation to change maladaptive patterns which lead to violence/aggression (Stover 2013) - *Timing/frequency* - Phase 1; topic 2 • Video interactive guidance - *What it involves* - Practitioner reviews video-recording of father-child play/interaction (from the assessment phases), selects segments to watch with the father, and highlights successful moments of connection between father and child (Stover 2023). - *Importance and mechanisms* - There is a range of supportive evidence of the use of video interactive guidance in parenting programmes (Stover et al., 2020) - *Timing/frequency* - Phase 1 topic 3 • Genogram - *What it involves* - This is a pictorial display of family relationships and patterns of behaviour (over at least 4 generations), and is drawn in collaboration between practitioner and father (Stover et al., 2020) - *Importance and mechanisms* - This is a way to introduce thinking about the kinds of fathering and relationship role models they have had in their lives and patterns across generations. Supports fathers to recognise the opportunity they have to break intergenerational cycles. - *Timing/frequency* - Phase 1 topic 4. **Phase 2 - Reflective functioning and skills building** • Self-focused emotion regulation - *What it involves* - Guided discussions of situations that have resulted in incidents of family violence in the past. 'Functional analysis' is a key aspect of cognitive-behavioural therapy and is used to assist in understanding a specific behaviour and its triggers (Stover et al., 2020) . It is conducted through discussion with practitioner and filling out a worksheet.

			- *Importance and mechanisms* - See 'outcomes' section relating to emotional regulation. - *Timing/frequency* - Phase 1 topic 5. • Identification, understanding and coping with feelings - *What it involves* - Subsequent checking in on how the week has gone and assessing it for triggers. An 'emotional thermometer' activity and worksheet is used to do this and to explore these triggers (Stover et al., 2020). Following this, the nervous system and the impact of the fight-or-flight response on thinking and behaviors is discussed and diaphragmatic controlled breathing exercises are introduced/practiced. - *Importance and mechanisms* - See 'outcomes' section relating to emotional regulation. - *Timing/frequency* - Phase 1 topic 6. • Physiological arousal and Distress tolerance - *What it involves* - Checking in on previous week's incidents and triggers and use of the diaphragmatic breathing exercise. Father is asked to put on a Heart Rate Monitor or other biofeedback device and recall an incident that resulted in anger or anxiety, observe how their heart rate changes, and then use the diaphragmatic breathing exercise, and then observe their decreased heart rate. A range of other techniques are then covered (to support a father developing a 'toolbox' of strategies) including: positive or guided imagery, urge surfing, taking space, mindfulness, polyvagal techniques to stimulate the vagus nerve, and exercise/physical activity. Cognitive processing is taught in topic 8 using the cognitive triangle exercise (using worksheet), where the father is encouraged to think about their first thought in relation to a triggering incident, then their first feeling, and then their first action. The thought is then changed into something more helpful to demonstrate how changing thoughts can lead to different feelings and actions (Stover et al., 2020). - *Importance and mechanisms* – These topics and activities are intended to support improved emotion regulation (see 'outcomes' section relating to emotional regulation), by enhancing a father's understanding of his nervous system and physiological indicators of arousal. - *Timing/frequency* - Phase 1 topics 7 and 8.

			Phase 3 - Co-parenting communication • Giving compliments - *What it involves* - Using the 'giving compliments activity', where each parent is asked to name something they think the other parent does well as a parent or with their child. Then review with parents how to give and receive compliments (Stover et al., 2020). - *Importance and mechanisms* - This activity is intended to support improved co-parenting (see 'outcomes' section relating to co-parenting), by increasing positive interactions between the two parents. - *Timing/frequency* - Phase 3 topic 9. • Communication skills - *What it involves* - Teaching active listening skills (using handout and modelling from practitioner and practice between coparents), and teaching/practising the use of 'I' statements to express emotions and needs (instead of criticising, instead saying how a situation makes you feel) (Stover et al., 2020) . - *Importance and mechanisms* - See 'outcomes' section relating to co-parenting. - *Timing/frequency* - Phase 3 topic 10, can take multiple sessions. The next 2 sessions – topics 11 and 12 - involve practising these skills and also reviewing rules for healthy relationships and reviewing homework practice of skills. **Phase 4 - Restorative parenting** • Emotion coaching - *What it involves* - Translating fathers' new knowledge about managing emotions into coaching the development of their children's emotional intelligence. This uses John Gottman's 5 steps to emotion coaching. Guided discussion is used with fathers to determine when they could have used these steps with their children. This is then practised in sessions. The importance of praising children is then discussed and fathers are encouraged to practice as homework. Behavioural interventions such as time out and time in are also discussed (Stover et al., 2020) - *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions.

			- *Timing/frequency* - Phase 4 Topic 13 • Making amends - *What it involves* - Fathers effectively write a script designed to be spoken to their children which acknowledges what the child experienced, an apology, and how they are trying to change. The father practises reading this aloud and considers how their children may respond. In the subsequent session the father reads this to their child, and then the father and child are able to ask questions and discuss what was shared (Stover et al., 2020) . - *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. - *Timing/frequency* - Phase 4 Topics 14 and 15. • Father-child play - *What it involves* - Unstructured, child-guided play time for the father and child. The practitioner provides direct modelling/coaching for the father. This uses the steps for child-directed play from the developers of Parent-child Interaction Therapy (PCIT) (Stover et al., 2020) . - *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. - *Timing/frequency* - Phase 4 Topic 16 • Father-child feelings identification and expression - *What it involves* - Playing games and reading books with child. Fathers write down a list of feelings and then the group makes a face that demonstrates the feeling together. Parents and children then take turns acting out different feelings and trying to guess the feeling the other acts out. The father shows his children some of the coping strategies he has learnt (Stover et al., 2020). - *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. - *Timing/frequency* - Phase 4 Topic 17 **Final session/ending treatment** • Fathers receive a post-programme assessment towards the end of treatment. Fathers may be referred to other services

			- **NB**: The post-programme assessment is similar to the pre-programme assessment which is described below in Inputs. **NB:** See session structure in Appendix 1. Activities must be delivered in the order specified in the curriculum, though the amount of time dedicated to each can vary depending on the needs of the father/family.
			'Core components'/moderators - relating to the delivery of programme activities (i.e. what is delivered, and how it is delivered). Core component 1 - Fatherhood as a motivator for change - a focus on the parenting role (instead of solely violent behaviours) and using positive reinforcement and a positive strengths-based approach to support parenting - • *What this involves* - F4C focuses on parenting by supporting fathers to find the moments when they and their child/ren are positively connected, to give them the opportunity to see times when they are competent, and to naturally incentivise them to more of these moments. • *Importance and mechanisms* - Increasing father's feelings of competence and sense of meaning around their parenting role, as well as concern about the impact of IPV on their children, will provide motivation to change maladaptive patterns which lead to violence/aggression (and use of substances) (Stover 2013) In addition, it is posited that this approach supports engagement with the programme in the following ways: - **Supporting reach and engagement** - Programmes primarily focused on putting fathers under scrutiny for their violent and angry behaviour and the harm they have caused, are likely to make them resistant to intervention (versus the parenting-focusing, person/family centered approach). - **Supporting 'therapeutic alliance'** - This parenting-focused, non-blaming, and positive approach also has benefits for building a working relationship between fathers and clinicians. - **Supporting better learning and understanding** - These benefits in turn incentivises fathers to learn more, share more in sessions, and understand more how their anger and physical violence happens in the context of their relationship.

			Core component 2 - A one-size-doesn't-fit-all approach - individualised assessment of families using an attachment-informed therapeutic approach • *What this involves* - A core component of F4C is attempting to assess and understand the specifics of a father's and families' case, and provide support to help the father individually depending on what is driving his violent behaviour, and help him in relation to his relationships with the co-parent and children (Stover 2023). This includes using an attachment-informed therapeutic approach - by focusing on the fathers' childhood experiences, including his own childhood adversity. Practitioners will assess participants' trauma history and PTSD and determine participants' ways of processing trauma to tailor emotional regulation content appropriately. Practitioners can also vary the degree of structure during sessions, such as whether to use programme handouts and will follow up flexibly to participants' responses (Source: Site visit) • *Importance and mechanisms* - This is important, as it enables responding individually to a specific fathers' and families' needs. An attachment-informed approach is important as secure attachments are key to effective stress regulation and regulation of negative emotions in adulthood. A tailored trauma-informed approach supports effective emotional regulation in participants. (Source: Site visit) Core component 3 - Family-level approach and focus on family systems • *What this involves* - F4C has sessions with a focus on family/co-parental communication, and incorporates flexible inclusion of co-parents and children in later sessions of the programme (Stover 2023). Parallel sessions allow clinicians to assess dynamics and risks within the family (Stover 2023). • *Importance and mechanisms* - Dynamics for some families are best tackled by thinking about the broader family system. For example, if one partner is attempting to use a new skill to manage emotions and the other partner is not receptive, it can undermine repeated use of that skill (Stover 2023). Inclusion of partners has been found to significantly improve treatment outcomes for men in substance use disorder treatment and their children (Kelley & FalsStewart, 2002). In addition, the programme developer notes that co-parenting content often increases buy-in from the father as the focus of the entire intervention is not exclusively them and their behaviours (Source: Developer interview). Programme overseers in the Connecticut Department of Children and Families note that treating the family as a whole is a way in which F4C fills gaps that other programmes do not cover (Source: CT DCF

			interview). Finally, incorporating the co-parent allows a full understanding of the 'full story' (Source: Site visit). Core component 4 - Working with families individually - Running sessions with individual fathers and their families rather than groups of fathers • *Importance and mechanisms* - Individual sessions can be more effective than group-based sessions (e.g. BIPs) as there is evidence that antisocial participants have a contagion effect within the group, which reduces engagement and the potential benefit of other participants (Meis 2008; Murphy and Meis 2008). Working individually represents a unique aspect that sets F4C apart from other programmes and fills gaps not addressed by other IPV programmes (Source: CT DFT interview).
	What inputs or resources are required to deliver these activities?	• **Well-specified -** Inputs/resources (such as practitioner background/skills/ qualifications, time, management/supervision requirements, venue space, materials, equipment, transportation) are specified in detail. • **Realistic in light of wider context and external factors -** The time and resource requirements required for the	Delivery • *Practitioner time* - 18 60-minute sessions (over 16-24 weeks). Delivered by one clinician/practitioner. NB: In practice this has varied across evaluated implementations and there is no 'set number of sessions', although around 18 is often considered complete for a court-ordered diversion in the US. • *Setting* - Can be delivered in and by a range of settings/agencies. Including residential substance misuse facilities, (Stover 2019) not-for-profit community mental health agencies (Stover 2020), and participants' homes (Source: CT DFT interview). • *Any support for travel/transport* - Unclear, presumably decided on a site-by-site basis. • *Materials and equipment used in sessions* - Paper-based worksheets, handouts, and forms; laptop/TV to play videos (e.g. video documentary Show Your Love in Topic 2) and potentially to draw genogram (topic 4); large sheets of paper and pens (to potentially draw genogram in topic 4). Heart rate monitor (topic 7). Children's books (topic 17). Training for practitioners and implementation support • *Site assessment* - Time for site to undergo an organisational readiness assessment (via self-complete form) and for local statutory environment to be investigated prior to implementation (Source: Developer interview). See Appendix 2. • *Practitioner background/qualifications* - - Masters' or doctoral-level level clinicians

		activities are realistic in terms of available workforce, budget.	- From a variety of backgrounds, ranging from master's-level social workers in community-based agencies to psychologists in private practice' (Stover 2023). - Providers should 'have a background in both adult and child clinical work' (and training in both adult and child psychopathology and intervention) and be comfortable working with children. - Must have adequate skill in individual, couple, parent, and family therapy. - Significant understanding of child development and impact on development for both children and adults is required. - White therapists must have had training in cultural humility, systemic racism, microaggressions, and the impact of colorism on families. - Prior training in methodological interviewing, parent-child treatments, or parent-child interaction therapy is helpful but certification is not required. - Practitioners should have robust and contemporary trauma training (Source: Site visit). - Supervisors must be licensed (Source: Site visit) - Experience and knowledge of motivational interviewing techniques is desirable (Source: Site visit). • *Practitioner programme-specific training* - - Process and time required: ■ 2.5 day basic training (seemingly in groups) with an F4C Master Trainer. This includes didactic and experiential exercises to build key skills. ■ Bimonthly consultation calls for 12 months following training while implementing first cases. This is done via video conference. It is expected participants will see 3 cases over this year and present 2 cases. ■ The requirements for Master Trainers are currently being developed but current guidance specifies: ● You must have completed the F4C basic training, one day of booster training, and the consultation calls & case presentations. ● Conducted fidelity reviews with Dr Stover. ● If you're a supervisor - you must complete 5 F4C cases as the primary clinician.

			• If you're not a supervisor - you must complete 10 F4C cases as the primary clinician. • You must co-train a basic training with Dr. Stover. • You must take the lead during 2 consultation calls. - Materials: ■ Training is supported by a standardised manual. NB: It seems initially this was a 2-day training led by Professor Stover (Stover et al., 2020). • *Practitioner management/supervision* - - Twice monthly consultation calls (over training period). (Stover et al., 2020) - It is recommended that practitioners stay connected with those in their original training group and/or develop a peer supervision group. - Ongoing fidelity assessment - taking the form of either a clinician self-complete checklist (see Appendix 3) or a review of session videos and coding on session observation rating sheet (see Appendix 4). <u>Recruitment of families</u> • Outreach approaches - F4C 'can be offered or suggested by CPS agencies, family courts, domestic violence courts, or community providers', in addition 'families or fathers can seek it out on their own' (Stover 2023). • State-funded referrals in Connecticut originate from child welfare services. IPV perpetrators can receive a judicial mandate through the court to participate in IPV services, including F4C. The severity of IPV dictates which service perpetrators are directed towards (Source: CT DFT interview) • Onboarding families - - Process and time required: ■ Cases referred to F4C through courts, other agencies, or fathers themselves. ■ An initial phone call with father/family is made to describe the programme and its components. Fathers should be interested in having their child participate (otherwise they are usually not considered appropriate for the intervention).

			■ Clinicians acquire a referral form and/or information from CPS/courts on current orders of protection. ■ Fathers are informed the child's coparent will be contacted to gather information about the child and their coparenting relationship but no information about timing of that call is given to the father. ■ Child's coparent called and informed about the programme and what it entails. Mothers must consent to their child's participation if they are to be involved. ■ Fathers are assessed to determine appropriateness for the programme (2 hour individual session). At this point fathers need to sign releases for clinicians to review criminal histories (if they refuse they should not be enrolled in the program). ● Prior to this, in Connecticut, IPV specialists meet with social workers to determine whether a referral to F4C is appropriate (Source: CT DFT interview). ■ Coparent assessment (1.5 hours individual session). ■ An assessment of child/ren is completed to determine that dyadic treatment with the father is appropriate (it wouldn't be in cases where treatment with father could exacerbate child problems). This involves a 30 minute self-report assessment, and 30 minute father-child play assessment, and if appropriate a family play assessment (30 minutes). Assessments for suitability based on severity, nature and context of family violence, risk and safety of all family members, and other characteristics of the father and their approach to parenting. - Materials required - Phones, ability to record video for assessments, toys appropriate for child for interaction assessments.
			'Core components'/moderators - relating to the work that *supports* the delivery of activities (i.e. training, implementation support, recruitment): Core component 5 - <u>Supporting an empathic approach</u> - practitioners as part of their training must be supported to confront and acknowledge their own attitudes towards family violence and perpetrators -

			• *Importance and mechanisms* - This approach requires clinicians to confront and acknowledge their own attitudes. The public and many clinicians will hold strong, often unconscious attitudes towards those who commit family violence. It is difficult to simultaneously keep the child's experience in mind, and maintain an open, curious, and empathic stance towards the adults responsible. This may result in clinicians being pulled to defending the partner, protecting the children, and judging or closing down any effort to connect empathically with the father (Stover et al., 2020). • *Notes* - Part of this is also selecting the right practitioners in the first place and providing appropriate training e.g. IPV advance training (Source: Developer interview, CT DFT interview). Core component 6 - Practitioners who can work with adults *and* children - having a background in both adult and child clinical work • *Importance and mechanisms* - 'Understanding child development and the impact on children of witnessing violence is crucial to being able to help fathers develop better reflective functioning related to their children' (Stover et al., 2020). 'Without this background, therapists may focus too heavily on the father's individual skills and not enough on helping him hold his children's experience and needs in mind' (Stover et al., 2020) ((Other sources: Developer interview, CT DFT interview)). Core component 7 - A supportive environment for practitioners • *Importance and mechanisms* - Delivering the programme can be challenging and emotionally taxing - 'you can feel isolated and the cases are difficult'. Burnout and turnover have been experienced in settings delivering this sort of programme. Support can take the form of i) setting having more than one person delivering the programme, ii) setting having a culture of reflective supervision, and iii) practitioners being part of a community through informal peer support networks (Source: Developer interview).

What will the intervention achieve?	What are the short/medium-term outcomes required to produce the medium-term outcomes?	• **Well-specified** - Outcomes are sufficiently specific (e.g. something broad and general like 'school readiness' is broken down into specific constituent outcomes like 'communication skills' and 'literacy) and measurable (i.e. there is a validated way of measuring the outcome). • **Evidence-based** - A clear account of why these longer-term goals are meaningful for families and children, why medium-term goals are likely to generate long-term outcomes, and why short-term goals are likely to generate medium-term outcomes, justified by scientific literature.	In the short/medium-term, F4C aims to improve: <u>Father outcomes</u> • **Reflective functioning** - a person's capacity to understand their own as well as their child's mental states (Stover et al., 2020). - *Importance* - The ability to understand the mental state of oneself or others underlies overt behaviour. It is associated with violent behaviours including IPV (Stover et al., 2020). - *Measurable* - Prementalizing subscale of the Parental Reflective Functioning Questionnaire (Stover et al., 2020). • Emotional regulation - *Importance* - Emotion dysregulation has been associated with violence including IPV (Dankoski et al., 2006; Finkel 2007; Finkel et al., 2019). Studies have shown improving emotional regulation reduces violence (Denson et al., 2011; Finkel et al., 2009). Significantly associated with reflective functioning. - *Measurable* - Difficulties with emotional regulation (DERS) (Gratz & Roemer, 2004); Multidimensional Anger Inventory (Siegel, 1986); Parental Reflective Functioning Questionnaire (Luyten et al., 2017) • Improved father-child interactions - *Importance* - Meta-analytic findings indicate fathers' involvement associated with child improved cognitive, academic and social functioning (Amodia-Bidakowska et al., 2020; Rolle et al., 2019). Suboptimal father involvement associated with social-emotional and educational issues (Gillette & Gudmundson 2014). - *Measurable* - Videotaped interactions coded using the Child Behavior Rating Scales (Stover 2015; Feldman, 2012). <u>Family outcomes</u> • Coparenting - - *Importance* - Positive coparenting even in the context of a conflicted intimate relationship can be protective and result in better child adjustment. Coparenting has been shown to have a much stronger influence on parenting and child adjustment than other aspects of the couple relationship and is associated with greater father

			involvement in high risk families (Stover et al., 2020; Stover, 2015; Camara & Resnick, 1989; Katz & Low, 2004; Feinberg, 2003; Snyder, Klein, Gdowski, Faulstich, & LaCombe, 1988; Waller, 2012)

	What are the desired long-term outcomes?		In the longer-term, F4C aims to improve: Father outcomes • **Reduction in incidents of violence/aggression (IPV)** - physical or sexual violence, stalking, or psychological harm between current or former partners - Measurable - Follow-back spousal violence and timeline (Stover, 2015; Stover et al., 2025); Abusive behaviour inventory (Stover et al., 2020); Conflict Tactics Scale - Revised (Stover 2015a); Abusive Behavior Inventory (Stover 2023). • Abstinence from substance abuse - Importance - Substance use and enrolment in substance misuse treatment is associated with **IPV** (Easton, Swan, & Sinha, 2000). Treatment of substance use problems alone has been shown to have small to moderate reductions on IPV (Murphy & Ting, 2010). Moreover substance use is associated with **negative parenting behaviours**, including harmful behaviours towards children (McMahon et al., 2008, Söderström and Skårderud, 2013) and fewer positive father-child interactions (Eiden, Chavez, & Leonard, 1999). - *Measurable* - Addiction severity index (Stover et al., 2017) - *Notes* - Substance misuse is more a focus of the programme (and evaluation) when implemented in relevant settings or with substance abusing populations. Child outcomes • Child maltreatment incidents, including children's exposure to conflict and violence - *Importance* - Exposure to violence in childhood associated with child aggression, conduct problems, juvenile delinquency, and depression, anxiety, PTDS, and attachment disorders (from Stover 2023 - Evans, Davies, & DiLillo 2008; Jouriles & McDonald, 2024; Kitzmann, Gaylord, Holt & Kenny, 2003; Chan & Yeung, 2009)). In addition children exposed to family violence are at increased risk for various physical health conditions (from Stover 20023 - Lanier, Jonson-Reid, Stahlschmidt, Drake, & constantino, 2010). Finally, "family violence often crosses generations. Adults who abuse children have a higher likelihood of having been abused themselves and/or exposed to domestic violence. Children witnessing or caught in

			the crossfire of domestic violence are at greater risk of repeating the same behaviour when they have their own families" (Bartlett, 2017. Merrick & Guinn, 2018.) - *Measurable* - Children's Exposure to Conflict Scale on the Coparenting Relationship Scale (Stover 2023).

Appendix C: Detailed implementation logic model (pre-adaptation)

Logic model field	Subcategory	Content
Determinants (context-specific barriers and facilitators that prevent or enable implementation)	**Innovation** (the "thing" being implemented)	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. **Innovation source** (The group that developed and/or visibly sponsored use of the innovation is reputable, credible, and/or trustable) • F4C was developed by Professor Carla Stover in the Yale School of Medicine, which may enhance stakeholder's views of the intervention as reputable and credible. **Innovation evidence base** (The innovation has robust evidence supporting its effectiveness) • F4C has evidence supporting its effectiveness from multiple RCTs and QED studies (Source: Stover, 2015; Stover et al., 2020; Stover et al., 2017; Stover et al., 2019; Stover et al., 2018; Beebe et al., 2023; Stover et al., 2025). **Innovation relative advantage** (The innovation is better than other available innovations or current practice) • Evidence from the literature shows that F4C has a greater impact on behavioural outcomes than Individual Drug Counselling (Stover, 2015) and a greater impact on substance use than 'Dads 'n' Kids', a psychoeducational intervention (Stover et al., 2019). A small pilot trial (Stover et al., 2025) found that F4C had better outcomes than both individual and group Duluth approaches, which we understand to be a common approach used in the UK (Source: Developer interview). • Alternative business-as-usual programmes are often survivor-focused, or 'batterer intervention programmes', which focus on challenging societal influences around family violence, holding perpetrators to account, and teaching anger management skills. In contrast, F4C focuses on fatherhood and the father-child relationship, takes a tailored approach with individual assessments, takes a family-level approach, and is delivered individually to fathers and families. **Innovation adaptability** (The innovation can be modified, tailored, or refined to fit local context or needs)

		• Intervention materials (e.g. worksheets) can be adapted to the local context. The programme is designed to be inherently flexible to fit with settings' requirements; for example, conjoint father-child sessions may not be possible in all settings. **Innovation trialability** (The innovation can be tested or piloted on a small scale and undone) • F4C is delivered individually, so initial pilot delivery can focus on a small number of fathers and their families before increasing the scale of delivery. F4C has been trialled successfully in the past. **Innovation complexity** (The innovation is complicated, which may be reflected by its scope and/or the nature and number of connections and steps) • While the scope of the programme is ambitious, it is not more complicated than would typically be expected in an intervention focusing on perpetrators of domestic violence, or an intervention delivered to families. **Innovation design** (The innovation is well designed and packaged, including how it is assembled, bundled, and presented) • The intervention is summarised in a book, "Fathers and Violence: A Program to Change Behavior, Improve Parenting, and Heal Relationships". **Innovation cost** (The innovation purchase and operating costs are affordable) • To the best of our knowledge, operating costs do not exceed what would be typically expected in delivery of an individual intervention to families. Required materials (e.g. worksheets, toys) are low-cost and widely accessible.
	Inner setting (the setting where the intervention is delivered - including its physical, IT, and work/organisational infrastructure, its culture, its	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. **Structural characteristics: physical infrastructure** (layout and configuration of space and other tangible material features support functional performance) and **Available resources: space** (physical space is available to implement the intervention). • F4C requires sufficient space for a practitioner to work with a family, and sufficient privacy to address sensitive topics.

	available resources, and its incentive systems)	**Relational connections** (high-quality formal and informal relationships, networks and teams) and **Culture: deliverer-centeredness** (values, beliefs and norms around caring, supporting, and addressing the needs and welfare of deliverers) • Delivering the programme can be challenging and emotionally taxing - 'you can feel isolated and the cases are difficult'. Burnout and turnover have been experienced in settings delivering this sort of programme (Source: Developer interview; CT DCF interview). **Culture: human-equality centredness** (values, beliefs and norms about the inherent equal worth and value of all human beings), **recipient-centredness** (values, beliefs and norms around caring, supporting, and addressing the needs and welfare of recipients) and **mission alignment** (implementing and delivering the intervention is in line with the overarching commitment, purpose, or goals of the setting). • A critical component of delivering F4C is taking an empathic approach and treating participants as 'more than the worst thing they ever did'. However, the public and many practitioners may hold strong, often unconscious attitudes towards those who commit family violence. This can make delivery challenging, requiring that practitioners confront and acknowledge their own attitudes (Sources: Stover 2023; Developer interview). **Compatibility** (the intervention fits with workflows, systems, and processes) • Some settings do not permit or have authorisation to allow children on premises to enable child participation (Source: Developer interview). • Some settings do not permit having perpetrators on site (Source: Developer interview). **Available resources: funding** (funding is available to implement the intervention) • Lack of funding has been highlighted as a barrier, with sites in Connecticut receiving funding that is not keeping up with cost of living increases (Source: CT DFT interview). Funding at these sites is given with a 6 month limit. However, if funding runs out, the site will ask for an extension if the participant remains engaged (Source: Site visit). **Available resources: material & equipment** (supplies are available to implement and deliver the intervention) • A set of materials are required to deliver the intervention - this includes the programme handbook, phones, the ability to record video, toys appropriate for child for interaction assessments, Paper-based worksheets,

		handouts, and forms; large sheets of paper and pens; laptop/TV to play videos and potentially to draw genogram; heart rate monitor; children's books and games. - However these materials are - generally speaking - low-cost and widely available and so are unlikely to present a barrier. **Access to knowledge & information** (guidance and/or training is accessible to implement the intervention) • Delivery of the programme requires specialist knowledge, training and experience. No specific contextual barriers and facilitators have been identified against the following domains for the 'Inner Setting'. This does not necessarily mean that there are no facilitators/barriers relevant to these domains, but rather that these have not specifically been surfaced in our research. On this basis, we expect that any relevant barriers/facilitators against the following domains do not exceed what would be typically expected in delivery of an intervention to families: • **Structural characteristics: information technology infrastructure -** technological systems for telecommunication, electronic documentation, data storage, management, reporting and analysis support functional performance • **Structural characteristics: work infrastructure** (organisation of tasks and responsibilities within and between individuals and teams, and general staffing levels, support functional performance) • **Relative priority (**implementing and delivering the innovation is important compared to other initiatives) • **Incentive systems** (tangible and/or intangible incentives and rewards and/or disincentives and punishments support implementation) • **Tension for change** (the current situation is intolerable and needs to change) • **Communications** (high-quality formal and informal informations sharing practices) • **Culture: learning-centredness** (values, beliefs and norms around psychological safety, continual improvement, and using data to inform practice)
	Outer setting (the setting the inner setting exists within - e.g., a	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. **Local attitudes** (sociocultural values and beliefs which may support/inhibit implementation)

	community or system -, including local economic/environmental/political conditions, and policies and laws)	• As described for the 'Inner Setting', views and beliefs around perpetrators may influence successful implementation of the programme, as it is predicated on taking an empathic and understanding approach. Historically, programmes based on the Duluth model have had a 'cultural hold' over service provision, which may mean that practitioners, referrers and other professionals could have some opposition to services based on a different approach and ethos (Sources: Stover 2023, Developer interview). **Local conditions** (economic, environmental, political and/or technology conditions which may support/inhibit implementation) • In Connecticut many participants are employed in fields such as truck driving which make engagement in regular service sessions more challenging (Source: CT DFT interview) **Partnerships and connections** (referral networks, academic affiliations, and professional organisation networks which may support/inhibit implementation) • Programme developers find partnerships/relationships with local child protective services are an especially strong source of referrals for the programme (Source: Developer interview). **Policies and laws** (legislation, regulations, professional group guidelines and recommendations which may support/inhibit implementation) • Participants with court-mandated protective orders are unable to take part in co-parenting and/or child engagement sessions, which may inhibit programme reach (Source: Stover 2023). • Programme developers find local/state statutory mandates around domestic abuse can inhibit implementation as other programmes (typically batterer intervention programmes) are often court-mandated, which crowds out the opportunity to deliver F4C (or means that F4C can only be delivered after a BIP is received by a father - at which point their motivation for further intervention may be exhausted) (Source: Developer interview). **Financing** (funding from external entities available to support implementation) • Lack of funding has been highlighted as a barrier, with sites in Connecticut receiving funding that is not keeping up with cost of living increases (Source: CT DFT interview). No context specific barriers and facilitators have been identified against the following domains for the 'Outer Setting'. This does not necessarily mean that there are no facilitators/barriers relevant to these domains, but rather that these have not specifically been surfaced in our research. On this basis, we expect that any relevant barriers/facilitators

		against the following domains do not exceed what would be typically expected in delivery of an intervention to families: • **Critical incidents** (large-scale and/or unanticipated events that disrupt implementation) • **External pressures: societal pressure** (mass media campaigns, advocacy groups, or social or protest movements which may support/inhibit implementation) • **External pressures: market pressure** (competing with peer entities which may support/inhibit implementation) • **External pressures: performance measurement pressure** (quality/benchmarking metrics or established service goals which may support/inhibit implementation)
	Characteristics of individuals (the roles and characteristics of leaders, facilitators/practitioners, implementation support workers, etc)	**Intervention deliverers** - individuals who are directly or indirectly delivering the intervention. • ***Capability*** **(competence, knowledge and skills to implement intervention)** - It is important that practitioners have: trauma specific training, understanding of family violence dynamics, understanding of child development, and experience of working with child, parent, adult, and family therapy (Sources: Developer interview; Stover 2023). • ***Opportunity*** **(availability, scope and power to implement intervention)** - It is sometimes important for programme retention that practitioners are demographically similar to participants (Source: Site visit). • ***Motivation*** **(commitment to fulfilling role)** - It is important that practitioners are bought in and committed to the programme (Source: Stover 2023; Site visit; Developer interview). **Intervention recipients** - individuals who are directly or indirectly receiving the intervention. • *Capability* (competence, knowledge and skills to implement intervention) - No specific requirements identified. • ***Opportunity*** **(availability, scope and power to implement intervention)** - Participants' demanding work schedules such as truck drivers can present a barrier to engagement as this makes engagement in regular service sessions more challenging. • ***Motivation*** **(commitment to fulfilling role)** - A barrier to participation for participants is concern that participation represents an admission of guilt, due to the involvement of child protection services and the criminal justice system.

		No context specific barriers and facilitators with respect to **high-level leaders**, **mid-level leaders**, **opinion leaders, implementation facilitators, leads or team members** have been identified to date.
Implementation strategies (the methods or techniques used to produce implementation outcomes)		**<u>Pre-implementation</u>** • **Assess readiness and identify barriers and facilitators** - Using the F4C organisational readiness form to assess an organisation to determine its degree of readiness to implement and barriers that may impede implementation. This can help mitigate risks and barriers around local/state statutory mandates and settings not permitting or having authorisation to allow children/perpetrators on-site (Source: Developer interview). • **Practitioner selection and training** - Practitioners receive F4C programme training, and ongoing consultation and supervision. Practitioners are trained by the model developer (or a 'Master Trainer') through a 2.5-day didactic and experiential training curriculum, followed by twice monthly consultation calls for 12 months. Training, alongside careful selection of practitioners, ensures that the right competencies and experience are in place and mitigates risks/barriers around practitioners being unable to take the empathic approach to fathers required to deliver the programme. • **Robust family eligibility assessment process** - Before delivery to a father/family, a rigorous assessment process takes place to ensure that F4C is the right intervention for their case, and to ensure that they can fully participate in it. • **Matching fathers/families to appropriate practitioner** - The eligibility assessment process can inform matching a practitioner to a father based on i) the fathers needs and the expertise of the practitioner, and ii) demographics, including ethnicity (Source: Site visit). • **Careful initial outreach to fathers** - Practitioners engaging with the participant as a person, to slowly build a trusting relationship. This can mitigate risks/barriers around participation and the fear that this is an admission of guilt (Sources: Stover 2023; Developer interview; CT DFT interview). **<u>During implementation</u>** • **Measures to support practitioners** - Sites are encouraged to i) have more than one person delivering the programme at any time, ii) establish a culture of reflective supervision, and iii) encourage practitioners to be a part of a community through informal peer support networks. These mitigate risks around burnout and turnover (Source: Developer interview). • **Supporting manageable workloads** - Ensuring that practitioners' catchment areas are manageable is an important facilitator (Source: Site visit).

	• **Flexible delivery** - Sites can be flexible in the time and place in which F4C is delivered (e.g. offered in evenings, or in the home). This helps to mitigate risks/barriers around local populations being employed in professions which make engagement in regular service sessions more challenging (Source: CT DFT interview). • **Audit and provide feedback** - In Connecticut, the Department of Children and Families collects performance and fidelity data from providers and specific sites and feeds this back (Source: CT DFT interview). • **Conduct ongoing training** - Yearly booster trainings. • **Implementing tools for quality monitoring** - Fidelity assessments are conducted, taking the form of either a practitioner self-complete checklist, or a review of session videos and coding on session observation rating sheet. • **Provide clinical supervision** - Provide practitioners with ongoing supervision at the site level. • **Rapport-building and maintaining engagement** - Connecticut sites added an additional preliminary session during Covid-19 called "rapport building" which aimed to build a relationship with the client before starting the curriculum. They also conduct a participant planning session if the participant starts to disengage, with the aim to explore how to get participants "back on track" (Source: Site visit). **<u>Sustaining implementation</u>** • **Use train-the-trainer strategies** - Local 'Master Trainers' can be trained to support ongoing training of practitioners. The requirements for Master Trainers are currently being developed but current guidance specifies: - You must have completed the F4C basic training, one day of booster training, and the 12 months of consultation calls & 2 case presentations during consultation. - Conducted fidelity reviews with Dr Stover. - If you're a F4C supervisor - you must complete 5 F4C cases as the primary clinician. - If you're not a supervisor - you must complete 10 F4C cases as the primary clinician. - You must co-train a basic training with Dr. Stover. - You must take the lead during 2 consultation calls with Dr. Stover. • **Provide ongoing consultation** - Programme developer can provide ongoing consultation to sites/agencies/departments.
Mechanisms	• Recruiting and retaining a skilled workforce. • Identifying and preparing appropriate settings for delivery. • Identifying appropriate sources of participant referrals.

(the processes by which implementation strategies are intended to produce implementation outcomes)	• Encouraging take-up of service. • Supporting sites to require less active intervention and support from the programme developer.
Implementation outcomes (the effects of intervention strategies)	• Reaching (recruiting and retaining) the intended population of fathers and their families where the father has participated in family violence and still has some contact with their children, aged under 12 years old. • Delivering the four phases of Fathers for Change with fidelity in a suitable manner within the UK context, including adoption of F4C as a programme for delivery within suitable setting(s). • Sustaining intervention recruitment and delivery over time and institutionalising F4C within suitable settings' ongoing, stable operations. • The perception of F4C as agreeable and satisfactory by the target population and programme delivery personnel.

Appendix D: Mismatch log – Handouts and worksheets

The table below shows the proposed adaptations for the participant facing materials (e.g. handouts and worksheets). A long list of proposed adaptations was collected during a workshop with the delivery partner. This long-list was reviewed by the adaptation group and a final list of adaptations was developed (the list in the table below). More details on the original proposed adaptations can be provided at request.

Note that the rationale for all the adaptations are language issues and all are considered surface level.

Potential mismatch	Risks of addressing the mismatch	Risks of not addressing the mismatch	Source	Adaptation
Suggested amendments to form 5.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The referral form may not be clear to referring practitioners or may not capture appropriate information	Delivery partner workshops	• Remove reference to fax • Remove reference to insurance • Amend 'state' and 'zip code' to 'county' and 'postcode' • Amend 'referring office' to 'name, profession, contact number, in what capacity do you know this family' • Amend 'current criminal charges' to 'is there a current investigation that has not yet been resolved? Does this relate to domestic abuse or violence?' • Increase size of box relating to 'current criminal charges' • Add question about contact with children • Add 'have you got consent for this referral' at the top of the form • Add a question about contact with children • Replace 'treatment' with 'programme' • Replace 'if referred by the courts' messaging with 'if available, please share the pre-assessment form' The form would not apply for self-referrals. An alternative form would need to be produced for self-referrals

Suggested amendments to form 5.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The form may not be clear to referring practitioners or may not capture appropriate information	Delivery partner workshops	• Use ‘programme’ instead of ‘program’ • Use 'practitioner' instead of 'clinician' • Use 'Support worker' or ‘co-parent practitioner’ instead of 'advocate' • Use 'co-parent' instead of 'victim'
Suggested amendments to form 6.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend language to plain language throughout. • Use ‘programme’ rather than ‘treatment’ • Remove reference to drugs testing • Change point 4 to ’Let us know if you are running late’ • Use of co-parent throughout • Changing clinician to practitioner
Suggested amendments to handout 6.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'parental violence' to 'domestic abuse' • Amend 'the more exposure over a longer period' to 'the longer it goes on' • Amend title to 'How domestic abuse affects children' • Amend 'sleep trouble' to 'problems with sleep' • Amend 'eating disruption' to 'eating problems'

Suggested amendments to handout 6.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend ‘fathers’ to ‘dads’ • Amend ‘teaching your sons how to treat women’ to ‘respect women’ • Replace ‘stonewalling’ with ‘ignoring’ • Replace ‘stores’ with ‘shops’ • Amend 'hold back your temper when you're mad' to 'angry' • Amend "if you use aggression and violence when you are angry' to remove 'when you are angry' • Add more visuals • Amend 'doing chores' to 'doing stuff at home' • Amend 'making contributions' to 'being involved and sharing responsibilities' • Use 'I understand that verbal and physical aggression, yelling, screaming, and controlling behaviours are unhealthy for my family.' instead of ‘Using force with the children’s other parent can cause fear and lasting hurt to your child.’ • Amend 'If you can be positive' to 'Being positive and treating people with respect'
Suggested amendments to worksheet 7.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Remove 'functional' from title • Amend 'behaviors' to 'behaviours'
Suggested amendments	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to	The programme materials may not appear to be targeted to the appropriate	Delivery partner workshops	• Amend 'yell' to 'shouted' • Amend 'apologize' to 'apologise' • Amend 'have empathy' to 'be kind to myself' • Amend 'talk to a therapist' to 'counsellor'

to handout 7.1	occur with specific wording or presentational changes	population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.		• Remove capitalisation of 'Shame' and 'Guilt' • Amend 'reflect on' to 'think about' • Amend 'alternative' to 'other' • Prompt practitioner to clarify that participant should not expect forgiveness if seeking forgiveness • Amend 'Apologize or seek to make amends' to 'apologise in a meaningful way' • Amend the wording for 'what do we do when we feel guilt' to reduce perceived intensity and align more with wording for shame • Amend layout of sheet e.g. as a flowchart. Consider additional visuals such as the pit of responsibility and the wall of shame • Retain 'we' instead of 'I'
Suggested amendments to worksheet 7.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'afterward' to 'afterwards' • Amend 'unexpected' to 'unexpectedly' • Amend 'place' to 'home' • Amend 'showed up' to 'turned up' • Amend 'yelled' to 'shouted.' • Amend example to a less gendered case study (e.g. I came home and my partner wanted to talk about money)
Suggested amendments to worksheet 7.3	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if	Delivery partner workshops	• Amend 'physiological' to 'what is my body doing' • Amend worksheet title to 'emotional thermometer' if/when used with fathers without substance misuse issues • Amend 'craving thoughts' to 'thoughts'

		words used are not familiar.		
Suggested amendments to handout 7.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend layout to make message clearer. BIT have produced a mock-up of this.
Suggested amendments to handout 7.3	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Use 2 different worksheets, one for fathers and one for coparents. • For the coparents section 'Do not' should be replaced with 'We recommend'
Suggested amendments to worksheet 7.5	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants	Delivery partner workshops	• Amend 'partner' to 'co-parent'

		may also not understand programme materials if words used are not familiar.		
Suggested amendments to handout 8.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'clinician' to 'practitioner' • Amend layout and design, using icons to make the handout more visually engaging • Change 'parent 1 and parent 2' to names of parents or 'Father' and 'coparent'
Suggested amendments to worksheet 8.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'fixed' to 'made breakfast' • Amend 'kids' to 'children' • Amend 'behavior' to 'behaviour' • Amend 'catch' to 'notice'
Suggested amendments to handout 8.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific	The programme materials may not appear to be targeted to the appropriate population, which could	Delivery partner workshops	• Amend font of *do NOT interrupt* to remove italics and capitalisation to avoid perception as patronising • Amend text to make handout less wordy

	wording or presentational changes	prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.		
Suggested amendments to handout 8.3	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'make' in 'it would make the evening go more smoothly' to 'help'
Suggested amendments to handout 8.4	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Remove 'division of labour' • Amend 'parenting of the kids' to 'parenting' • Amend 'falls behind' to 'when one parent needs more help' • Use stock images rather than clip art • Add 'managing family relationships' under point 2 • Consider combining points 2 and 4 • Add a reference to emotional labour and the mental load • Add 'earning money' as point below 'finances' • Amend 'finances' to 'managing household finances' • Add 'organising and coordinating childcare' under family management • Amend 'transportation' to 'taking the children to places'

Suggested amendments to handout 8.5	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend document to make less text-heavy • Amend 'flooded' to 'overwhelmed'
Suggested amendments to worksheet 8.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'dredging' to 'bringing up the past'
Suggested amendments to worksheet 8.4	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if	Delivery partner workshops	• Amend 'highlight' to 'circle'

		words used are not familiar.		
Suggested amendments to worksheet 9.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend 'catch' to 'notice' • Amend 'date' to list days of the week • Amend 'praise given' to 'what praise did you give them' • Consider amending 'ALWAYS POSSIBLE' to remove capitalisation
Suggested amendments to handout 9.1	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend worksheet to make it less wordy, or re-structure so text is less dense • Consider removing capitalisation • Amend 'misbehavior' and 'behavior' to 'misbehaviour' and 'behaviour' throughout • Amend 'couch' to 'sofa' • Amend 'porch' to 'outside' • Remove 'restitution' • Amend 'oppositional behaviours' to 'challenging behaviours' • Consider adding content on internalising behaviours (especially as these are more common in girls)
Suggested amendments to handout 9.3	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants	Delivery partner workshops	• Amend 'spanking' to 'smacking' • Add as the first reason not to smack that it is upsetting and hurts • Add content about legality as smacking is illegal in the UK • Take out 'it becomes less effective over time' • Put the 'children who have been repeatedly spanked' section first

	wording or presentational changes	may also not understand programme materials if words used are not familiar.		
Suggested amendments to worksheet 9.2	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend title to 'how to make amends' • Split the first sentence into two questions • Amend first sentence to be specific to father's behaviour e.g. 'what have your children experienced that you need to take responsibility for' • Amend question 2 to 'in what ways have these behaviours impacted your children (or may have impacted)? • Amend in question 4 'write a statement in developmentally appropriate language for your children' to 'write a statement that your child can understand'
Suggested amendments to handout 9.5	Changing the programme materials extensively may impact their meaning, but this is highly unlikely to occur with specific wording or presentational changes	The programme materials may not appear to be targeted to the appropriate population, which could prompt participants to disengage. Participants may also not understand programme materials if words used are not familiar.	Delivery partner workshops	• Amend ‘catch’ to ‘notice’

Appendix E: Adapted TIDieR framework

TIDieR field	Guidance	Content
Name	Provide a name or phrase that describes the intervention	Fathers for Change (F4C)
Why	Describe any rationale, theory, or goal of the elements essential to the intervention	• Children's exposure to domestic abuse (DA; interchangeably used with intimate partner violence (IPV) in this document) is prevalent, with 12% of under 11-year-olds in the UK having been exposed to domestic abuse (DA) between the adults in their home (NSPCC). There has been a 106% increase of reported child cruelty and neglect offences in England in the last 5 years, according to the children's welfare charity NSPCC. • *Developmental impact* - IPV-exposed children face serious risk of developmental and emotional-behavioral repercussions (Briggs-Gowan et al., 2019; Gilbert et al., 2013; Grasso et al., 2016a, 2016b; Lee et al., 2022; Weir et al., 2021). Exposure to adversity and trauma can accumulate across childhood to impose detrimental effects on development and functioning that can persist into adolescence and adulthood. (Casaneuva et al. 2009; Colletti et al. 2008; Grasso et al. 2019; O'Dea et al. 2020; Stover et al. 2017; Grasso et al. 2016; Kitzmann et al. 2003). ○ *Child maltreatment* - These children often experience other forms of victimization or neglect that co-occur with IPV (Browne et al., 2020; Grasso et al., 2016b, 2021). • There are often missed opportunities to interrupt domestic violence. One contributing factor is the tendency to focus exclusively on mothers in interventions for safety and treatment of family violence. Alternatively, fathers are referred to programmes that challenge societal influences that perpetuate violence against women and teach skills for anger management, but do not: i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes that trigger and maintain violence in fathers, and iii) they ignore the family dynamic. • Effective programmes are required which work with fathers and i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes which trigger and maintain violence in fathers, and iii) address issues at the family level. • F4C, unlike other more traditional approaches, incorporates a focus on fatherhood and on the father-child relationship - F4C's central premise is that a focus on men's roles as fathers provides motivation to change maladaptive patterns of communication and aggressive or unhealthy interactions in relationships. (Stover et al., 2020). It also uses an individualised assessment of families using an attachment-informed therapeutic

		approach, investigates what is triggering violent behaviour, and aims for cessation of this through supporting improved emotion regulation and reflective functioning (Stover et al., 2020). Finally, it focuses on family systems through parallel and conjoint sessions with co-parents and children, and programme content focusing on family/co-parental communication. ● In order to achieve parity of support and deliver a family intervention, the co-parent receives individual sessions in parallel to the father if this is deemed suitable. There are two separate practitioners assigned to the two parties: a mother practitioner (MP) to the co-parent and a father practitioner (FP) to the father.
What - Materials	Describe any physical or informational materials used in the intervention, including those provided to participants or used in intervention delivery or in training of intervention providers. Provide information on where the materials can be accessed.	Materials used in training for practitioners: ● Standardised manual Materials used in family assessments: ● Phones, ability to record video for assessments, toys appropriate for child for interaction assessments. Materials required for delivery of sessions: ● Paper-based worksheets, handouts, and forms; large sheets of paper and pens; laptop/TV to play videos and potentially to draw genogram; heart rate monitor; children's books and games, HeartMath App.
What - Procedures	Describe each of the procedures, activities, and/or processes used in the intervention, including any enabling or support activities.	There are 18 topics overall: 16 father-focused, four coparent focused sessions, and 5 father-child focused (Stover et al., 2020). These are delivered across four phases which can compromise a variable number of sessions. There is no set number of sessions, but the father-focussed programme runs over 26 weeks. After four assessment sessions the treatment starts with 12 individual father focussed sessions, after which the FP and MP decide together whether joint sessions with the co-parent and child are helpful and safe for all participants. If the joint sessions are deemed as feasible, the father has roughly 10 more sessions which includes joint sessions with his co-parent and child. Activities include: **Activities for phase 1 - Engagement and motivational enhancement** ● Motivational interviewing. ● Guided discussions and educational content. ● Genogram (pictorial display of family relationships and patterns of behaviour) ● Fatherhood models/meaning. ● Video interactive guidance. ● Understanding the role of gender, power and control (the exact nature and extent of this section is currently in development)

		Activities for phase 2 - Reflective functioning and skills building ● Guided discussions relating to incidents of family violence in the past. ● 'Functional analysis' ● Diaphragmatic controlled breathing exercise. ● Heart rate monitor exercise to observe influence of triggers and coping strategies. ● Positive or guided imagery. ● Urge surfing. ● Taking space. ● Mindfulness techniques. ● Exercise/physical activities. **Activities for phase 3 - Co-parenting communication** ● Giving compliments activity. ● Teaching active listening skills. ● Practising use of 'I' statements. **Activities for phase 4 - Restorative parenting** ● Fathers' learning John Gottman's 5 steps to emotion coaching and applying to their children. ● Making amends exercise. ● Unstructured, child-guided play time. ● Father-child feelings identification and expression exercise. **Activities for ending treatment** ● Referral to other services if needed. In addition to the father-focussed sessions, support for the victim-survivor will be offered in parallel by the mother practitioner. The co-parent focussed F4C sessions are supplemented by IDVA support delivered by the mother practitioner. Following the completion of the standard co-parent programme, the co-parent is discharged to the children's social worker who will decide about possible onward referrals.
Who	For each category of intervention provider (such as psychologist, nursing assistant), describe their expertise, background, and any specific training given.	● UK practitioners need a good standard of general education. A university degree or relevant professional training are desirable but not essential. UK practitioners have experience in working with perpetrators and victims of DV. Ideally a practitioner has experience in working with both, adults and children and has knowledge of child development, however the practitioners are likely to come from various professional

		backgrounds and therefore may lack experience or professional qualifications in certain areas. These gaps will be supplemented with additional training by the programme developer and from other sources. • Practitioners will be trained by model developer using three-day didactic and experiential training curriculum followed by twice monthly consultation calls and yearly booster trainings to ensure fidelity to the model (Stover et al., 2020). They will also receive an additional one-day online briefing on additional topics as part of the set-up phase. Additional quarterly supervision will be provided by Tara Dickens with focus on risk management and rapport building.
How	Describe the modes of delivery (such as face to face or by some other mechanism such as internet or telephone) of the intervention and whether it was provided individually or in a group.	Sessions are delivered face-to-face. They are delivered to individual families: • Some sessions are delivered individually to the father, • Other 'parallel' sessions are delivered individually to the coparent, • Some sessions are conjointly delivered to both the father and the coparent. • Some sessions are conjointly delivered to both the father and to the child.
Where	Describe the type(s) of location(s) where the intervention occurred, including any necessary infrastructure or relevant features.	Can be delivered in and by a range of settings/agencies. Including residential substance misuse facilities (Stover 2019) and not-for-profit community mental health agencies (Stover 2020).
When and how much	Describe the number of times the intervention was delivered and over what period of time including the number of sessions, their schedule, and their duration, intensity, or dose.	18 topics delivered in 60-minute sessions over 26 weeks for the father and separate 26 individual 60-minute sessions for the victim-survivor (including at least 2 joint sessions with the co-parent and child).

Tailoring (planned)	If the intervention was planned to be personalised, titrated or adapted, then describe what, why, when and how.	Number of sessions, and emphasis across the 18 topics, can vary depending on the situation of the family.
		
		Conjoint sessions are not always used depending on the situation of the family:
		
		• Co-parent participation:
		  • Conjoint sessions with the mother target communication skills pertinent to coparenting, but only if the clinician determines through ongoing assessment with the mother that doing so would be safe and appropriate, and if the mother wishes to participate.
		  • If so, conjoint sessions must follow a minimum of 16 sessions with the father (Stover et al., 2020)
		  • If it is unsafe or not possible to hold conjoint coparent sessions, fathers can work

		individually with their clinician to improve their coparenting skills; e.g., practice how to give compliments, use active listening, make I statements, and problem solve
		
		● Father-child sessions
		  ● Father-child sessions focus on reparations that benefit children including: the father taking responsibility for his violence, making an apology and sharing what he is learning in treatment to change his behaviours
		  ● Clinicians only go forward with father-child sessions if they feel they will be beneficial to the child and the father is fully prepared to take responsibility for his past behaviour, not seek forgiveness during the session and understands this is a first step in facilitating a strong relationship with his child that may take time to build.
		  ● Mothers are invited to participate in one of these final father-child phase sessions when deemed appropriate and clinically indicated by the therapist. (Stover, 2015)

How well (planned)	If adherence or fidelity was assessed, describe how and by whom, and if any strategies were used to maintain or improve fidelity, describe them.	Fidelity is assessed using either: ● A clinician self-complete checklist, or ● A review of session videos and coding on session observation rating sheet. Fidelity is maintained via: ● Twice monthly consultation calls and ● Yearly booster trainings to ensure fidelity to the model.

Appendix F: Adapted ToC/logic model

Area of focus	Key questions	Characteristics of a strong ToC/logic model	Description
Why is the intervention needed?	What is the problem the intervention seeks to address? What need does this generate?	• **Well-specified** - Problem and need are described in detail. • **Evidence-based** - The existence and nature of the problem and need are demonstrated by rigorous evidence and grounded in scientific literature.	**Problem** Intimate partner violence (IPV) is prevalent, costly, and detrimental to children's health and development (Beebe et al., 2023). 2.1 million people aged 16 and over (1.4 million women and 751,000 men) experienced domestic abuse (DA; used interchangeably with IPV in this document) in a year (2022-23) in England and Wales (ONS, 2023). Domestic violence and abuse describe any incident or pattern of incidents of controlling behaviours, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners (NICE, 2016). • Across the UK, 12% of under 11-year-olds have been exposed to domestic abuse (DA) between the adults in their home (NSPCC). There has been a 106% increase of reported child cruelty and neglect offences in England in the last 5 years, according to the children's welfare charity NSPCC. ○ *Developmental impact* - IPV-exposed children face serious risk of developmental and emotional-behavioral repercussions (Briggs-Gowan et al., 2019; Gilbert et al., 2013; Grasso et al., 2016a, 2016b; Lee et al., 2022; Weir et al., 2021). Exposure to adversity and trauma can accumulate across childhood to impose detrimental effects on development and functioning that can persist into adolescence and adulthood. (Casaneuva et al. 2009; Colletti et al. 2008; Grasso et al. 2019; O'Dea et al. 2020; Stover et al. 2017; Grasso et al. 2016; Kitzmann et al. 2003). ○ *Child maltreatment* - These children often experience other forms of victimization or neglect that co-occur with IPV (Browne et al., 2020; Grasso et al., 2016b, 2021). **Need** • There are often missed opportunities to interrupt family violence. One contributing factor is the tendency to focus exclusively on mothers in interventions for safety and treatment of family violence. Alternatively, fathers are mandated to programmes which challenge societal influences that perpetuate violence against women and teach skills for anger management, but do not: i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes that trigger and maintain violence in fathers, and iii) they ignore the family dynamic (see core components). • Effective programmes are required which work with fathers and i) spend sufficient time on parenting and fatherhood, ii) spend sufficient time assessing and addressing the processes which trigger and maintain violence in fathers, and iii) address issues at the family level.

	Who does this apply to?	• **Well-specified -** The target population is clearly defined in terms of recipients' level of need and the target age of the population. Ineligibility/eligibility criteria are clearly specified. Constructs are operationalised and measurable. • **Realistic in light of wider context and external factors -** i.e. there is a plausible approach to recruiting the target population into the intervention in sufficient numbers, seasonal considerations (including school cycles) that may stand in the way of recruitment are considered, alternative services/offers that may crowd out recruitment for the intervention are considered.	• **Families where there is a history of family violence** - Reported physical or verbal intimate partner violence history, defined as threatened or actual sexual or physical violence against an intimate partner (in the last 12 months - Stover 2023) ○ *Importance* - There is evidence of greater IPV in the coparenting relationships of opioid-dependent men compared to non-drug abusing coparenting couples, and fathers with co-occurring IPV and substance abuse have more negative coparenting relationships (e.g., disagreement about how to parent, lack of communication about parenting) than men from the same community without histories of IPV and substance abuse (Stover, 2015; Moore, Easton, & McMahon, 2011; Stover, Easton, & McMahon, 2013) ○ *Notes* - Can also be used where violence is mutual/bidirectional within the relationship. • **Fathers with some contact with child(ren)** ○ *Importance* - More than 60% of men entering batterer intervention programmes (BIPs) are fathers. More than half of women who experience IPV continue living or having frequent contact with the male perpetrator due to shared children (Litton Fox, Sayers, & Bruce, 2001; Mbilinyi et al., 2009; Rothman, Mandel, & Silverman, 2007; Salisbury, Henning, & Holdford, 2009; Hunter & Graham-Bermann, 2013; Israel & Stover, 2009) • Fathers of **children under age 12** - ○ *Importance* - Family violence has differential impacts on children depending on their ages. Earlier exposure has the most detrimental impact on children's developing brains and nervous systems (Stover 2023). ○ *Other* - Upper boundary of age limit has shifted previously from implementation to implementation - from 10 years old (Stover 2015) to 14 years old (Beebe et al., 2023). While not an eligibility criteria or a necessary characteristic of the target population, programme literature notes that fathers may have **co-occurring substance misuse problems**. This is on the basis that co-occurrence of substance misuse and family violence are high as they share common causes, i.e. childhood adversity (Stover 2023). Prevalence rates of IPV in men who enrol in substance use disorder treatment are approximately 50% (Easton, Swan, & Sinha, 2000) with acute and heavy alcohol use and acute cocaine use the most associated with violence overall (Chermack et al., 2010).

			Moreover the integration of interventions to target both IPV and substance abuse has been shown to be effective (Easton et al., 2007; Stover, 2015). F4C was originally developed for delivery in outpatient substance use treatment settings, however it appears to have broadened out from this over time (Stover et al., 2019). Exclusion criteria at assessment stage include: • **The potential participant is not a father** • **Standard (not high) risk of DA** - Men who score highly on the Abusive Behaviour Inventory (particularly on items relating to use of weapons or significant injuries experienced, or on the Domestic abuse, stalking and 'honour'-based abuse checklist (DASH) suggesting severe risk of domestic homicide, should not be enrolled and other interventions should be considered (and safety planning should take place). There are no specific cut-offs on the measures to decide eligibility, instead the F4C practitioners will triangulate each case based on the answers and the measures and decide eligibility in regards to severity of DA on a case-by-case basis. • **Substance abuse that interferes with daily functioning** - If the severity of a father's substance use is considered high and likely to interfere with full participation in the programme (i.e. in cases where residential substance misuse treatment is required), alternate treatment may be considered more appropriate. • **Serious mental health issues that would hinder participation** - Fathers with untreated psychotic disorders, bipolar I disorder, or narcissistic personality disorder, are not considered to be a good fit for the programme. • **Stalking or coercive control** - Men who exhibit stalking or coercive control (i.e. stalk their partner frequently, control their access to family, friends or money to control them). • **An active no-contact protective order pertaining to the child is in place**. • **Currently suicidal or homicidal.** • **Cognitive impairment (i.e. intellectual disability)** that would prevent benefitting from F4C. **Core components/moderators relating to target population:** • Evidence on F4C does not appear to investigate moderators in terms of participant characteristics. However, in terms of implementation outcomes, Stover (2023) notes that in the IPV-FAIR implementation, programme completion rates did not differ due to fathers' age, severity of IPV, employment, education, or ethnicity.

	With respect to this problem, need and population, why will the intervention add value over what is currently available for children and families?	• **A specific, plausible & logical** hypothesis (or ideally evidence-based case) that the intervention is likely to have a greater impact than other programmes available in the UK.	In the UK, support for DA often focusses on women, particularly women who want to leave the perpetrator. There is limited support for perpetrators of DA and among perpetrator support, there are few individual programmes or programmes focussed on fatherhood (source: stakeholder interviews - DA experts). Within the class of interventions for men who have caused harm, programmes that focus on the nature of control, power and abuse in relationships are the most common. This overall approach lacks the following characteristics: **Focus on fatherhood and on father-child relationship:** • Historically, interventions with families generally have been very maternal-centric. Parenting seems to be traditionally associated with mothering and men's experience of parenting often goes unnoticed (Stover 2023). 'Fathers in general are often ignored or minimized in their roles as parents by service providers…' (Stover 2023). • Few alternative interventions provide guidance on 'how to intervene with fathers and their children' (Stover 2023). They do not spend sufficient time focusing on parenting and fatherhood. • F4C ensures that fathers also have equitable access to programmes (Source: CT DFT interview). **Individualised assessment of families using an attachment-informed therapeutic approach:** • Within the traditional responses, there is limited opportunity to tailor intervention topics to the specific needs of fathers (Beebe et al., 2023). This means they do not address the processes that trigger and maintain violence in fathers who are involved in family violence. Unlike F4C they lack a focus on reflective functioning related to self, partner, and children (Stover 2023). **Focus on family systems:** • Few alternative interventions 'provide guidance on work with coparents together' (Stover 2023). • 'The current system of care for family violence is often siloed, with those who cause harm and their families being treated separately, without coordination among providers or across systems' (Stover 2023). • F4C treating the family as a whole fills a gap in other service provision (Source: DFT interview)

How will the intervention achieve its outcomes?	What activities (in the context of the intervention) are required to produce its outcomes?	• **Well-specified -** Activities and what they involve are specified in detail. • **Evidence-based -** There is evidence from the scientific literature and robust evaluation that any given activity has improved the desired outcome/s.	Prior to intervention delivery **fathers and mothers** receive a pre-treatment assessment to determine eligibility and to develop treatment goals. Children are to be assessed by the children's social worker. Fathers and their families are signposted by a family coordinator to other relevant services if they need additional support. Activities and techniques involved in sessions with fathers include: **Phase 1 - Engagement and motivational enhancement** ● Motivational interviewing ○ *What it involves* - Using open questions, affirmations (giving compliments or affirming a behaviour of a father) and reflections to validate fathers' feelings, and summarising fathers' points back to them. Broadly the idea is to roll with resistance (not arguing back or confronting) and to navigate defensive responses from fathers (Stover et al., 2020) ○ *Importance and mechanisms* - Builds rapport with practitioners (Miller & Rollnick, 2023) and aims to gain some commitment to participation (Stover 2023). ○ *Timing/frequency* - Phase 1 session 1; session 2 ● Fatherhood models/meaning ○ *What it involves* - Guided discussion and educational content around role of fathers and the impact of family violence on children (Stover et al., 2020) ○ *Importance and mechanisms* - A focus on fatherhood is believed to provide motivation to change maladaptive patterns which lead to violence/aggression (Stover 2013) ○ *Timing/frequency* - Phase 1; session 2 ● Video-tape reviews of father-child interaction ○ *What it involves* - Practitioner reviews video-recording of father-child play/interaction (from the assessment phases), selects segments to watch with the father, and highlights successful moments of connection between father and child (Stover 2023). ○ *Importance and mechanisms* - There is a range of supportive evidence of the use of video interactive guidance in parenting programmes (Stover et al., 2020) ○ *Timing/frequency* - Phase 1 Session 3 ● Genogram ○ *What it involves* - This is a pictorial display of family relationships and patterns of

			behaviour (over at least 4 generations), and is drawn in collaboration between practitioner and father (Stover et al., 2020) ○ *Importance and mechanisms* - This is a way to introduce thinking about the kinds of fathering and relationship role models they have had in their lives and patterns across generations. Supports fathers to recognise the opportunity they have to break intergenerational cycles. ○ *Timing/frequency* - Phase 1 Session 4. ● Understanding gender, power and control ○ This section and how it will be incorporated into the programme is currently being developed. **Phase 2 - Reflective functioning and skills building** ● Self-focused emotion regulation ○ *What it involves* - Guided discussions of situations that have resulted in incidents of family violence in the past. 'Functional analysis' is a key aspect of cognitive-behavioural therapy and is used to assist in understanding a specific behaviour and its triggers (Stover et al., 2020) . It is conducted through discussion with practitioner and filling out a worksheet. ○ *Importance and mechanisms* - See 'outcomes' section relating to emotional regulation. ○ *Timing/frequency* - Phase 1 Session 5. ● Identification, understanding and coping with feelings ○ *What it involves* - Subsequent checking in on how the week has gone and assessing it for triggers. An 'emotional thermometer' activity and worksheet is used to do this and to explore these triggers (Stover et al., 2020). Following this, the flight-or-fight response is discussed and diaphragmatic controlled breathing exercises. ○ *Importance and mechanisms* - See 'outcomes' section relating to emotional regulation. ○ *Timing/frequency* - Phase 1 Session 6. ● Distress tolerance ○ *What it involves* - Checking in on previous week's incidents and triggers and use of the diaphragmatic breathing exercise. Father is asked to put on a Heart Rate Monitor and recall an incident that resulted in anger or anxiety, observe how their heart rate changes, and then use the diaphragmatic breathing exercise, and then

observe their decreased heart rate. A range of other techniques are then covered (to support a father developing a 'toolbox' of strategies) including: positive or guided imagery, urge surfing, taking space, mindfulness, techniques to stimulate the vagus nerve, and exercise/physical activity. Cognitive processing is taught in session 8 using the cognitive triangle exercise (using worksheet), where the father is encouraged to think about their first thought in relation to a triggering incident, then their first feeling, and then their first action. The thought is then changed into something more helpful to demonstrate how changing thoughts can lead to different feelings and actions (Stover et al., 2020).

- *Importance and mechanisms* - This activity is intended to support improved emotion regulation (see 'outcomes' section relating to emotional regulation), by enhancing a father's understanding of his nervous system and physiological indicators of arousal.
- *Timing/frequency* - Phase 1 Session 7 and 8.

Phase 3 - Co-parenting communication

Joint sessions between fathers and victim-survivors will only potentially go ahead once a minimum of 16 father-focussed behaviour change sessions have been completed. Once this stage has been reached, the family navigator, the social worker, the mother practitioner and the father practitioner will assess the appropriateness of joint sessions with both parents. The programme will only move onto joint work if they are consented to, and are deemed as safe and helpful for all participants.

- Giving compliments
  - *What it involves* - Using the 'giving compliments activity', where each parent is asked to name something they think the other parent does well as a parent or with their child. Then review with parents how to give and receive compliments (Stover et al., 2020).
  - *Importance and mechanisms* - This activity is intended to support improved co-parenting (see 'outcomes' section relating to co-parenting), by increasing positive interactions between the two parents.
  - *Timing/frequency* - Phase 3 Session 9.
- Communication skills
  - *What it involves* - Teaching active listening skills (using handout and modelling from practitioner and practice between couple), and teaching/practising the use of 'I' statements to express emotions and needs (instead of criticising, instead saying

			how a situation makes you feel) (Stover et al., 2020) . ○ *Importance and mechanisms* - See 'outcomes' section relating to co-parenting. ○ *Timing/frequency* - Phase 3 Session 10, though can take multiple sessions. The next 2 sessions - 11 and 12 - involve practising these skills and also reviewing rules for healthy relationships and reviewing homework practice of skills. **Phase 4 - Restorative parenting** ● Emotion coaching ○ *What it involves* - Translating fathers' new knowledge about managing emotions into coaching the development of their children's emotional intelligence. This uses John Gottman's 5 steps to emotion coaching. Guided discussion is used with fathers to determine when they could have used these steps with their children. This is then practised in sessions. The importance of praising children is then discussed and fathers are encouraged to practice as homework. Behavioural interventions such as time out and time in are also discussed (Stover et al., 2020) . ○ *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. ○ *Timing/frequency* - Phase 4 Session 13 ● Making amends ○ *What it involves* - Fathers effectively write a script designed to be spoken to their children which acknowledges what the child experienced, an apology, and how they are trying to change. The father practises reading this aloud and considers how their children may respond. In the subsequent session the father reads this to their child, and then the father and child are able to ask questions and discuss what was shared (Stover et al., 2020) . ○ *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. ○ *Timing/frequency* - Phase 4 Session 14 and 15. ● Father-child play ○ *What it involves* - Unstructured, child-guided play time for the father and child. The practitioner provides direct modeling/coaching for the father. This uses the steps for child-directed play from the developers of Parent-child Interaction Therapy (PCIT) (Stover et al., 2020) . ○ *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions.

			○ *Timing/frequency* - Phase 4 Session 16 ● Father-child feelings identification and expression ○ *What it involves* - Playing games and reading books with child. Fathers write down a list of feelings and then the group makes a face that demonstrates the feeling together. Parents and children then take turns acting out different feelings and trying to guess the feeling the other acts out. The father shows his children some of the coping strategies he has learnt (Stover et al., 2020). ○ *Importance and mechanisms* - See 'outcomes' section relating to positive father-child interactions. ○ *Timing/frequency* - Phase 4 Session 17 **Ending treatment** ● Fathers complete treatment and a final report is completed by the father practitioner to be sent to the family's social worker. **NB:** See session structure in Annex 1. Activities must be delivered in the order specified in the curriculum, though the amount of time dedicated to each can vary depending on the needs of the father/family. **Post treatment** ● The social worker receives the final report and makes a decision about further referrals and additional support services the family might benefit from. In addition to the father-focussed sessions, support for the victim-survivor will be offered in parallel by the mother practitioner. The standard co-parent focussed F4C sessions are supplemented by IDVA support delivered by the mother practitioner. Following the completion of the F4C co-parent treatment, the co-parent is discharged to the children's social workers, who can make onward referrals as they see fit.
			'Core components'/moderators - relating to the delivery of programme activities (i.e. what is delivered, and how it is delivered).

			• **Core component 1 - <u>Fatherhood as a motivator for change</u> - a focus on the parenting role (instead of solely violent behaviours) and using positive reinforcement and a positive strengths-based approach to support parenting** - ○ *What this involves* - F4C focuses on parenting by supporting fathers to find the moments when they and their child/ren are positively connected, to give them the opportunity to see times when they are competent, and to naturally incentivise them to more of these moments. ○ *Importance and mechanisms* - Increasing father's feelings of competence and sense of meaning around their parenting role, as well as concern about the impact of IPV on their children, will provide motivation to change maladaptive patterns which lead to violence/aggression (and use of substances) (Stover 2013) In addition, it is posited that this approach supports engagement with the programme in the following ways: ■ **Supporting reach and engagement** - Programmes primarily focused on putting fathers under scrutiny for their violent and angry behaviour and the harm they have caused, are likely to make them resistant to intervention (versus the parenting-focusing, non-blaming and positive approach). ■ **Supporting 'therapeutic alliance'** - This parenting-focused, non-blaming, and positive approach also has benefits for building a working relationship between fathers and clinicians. ■ **Supporting better learning and understanding** - These benefits in turn incentivises fathers to learn more, share more in sessions, and understand more how their anger and physical violence happens in the context of their relationship. • **Core component 2 - <u>A one-size-doesn't-fit-all approach</u> - individualised assessment of families using an attachment-informed therapeutic approach** ○ *What this involves* - A core component of F4C is attempting to assess and understand the specifics of a father's and families' case, and provide support to help the father individually depending on what is driving his violent behaviour, and help him in relation to his relationships with the co-parent and children (Stover 2023). This includes using an attachment-informed therapeutic approach - by focusing on the fathers' childhood experiences, including his own childhood adversity. Practitioners will assess participants' trauma history and PTSD and determine participants' ways of processing trauma to tailor emotional regulation

			content appropriately. Practitioners can also vary the degree of structure during sessions, such as whether to use programme materials, and will follow up flexibly to participants' responses (Source: Site visit) ○ *Importance and mechanisms* - This is important, as it enables responding individually to a specific fathers' and families' needs. An attachment-informed approach is important as secure attachments are key to effective stress regulation and regulation of negative emotions in adulthood. A tailored trauma-informed approach supports effective emotional regulation in participants. (Source: Site visit) • **Core component 3 - <u>Family-level approach</u> and focus on family systems** ○ *What this involves* - F4C has sessions with a focus on family/co-parental communication, and incorporates flexible inclusion of co-parents and children in later sessions of the programme. (Stover 2023). Parallel co-parent sessions allow clinicians to support both parents and to assess dynamics and risks within the family (Stover 2023). ○ *Importance and mechanisms* - Dynamics for some families are best tackled by thinking about the broader family system. For example, if one partner is attempting to use a new skill to manage emotions and the other partner is not supportive/hostile, it can undermine repeated use of that skill (Stover 2023). Inclusion of partners has been found to significantly improve treatment outcomes for men in substance use disorder treatment and their children (Kelley & FalsStewart, 2002). In addition, the programme developer notes that co-parenting content often increases buy-in from the father as the focus of the entire intervention is not exclusively them and their behaviours (Source: Developer interview). Programme overseers in the Connecticut Department of Children and Families note that treating the family as a whole is a way in which F4C fills gaps that other programmes do not cover (Source: CT DFT interview). Finally, incorporating the co-parent allows a full understanding of the 'full story' (Source: Site visit). • **Core component 4 - <u>Working with families individually</u> - Running sessions with individual fathers and their families rather than groups of fathers** ○ *Importance and mechanisms* - Individual sessions are more effective than group-based sessions (e.g. BIPs) as there is evidence that antisocial participants have a contagion effect within the group, which reduces engagement and the potential

			benefit of other participants (Meis 2008; Murphy and Meis 2008). Working individually represents a unique aspect that sets F4C apart from other programmes and fills gaps not addressed by other IPV programmes (Source: CT DFT interview).
	What inputs or resources are required to deliver these activities?	• **Well-specified -** Inputs/resources (such as practitioner background/skills/ qualifications, time, management/supervision requirements, venue space, materials, equipment, transportation) are specified in detail. • **Realistic in light of wider context and external factors -** The time and resource requirements required for the activities are realistic in terms of available workforce, budget.	<u>Delivery</u> • *Practitioner time* - ○ 18 themes covered in 26 60-minute sessions (over 24 - 32 weeks) by the FP for the father. These sessions are split up into 4 assessment sessions, 12 father-focussed sessions at the beginning of treatment, and (if deemed suitable) 10 further sessions including joint sessions with the co-parent and child. ○ 26 60-minute individual sessions for the victim-survivor (including at least 2 joint sessions with the child) delivered by the MP. NB: In practice this has varied across evaluated implementations and there is no 'set number of sessions'. The Home Office guidelines require at least 16 individual father-focussed sessions before joint work with the victim-survivor can take place as well as parity of support for the victim-survivor. • *Family Navigator time* - The family navigator supports the family during the assessment stage and in the following stages as and when needed. • *Setting* - Can be delivered in and by a range of settings/agencies. In the UK, F4C will be initially delivered at the premises of the charity organisation for perpetrators of domestic violence who have been tasked with the delivery of the programme (St. Michael's Fellowship). • *Any support for travel/transport* - Unclear, presumably decided on a site-by-site basis. • *Materials and equipment used in sessions* - Paper-based worksheets, handouts, and forms; laptop/TV to play videos (e.g. video documentary Show Your Love in session 2) and potentially to draw genogram (session 4); large sheets of paper and pens (to potentially draw genogram in session 4). Heart rate monitor (session 7). Children's books (session 17). <u>Training for practitioners and implementation support</u> • *Site assessment* - Time for site to undergo an organisational readiness assessment (via self-complete form) and for local statutory environment to be investigated prior to implementation (Source: Developer interview). See Annex 2. • *Practitioner background/qualifications* - ○ **Father practitioner:** ■ Essential • Good standard of general education • Experience of working with adults with complex needs and perpetrators and/or victims of DA. • Experience of safeguarding children and vulnerable adults.

			● Experience of delivering family interventions/ programmes. ● Good understanding of domestic abuse (including coercive control), and its impacts on victims. ● Understanding of the principles of risk assessment, safety planning and risk management. ● Understanding of safeguarding issues, and the legal responsibilities surrounding these issues. ● Understanding of, and commitment to, equal opportunities and diversity issues in policy and practice. ● Knowledge and understanding of the issues facing victim-survivors. ● Ability to plan own workload, manage time effectively and deal with changing and competing demands. ● Ability to think creatively and show initiative. ● Ability to communicate with distressed people empathically. ● Ability to establish and maintain appropriate boundaries when working with people who may experience a personal crisis. ● Ability to establish and maintain professional working relationships with both clients and other professionals. ● Ability to communicate effectively with a range of professionals. ● Excellent verbal and written communication skills, including report writing and presentation. ● Ability to maintain effective administrative and monitoring systems. ● Ability to work under pressure and also to be aware of own needs and take responsibility for self-care. ● Attitudes and presentation: ○ Reliable and trustworthy ○ Efficient and punctual ○ Non-judgemental ○ Willingness to critically assess own performance and reflect on own practice ○ Strong team player - ability to work both by themselves and with others. ■ Desirable ● Higher level education (degree, Masters or relevant professional qualification, e.g. in motivational interviewing). ● Experience delivering 1-2-1 therapeutic programmes, for example within mental health or substance misuse contexts. ● Experience working with children. ● Experience of delivery within the context of a programme

			evaluation. ● Knowledge and understanding of child development. ● Knowledge and understanding of trauma-informed practice. ● Theoretical, practical and procedural knowledge of civil and criminal justice remedies for victims of domestic abuse and their children. ○ **Mother practitioner:** ■ Essential: ● Good standard of general education. ● Experience of conducting needs and risk assessments. ● Experience of managing risk. ● Experience of delivering family interventions/ programmes. ● Experience of working with victims of domestic abuse. ● Good understanding of domestic abuse (including coercive control), and its impacts on victims and their children. ● Knowledge of child protection and safeguarding. ● Understanding of the principles of risk assessment, safety planning and risk management. ● Understanding of safeguarding issues, and the legal responsibilities surrounding these issues. ● Understanding of, and commitment to, equal opportunities and diversity issues in policy and practice. ● Understanding of confidentiality principles. ● Ability to plan own workload, manage time effectively and deal with changing and competing demands. ● Ability to think creatively and show initiative. ● Ability to communicate with distressed people empathically. ● Ability to establish and maintain appropriate boundaries when working with people who may experience a personal crisis. ● Ability to establish and maintain professional working relationships with both clients and other professionals. ● Ability to communicate effectively with a range of professionals. ● Excellent verbal and written communication skills, including report writing and presentation. ● Ability to maintain effective administrative and monitoring systems. ● Ability to work under pressure and also to be aware of own needs and take responsibility for self-care. ● Attitudes and presentation: ○ Reliable and trustworthy

			○ Efficient and punctual ○ Non-judgemental ○ Willingness to critically assess own performance and reflect on own practice ○ Strong team player - ability to work both by themselves and with others. ■ Desirable: ● Higher level education (degree, Masters or relevant professional qualifications). ● Experience of delivering 1-2-1 therapeutic programmes. ● Experience working with children. ● Experience of delivery in the context of a programme evaluation. ● Knowledge of domestic abuse legislation, including civil and criminal law, and of relevant statutory services. ● Knowledge and understanding of trauma and its impact. • **Family Navigator** ○ *Essential:* ■ Good standard of general education ■ Experience of managing difficult and/or emotive conversations. ■ Experience of managing data and producing reports. ■ Good understanding of domestic abuse, including the impact of it on victims and children. ■ Knowledge of child protection and safeguarding. ■ Understanding of the principles of risk assessment, safety planning and risk management. ■ Understanding of safeguarding issues, and the legal responsibilities surrounding these issues. ■ Understanding of, and commitment to, equal opportunities and diversity issues in policy and practice. ■ Understanding of confidentiality principles. ■ Ability to plan own workload, manage time effectively and deal with changing and competing demands. ■ Ability to think creatively and show initiative. ■ Ability to communicate with distressed people empathically. ■ Ability to establish and maintain appropriate boundaries when working with people who may experience a personal crisis. ■ Ability to establish and maintain professional working relationships with both clients and other professionals. ■ Ability to communicate effectively with a range of professionals.

			■ Excellent verbal and written communication skills, including report writing and presentation. ■ Ability to maintain effective administrative and monitoring systems. ■ Ability to work under pressure and also to be aware of own needs and take responsibility for self-care. ■ Attitudes and presentation: ● Reliable and trustworthy ● Efficient and punctual ● Non-judgemental ● Willingness to critically assess own performance and reflect on own practice ● Strong team player - ability to work both by themselves and with others. ○ Desirable: ■ Higher level education (degree, Masters or relevant professional qualifications). ■ Experience of managing/administering the delivery of family interventions/programmes. ■ Experience of working with victims of domestic abuse. ■ Experience of working with children. ■ Experience working with men/fathers in the context of a family/focussed service. ■ Experience of delivery in the context of a programme evaluation. ■ Knowledge of domestic abuse legislation, including civil and criminal law, and of relevant statutory services. ■ Knowledge and understanding of trauma and its impact. ○ **Practice supervisor** ■ Essential: ● Good standard of general education. ● Higher level education (degree, Masters or relevant professional qualification). ● Experience of delivering domestic abuse interventions to both perpetrators and victim-survivors. ● Experience of risk management and safety planning. ● Experience of managing/ administering the delivery of family interventions/programmes. ● Good understanding of domestic abuse, including the impact of domestic abuse on victims and children. ● Knowledge of child protection and safeguarding.

			• Understanding of the principles of risk assessment, safety planning and risk management. • Understanding of safeguarding issues, and the legal responsibilities surrounding these issues. • Understanding of, and commitment to, equal opportunities and diversity issues in policy and practice. • Understanding confidentiality principles. • Ability to plan own workload, manage time effectively and deal with changing and competing demands. • Ability to think creatively and show initiative. • Ability to communicate with distressed people empathically. • Ability to establish and maintain appropriate boundaries when working with people who may experience a personal crisis. • Ability to establish and maintain professional working relationships with both clients and other professionals. • Ability to communicate effectively with a range of professionals. • Excellent verbal and written communication skills, including report writing and presentation. • Ability to maintain effective administrative and monitoring systems. • Ability to work under pressure and also to be aware of own needs and take responsibility for self-care. • Attitudes and presentation: ○ Reliable and trustworthy ○ Efficient and punctual ○ Non-judgemental ○ Willingness to critically assess own performance and reflect on own practice ○ Strong team player - ability to work both by themselves and with others. ▪ Desirable: • Experience working with children. • Experience of delivery in the context of a programme evaluation. • Knowledge of domestic abuse legislation, including civil and criminal law, and of relevant statutory services. • Knowledge and understanding of trauma and its impact. • *Practitioner programme-specific training* ▪ Process and time required: • 3 day basic training (seemingly in groups) with the F4C developer

			(Master trainers can also deliver training). This includes didactic and experiential exercises to build key skills. ● Bimonthly 90-minute consultation calls for 12 months following training while implementing first cases. This is done via video conference. It is expected participants will see 3 cases over this year and present 2 cases. ● Practitioners also receive a two hour briefing on EDIE and a two hour briefing on risk management and rapport building from Dr Tara Dickens and two hours from FI on father-inclusive practice. ● The requirements for Master Trainers are currently being developed but current guidance specifies: ○ You must have completed the F4C basic training, one day of booster training, and the consultation calls & case presentations. ○ Conducted fidelity reviews with Dr Stover. ○ If you're a supervisor - you must complete 5 F4C cases as the primary clinician. ○ If you're not a supervisor - you must complete 10 F4C cases as the primary clinician. ○ You must co-train a basic training with Dr. Stover. ○ You must take the lead during 2 consultation calls. ■ Materials: ● Training is supported by a standardised manual. ■ NB: It seems initially this was a 2-day training led by Professor Stover (Stover et al., 2020). ● *Practitioner management/supervision* - ○ Twice monthly 90-minute supervision calls (over training period) and yearly booster trainings. (Stover et al., 2020). ○ Additional quarterly supervision will be provided by Tara Dickens with focus on risk management and rapport building. ○ It is recommended that practitioners stay connected with those in their original training group and/or develop a peer supervision group. ○ A duty supervisor is available for more immediate support of the practitioners. ○ Ongoing fidelity assessment - taking the form of either a clinician self-complete checklist (see Annex 3) or a review of session videos and coding on session observation rating sheet (see Annex 4). <u>Recruitment of families</u>

			• Referral sources: In the UK, court mandated referrals are less common. The main referral source are children's social services.
			• Referral process:
			  ○ The social worker identifies a father who could benefit from F4C and prepares the referral by filling out a referral form.
			  ○ The social worker checks eligibility, contacts the father and completes the DASH questionnaire.
			  ○ The social worker informs the co-parent of the intention of referring the family to F4C.
			  ○ The social worker sends the completed referral to the F4C Family Navigator and keeps the case open.
			  ○ Once the referral is received, the Family Navigator allocates the case to a Father practitioner (FP) and a Mother Practitioner (MP).
			  ○ The Family Navigator organises a three-way meeting with the social worker, the FP and MP to discuss the DASH results and other dase details, confirm the plan for the subsequent assessment and agree on a risk management plan.
			
			• Onboarding families -
			  ○ Process and time required:
			  ■ The FP meets with the father for 4 sessions and completes the following questionnaires:
			  ● DASH
			  ● Abusive Behaviour Inventory
			  ● DAST-10
			  ● Brief Symptom Inventory
			  ● Co-parenting Relationship Scale
			  ● Difficulties with Emotion Regulation Scale
			  ● Reflective Functioning Questionnaire
			  ● Parental Relationship Reflective Functioning Questionnaire
			  ● Brief Trauma Questionnaire
			  ■ The MP informs the mother about F4C, completes the DASH and safety plan, offers a referral IDVA and signposts to other relevant services. The MP also completes the mother report with the co-parent for the child assessment and asks for maternal consent for the child's participation in F4C. The MP agrees the future contact arrangement with the mother (high, medium (regular and defined), or low/ no contact). The length of this assessment process is determined by the pace of the family.
			  ■ Ongoing risk management via a three-way group (FP, MP and Family Navigator).
			  ● The group regularly updates and liaises with the social worker.
			  ● If necessary, makes referrals to MARAC and the police

			■ Following the above steps, the FP, MP and Family Navigator decide whether the father can proceed and commence treatment. ● If the father is eligible, motivated and it is safe to do so, he proceeds to treatment. ● If the mother consents and it is safe to do so, she proceeds to the treatment phase. ● Eligibility to proceed to joint sessions is decided on a case-by-case basis drawing on discussions of the three practitioners and the social worker and the questionnaire scores. ○ Materials required - Phones, ability to record video for assessments, toys appropriate for child for interaction assessments.
			'Core components'/moderators - relating to the work that *supports* the delivery of activities (i.e. training, implementation support, recruitment): ● **Core component 5 - <u>Supporting an empathic approach</u> - practitioners as part of their training must be supported to confront and acknowledge their own attitudes towards family violence and perpetrators** - ○ *Importance and mechanisms* - This approach requires clinicians to confront and acknowledge their own attitudes. The public and many clinicians will hold strong, often unconscious attitudes towards those who commit family violence. It is difficult to simultaneously keep the child's experience in mind, and maintain an open, curious, and empathic stance towards the adults responsible. This may result in clinicians being pulled to defending the partner, protecting the children, and judging or closing down any effort to connect empathically with the father (Stover et al., 2020). ○ *Notes* - Part of this is also selecting the right practitioners in the first place and providing appropriate training e.g. IPV advance training (Source: Developer interview, CT DFT interview). ● **Core component 6 - <u>Practitioners who can work with adults *and* children</u> - having a background in both adult and child clinical work** ○ *Importance and mechanisms* - 'Understanding child development and the impact on children of witnessing violence is crucial to being able to help fathers develop better reflective functioning related to their children' (Stover et al., 2020). 'Without this background, therapists may focus too heavily on the father's

			individual skills and not enough on helping him hold his children's experience and needs in mind' (Stover et al., 2020) ((Other sources: Developer interview, CT DFT interview)). • **Core component 7 - <u>A supportive environment for practitioners</u>** ○ *Importance and mechanisms* - Delivering the programme can be challenging and emotionally taxing - 'you can feel isolated and the cases are difficult'. Burnout and turnover have been experienced in settings delivering this sort of programme. Support can take the form of i) setting having more than one person delivering the programme, ii) setting having a culture of reflective supervision, and iii) practitioners being part of a community through informal peer support networks (Source: Developer interview).
What will the intervention achieve?	What are the short/medium-term outcomes required to produce the medium-term outcomes?	• **Well-specified -** Outcomes are sufficiently specific (e.g. something broad and general like 'school readiness' is broken down into specific constituent outcomes like 'communication skills' and 'literacy) and measurable (i.e. there is a validated way of measuring the outcome). • **Evidence-based** - A clear account of why these longer-term goals are meaningful for families and children, why medium-term	In the short/medium-term, F4C aims to improve: <u>Father outcomes</u> • **Reflective functioning** - a person's capacity to understand their own as well as their child's mental states (Stover et al., 2020). • *Importance* - The ability to understand the mental state of oneself or others underlies overt behaviour. It is associated with violent behaviours including IPV (Stover et al., 2020). • *Measurable* - Prementalizing subscale of the Parental Reflective Functioning Questionnaire (Stover et al., 2020). • **Emotional regulation** • *Importance* - Emotion dysregulation has been associated with violence including IPV (Dankoski et al., 2006; Finkel 2007; Finkel et al., 2019). Studies have shown improving emotional regulation reduces violence (Denson et al., 2011; Finkel et al., 2009). Significantly associated with reflective functioning. • *Measurable* - Difficulties with emotional regulation (DERS); Multidimensional Anger Inventory; Parental Reflective Functioning Questionnaire (Stover 2019) • **Improved father-child interactions** • *Importance* - Meta-analytic findings indicate fathers' involvement associated with child improved cognitive, academic and social functioning (Amodia-Bidakowska et al., 2020; Rolle et al., 2019). Suboptimal father involvement associated with social-emotional and educational issues (Gillette & Gudmundson 2014).

		goals are likely to generate long-term outcomes, and why short-term goals are likely to generate medium-term outcomes, justified by scientific literature.	• *Measurable* - Videotaped interactions coded using the Child Behavior Rating Scales (Stover 2015). <u>Family outcomes</u> • **Coparenting** - • *Importance* - Positive coparenting even in the context of a conflicted intimate relationship can be protective and result in better child adjustment. Coparenting has been shown to have a much stronger influence on parenting and child adjustment than other aspects of the couple relationship and is associated with greater father involvement in high risk families (Stover et al., 2020; Stover, 2015; Camara & Resnick, 1989; Katz & Low, 2004; Feinberg, 2003; Snyder, Klein, Gdowski, Faulstich, & LaCombe, 1988; Waller, 2012)

	What are the desired long-term outcomes?		In the longer-term, F4C aims to improve:
			
			<u>Father outcomes</u>
			
			• **Reduction in incidents of violence/aggression (IPV)** - physical or sexual violence, stalking, or psychological harm between current or former partners
			  • Measurable - Follow-back spousal violence and timeline (Stover, 2015); Abusive behaviour inventory (Stover et al., 2020); Conflict Tactics Scale - Revised (Stover 2015a); Abusive Behavior Inventory (Stover 2022).
			• **Abstinence from substance abuse**
			  • Importance - Substance use and enrolment in substance misuse treatment is associated with **IPV** (Easton, Swan, & Sinha, 2000). Treatment of substance use problems alone has been shown to have small to moderate reductions on IPV (Murphy & Ting, 2010). Moreover substance use is associated with **negative parenting behaviours**, including harmful behaviours towards children (McMahon et al., 2008, Söderström and Skårderud, 2013) and fewer positive father-child interactions (Eiden, Chavez, & Leonard, 1999).
			  • *Measurable* - Addiction severity index (Stover et al., 2017)
			  • *Notes* - Substance misuse is more a focus of the programme (and evaluation) when

			implemented in relevant settings or with substance abusing populations. <u>Child outcomes</u> ● **Child maltreatment incidents, including children's exposure to conflict and violence** ● *Importance* - Exposure to violence in childhood associated with child aggression, conduct problems, juvenile delinquency, and depression, anxiety, PTDS, and attachment disorders (from Stover 2023 - Evans, Davies, & DiLillo 2008; Jouriles & McDonald, 2024; Kitzmann, Gaylord, Holt & Kenny, 2003; Chan & Yeung, 2009)). In addition children exposed to family violence are at increased risk for various physical health conditions (from Stover 20023 - Lanier, Jonson-Reid, Stahlschmidt, Drake, & constantino, 2010). Finally, "family violence often crosses generations. Adults who abuse children have a higher likelihood of having been abused themselves and/or exposed to domestic violence. Children witnessing or caught in the crossfire of domestic violence are at greater risk of repeating the same behaviour when they have their own families" (Bartlett, 2017. Merrick & Guinn, 2018.) ● *Measurable* - Children's Exposure to Conflict Scale on the Coparenting Relationship Scale (Stover 2022).

Appendix G: Adapted implementation logic model

Logic model field	Subcategory	Content
Determinants **(context-specific barriers and facilitators that prevent or enable implementation)** **Row title** **Row title**	Innovation (the "thing" being implemented)	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. Innovation source (The group that developed and/or visibly sponsored use of the innovation is reputable, credible, and/or trustable) • F4C was developed by Professor Carla Stover in the Yale School of Medicine, which may enhance stakeholder's views of the intervention as reputable and credible. Innovation evidence base (The innovation has robust evidence supporting its effectiveness) • F4C has evidence supporting its effectiveness from multiple RCTs and QED studies (Source: Stover, 2015; Stover et al., 2020; Stover et al., 2017; Stover et al., 2019; Stover et al., 2018; Beeb et al., 2023). Innovation relative advantage (The innovation is better than other available innovations or current practice) • Evidence from the literature shows that F4C has a greater impact on behavioural outcomes than Individual Drug Counselling (Stover, 2015) and a greater impact on substance use than 'Dads 'n' Kids', a psychoeducational intervention (Stover et al., 2019). A small pilot trial (pre-publication) found that F4C had better outcomes than both individual and group Duluth approaches, the typical approach used in the UK (Source: Developer interview). • Alternative business-as-usual programmes are often survivor-focused, or perpetrator programmes that largely focus on challenging societal influences around family violence, holding perpetrators to account, and teaching anger management skills. In contrast, F4C focuses on fatherhood and the father-child relationship, takes a tailored approach with individual assessments, takes a family-level approach, and is delivered individually to fathers and families. Innovation adaptability (The innovation can be modified, tailored, or refined to fit local context or needs)

		• Intervention materials (e.g. worksheets) can be adapted to the local context. The programme is designed to be inherently flexible to fit with settings' requirements; for example, conjoint father-child sessions may not be possible in all settings. Innovation trialability (The innovation can be tested or piloted on a small scale and undone) • F4C is delivered individually, so initial pilot delivery can focus on a small number of fathers and their families before increasing the scale of delivery. F4C has been trialled successfully in the past. Innovation complexity (The innovation is complicated, which may be reflected by its scope and/or the nature and number of connections and steps) • While the scope of the programme is ambitious, it is not more complicated than would typically be expected in an intervention focusing on perpetrators of domestic violence, or an intervention delivered to families. Innovation design (The innovation is well designed and packaged, including how it is assembled, bundled, and presented) • The intervention is summarised in a book, "Fathers and Violence: A Program to Change Behavior, Improve Parenting, and Heal Relationships". Innovation cost (The innovation purchase and operating costs are affordable) • To the best of our knowledge, operating costs do not exceed what would be typically expected in delivery of an individual intervention to families. Required materials (e.g. worksheets, toys) are low-cost and widely accessible.
	Inner setting (the setting where the intervention is delivered - including its physical, IT, and work/organisational infrastructure, its culture, its available	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. **Structural characteristics: physical infrastructure** (layout and configuration of space and other tangible material features support functional performance) and **Available resources: space** (physical space is available to implement the intervention). • F4C requires sufficient space for a practitioner to work with a family, and sufficient privacy to address

	resources, and its incentive systems)	sensitive topics. **Relational connections** (high-quality formal and informal relationships, networks and teams) and **Culture: deliverer-centeredness** (values, beliefs and norms around caring, supporting, and addressing the needs and welfare of deliverers) ● Delivering the programme can be challenging and emotionally taxing - 'you can feel isolated and the cases are difficult'. Burnout and turnover have been experienced in settings delivering this sort of programme. **Culture: human-equality centredness** (values, beliefs and norms about the inherent equal worth and value of all human beings), **recipient-centredness** (values, beliefs and norms around caring, supporting, and addressing the needs and welfare of recipients) and **mission alignment** (implementing and delivering the intervention is in line with the overarching commitment, purpose, or goals of the setting). ● A critical component of delivering F4C is taking an empathic approach and treating participants as 'more than the worst thing they ever did'. However, the public and many practitioners may hold strong, often unconscious attitudes towards those who commit family violence. This can make delivery challenging, requiring that practitioners confront and acknowledge their own attitudes (Sources: Stover 2022; Developer interview). **Compatibility** (the intervention fits with workflows, systems, and processes) ● Some settings do not permit or have authorisation to allow children on premises to enable child participation (Source: Developer interview). ● Some settings do not permit having perpetrators on site (Source: Developer interview). **Available resources: funding** (funding is available to implement the intervention) ● Lack of funding has been highlighted as a barrier, with sites in Connecticut receiving funding that is not keeping up with cost of living increases (Source: CT DFT interview). Funding at these sites is given with a 6 month limit. However, if funding runs out, the site will ask for an extension if the participant remains engaged (Source: Site visit). ● There is a significant issue about funding for evidence based interventions in the UK. Many programmes for families are funded in the short term (1, 2 or 3 years) by local authorities spending budgets received by the central government. Foundations and Nesta are collaborating to address this issue. However, the programme stands a good chance of being commissioned by LAs as it is compliant

		with Home Office Standards and there is a dearth of one to one interventions for perpetrators. **Available resources: material & equipment** (supplies are available to implement and deliver the intervention) ● A set of materials are required to deliver the intervention - this includes the programme handbook, phones, the ability to record video, toys appropriate for child for interaction assessments, Paper-based worksheets, handouts, and forms; large sheets of paper and pens; laptop/TV to play videos and potentially to draw genogram; heart rate monitor; children's books and games, heartmath app. ○ However these materials are - generally speaking - low-cost and widely available and so are unlikely to present a barrier. **Access to knowledge & information** (guidance and/or training is accessible to implement the intervention) ● Delivery of the programme requires specialist knowledge, training and experience. No specific contextual barriers and facilitators have been identified against the following domains for the 'Inner Setting'. This does not necessarily mean that there are no facilitators/barriers relevant to these domains, but rather that these have not specifically been surfaced in our research. On this basis, we expect that any relevant barriers/facilitators against the following domains do not exceed what would be typically expected in delivery of an intervention to families: ● **Structural characteristics: information technology infrastructure -** technological systems for telecommunication, electronic documentation, data storage, management, reporting and analysis support functional performance ● **Structural characteristics: work infrastructure** (organisation of tasks and responsibilities within and between individuals and teams, and general staffing levels, support functional performance) ● **Relative priority (**implementing and delivering the innovation is important compared to other initiatives) ● **Incentive systems** (tangible and/or intangible incentives and rewards and/or disincentives and punishments support implementation) ● **Tension for change** (the current situation is intolerable and needs to change) ● **Communications** (high-quality formal and informal informations sharing practices)

		Culture: learning-centredness (values, beliefs and norms around psychological safety, continual improvement, and using data to inform practice)
	Outer setting (the setting the inner setting exists within - e.g., a community or system -, including local economic/environmental/political conditions, and policies and laws)	Each bolded subheading below corresponds to the CFIR domains, i.e. categories of context-specific barriers and facilitators. Beneath each we describe relevant barriers and facilitators that have surfaced through our research. **Local attitudes** (sociocultural values and beliefs which may support/inhibit implementation) ● As described for the 'Inner Setting', views and beliefs around perpetrators may influence successful implementation of the programme, as it is predicated on taking an empathic and understanding approach. Historically, programmes based on the Duluth model have had a 'cultural hold' over service provision, which may mean that practitioners, referrers and other professionals could have some opposition to services based on a different approach and ethos (Sources: Stover 2022, Developer interview). **Local conditions** (economic, environmental, political and/or technology conditions which may support/inhibit implementation) ● In the UK, we expect that transportation to delivery sites, socio-economic stressors, and/or being engaged with multiple other services may impact father's ability to engage with the programme. **Partnerships and connections** (referral networks, academic affiliations, and professional organisation networks which may support/inhibit implementation) ● Programme developers find partnerships/relationships with local child protective services are an especially strong source of referrals for the programme (Source: Developer interview). ● Families will be referred into the programme via children's social care in each local authority. **Policies and laws** (legislation, regulations, professional group guidelines and recommendations which may support/inhibit implementation) ● The Home Office and Respect standards specify a number of requirements for perpetrator programmes. This includes a requirement for a minimum of 16 individual perpetrator-focussed sessions to have taken place before joint sessions with the victim survivor can be considered. The standards also require the victim-survivor to be offered support alongside the perpetrator's sessions,

		delivered by a separate practitioner. F4C is aiming to comply with the Home Office standards as above. **Financing** (funding from external entities available to support implementation) ● There is a significant issue about funding for evidence based interventions in the UK. Many programmes for families are funded in the short term (1, 2 or 3 years) by local authorities spending budgets received by the central government. Commissioning is a potential barrier for the programme No context specific barriers and facilitators have been identified against the following domains for the 'Outer Setting'. This does not necessarily mean that there are no facilitators/barriers relevant to these domains, but rather that these have not specifically been surfaced in our research. On this basis, we expect that any relevant barriers/facilitators against the following domains do not exceed what would be typically expected in delivery of an intervention to families: ● **Critical incidents** (large-scale and/or unanticipated events that disrupt implementation) ● **External pressures: societal pressure** (mass media campaigns, advocacy groups, or social or protest movements which may support/inhibit implementation) ● **External pressures: market pressure** (competing with peer entities which may support/inhibit implementation) **External pressures: performance measurement pressure** (quality/benchmarking metrics or established service goals which may support/inhibit implementation)
	Characteristics of individuals **(the roles and characteristics of leaders, facilitators/practitioners, implementation**	**Intervention deliverers** - individuals who are directly or indirectly delivering the intervention. ● ***Capability*** **(competence, knowledge and skills to implement intervention)** - It is important that practitioners have: trauma specific training, understanding of family violence dynamics, understanding of child development, and experience of working with child, parent, adult, and family therapy (Sources: Developer interview; Stover 2022). ● ***Opportunity*** **(availability, scope and power to implement intervention)** - It is sometimes important for programme retention that practitioners are demographically similar to participants (Source: Site visit). ● ***Motivation*** **(commitment to fulfilling role)** - It is important that practitioners are bought in and

	support workers, etc)	committed to the programme (Source: Stover 2022; Site visit; Developer interview). **Intervention recipients** - individuals who are directly or indirectly receiving the intervention. • ***Capability*** **(competence, knowledge and skills to implement intervention)** - No specific requirements identified. • ***Opportunity*** **(availability, scope and power to implement intervention)** - In the UK, we expect that transportation to delivery sites, socio-economic stressors, child-care and work commitments, and/or being engaged with multiple other services may impact father's ability to engage with the programme. • ***Motivation*** **(commitment to fulfilling role)** - A barrier to participation for participants is concern that participation represents an admission of guilt, due to the involvement of child protection services and the criminal justice system. No context specific barriers and facilitators with respect to **high-level leaders**, **mid-level leaders**, **opinion leaders, implementation facilitators, leads or team members** have been identified to date.

Implementation strategies (the methods or techniques used to produce implementation outcomes)	**<u>Pre-implementation</u>** • **Promoting the intervention among referrers** - Providing training and information for referring social workers, making the case for the ethos of the intervention, its credibility and evidence base. Reassuring referrers regarding potential concerns about the involvement of co-parents and children; emphasising the robustness of the assessment process and the eligibility criteria and possible gains of family-level work. • **Assess readiness and identify barriers and facilitators** - Using the F4C organisational readiness form to assess an organisation to determine its degree of readiness to implement and barriers that may impede implementation. This can help mitigate risks and barriers around local/state statutory mandates and settings not permitting or having authorisation to allow children/perpetrators on-site (Source: Developer interview). • **Signposting and co-ordinating additional support with referrers and local authorities** - signposting fathers and/or their co-parent and/or child to relevant services if they are in need of additional support that is not available through the F4C programme • **Practitioner selection and training** - Practitioners receive F4C programme training, and ongoing consultation and supervision. Practitioners will receive four days of training in total: Practitioners are trained by the model developer (or a 'Master Trainer') through a 3-day didactic and experiential training curriculum, followed by twice monthly consultation calls. Practitioners also receive a two hour briefing on EDIE and a two hour briefing on risk management and rapport building from Dr Tara Dickens and two hours from FI on father-inclusive practice. • **Training, alongside careful selection of practitioners**, ensures that the right competencies and experience are in place and mitigates risks/barriers around practitioners being unable to take the empathic approach to fathers required to deliver the programme. • **Robust family eligibility assessment process** - Before delivery to a father/family, a rigorous assessment process takes place to ensure that F4C is the right intervention for their case, and to ensure that they can fully participate in it. • **Matching fathers/co-parents/families to appropriate practitioner** - The eligibility assessment process can inform matching a practitioner to a father/co-parent based on i) the fathers needs and the expertise of the practitioner, and ii) demographics, including ethnicity (Source: Site visit). • **Careful initial outreach to fathers** - Practitioners engaging with the participant as a person, to slowly build a trusting relationship. This can mitigate risks/barriers around participation and the fear that this is an admission of guilt (Sources: Stover 2022; Developer interview; CT DFT interview). **<u>During implementation</u>** • **Measures to support practitioners** - Sites are encouraged to i) have more than one person delivering the programme at any time, ii) establish a culture of reflective supervision, and iii) encourage

	practitioners to be a part of a community through informal peer support networks. These mitigate risks around burnout and turnover (Source: Developer interview). • **Supporting manageable workloads** - Ensuring that practitioners' catchment areas are manageable is an important facilitator (Source: Site visit). • **Flexible delivery** - Sites can be flexible in the time and place in which F4C is delivered (e.g. offered in evenings, or in the home). This helps to mitigate risks/barriers around local populations being employed in professions which make engagement in regular service sessions more challenging (Source: CT DFT interview). • **Audit and provide feedback** - In the UK, during the feasibility study, the programme developer will be responsible for auditing the programme and providing feedback. • **Conduct ongoing training** - Yearly booster trainings. • **Implementing tools for quality monitoring** - Fidelity assessments are conducted, taking the form of either a practitioner self-complete checklist, or a review of session videos and coding on session observation rating sheet. • **Provide clinical supervision** - Provide practitioners with ongoing supervision at the site level. • **Rapport-building and maintaining engagement** - The first phase of the F4C programme focusses on engagement and motivational enhancement, using motivational interviewing techniques. Engagement throughout the process is maintained through the creation of a strong practitioner-participant relationship, self-reflection and the learning and practice of helpful skills for emotional regulation and parenting and ongoing feedback from the practitioner. **<u>Sustaining implementation</u>** • **Use train-the-trainer strategies** - Local 'Master Trainers' can be trained to support ongoing training of practitioners. The requirements for Master Trainers are currently being developed but current guidance specifies: ○ You must have completed the F4C basic training, one day of booster training, and the consultation calls & case presentations. ○ Conducted fidelity reviews with Dr Stover. ○ If you're a supervisor - you must complete 5 F4C cases as the primary clinician. ○ If you're not a supervisor - you must complete 10 F4C cases as the primary clinician. ○ You must co-train a basic training with Dr. Stover. ○ You must take the lead during 2 consultation calls. **Provide ongoing consultation** - Programme developer can provide ongoing consultation to sites/agencies/departments.

Mechanisms (the processes by which implementation strategies are intended to produce implementation outcomes)	• Recruiting and retaining a skilled workforce. • Identifying and preparing appropriate settings for delivery. • Identifying appropriate sources of participant referrals. • Encouraging take-up of service. Supporting sites to require less active intervention and support from the programme developer.
Implementation outcomes (the effects of intervention strategies)	• Reaching (recruiting and retaining) the intended population of fathers and their families where the father has participated in family violence and still has some contact with their children, aged under 12 years old. • Delivering the four phases of Fathers for Change with fidelity in a suitable manner within the UK context, including adoption of F4C as a programme for delivery within suitable setting(s). • Sustaining intervention recruitment and delivery over time and institutionalising F4C within suitable settings' ongoing, stable operations. The perception of F4C as agreeable and satisfactory by the target population and programme delivery personnel.

Appendix H - Clearinghouses

Early Intervention Foundation Guidebook: https://guidebook.eif.org.uk/

What Works Centre for Children's Social Care Evidence Store: https://whatworks-csc.org.uk/

What Works Centre for Crime Reduction (College of Policing): https://whatworks.college.police.uk/About/Pages/default.aspx

Blueprints for Healthy Youth Development: https://www.blueprintsprograms.org/

Social Programs That Work: https://evidencebasedprograms.org/

Promising Practices Network: https://www.rand.org/well-being/social-and-behavioral-policy/projects/promising-practices.html

Office of Justice Programmes Crime Solutions: https://crimesolutions.ojp.gov/

Evidence Based Practices (European Platform for Investing in Children): https://ec.europa.eu/social/main.jsp?catId=1246&langId=en

Home Visiting Evidence of Effectiveness (U.S. Department of Health & Human Services) HomVEE: https://homvee.acf.hhs.gov/

Top Tier Evidence (Coalition for Evidence-Based Policy): http://coalition4evidence.org/ – amalgamated into https://www.arnoldventures.org/work/

California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/

PennStateClearinghouseforMilitaryFamilyReadiness:https://militaryfamilies.psu.edu/

Appendix I - Rapid review of reviews

Inclusion/exclusion criteria

Population

- Reviews investigating studies focused on families including a child between the ages of 0-18.

Intervention

- Reviews investigating interventions whose primary goal is to reduce domestic abuse (i.e., abusive behaviour of a person aged 16+ towards another person aged 16+, who are personally connected to each other, where the behaviour is abusive).
- Reviews investigating interventions that specifically aim to reduce domestic abuse specifically in the context of abusive behaviour between parents/caregivers.

- Reviews investigating perpetrator-focused interventions, i.e., delivered directly to individuals perpetrating domestic abuse (the review does not have to exclusively focus on studies of these interventions, but must include them).

Comparison

- No restriction.

Outcomes

- Reviews investigating studies measuring.
    - i) domestic abuse perpetration
    - ii) interparental conflict/relationship quality
    - iii) quality of parenting/co-parenting
    - iv) wellbeing/mental health of parent/s, v) any child outcome

Study

- Reviews investigating quantitative studies.
- English-language studies only.
- No restriction in terms of study location.
- No restriction in terms of date of publication.

Search methodology

In terms of search strings, we will use a bespoke search approach depending on the functionality of the database, but it will involve a variation on:

Population terms	Intervention terms	Outcome terms	Study terms
parents	*intervention*	*'Domestic abuse'*	*'Systematic review'*
families	*programme*	*'Domestic violence'*	*'Narrative review'*
fathers	*program*	*'Family violence'*	*'Rapid review'*
perpetrators	*service*	*'Intimate partner violence'*	*'Literature review'*
	therapy	*abuse*	*review*
	treatment		*'meta-analysis'*
	practice		*'Meta analysis'*
(parents OR families OR fathers OR perpetrators) AND (intervention OR programme OR program OR service OR therapy OR treatment OR practice) AND ('domestic abuse' OR 'domestic violence' OR 'family violence' OR 'intimate partner violence' OR abuse) AND			

('systematic review' OR 'narrative review' OR 'rapid review' OR 'literature review' OR review OR 'meta-analysis' OR 'meta analysis')

Appendix J - F4C structure (Stover, 2023)

Topic	Participants	Session type
Assessment Phase		
Father assessment	Father	Individual
Coparent assessment	Coparent	Individual
Child assessment	Child	Individual
Family	Father, child (coparent optional)	Conjoint
Phase 1 - Engagement and motivational enhancement		
1 - Introduction to Fathers for Change	Father Coparent	Individual Parallel individual
2 - Fathers' roles and the importance of fathers to child development	Father Coparent (optional)	Individual Parallel individual
3 - Reflecting on father-child interactions	Father Coparent (optional)	Individual Parallel individual
4 - Reflecting on the family of origin	Father Coparent	Individual Parallel individual
Phase 2 - Reflective functioning and skills building		
5 - Exploring triggers for FV, need for control, and use of substances	Father Coparent (optional)	Individual Parallel individual
6 - Understanding emotional arousal and the body's stress response	Father Coparent (optional)	Individual Parallel individual
7 - Physiological reactivity and management skills	Father Coparent (optional)	Individual Parallel individual
8 - How thinking impacts behaviour	Father Coparent	Individual Parallel individual
Phase 3 - Co-parenting communication		

9 - Increasing coparent positive interactions	Father Coparent	Individual in parallel OR conjoint
10 - Positive communication skills	Father Coparent	Individual in parallel OR conjoint
11 - Coparent problem solving (pt.1)	Father Coparent	Individual in parallel OR conjoint
12 - Coparent problem solving (pt.2)	Father Coparent	Individual in parallel OR conjoint
Phase 4 - Restorative Parenting		
13 - Parenting skills	Father Coparent	Individual in parallel OR conjoint
14 - Preparing to make amends	Father	Individual
15 - Taking responsibility	Father Child	Conjoint
16 - Father-child play	Father Child	Conjoint
17 - Father-child feelings identification and expression	Father Child	Conjoint
Final session		
18 - Ending treatment	Father Coparent	Individual Individual in parallel

Appendix K - Longlist of implementation strategies suggested by ILM framework

- Access new funding - Access new or existing money to facilitate the implementation
- Alter incentive/allowance structures - Work to incentivize the adoption and implementation of the clinical innovation
- Alter patient/consumer fees - Create fee structures where patients/consumers pay less for preferred treatments (the clinical innovation) and more for less-preferred treatments
- Assess for readiness and identify barriers and facilitators - Assess various aspects of an organization to determine its degree of readiness to implement, barriers that may impede implementation, and strengths that can be used in the implementation effort.
- Audit and provide feedback - Collect and summarize clinical performance data over a specified time period and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior
- Build a coalition - Recruit and cultivate relationships with partners in the implementation effort
- Capture and share local knowledge - Capture local knowledge from implementation sites on how implementers and clinicians made something work in their setting and then share it with other sites.
- Centralize technical assistance - Develop and use a centralized system to deliver technical assistance focused on implementation issues.
- Change accreditation or membership requirements - Strive to alter accreditation standards so that they require or encourage use of the clinical innovation. Work to alter membership organization requirements so that those who want to affiliate with the organization are encouraged or required to use the clinical innovation
- Change liability laws - Participate in liability reform efforts that make clinicians more willing to deliver the clinical innovation
- Change physical structure and equipment - Evaluate current configurations and adapt, as needed, the physical structure and/or equipment (*e.g.*, changing the layout of a room, adding equipment) to best accommodate the targeted innovation.
- Change record systems - Change records systems to allow better assessment of implementation or clinical outcomes.
- Change service sites - Change the location of clinical service sites to increase access.
- Conduct cyclical small tests of change - Implement changes in a cyclical fashion using small tests of change before taking changes system-wide. Tests of change benefit from systematic measurement, and results of the tests of change are studied for insights on how to do better. This process continues serially over time, and refinement is added with each cycle.
- Conduct educational meetings - Hold meetings targeted toward different stakeholder groups (*e.g.*, providers, administrators, other organizational stakeholders, and community, patient/consumer, and family stakeholders) to teach them about the clinical innovation.
- Conduct educational outreach visits - Have a trained person meet with providers in their practice settings to educate providers about the clinical innovation with the intent of changing the provider's practice.

- Conduct local consensus discussions - Include local providers and other stakeholders in discussions that address whether the chosen problem is important and whether the clinical innovation to address it is appropriate.
- Conduct local needs assessment - Collect and analyze data related to the need for the innovation.
- Conduct ongoing training - Plan for and conduct training in the clinical innovation in an ongoing way.
- Create a learning collaborative - Facilitate the formation of groups of providers or provider organizations and foster a collaborative learning environment to improve implementation of the clinical innovation.
- Create new clinical teams - Change who serves on the clinical team, adding different disciplines and different skills to make it more likely that the clinical innovation is delivered (or is more successfully delivered).
- Create or change credentialing and/or licensure standards - Create an organization that certifies clinicians in the innovation or encourage an existing organization to do so. Change governmental professional certification or licensure requirements to include delivering the innovation. Work to alter continuing education requirements to shape professional practice toward the innovation.
- Develop a formal implementation blueprint - Develop a formal implementation blueprint that includes all goals and strategies. The blueprint should include the following: 1) aim/purpose of the implementation; 2) scope of the change (*e.g.*, what organizational units are affected); 3) timeframe and milestones; and 4) appropriate performance/progress measures. Use and update this plan to guide the implementation effort over time.
- Develop academic partnerships - Partner with a university or academic unit for the purposes of shared training and bringing research skills to an implementation project.
- Develop an implementation glossary - Develop and distribute a list of terms describing the innovation, implementation, and stakeholders in the organizational change.
- Develop and implement tools for quality monitoring - Develop, test, and introduce into quality-monitoring systems the right input—the appropriate language, protocols, algorithms, standards, and measures (of processes, patient/consumer outcomes, and implementation outcomes) that are often specific to the innovation being implemented.
- Develop and organize quality monitoring systems - Develop and organize systems and procedures that monitor clinical processes and/or outcomes for the purpose of quality assurance and improvement.
- Develop disincentives - Provide financial disincentives for failure to implement or use the clinical innovations.
- Develop educational materials - Develop and format manuals, toolkits, and other supporting materials in ways that make it easier for stakeholders to learn about the innovation and for clinicians to learn how to deliver the clinical innovation.
- Develop resource sharing agreements - Develop partnerships with organizations that have resources needed to implement the innovation.
- Distribute educational materials - Distribute educational materials (including guidelines, manuals, and toolkits) in person, by mail, and/or electronically.

- Facilitate relay of clinical data to providers - Provide as close to real-time data as possible about key measures of process/outcomes using integrated modes/channels of communication in a way that promotes use of the targeted innovation.
- Facilitation - A process of interactive problem solving and support that occurs in a context of a recognized need for improvement and a supportive interpersonal relationship.
- Fund and contract for the clinical innovation - Governments and other payers of services issue requests for proposals to deliver the innovation, use contracting processes to motivate providers to deliver the clinical innovation, and develop new funding formulas that make it more likely that providers will deliver the innovation.
- Identify and prepare champions - Identify and prepare individuals who dedicate themselves to supporting, marketing, and driving through an implementation, overcoming indifference or resistance that the intervention may provoke in an organization.
- Identify early adopters - Identify early adopters at the local site to learn from their experiences with the practice innovation.
- Increase demand - Attempt to influence the market for the clinical innovation to increase competition intensity and to increase the maturity of the market for the clinical innovation.
- Inform local opinion leaders - Inform providers identified by colleagues as opinion leaders or "educationally influential" about the clinical innovation in the hopes that they will influence colleagues to adopt it.
- Intervene with patients/consumers to enhance uptake and adherence - Develop strategies with patients to encourage and problem solve around adherence.
- Involve executive boards - Involve existing governing structures (*e.g.*, boards of directors, medical staff boards of governance) in the implementation effort, including the review of data on implementation processes.
- Involve patients/consumers and family members - Engage or include patients/consumers and families in the implementation effort.
- Make billing easier - Make it easier to bill for the clinical innovation.
- Make training dynamic - Vary the information delivery methods to cater to different learning styles and work contexts, and shape the training in the innovation to be interactive.
- Mandate change - Have leadership declare the priority of the innovation and their determination to have it implemented.
- Model and simulate change - Model or simulate the change that will be implemented prior to implementation.
- Obtain and use patients/consumers and family feedback - Develop strategies to increase patient/consumer and family feedback on the implementation effort.
- Obtain formal commitments - Obtain written commitments from key partners that state what they will do to implement the innovation.
- Organize clinician implementation team meetings - Develop and support teams of clinicians who are implementing the innovation and give them protected time to reflect on the implementation effort, share lessons learned, and support one another's learning.
- Place innovation on fee for service lists/formularies - Work to place the clinical innovation on lists of actions for which providers can be reimbursed (*e.g.*, a drug is placed on a formulary, a procedure is now reimbursable).

- Prepare patients/consumers to be active participants - Prepare patients/consumers to be active in their care, to ask questions, and specifically to inquire about care guidelines, the evidence behind clinical decisions, or about available evidence-supported treatments.
- Promote adaptability - Identify the ways a clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity.
- Promote network weaving - Identify and build on existing high-quality working relationships and networks within and outside the organization, organizational units, teams, etc. to promote information sharing, collaborative problem-solving, and a shared vision/goal related to implementing the innovation.
- Provide clinical supervision - Provide clinicians with ongoing supervision focusing on the innovation. Provide training for clinical supervisors who will supervise clinicians who provide the innovation.
- Provide local technical assistance - Develop and use a system to deliver technical assistance focused on implementation issues using local personnel.
- Provide ongoing consultation - Provide ongoing consultation with one or more experts in the strategies used to support implementing the innovation.
- Purposely reexamine the implementation - Monitor progress and adjust clinical practices and implementation strategies to continuously improve the quality of care.
- Recruit, designate, and train for leadership - Recruit, designate, and train leaders for the change effort.
- Remind clinicians - Develop reminder systems designed to help clinicians to recall information and/or prompt them to use the clinical innovation.
- Revise professional roles - Shift and revise roles among professionals who provide care, and redesign job characteristics.
- Shadow other experts - Provide ways for key individuals to directly observe experienced people engage with or use the targeted practice change/innovation.
- Stage implementation scale up - Phase implementation efforts by starting with small pilots or demonstration projects and gradually move to a system wide rollout.
- Start a dissemination organization - Identify or start a separate organization that is responsible for disseminating the clinical innovation. It could be a for-profit or non-profit organization.
- Tailor strategies - Tailor the implementation strategies to address barriers and leverage facilitators that were identified through earlier data collection.
- Use advisory boards and workgroups - Create and engage a formal group of multiple kinds of stakeholders to provide input and advice on implementation efforts and to elicit recommendations for improvements
- Use an implementation advisor - Seek guidance from experts in implementation
- Use capitated payments - Pay providers or care systems a set amount per patient/consumer for delivering clinical care.
- Use data experts - Involve, hire, and/or consult experts to inform management on the use of data generated by implementation efforts.
- Use data warehousing techniques - Integrate clinical records across facilities and organizations to facilitate implementation across systems.
- Use mass media - Use media to reach large numbers of people to spread the word about the clinical innovation.

- Use other payment schemes - Introduce payment approaches (in a catch-all category).
- Use train-the-trainer strategies - Train designated clinicians or organizations to train others in the clinical innovation.
- Visit other sites - Visit sites where a similar implementation effort has been considered successful.
- Work with educational institutions - Encourage educational institutions to train clinicians in the innovation

Appendix L - Matrix of strategies and determinants

The following grid matches determinants with implementation strategies which are designed to address them. Note that determinants (either barriers, or facilitators to be potentially harnessed) without a corresponding implementation strategy may need further thinking ahead of delivery.

			Strategies														
			Pre-implementation					During implementation								Sustaining implementation	
			Assess readiness and identify barriers and facilitators	Practitioner selection and training	Robust family eligibility assessment process	Matching fathers/ families to appropriate practitioner	Careful initial outreach to fathers	Measures to support practitioners	Supporting manageable workloads	Flexible delivery	Audit and provide feedback	Conduct ongoing training	Implementing tools for quality monitoring	Provide clinical supervision	Rapport-building and maintaining engagement	Use train-the-trainer strategies	Provide ongoing consultation
Determinants	Innovation	Innovation source															
		Innovation evidence base															
		Innovation relative advantage															
		Innovation adapta															

		bility															
		Innovation trialability															
		Innovation complexity															
		Innovation design															
		Innovation cost															
	Inner setting	Structural characteristics: physical infrastructure															
		Available resources: space															
		Relational connectedness															
		Culture: deliverer-centred															

		ness															
		Culture: human-equality centredness															
		Recipient-centeredness															
		Mission alignment															
		Compatibility															
		Available resources: funding															
		Available resources: material & equipment															
		Access to knowledge and information															

	Outer setting	Local attitudes															
		Local conditions															
		Partnerships and connections															
		Policies and laws															
		Financing															
	Characteristics of individuals	Intervention deliverers' capability															
		Intervention deliverers' opportunity															
		Intervention deliverers' motivation															
		Intervention															

		recipients' opportunity															
		Intervention recipients' motivation															