Lewisham's Prevent-Protect-Repair Programme

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Pilot Evaluation Summary	
Intervention Developer	London Borough of Lewisham
Delivery Organisations	London Borough of Lewisham
Evaluator	Anna Freud National Centre for Children and Families
Principal Investigator	Julian Edbrooke-Childs
Protocol Author(s)	Julian Edbrooke-Childs Giulia Gaia Ravaccia
Pilot Intervention Recipients	Families experiencing domestic abuse in Lewisham Social care professionals responding to domestic abuse in Lewisham
Pilot Evaluation Participants	Service users of PPR PPR staff in the delivery team PPR trainees
Number of Pilot Sites	1
Protocol Date	23.04.2021
Version	7

Summary

This document outlines the pilot evaluation of **PREVENT-PROTECT-REPAIR (PPR)** programme.

The **PREVENT-PROTECT-REPAIR (PPR)** programme is a three-stage intervention aimed at enhancing the skills, confidence and capacity within social care staff and the wider statutory partnership, responding to domestic abuse (DA), in the London borough of Lewisham. The three stages of the programme are: **prevent**, where social care professionals are trained to effectively identify the effects of DA in children and offer support; **protect**, where case formulation 'surgeries' from a DA Advisory Hub, provide effective interventions for families experiencing DA and improve social care professionals' response to DA; and **repair,** where group and individual therapeutic support is supplied to all individuals experiencing DA.

The overall aims of the feasibility study are to examine whether PPR is possible to implement and evaluate the effectiveness of PPR training, consultation, and intervention in supporting children, families, and their surrounding networks, in terms of identifying and managing risk, and improving wellbeing. To evaluate the implementation of the PPR programme, researchers will work with PPR staff to complete a logic model and a Template for Description and Replication (TiDIER) to describe the conceptualisation and provision of the PPR programme to better examine the implementation of its different components. The evaluation will also examine evidence of promise of the three stages of the PPR programme such as: whether confidence in identifying and managing risk increases in social care staff who have attended the **prevent** training; whether trauma-informed, multi-agency, and compassion-focussed working increases in social workers who have attended the **protect** consultation; and whether safety, mental health and wellbeing increases in children and families accessing the **repair** interventions. Additionally, the evaluation will analyse the potential to measure cost-effectiveness of the PPR programme. To achieve these aims, three strands of quantitative data will be collected: routine service data, parent and young person outcome and experience measures, and staff surveys. Finally, in-depth qualitative data will be collected using semi-structured interviews with a range of participants, including professionals delivering support as well as parents and their children receiving support. These interviews will also provide further insight in the evaluation of the implementation of the PPR programme and the perceived efficacy of its three stages.

Regarding the key timeline of the evaluation, the establishment of the logic model, TiDIER with staff, and the ethics approval will be completed by January 2021. The implementation and research data collection begins in February 2021, followed by the quantitative data collection commencing in March 2021. Interviews and focus groups will start in April 2021 and all quantitative and qualitative data collection will end in August 2021. The analysis and write up of the data collected will take place in August and September 2021, and the final report will be completed by March 2022.

Background and Problem Statement

There is a lack of capacity in the existing response to DA, both in terms of interventions for families and skills and confidence of non-specialist professionals, particularly at a social care level. Additionally, many social care professionals are lacking the confidence and skills to maintain sufficient involvement in cases of DA, which leads to a culture of referral onwards to specialist support, and then case closure. In general, professionals also have a limited understanding of approaches to working with fathers that are perpetrators of DA, and the importance of engaging fathers as protective factors, throughout our interventions.

In 2019/20 the second highest levels of domestic abuse (DA) crime in London were recorded in Lewisham [1]. Of all the 72 Child Protection (CP) plans reviewed by social workers, which were due a review in June 2019, forty-six (64%) included a direct concern regarding DA within the family home. [2] Additionally, the 2019 Ofsted inspections in Lewisham identified DA as an area of improvement, particularly regarding the provision of support to children and families, and the assessment and consideration of risks presented by male partners.[23] The PPR programme, developed by the London Borough of Lewisham, aims to address the severe and enduring effects of DA on victims and children. These effects include: increased risk of sexual exploitation of young people within and outside the family home[4]; increased likelihood of offending behaviour among young people experiencing DA[5]; and poorer emotional wellbeing and physical health, substance misuse and increased likelihood of engaging in risky sexual behaviours amongst young people experiencing DA[6].

The PPR programme also aims to address the challenges social care professionals responding to incidences of DA. These challenges stem from time pressures due to the lack of capacity amongst social care professionals, which in turn affect their caseload management and decision-making outcomes[3]. Wider research suggests that these time pressures often lead to increased tension between social care professionals and families as professionals have often limited time for thorough case planning and relationship building with families[7]. There is also research suggesting that social care and mental health professionals experience a lack of clarity regarding their roles when their priorities and practices, informed by different paradigms, conflict[8]. This can lead to miscommunication and misunderstandings between social care and mental health professionals regarding the CP and mental health needs of families experiencing DA[8]. Additionally, research suggests that young people experiencing abuse become "lost" in the system and do not receive adequate support from mental health and social care services[9].This is because of the pressure experienced by professionals to "refer and close the case" and not being able to respond with flexibility to an individual young person's unique circumstances[9]. Indeed, this pressure experienced by professionals has encouraged the development of a culture within social care where professionals refer and close cases as quickly as possible, because capacity cannot meet demand and professionals do not have the skills and confidence to maintain adequate involvement in cases; within the

[1] Metropolitan Police (2021). *Stats and data, hate crime and special crime category.* Retrieved on 18 January 2021 from: https://www.met.police.uk/sd/stats-and-data/met/hate-crime-dashboard/

[2] Ofsted (2019). *London Borough of Lewisham, Inspection of children's social care services,* pp. 1-11.

[3] Ghoshal, P. & Brown, T. (2020) PREVENT-PROTECT-REPAIR – Strengthening our social care and partnership response to families affected by domestic abuse in Lewisham. Internal Proposal by the London Borough of Lewisham to What works for Children's Social Care, pp. 1-13.

[4] Liabo, K., Bolton, A., Copperman, J., Curtis, K., Downie, A., Palmer, T., & Roberts, H. (2000). The Sexual Exploitation of Children and Young People in Lambeth, Southwark and Lewisham. Essex, Barnardo's Policy, Planning and Research Unit.

[5] Paton, J., Crouch, W., & Camic, P. (2009). Young offenders' experiences of traumatic life events: A qualitative investigation. *Clinical child psychology and psychiatry, 14*(1), pp. 43-62.

[6] Lambeth, Southwark, and Lewisham Public Health Departments (2018). *Lewisham Sexual and Reproductive Health Strategy,* pp. 2018-23.

[7] Darlington, Y., Healy, K., & Feeney, J. A. (2010). Challenges in implementing participatory practice in child protection: A contingency approach. *Children and Youth Services Review, 32*(7), pp. 1020-1027.

[8] Darlington, Y., Feeney, J. A., & Rixon, K. (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review, 26*(12), pp. 1175-1192.

[9] Humphreys, C. (1995). Whatever happened on the way to counselling? Hurdles in the interagency environment. *Child Abuse & Neglect*, *19*(7), pp. 801-809.

context of the Lewisham PPR programme, this culture is referred to as the 'refer and close' culture[3].

In sum, the PPR programme intends to address these issues by considering three priority areas: lack of capacity in existing DA response; the 'refer and close' culture; and a limited understanding by social care professionals of approaches to fathers that are perpetrators of DA, such as the importance of considering the role of fathers for risk and protective factors.

Intervention and Theory of Change

The PPR programme is an intervention consisting of a three-stage programme aimed at developing the skills, confidence and capacity within Children's Social Care (CSC) teams and the broader statutory partnership. The programme intends to enable non-DA specialist professionals to identify, record and report DA by understanding the effects of DA on children and families, directly providing evidence-based support, and considering the role of fathers for risk and protective factors. The three stages of the programme are:

1. **Prevent** (awareness raising and identification phase). The **prevent** stage ensures that social care professionals are aware of the effects of DA in children, are able to identify these effects, and are able to effectively offer support. This stage involves a multi-level training programme (approximately 55 staff, the majority of whom are social workers) and analytical review of existing CP cases. Training includes CODA, Caring Dads, The Freedom Programme, Escape the Trap and Trauma Informed and Restorative Practice. Staff are trained to go on to directly deliver evidence-based interventions to families. Escape the Trap gives practitioners an understanding of the complex dynamics of teenage relationship abuse, grooming & CSE.[10] Areas covered include: exploring one's own thinking and understanding about teenage relationship abuse; additional risk factors; generating discussion with young people; develop ways to address the difficult and sensitive issue of teenage relationship abuse using experiential activities and self-reflection; understanding prevalence of abuse via social media platforms; working flexibly to meet the needs of your group; safety planning with young people; monitoring risk; applying the programme in one to one work. [10]

2. **Protect** (response phase). The **protect** stage provides case formulation 'surgeries' from a DA advisory hub, offers different interventions for families experiencing DA, and develops social workers' vocabulary for responding to DA. This stage involves establishment of **an Advisory Hub of specialist professionals** offering case formulation panels and 'surgeries' for social care professionals. In this hub three-five cases can be discussed per session, totalling to approximately 100 cases reviewed over the course of a year. This stage also proposes to **create new specialist roles in response to identified gaps**. These roles will be strategic leads across CSC teams and will include: a father's worker; a crisis response role (Independent Gender Violence Advocate); and a specialist social worker. All three posts will be recruited within a 3-month mobilisation period between October to December 2020. These staff will work support the work of social workers, but also hold small caseloads. We expect them to support approximately 65 families with one-to-one work.

3. **Repair** (therapeutic phase). The **repair** stage provides group and individual therapeutic support for all family members experiencing DA. This stage involves provision of a range of specialist programmes for families (approximately 204 families).

[10] Escape the Trap (2021). *Training.* Retrieved on 16 March 2021 from: https://escapethetrap.co.uk/training/

Group programmes include: **Children Overcoming Domestic Abuse (CODA), Caring Dads, Freedom Programme,** and **the Healthy Relationships Programme.**

The **CODA** programme, formerly known as the 'Community Group Programme' and originally developed in Canada, is a 12-week programme for children, young people and their mothers who have experienced domestic violence[11]. It provides a community-based setting to share and talk about their experiences. The programme offers a 3 day training course for practitioners to enable to set up the programme and deliver it to children, young people and their mothers[10].

Caring Dads is a programme aimed at fathers whose relationship with their children or children's mothers is problematic[12]. This may include over-controlling, over-involved, distant and/or irresponsible, emotionally abusive fathers or fathers who have hostile, highly conflictual, or abusive relationships with the children's mothers[10]. The programme addresses elements of parenting, fathering, battering and child protection practice to enhance the safety and well-being of children[11]. Its aims are: to enhance fathers' motivation; promote child-centered fathering; address fathers' ability to engage in respectful, non-abusive co-parenting with children's mothers; recognize that children's experience of trauma will impact the rate of possible change; and work collaboratively with other service providers to ensure that children benefit (and are not unintentionally harmed) as a result of fathers' participation in intervention[13]. The programme is structured in a group format, of 10 to 15 fathers, which runs for 2 hours, one night a week, for 17 weeks, led by accredited Caring Dads facilitators[11]. Due to COVID-19 Caring Dads programme will be delivered in a group face-to-face format only in the latter part of 2021. In the interim, the PPR team is developing a new 121 offer for fathers in partnership with Caring Dads, based on the same principles as the group programme and other effective perpetrator programmes. Indeed, this new training – **'Direct Work with Fathers in CSC'** – will enable social workers to deliver 121 work with fathers that have perpetrated domestic abuse, from May 2021 onwards. The PPR team feels that this will increase the sustainability and reach of PPR past this year, as this will be a more flexible offer both for fathers and for staff. It is being developed as a bespoke programme for Lewisham.

The **Freedom Programme,** developed by Pat Craven, is a domestic violence programme created for women as victims of domestic violence[14]. However, the programme, when supplied as an accelerated two-day course, is also applicable for men, whether abusive and wanting to change their attitudes and behaviour or whether victims of same sex domestic abuse themselves[10]. The programme lasts up to 12 weeks and is free. It investigates the roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors, aiming to aid them to make sense of and understand what has happened to them[10]. The programme also illustrates how children are impacted by this type of abuse and how their lives are improved when the abuse is removed[10].

Healthy Relationships Programme (HRP) is an eight-week coaching programme for young people aged 11 -18yrs. The programme focuses on the negative impact of unhealthy relationships, (including how to keep safe and how to get help) and how to establish and maintain healthy relationships. The programme builds confidence, resilience and emotional

[11] Against Violence & Abuse (AVA) (2018). *Community Groups Programme Training – Groups for Mothers & Children.* Retrieved on 26 February 2021 from: https://avaproject.org.uk/in-house-training/community-groups-training-groups-mother-children/

[12] Caring Dads (2017). *Programme Eligibility.* Retrieved on 26 February 2021 from: **https://caringdads.org/about-caring-dads-1**

[13] Caring Dads (2017). *Programme Format..* Retrieved on 26 February 2021 from: **https://caringdads.org/about-caring-dads-1**

[14] Freedom Programme (2018). *What is the Freedom Programme?.* Retrieved on 26 February 2021 from: https://www.freedomprogramme.co.uk/

wellbeing and equips young people with the tools to stay safe.[15] The programme reviews beliefs, values and behaviour and support young people to set and achieve goals, which establish healthier habits and build confidence[15]. As part of the PPR programme the team has commissioned 2 programmes for up to 20 young people on each session. However this will be all delivered via schools and therefore given the current circumstances due to COVID-19, the PPR team expects that delivery will start after September.

Finally, there will also be specialist therapeutic support provided by PPR (e.g., Play Therapy) and support provided by other services.

A Logic Model and a TiDIER providing an overview of the intervention and its evaluation can be found in appendices 1 and 7, respectively.

Research questions

A feasibility study will be conducted to examine whether it is possible to implement and evaluate the effectiveness of PPR training, consultation, and intervention in supporting children, families, and their surrounding networks, in terms of identifying and managing risk, and improving wellbeing.

Research Question (RQ) 1: Is PPR ready to proceed to a full trial based on the Go/No-Go criteria?

a) Can the PPR intervention components be articulated to make them replicable?
b) Do the intervention and research recruitment and retention rates meet acceptable levels?
c) Can the research data be collected and can fidelity be monitored?

RQ 2: To what extent can Prevent, Protect, Repair be implemented as planned?

a) What are the barriers and facilitators to implementation?
b) What are the views of staff and families on sharing and linking data in the full study?
c) How does implementation need to be adapted to different needs?
d) Is PPR acceptable to practitioners, trainees, and families?

RQ3: Is there evidence of promise of PPR?

a) Does confidence in identifying and managing risk increase in social care staff and others in the network around the child who have attended prevent training?
b) Does trauma-informed, multi-agency, and compassion-focussed working increase in social workers and other professionals who have attended Protect consultations?
c) Does safety, mental health, and wellbeing increase in children and families who have accessed Repair interventions?

RQ4: Can the cost-effectiveness of PPR be analysed?

a) Can the data for cost-effectiveness be collected?
b) Can the data from the trial inform the cost-effectiveness analysis?
c) What threshold would be needed to determine PPR is cost-effective?

[15] Birch, A. (2019). Commissioner Information: Healthy Relationships -improving Health & Well Being**,** *CSUK Coaching* pp. 1-15.

Outcomes

The following Go/No Go Criteria will be used on which to inform the decision to proceed to the evaluation full trial, which would be indicated by not more than 1 criterion is not met and/or not more than 3 criteria are partially met, with the Steering Group agreeing the plan to increase adherence:

			Go/No-Go Criteria		
Research Question (RQ)	**Method**	**Indicator**	**Fully Met**	**Partially Met**	**Not Met**
RQ1a	Logic model and TiDIER	Agreed by Steering Group	Yes	-	No
RQ1b	Routine service data	Proportion of parents/carers completing required number of sessions	55-100%	40-54%	0-39%
RQ1b	Questionnaires completed by parents/carers	Proportion of parents/carers completing baseline questionnaires	55-100%	40-54%	0-39%
RQ1b	Questionnaires completed by parents/carers	Proportion of parents/carers completing follow up questionnaires (out of those with complete baseline measures)	55-100%	40-54%	0-39%
RQ4	Questionnaires completed by parents/carers	Proportion of complete follow up EQ5DY/EQ5D (out of those with complete baseline EQ5DY/EQ5D measures)	75-100%	50-74%	0-49%
RQ2b	Interviews with professionals	Proportion of respondents stating that data sharing and linking is acceptable	Professionals report data sharing as acceptable and/or how	Professionals report data sharing as unacceptable but not how acceptability could be increased.	Professionals report data sharing as unacceptable and the research team does not identify a

			acceptability could be increased.	The research team identifies a plan to increase acceptability.	plan to increase acceptability.
RQ2b	Interviews with parents/carers and families	Proportion of respondents stating that data sharing and linking is acceptable	Parents/carers report data sharing as acceptable and/or how acceptability could be increased.	Parents/carers report data sharing as unacceptable but not how acceptability could be increased. The research team identifies a plan to increase acceptability.	Parents/carers report data sharing as unacceptable and the research team does not identify a plan to increase acceptability.
RQ2d	Questionnaire with parents/carers	Proportion of respondents stating that PPR is acceptable	60-100%	40-59%	0-39%
RQ2d	Questionnaire with parents/carers	Proportion of respondents stating the evaluation is acceptable	60-100%	40-59%	0-39%

Methods

RQ1, RQ2 - Implementation and Research Log

Data Collection

During the project set-up, we will work with PPR staff to complete a logic model[16] (appendix 1), to provide a transparent description of the conceptualisation of the intervention and to map on data that need to be collected, and a Template for Intervention Description and Replication (TiDIER) [17] (appendix 7) to provide a rich, comprehensive description of the provision of PPR. Through the logic model and TiDIER frameworks, we will achieve a detailed understanding of the core components of PPR, crucial within implementation science[18]. Based on the TiDIER, we will develop an implementation log to capture activity data (e.g., numbers of workforce trained) and fidelity to model (at least one for each of the three workstreams), which will in turn inform adaptations necessary to increase sustainability in the full trial, and participant flow (e.g., numbers of potential participants approached vs. recruited).

RQ3, RQ4 - Quantitative data

Three strands of quantitative data will be collected: routine service data, outcome and experience measures, and staff surveys.

Routine service data

Data Collection

Routine service data will be collected through a bespoke data specification following established, secure data sharing processes used in previous projects. The data specification will be developed in line with the intervention logic model, principally to capture social care outcomes in addition to service activity. Examples of routine service data variables are: number of referrals received, referral source, referral outcome (e.g., accepted, onward referral), referral feedback, contact type (e.g., indirect contact vs. direct contact), contact duration, type of professionals involved, training of professionals involved (e.g., advanced specialist cross-agency training), number and type of services involved, CPP status, duration of CPP, and information about services provided to young people/families/referrers.

Sample selection and recruitment

Routine service data will be collected from service users accessing the Repair interventions.

[16] Wolpert M., Sharpe H., Humphrey N., Patalay P. & Deighton, J. (2016) *EBPU Logic Model*. London: CAMHS Press

[17] Hoffman, T. et al (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *British Medical Journal*, 348, 1687-1699.

[18] Fixsen et al. (2005). *Implementation research: A synthesis of the literature*. Florida: University of South Florida.

Outcome and experience measures

Data Collection

The following domains using the measures below (which are currently under review and may be subject to change):

1. General mental health collected from service users accessing any of the PPR therapeutic support and programmes for families; e.g., Outcome Rating Scale[19]
2. Quality of life collected from service users accessing one-to-one therapeutic support; e.g., EQ-5D-Y[20]
3. Bespoke questions on the acceptability and satisfaction with the service

Sample selection and recruitment

Recruitment and retention rates will be examined approximately for families accessing specialist interventions, with measures of parent/carer outcome and experience being collected on referral and three months later/on completion of required number of sessions as part of usual practice either online or by telephone. Although one of the aims of the study is to examine the ability to collect baseline and follow up measures, we expect to collect paired baseline and follow up measures from approximately 100 service users.

Staff surveys

Data Collection

Staff surveys will be collected online and will include the following:

1. Trauma-informed knowledge[21] (PPR staff only)
2. Bespoke questions on the acceptability and satisfaction with the service, including training

Sample selection and recruitment

Staff surveys will be collected at two time points from 12 PPR staff and ongoing feedback surveys will be collected from staff in contact with the services, representing 50 children's social care professionals and 25 wider multi-agency staff.

RQ2, RQ3 - Qualitative

Data Collection

In-depth qualitative data will be collected using semi-structured interviews of up to 45 minutes to an hour conducted by the Research Fellow and Research Assistant**.** The interview topic

[19] Miller, S. D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, pp. 91-100.
[20] Wille, N., et al., (2010). Development of the EQ-5D-Y: a child-friendly version of the EQ-5D. *Quality of Life Research, 19(6),* pp. 875-886.
[21] Madden E. E., Scannapieco M., Killian M. O. & Adorno G. (2017) Exploratory Factor Analysis and Reliability of the Child Welfare Trauma-Informed Individual Assessment Tool, *Journal of Public Child Welfare, 11*(1), pp. 58-72, DOI: 10.1080/15548732.2016.1231653

guides (appendices 3 and 4) will be developed with the implementation team and will primarily explore: children's services' journey through the stages of implementation (i.e., exploration and adoption, program installation, initial implementation, full operation, innovation and sustainability); experiences of service delivery; possible mechanisms behind service impact; and perceptions of service impact. Interviews will also explore the barriers and facilitators to implementation (particularly regarding multidisciplinary working), as well as how implementation has differed from TIDIER frameworks, the challenges facing the project and insights into how challenges can be overcome. Particular questions the qualitative data will address are:

- Involvement and engagement of fathers.
- Is the advisory hub a practical model and does it allow social workers the space to think about DA differently?
- Are specific specialist roles perceived to increase practitioner awareness, understanding and response?
- What are families views on data sharing and linkage?

Sample selection and recruitment

To gather data from participants with variation in experiences and perspectives, a heterogeneous sample will be recruited, with job roles varying for staff (e.g., social workers, senior leads, PPR implementers), and contact with the service varying for service users. This will be achieved through publicising the expression of interest of the study across services working with PPR and giving participants a range of ways of expressing interest in taking part in the research (e.g., directly to the research team, online, via PPR staff) and giving participants a range of ways of expressing their views (e.g., through telephone or video call. The sample will include 15 staff, 15 parents/carers, and 15 young people aged 10-18 years.

The sample size was determined based on the research team's extensive experience of conducting similar interviews, with the aim of gathering rich, in-depth data on a range of participants' experiences of delivering and receiving interventions and support.

In summary, pilot data will be captured through:

Data Collection Method	Sample Size	Collection Timeline
Implementation and research log	N/A	January – February 2021
Quantitative – routine service data	All service users referred to the programme	March – December 2021
Quantitative – outcome and measures	Although one of the aims of the study is to examine the ability to collect baseline and follow up measures, we expect to collect paired baseline and follow up measures from approximately 100 service users	March – December 2021

Quantitative – PPR staff surveys	12 PPR programme delivery team staff members	First time point in April 2021; second time point in September 2021
Quantitative – ongoing feedback staff surveys	55 trainees	March - December 2021
Qualitative - semi structured interviews	n=15 staff, 15 parents/carers, and 15 young people	April – December 2021
Feasibility and Cost-analysis assessment	Findings from implementation evaluation; Findings from the quantitative strands of the evaluation; Findings from the qualitative strand of the evaluation.	January – March 2022

Analysis

The findings of the feasibility study will be assessed against the Go/No-Go Criteria. Quantitative data will be analysed using descriptive statics (e.g., mean, standard deviation, 95% confidence interval; proportion, 95% confidence interval) and evidence of promise will be examined by exploring pre-post change in quantitative measures (e.g., using t-tests or chi-square tests, reporting test-statistics including p-values, 95% confidence intervals, and standardized effect sizes).

Qualitative data (i.e. transcripts of recorded interviews) will be analysed using the NVivo qualitative data analysis software, drawing on the framework analysis[22] approach to manage the data and thematic analysis[23] to analyse the data and explore themes across participants' experiences and perspectives. At least two members of staff will be involved and there will be regular coding review meetings throughout the stages of the analysis. This analysis process will involve staff familiarising themselves with the data, checking the accuracy of transcripts, and using descriptive codes to label the data. These codes will help staff develop themes describing patterns across the data, such as consistencies and inconsistencies across different interviewees, which will address and inform research questions 2 and 4. Different reliability processes are available for qualitative data than quantitative data and the research team will adhere to quality standards for establishing the trustworthiness of the data (i.e., credibility, transferability, dependability and confirmability)[24]. Such approaches are commonly used in applied policy evaluations.

Quantitative findings will be triangulated with qualitative findings to answer research question n. 3. This will be done following the Triangulation Design method, a mixed methods approach which aims at achieving different but complementary data on a topic to gain thorough insight

[22] Ritchie J, Lewis J. (2003) *Qualitative research practice: a guide for social science students and researchers*. London: Sage.
[23] Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3* (2). pp. 77-101. ISSN 1478-0887 Available from: http://eprints.uwe.ac.uk/11735
[24] Yardley, L. (2000). Dilemmas in qualitative health research, *Psychology & Health, 15*(2), pp. 215-228, DOI: 10.1080/08870440008400302

in a research question[25]. This method combines contrasting strengths and non-overlapping weaknesses of quantitative methods (such as large sample size, trends, generalisation) with those of qualitative methods (such as small sample size, details, in depth)[25]. Indeed, we would like to use this method to expand quantitative findings with qualitative data to explore whether there is promise for Lewisham's PPR. Similarly, we will also triangulate the implementation and research log data with qualitative findings to answer research question n. 2 which investigates whether Lewisham's PPR has been implemented as planned.

RQ 4: Cost Evaluation - the value of outcomes

The partial, light touch cost utility economic analysis aims to answer the following questions in the pre trail, feasibility phase:

Can the cost-effectiveness of PPR be analysed?

a) Can the data for cost-effectiveness be collected?
b) Can the data from the trial inform the cost-effectiveness analysis?
c) What threshold would be needed to determine PPR is cost-effective?

Cost-utility analysis is a form of cost-effectiveness analysis that uses utility as a common outcome. Utilities measure preferences under uncertainty, which is appropriate for PPR interventions as future health is uncertain. The preferred measure used in the UK is the quality-adjusted life year (QALY).[26]This utility measure allows us to consider both people's quality of life and the length of life they will gain as a result of a care intervention, with one year in perfect health being equal to one QALY. Expressing health benefits in this well-established methodological approach with QALYs allows comparisons between different client groups and PPR like interventions and enables the value of the investment and improvement in clients to be considered.

In order to include care outcomes in an economic evaluation we require QALY data on the time spent in each state of wellbeing. From this it is possible to measure the QALY gain of additional time spent in the improved state of wellbeing over a given time period. In the feasibility phase proxy EQ-5 and self-report EQ-5-DY data is being collected (e.g. for one to one work with therapeutic support).

For a standard economic evaluation, the cost-effectiveness of an intervention is compared to the next best alternative:

$$\frac{Incremental\ cost\ A\ compared\ to\ B}{Incremental\ Effect\ A\ compared\ to\ B} = Incremental\ Cost\ Effectiveness\ Ratio\ (ICER)$$

The standard decision rule for care in the UK is that the ICER would be considered cost - effective if it is below £20,000 per QALY gained[Error! Bookmark not defined.]. This means the local tax payer would be willing to pay £20,000 for an intervention that improves wellbeing outcomes equivalent to one year of life in full health.

[25] Creswell, J. W., & Plano Clark, V. L. (2011*). Choosing a mixed methods design. Designing and conducting mixed methods research, 2,* 53-106.
[26] National Institute for Health and Care Excellence (NICE) (2012). *The guidelines manual* 1-199. Available from: https://www.nice.org.uk/process/pmg6/resources/the-guidelines-manual-pdf-2007970804933

So, it is possible to work backwards from the formula above and ask the question 'how effective would the intervention need to be to be considered cost effective? In other words what would good look like and are we willing to pay for it?

$$\frac{Incremental\ cost\ A\ compared\ to\ B}{ICER\ (£20{,}000)} = Incremental\ effect\ A\ compared\ to\ B$$

This approach is useful to decision and policy makers, especially in feasibility phase of a trail, as it aims to simply estimate the scale of improvements required for an intervention like PPR to be of value.

A social perspective will be taken in the evaluation using Personal Social Services (PSS). As we are concerned with incremental costs, the new investment cost of PPR will be used as a cost, the significant proportion of it being staff time. Standard methodology will be used to assess costs using the Unit costs are reported annually by the Personal Social Services Research Unit (www.pssru.ac.uk) to enable economic analysis. The costs of social care staff time (including employer on costs and overheads) will be estimated in targeted PPR interventions where an outcome is being measured (e.g. one-to-one support). Where appropriate, other new resources items such as travel and room costs will be included. Grade, length of a session with a client/family, and number of sessions will be sampled via discussion with the implementation team and their knowledge of the intervention. Published unit cost will then be applied to estimate the cost of PPR interventions where an outcome is anticipated, and effective change is demonstrated, to inform the cost effectiveness analysis. The results of the feasibility phase will subsequently inform the need and usefulness of further targeted cost data collection, or alternatively comprehensive cost surveys, in the trial phase.

Ethics

Ethical Consideration	Mitigation
Research ethics and governance	Ethics approval has been obtained from the University College London Research Ethics Committee. Research will adhere to relevant guidelines, including the Declaration of Helsinki and research and governance frameworks.
Interviews with vulnerable groups and sensitive topics	The research team has considerable expertise and specialist knowledge in the fields associated with this study. The Centre has extensive clinical experience of working with young people with complex psychological and mental health difficulties often underpinned by neuro-disabilities, developmental trauma and complex socio/economic, familial, educational and wider care context. We will work with Lewisham PPR to identify appropriate resources to signpost participants to if they feel distressed, in which case participants may be advised to withdraw, continue, or take a break. Questionnaires and interviews will be carefully piloted (e.g., by parents/carers with lived experience) to anticipate such distress as rare.

Safeguarding	The research team will work to safeguard procedures of Lewisham PPR and the Centre. All researchers have child protection and safeguarding (Level 1 and 2) training and Disclosure and Barring approvals.
Participants feel pressure to take part in interviews	Information sheets and consent forms will be based on ones previously used, developed with families, outlining: a) why we are doing the research, b) what will happen to them and their data if they agree to participate, c) that participation is voluntary, and refusal will not impact their care or rights, and d) they are free to withdraw at any time: “You can contact us using the contact details included at the top of this notice to make such a request. The only exception to this is where we have already included your data in our analysis – at this point your data would have been combined with all the other data, and it wouldn’t be possible for us to remove yours from the analysis”. (please see privacy notice). For children under 16 years, assent will be recorded, and parent/carer consent will be recorded.
Confidentiality and anonymity	Participants will be informed that participation is anonymous and confidential, only to be broken if something they say puts themselves or others at risk, and participant safety will override confidentiality. Researchers will work in accordance with our and local safeguarding policies.
Participants disclose difficulties not known to the clinical team or problems with care received or staff report work practices that are not in line with best practice	The precise response to such situations will be agreed with the site and approved by the ethics committee. We will use a safeguarding risk log outlining how safeguarding issues will be managed. The PI will be immediately notified of any adverse events, which will be recorded and escalated in line with standard procedures, notifying the participant's team.

Data Protection

Potential participants will be given an expression of interest form by PPR staff (e.g., Microsoft Forms) and asked to either contact the research team or include their contact details in the expression of interest form for the research team to contact them. Contact details will be stored separately to other research data. Consent forms and questionnaires will be collected online (e.g., Microsoft Forms on the secure folders at AFNNCF). Interviews will be conducted remotely (e.g., using Teams). Audio files will be securely sent to an external transcription service, with whom there is an existing data sharing agreement in place. All computerised data will be stored under password protection in the secure folders at the AFNCCF. Data will be stored and managed in line with the AFNNCF Information Governance policy and in accordance with data protection legislations (e.g., General Data Protection Regulations, Data Protection Act 2018) (ICO Registration Number: Z479393X). As outlined in the Data Protection Impact Assessment for this project, the legal basis for processing these data for the research project is performance of a task in the public interest (Article 6 (1)(e) and Article 9(2)(j) of the

General Data Protection Regulation). This means that personal data can be processed where necessary for the performance of a task carried out in the public interest. In this case it is to carry out research and inform future health provision. Please see privacy notice for this project in the appendix 2. The Anna Freud Centre, also known as the Anna Freud National Centre for Children and Families, is the data controller for this data processing. What Works for Children's Social Care, who is funding the study, is also a data controller. Our Data Protection Officer is Susan Henry, DPO@annafreud.org 020 7794 2313

Personnel

- **Dr Julian Edbrooke-Childs.** Role and responsibilities: PI. Overall leadership, ensure project is on time and on budget, main link with WWCSC, spokesperson. Dr Julian Edbrooke-Childs will be the point of contact for all communications. Julian will be responsible for providing monthly written updates of progress against project deliverables and agreed Key Performance Indicators, as well as for raising any issues or risks in a timely fashion.
- **Prof. Jess Deighton.** Role and responsibilities: Strategic Lead. Senior oversight and quality assurance and input and advice on trial methodology and conduct. Affiliation: Professor in Child Mental Health and Wellbeing, UCL; Director, Evidence Based Practice Unit.
- **Dr Emily Stapley.** Role and responsibilities: Research Fellow. Operational management of the qualitative research, including day-to-day running of this strand and support and management of the Research Assistant. Affiliation: EBPU (as above).
- **Wendy Riches.** Role and responsibilities: Economist providing advice and development of the cost analysis aligning with prioritised aspects of the logic model to support the feasibility stage. Developing 'what if?' threshold analysis to provide an indication of how effective the intervention would need to be for example in terms of improved family and child outcomes for it to be considered cost-effective.
- **Dr Roz Ullman.** Role and responsibilities: Senior researcher. Research support for the health economics component of the project including identifying values for cost data, both from published and local primary sources, and analysis of cost-related primary data e.g. from staff survey questions.
- **Giulia Ravaccia.** Role and responsibilities: Research Assistant. Assisting PI and Research Fellow in research duties. Evidence Based Practice Unit.

Risks

This section outlines the risks to the anticipated risks that may arise and steps that will be taken to mitigate against these.

Risk	Mitigation
COVID-19	The study has been designed to be delivered entirely remotely. Restrictions to movement and sickness may impact the delivery of the intervention and the study. In particular, we have set the study up, in accordance with our Business Continuity Planning, to ensure there is clear handover and cover in the case of research staff absence. In terms of the PPR intervention, though much of this can be delivered virtually, this may reduce the total number of families benefitting. If delivery of the intervention is delayed, we will discuss extending the evaluation timelines with the funders.

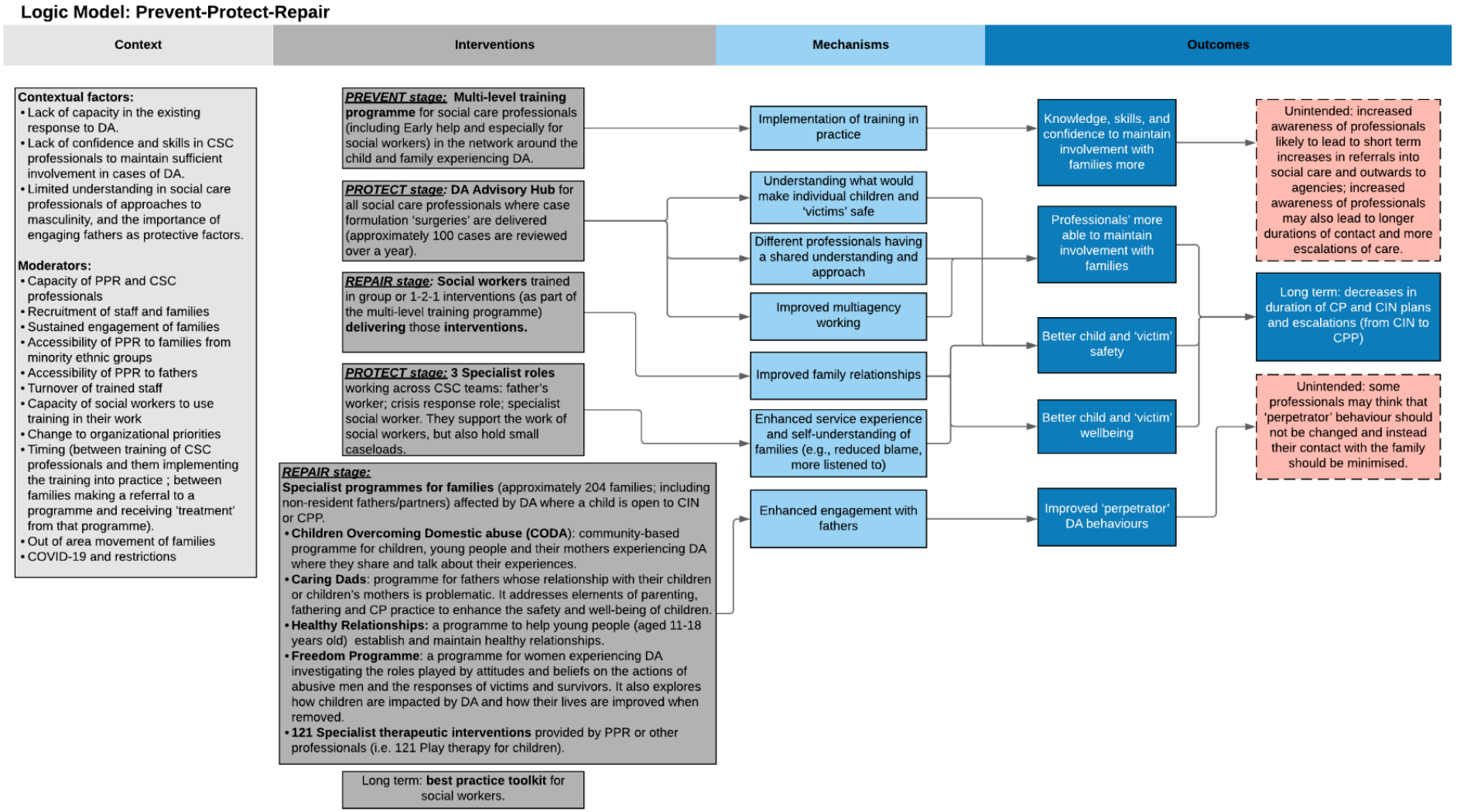
Brexit	As this is a study solely in the UK, we are not anticipating any changes or implications in relation to Brexit. We will follow and update our data processing arrangements in light of any changes to UK GDPR.
Recruitment and turnover of staff	Recruitment of PPR staff is progressing well and is on track for the agreed timescales. The implementation team has also included clear contingency arrangements for staff turnover (i.e., detailed handover documentation and dedicated staff for this)
Recruitment of families	The study is being designed with parent/carer involvement. Questionnaires (approx. 10-15 mins) are as short as possible, and we have chosen questionnaires and designed the interview questions to meet the particular needs of young people, so it does not seem a difficult task to them.
Recruitment of staff to the evaluation	There is a strong relationship between the evaluation and implementation teams and the evaluation has been co-produced to ensure it is deliverable within practice. Evaluation methods will be covered with new staff in introductory training and materials.
Overrunning timelines	Given our extensive experience of conducting research in similar settings, we are confident in our ability to deliver the study to time and target.

Timeline

Phase	Timing	Lead
Agreement of funding and contracts	Dec. 2020	JEC/WWCSC
Steering group meeting to establish Go/No-Go criteria, Logic Model and TiDIER, Ethics approval, PPI workshop on study design data collection	Jan. 2021	JEC
Pre-registration of protocol, implementation and research data collection begins	Mar. 2021	JEC
Quantitative data collection begins, PPI workshop on qualitative data collection	Mar. 2021	GR
Stakeholder workshop on economic data. Interviews and focus groups	Apr. 2021	WR
Interviews and focus groups	May-Dec.21	ES
Quantitative data collection ends	Dec. 2021	GR
Analysis	Jan.-Mar. 2021	JEC

Analysis and write up	Jan.-Mar. 2022	JEC
PPI workshop on analytic interpretation & reporting. Steering group meeting to agree Go/No-Go criteria findings	Feb. 2022	GR
Final report	Mar. 2022	JEC

Appendix 1: Logic Model



Appendix 2: Privacy Notice

Privacy Notice

This notice is to outline the basis for data processing for this research project and to outline your rights with respect to processing of those data. These rights are as set out in the General Data Protection Regulation (GDPR), which superseded the Data Protection Act from May 2018.

1. Who we are

The Anna Freud Centre, also known as the Anna Freud National Centre for Children and Families, is a registered mental health charity, and is the data controller for this data processing. What Works for Children's Social Care, who is funding the study, is also a data controller. This notice informs you how we may use the personal data we collect from families who participate in this study. If you have any questions about the content of this notice you can contact us at:

- Julian Edbrooke-Childs: julian.edbrooke-childs@annafreud.org
- Write to us: Anna Freud National Centre for Children and Families, 4-8 Rodney Street, London N1 9JH.
- Our Data Protection Officer is Susan Henry, DPO@annafreud.org 020 7794 2313

2. Purpose of the processing and the lawful basis for the processing

We are collecting your personal data to enable us to conduct a research study, which evaluates the Lewisham Prevent-Protect-Repair service. This will help us to understand whether the service works to help improve family relationships and how to improve the service in the future. We collect data about you at the start, to ensure that the service is appropriate for you. The information you provide during the study will be used to understand more about whether and how your family relationships change whilst you are receiving the service. Your participation and data will not affect your rights or access of the service.

This research project will hold up to 3 types of your data:

- Your interview audio recording and (anonymised) interview transcript
- Your survey data
- Your name and contact details
- Your gender and ethnic identities

The legal basis for processing these data for the research project is performance of a task in the public interest (Article 6 (1)(e) and Article 9(2)(j) of the General Data Protection Regulation). This means that personal data can be processed where necessary for the performance of a task carried out in the public interest. In this case it is to carry out research and inform future health provision.

3. Who we share your data with

We will not be transferring any identifiable information outside the UK and will be taking appropriate measures to ensure it remains secure at all times. If we ask a different organisation to transcribe the recordings for us, we will make sure that this organisation also keeps your interview strictly confidential.

4. How long we retain your data

Your data will be held securely until the end of the research study, December 2021, after which it will be anonymised and kept for up to 10 years for research purposes. Then we review it before secure disposal.

5. Your data rights

Under data protection law, you have rights we want to make you aware of. The rights available to you depend on our reason for processing your information and may only apply in certain circumstances. You can check the Information Commissioner's website for more detail or contact the DPO.

The General Data Protection Regulation is designed to protect and support the following personal data rights for everyone in the UK:

- **The right to be informed**
  - about who is processing your data, this is set out at the bottom of this note.
- **The right of access**
  - to understand what is being collected and how it is being used, a Subject Access Request.
- **The right to correct data**
  - the right to correct incorrect records
- **The right to be forgotten**
  - the right to request that data is removed/deleted
- **The right to restrict processing**
  - the right to request that data be held but not processed unless necessary
- **The right to data portability**
  - the right to a copy of your data in a useable format
- **The right to object**
  - you may object to your data being processed although this does not apply to the processing of data for research purposes, as in this instance.

You are not required to pay a charge for exercising your rights. We generally have one month within which to respond to your request.

Please contact us at DPO@annafreud.org if you wish to make a request with regard to any of your rights.

6. Ethics Consent

In addition to these data protection rights we also consider your ethical rights. This evaluation has been approved by the UCL Research Ethics Committee [Project ID Number: TBC] and as part of that approval process we are required to have your consent for your participation in this evaluation.

If you, at any time, want to withdraw from the evaluation we will respect that decision and cease to use your data. You can contact us using the contact details included at the top of this notice to make such a request. The only exception to this is where we have already included your data in our analysis – at this point your data would have been combined with all the other data, and it wouldn't be possible for us to remove yours from the analysis.

7. Making a complaint

If you feel we may not be handling your data appropriately or if you have any queries or concerns about this you can contact us, dpo@annafreud.org.

You can also, at any time, make a complaint about our processing of your data to the Information Commissioner, https://ico.org.uk/global/contact-us.

8. Obligation to provide data and automated decision making

You can choose to participate in the study, in which case we do require your data. We do not use profiling or automated decision making when processing your data for any purpose.

This notice was last updated on 05/02/2021

Appendix 3: Topic Guide for Professionals interviews

Topic Guide for Professionals interviews: Experiences of Lewisham's Prevent-Protect-Repair

- Welcome and introductions
- Questions about the study and confirmation of consent
- How Lewisham's Prevent-Protect-Repair programme and training has been accessed, if at all, including examples of times it was used
- Impact or changes noticed in the service after engaging with Lewisham's Prevent-Protect-Repair programme and training
- Reasons for impact or changes noticed in the service after engaging with Lewisham's Prevent-Protect-Repair programme and training
- Changes noticed in timing of referral to support after engaging with Lewisham's Prevent-Protect-Repair programme and training
- Experiences of improving 'perpetrator' behaviour after engaging with Lewisham's Prevent-Protect-Repair programme and training
- Views on changing 'perpetrator' behaviour after engaging with Lewisham's Prevent-Protect-Repair programme and training
- Information from Lewisham's Prevent-Protect-Repair that would be helpful to access, how it could be most readily accessible, and who should have access to such information
- Views and experiences on the capacity to use the Lewisham's Prevent-Protect-Repair training in practice
- Views and experiences on the timing between Lewisham's Prevent-Protect-Repair training and its practice
- Views and experiences on the practical applications of the Lewisham's Prevent-Protect-Repair training
- Views and experiences on barriers of the Lewisham' Prevent-Protect-Repair programme and training, especially regarding multi-disciplinary working
- Views and experiences on facilitators of the Lewisham' Prevent-Protect-Repair programme and training, especially regarding multi-disciplinary working
- Views and experiences on whether the advisory hub is a practical model
- Views and experiences on whether the advisory hub allows social workers the space to think about domestic abuse differently
- Future changes to Lewisham's Prevent-Protect-Repair and how it could be improved
- Questions about the study, thanks, and close

Appendix 4: Topic Guide for CYP and Parent/Carer interviews

Topic Guide for CYP and Parent/Carer interviews: Experiences of Lewisham's Prevent-Protect-Repair

- Welcome and introductions
- Introduction: ***We are interested in your views and experiences of the Lewisham's PPR programmes and not in your reasons for coming into contact with the service***
- Questions about the study and confirmation of consent
- How Lewisham's Prevent-Protect-Repair programmes have been accessed, if at all, including examples of times it was used
- Impact or changes noticed in the service after engaging with Lewisham's Prevent-Protect-Repair programmes
- Reasons for impact or changes noticed in the service after engaging with Lewisham's Prevent-Protect-Repair programmes
- Changes noticed in timing of referral to support after engaging with Lewisham's Prevent-Protect-Repair programmes
- Information from Lewisham's Prevent-Protect-Repair that would be helpful to access, how it could be most readily accessible, and who should have access to such information
- Views and experiences of the involvement and engagement with fathers after engaging with Lewisham's Prevent-Protect-Repair programmes
- Future changes to Lewisham's Prevent-Protect-Repair programmes and how they could be improved
- Questions about the study, thanks, and close

Appendix 5: Advertisement and Contact Form - Professionals

Advertisement and Contact Form - Professionals

Are you interested in sharing your experiences of Lewisham's Prevent-Protect-Repair?

Have you used Lewisham's Prevent-Protect-Repair?

What do you think of it?

How could it be improved?

We want to find out what you think about a Lewisham's Prevent-Protect-Repair. We think it is really important to give people like you a chance to be heard, and we want to hear in your own words about what matters to you.

What's involved?

Are you a professional delivering or accessing Lewisham's Prevent-Protect-Repair?

Do you want to take part in a survey about Lewisham's Prevent-Protect-Repair (15 minutes)?

Do you want to take part in an interview discussion about Lewisham's Prevent-Protect-Repair (30-60 mins)?

After reading more about what is involved and agreeing to take part, we will contact you to arrange a time to speak.

Get in touch!

If you're interested and for more information, please click this link [insert link to information sheet] or return the form below and email Giulia.Ravaccia@annafreud.org.

Who are we?

This research is insured by University College London and funded by the What Works Centre for Children's Social Care. The research is being carried out by researchers at the Evidence Based Practice Unit, based at University College London. This research has been reviewed and approved by University College London Research Ethics Committee (ref.: 14037/006).

_____	_____	_____
My name	Phone number	Email address

Advertisement and Contact Form - CYP and Parents/Carers

Are you interested in sharing your experiences of Lewisham's Prevent-Protect-Repair?

Have you used Lewisham's Prevent-Protect-Repair?

What do you think of it?

How could it be improved?

We want to find out what you think about a Lewisham's Prevent-Protect-Repair. We think it is really important to give people like you a chance to be heard, and we want to hear in your own words about what matters to you.

What's involved?

Are you a family accessing Lewisham's Prevent-Protect-Repair?

Do you want to take part in an interview discussion about Lewisham's Prevent-Protect-Repair (30-60 mins)?

There will be a £15 voucher reimbursement for your participation!

If you decide to withdraw at any point from the study, this will not forfeit your voucher.

After reading more about what is involved and agreeing to take part, we will contact you to arrange a time to speak.

Get in touch!

If you're interested and for more information, please click this link [insert link to information sheet] or return the form below and email Giulia.Ravaccia@annafreud.org.

Who are we?

This research is insured by University College London and funded by the What Works Centre for Children's Social Care. The research is being carried out by researchers at the Evidence Based Practice Unit, based at University College London. This research has been reviewed and approved by University College London Research Ethics Committee (ref.: 14037/006).

_____	_____	_____
My name	Phone number	Email address

Appendix 7: TiDIER (Template for Intervention Description and Replication)

Intervention Description Worksheet
Lewisham PREVENT-PROTECT-REPAIR (16.03.21)

The following questions have been adapted from the template for intervention description and replication (TIDieR) checklist and guide (Hoffman et al, 2014). Please provide a few sentences on each.

1. **Brief name: provide the name or phrase that describes your intervention**

   Lewisham PREVENT-PROTECT-REPAIR (PPR)

2. **Why: describe any rationale, theory, or goal of the elements essential to the intervention**

- Intervention consisting of a three-stage programme
- Aims to develop the skills, confidence and capacity within Children's Social Care (CSC) teams responding to domestic abuse (DA)
- Specifically aims to enable non-DA specialist professionals to identify, record and report DA by understanding the effects of DA on children and families, directly providing evidence-based support, and considering the role of fathers for risk and protective factors.
- The three stages of the programme are:

1. **Prevent** (awareness raising and identification phase).
   - Ensures that social care professionals are aware of the effects of DA in children, are able to identify these effects, and are able to effectively offer support.
   - Involves a multi-level training programme (approximately 55 staff, the majority of which are social workers) and analytical review of existing CP cases. Training includes Children Overcoming Domestic Abuse (CODA), Caring Dads, The Freedom Programme, Escape the Trap and Trauma Informed and Restorative Practice. Staff are trained to go on to directly deliver evidence-based interventions to families. Escape the Trap provides practitioners with an understanding of the complex dynamics of teenage relationship abuse, grooming & CSE.

2. **Protect** (response phase)
   - Provides a DA Advisory Hub of specialist professionals offering case formulation panels and 'surgeries' for social care professionals. In this hub three-five cases can be discussed per session, totalling to approximately 100 cases reviewed over the course of a year. This hub also aims to develop social workers' vocabulary and tools for responding to DA.
   - Creates new specialist roles in response to identified gaps. These roles will be strategic leads across CSC teams and will include: a father's worker; a crisis response (IGVA) role; and a specialist social worker. These staff will

work support the work of social workers, but also hold small caseloads. We expect them to support approx. 65 families with one-to-one work.

3. **Repair** (therapeutic phase)
   - Offers a range of interventions for families experiencing DA (approx. 204 families).
   - Provides individual 121 therapeutic support for all family members experiencing DA (i.e. play therapy for CYP).
   - Provides group therapeutic support for all family members experiencing DA:
     i. Children Overcoming Domestic Abuse (CODA) for young people and their mothers who experienced DA.
     ii. Caring Dads for fathers who have abused, neglected or exposed their children to domestic abuse.
     iii. Freedom Programme for women who experienced DA.
     iv. Healthy Relationships Programme delivered in schools for 14-18 year olds at risk of experiencing DA

3. What (materials): describe any physical or informational materials used in the intervention, including those provided to participants, used in intervention delivery, and/or training of intervention providers

- Training material provided to professionals attending the multi-level training programme in the **Prevent** stage.
- Training material provided to professionals attending the DA Advisory Hub in the **Protect** stage.
- Materials provided to fathers attending the Caring Dads programme.
- Material provided to mothers attending the CODA programme.
- Material provided to children and young people attending the CODA programme.
- Material provided to young people attending Healthy Relationships programme.
- Material provided to women attending the Freedom programme.
- Outcome Rating Scale (ORS) measuring general mental health, collected from service users accessing any of the PPR therapeutic support and programmes for families.
- Feedback questionnaire from fathers attending the Caring Dads programme.
- Feedback questionnaire from mothers attending the CODA programme.
- Feedback questionnaire from children and young people attending the CODA programme.
- Feedback questionnaire from young people attending the Healthy Relationships programme.
- EQ-5D-Y measuring quality of life collected from service users accessing one-to-one therapeutic support.
- Bespoke questions on the acceptability and satisfaction with the service, collected from service users
- Trauma-informed Knowledge from PPR staff.

- Bespoke questions on the acceptability and satisfaction with the service, including training, from staff.
- Feedback survey from DA Hub attendees.

4. **What (procedures): Describe each of the procedures, activities and/or processes used in the intervention, including any enabling or support activities**

    - PPR staff will invite social care professionals to attend the multilevel training programmes. A number of these equip staff to become facilitators of group programmes for families. Following training, groups for families will be set up and delivered by the trained staff.
    - Social workers are invited to anonymously submit cases to the DA Advisory Hub for discussion. They are given a 45 minute slot to discuss their case with specialist multi-agency professionals, and given recommendations for action with the families.
    - Families are referred from the PPR service to individual specialist support with one of the three specialist workers and/or to different group interventions.
    - Women attending the Freedom Programme enrol in a 12 weeks free course where roles played by attitudes and beliefs on the actions of abusive men and the responses of victims and survivors are investigated. How children are impacted by DA and how their lives are improved when removed, is also explored in the course.
    - Young people attending the Healthy Relationships Programme enrol in a 12-month programme consisting of 8 weekly workshops up to 2 hours duration, with quarterly tracking.
    - Fathers attending the Caring Dads programme, take part in a group programme of 10 to 15 fathers, which runs for 2 hours, one night a week, for 17 weeks. The programme addresses elements of parenting, fathering, battering and child protection practice to enhance the safety and well-being of children.
    - Women and children attending the CODA programme enroll in a 12 week programme that seeks to: validate the children's experiences; reduce the self-blame that is commonly associated with children experiencing abuse; develop a child-appropriate safety plan; manage appropriate and inappropriate expressions of emotions; enhance the mother-child relationship; enable both the mother and child to heal together.
    - Children and young people attending Play Therapy receive 20 one-hour sessions in a safe, private and confidential space to explore and process their experiences through the medium of play.

5. **Who provides: For each intervention provider (e.g. teacher, psychologist, youth worker), describe their expertise, background and any specific training given)**

    - External trainers run the multi-level training

- A PPR Programme Co-ordinator runs the DA Advisory hub and the hub is staffed by the three specialist workers plus a coercive control expert.
- Trained facilitators run the CODA programme
- Trained facilitators run the Caring Dads programme
- Trained facilitators run the Freedom programme
- Trained facilitators run the Healthy Relationships programme
- An independent provider provides individual specialised 121 therapeutic support (i.e. play therapy).
- Specialist roles such as a father's worker; a crisis response role; and a specialist social worker, all provide advisory support to social workers and 121 casework with families experiencing DA

6. Who receives: Provide a description of the target population for the intervention

- Social care professionals who are non-specialists in responding to DA.
- Families who experienced DA in the London borough of Lewisham. The majority will be on Child in Need or Child Protection Plans.

7. How: Describe the mode(s) of delivery (e.g. face to face) of the intervention and whether it is provided individually or in a group

- Some interventions are delivered in groups (CODA, Freedom Programme, Caring Dads, and Healthy Relationships Programme) and some are delivered on a one-to-one basis (casework with specialist workers, play therapy, 121 versions of CODA, and 121 versions of Caring Dads).
- At the start of the project, any group interventions will be delivered virtually using MS Teams or Zoom. In normal times, these would all be delivered face to face (in line with local and national guidelines), and this is the aim for the latter stages of the project.
- The majority of 121 interventions will be delivered face to face, unless virtual is more appropriate.

8. Where: Describe the type(s) of location(s) where the intervention occurs, including any necessary infrastructure or relevant features

- Ordinarily (pre-COVID), intervention occurs in a Children and Family Centre and/or other community-based settings (in line with local and national guidelines). At the moment, interventions will occur virtually via MS Teams or Zoom.
- Robust safety planning and risk assessments are conducted to ensure that intervention is delivered securely and safely.

9. When and how much: Describe the number of times the intervention is to be delivered and over what period of time including (if applicable) the number of sessions, their schedule, and their duration, intensity or dose

Training programmes:

- 1x course of the The Freedom Programme training for 20 delegates
- 2x courses of the CODA training for 16 delegates
- 1x course of Caring Dads group training for 16 delegates
- 1x course of 121 Working with Fathers training for 16 delegates
- 1x course of Escape the TRAP training for 20 delegates
- 2x courses of Trauma Informed and Restorative Practice training for 12 delegates

DA Advisory Hub:

- 24 sessions over the course of the year. Fortnightly for 4 hours with a pre-meet and debrief
- 3-5 cases discussed each week. Approx. 100 over the course of the year

Group Programmes:

- Women attending the Freedom Programme enrol in a free course lasting 12 weeks.
- Young people attending the Healthy Relationships Programme enrol in a 12-month programme consisting of 8 weekly workshops up to 2 hours duration, with quarterly tracking.
- Fathers attending the Caring Dads enrol which runs for 2 hours, one night a week, for 17 weeks.
- Women and children attending the CODA programme enroll in a concurrent programme lasting 12 weeks.

One to one work:

- Specialised therapeutic 121 sessions will run as required depending on need

3x specialist workers hold small caseloads, seeing approximately 65 families (between them) over the course of the year, as required by families depending on need

10. Tailoring: If the intervention is planned to be personalised or adapted, then describe what, why, when and how

- DA Advisory Hub – As this is a new and innovative model for Lewisham, delivery of the intervention will need to be adapted over the course of the year in response to testing.
- Group interventions – These may need to be adapted as the COVID pandemic means that virtual work is necessary, which in some cases means fewer families accessing groups

References:

Hoffman, T. et al (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *British Medical Journal*, 348, 1687-1699. Available at: www.bmj.com/content/348/bmj.g1687