EVALUATION REPORT

RISE Mutual CIC: Child to Parent Violence Programme

Feasibility and pilot study report

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University of Hertfordshire UH
YOUTH ENDOWMENT FUND

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About the Evaluator

This independent report, funded by YEF, has been produced by a multi-disciplinary team based at the University of Hertfordshire (UH). The UH evaluation team has proven knowledge and competence in the field of youth violence and crime, and considerable experience conducting research involving vulnerable and at-risk children and families and evaluating the feasibility of different projects.

As members of YEF's Evaluation Panel with responsibility for evaluating four launch grant round family-focused projects, the programme of work was led by Professor Joanna R Adler as Principal Investigator, with Professor Brian Littlechild, Dr David Wellsted and Dr Tim McSweeney as Co-Investigators. Dr Muna Sabbagh assisted during feasibility fieldwork. Dr Caroline Cresswell joined the team during the pilot evaluation, leading on qualitative analyses of fieldwork thereafter. Natalie Hall and Amanda Busby from UH's Centre for Health Services and Clinical Research facilitated training for the RISE team in the use of REDCap, oversaw processes to enable data capture and conducted analysis of YEF's core measures data – collected by the intervention staff using the software.

If you notice inaccuracies in this document, please report them to Professor Joanna R Adler: J.R.Adler@herts.ac.uk

List of abbreviations

ASD	Autism Spectrum Disorder
BMSLSS	Brief Multi-Dimensional Students Life Satisfaction Scale
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPV	Child to Parent Violence.
CRIES-8	Children’s Revised Impact of Events Scale-Eight item
DSA	Data Sharing Agreement
ESYTC	Edinburgh Study of Youth Transitions (sweep 3 measure used)
GDPR	General Data Protection Regulation
IES-R	Impact of Events Scale-Revised
NICE	National Institute for Health and Care Excellence
NVR	Non-Violent Resistance
PTSD	Post Traumatic Stress Disorder
REDCap	Research Evaluation Data Capture system
SCORE 15	SCORE 15 Index of Family Functioning and Change
TIC/A	Trauma Informed Care/Approach
SDQ	Strengths and Difficulties Questionnaire
UH	University of Hertfordshire
YEF	Youth Endowment Fund

Executive Summary

The project

The Child to Parent Violence (CPV) programme aims to improve the behaviour of violent 10–14-year-olds by showing their parents and carers techniques to de-escalate and avoid violence. Young people who have been violent towards their parents/carers may be referred to the programme by social workers, schools, Child and Adolescent Mental Health Services, family intervention workers and early help teams. Delivered by RISE Mutual CIC, the intervention provides sessions to parents/carers. If judged appropriate, separate sessions are then delivered to children, with up to 20 home-based sessions implemented with families. Work with parents teaches non-violent resistance (NVR) techniques, including reconciliation methods. Sessions with children use cognitive behavioural therapy (CBT) techniques that aim to change negative behaviours. The content of the programme is tailored to the specific needs presented by each young person.

YEF funded a feasibility and pilot evaluation of the CPV programme. The feasibility phase of the evaluation aimed to ascertain what factors supported or interfered with the successful delivery of the programme; whether the intervention's recruitment, retention and reach were feasible; and service users' views and experiences of the intervention. The pilot study then aimed to describe the referral and screening process, assess family retention, ascertain the readiness for a larger-scale evaluation, evaluate the implementation process, and assess the direction and magnitude of changes in child behaviour and family-functioning outcomes over time. By the end of the feasibility phase, 90 families had been enrolled to the CPV programme, and over both phases, 104 families (107 children) were enrolled. Eleven participants (including six RISE practitioners, three referrers and two parents/carers) took part in interviews for the feasibility study. For the pilot study, 15 participants (including five participants with parental responsibility, three referrers and seven RISE members of staff) were interviewed, and quantitative data for the 104 families involved were analysed. Data initially collected related to the delivery of the programme, demographic data and some core measures (including the Strengths and Difficulties Questionnaire [SDQ], a measure of behaviour, and the SCORE 15 Index of Family Functioning and Change). The SCORE 15 was dropped during the feasibility phase. The evaluation was undertaken from February 2020–June 2022. Both evaluation phases took place during the COVID-19 pandemic, requiring both the delivery and evaluation teams to adapt to challenging circumstances.

Key conclusions
In the feasibility study, delivery of the CPV programme was supported by the regular exchange of information between referrers and RISE practitioners. Referrers were positive about the planning and communication from RISE staff and appreciated being updated on the progress of families. RISE project staff reported that non-judgemental, supportive approaches were important for facilitating delivery. They also observed that many families had very complex needs beyond those initially anticipated.
In the feasibility study, most of the referrals met the eligibility criteria. Demand for the intervention was high, while initial enrolment and retention rates were promising. The two parent/carers interviewed gave very positive comments about the attentive and flexible support provided. Staff, referrers and parents also noted that the blended model of phone calls and face-to-face meetings imposed as a result of COVID-19 restrictions worked well.
In the pilot study, retention in the intervention was high, with 76% of enrolled families completing the programme. However, core measure completion was a serious challenge. Less than half of families provided SDQ data after 12 months. COVID-19 contributed to challenges with data collection. However, even in this context, data collection was low.
The pilot study found that the referral and screening processes worked well, and the programme was largely delivered as intended for parents. Children's perceptions of the CPV programme, and the implementation of the child-focused components, could not be assessed due to their limited engagement in the intervention and non-engagement with the evaluation.
The evaluator judges that the CPV programme has the potential to be evaluated in a large-scale randomised controlled trial. However, several issues require resolving before proceeding, including improving measure completion rates.

Interpretation

In the feasibility study, delivery of the CPV programme was supported by the regular exchange of information between referrers and RISE practitioners. The three referrers interviewed were positive about the planning and communication from RISE staff and appreciated being updated on the progress of families. Referrers also mentioned that they had seen positive changes in families they had worked with and were very satisfied with what had happened for families in the intervention. RISE project staff reflected that non-judgemental, supportive approaches were also seen to be important for facilitating delivery. RISE project staff reflected that many families had very complex needs, which required additional inter-agency collaboration. Indeed, many of these needs (such as involvement in county lines criminal exploitation, drug misuse, staying out overnight, autism spectrum disorder, attention deficit hyperactivity disorder or oppositional defiance disorder) were greater than had been anticipated.

In the feasibility phase, most of the referrals met the eligibility criteria. Demand for the intervention was high, while initial enrolment and retention rates were promising. The two parents interviewed gave very positive comments about the attentive and flexible support provided. They felt respected by the RISE staff and would recommend the programme to other parents. Staff, referrers and parents also noted how the blended model (combining phone and video calls with face-to-face meetings when possible) imposed as a result of COVID-19 restrictions worked well.

In the pilot study, retention in the intervention was high, with 81 of 107 (76%) enrolled young people and their families completing the programme. However, data collection was a serious challenge. Only two children competed the child outcome measures, and the maximum number of families providing data at follow-up was 17 (16%) at six months and 47 (44% of those enrolled) at 12 months. Where data were collected from parent-reported measures, there were improvements in behaviour and family functioning. However, without a counterfactual group that did not receive the CPV programme, we are unable to be sure that all positive effects are attributable to the programme.

The pilot study found that the referral and screening processes worked well. One hundred and seven young people were initially enrolled following the referral of 170 families. For most, time from referral to enrolment was rapid (ranging from two to 14 days), and there appears to be very little risk of bias in the process. The programme was also largely delivered as intended for parents. An average of 15 sessions were received by those families who completed the programme (in line with the 'up to 20' offered), and sessions appeared to support parents and carers to consider practical NVR, de-escalation techniques and different affirmation strategies to improve children's behaviour. In addition, across interviews with parent/carers and professionals, it was commonly reported that the programme of support was flexible and responsive to the needs of families.

Differences from the originally intended model include the age of children enrolled; this ranged from 9–17 (rather than 10-14 as commissioned). This appeared to be because the RISE team accepted referrals of older and younger children due to their high needs and current distress. Children's perceptions of, and engagement in, the CPV programme could not be assessed due to their limited engagement in the intervention and non-engagement with the evaluation. It is therefore not possible to comment on the implementation of the child-focused elements (such as the teaching of CBT techniques).

The evaluators judge that the CPV programme has the potential to be evaluated in a large-scale randomised controlled trial. However, several issues require resolving before proceeding. Most notably, the primary risk to a trial is the lack of measure completion. The impact of the COVID-19 pandemic needs to be considered, but even under these circumstances, the level of data completion in this evaluation is very low. YEF is currently exploring further evaluation of the programme.

Introduction

Background

The Child to Parent Violence (CPV) programme seeks to change behaviours of 10–14-year-olds showing violence towards their parents. Sessions with parents use and teach non-violent resistance (NVR) techniques, including reconciliation methods. Sessions with young people are skills-based, trauma-informed and teach cognitive behavioural therapy (CBT) techniques to break negative cycles. This is a novel programme, working in a domain where there is no alternative intervention routinely offered to families.

The CPV programme is offered by RISE Mutual CIC (RISE). Intervention starts with the parents and only moves onto young people if/when they are ready to engage. NVR and/or the New Authority are relatively novel techniques in parental/family interventions and were largely developed by Omer (e.g. 2004, 2011). The approaches have gained some popularity in practice, and several relatively small-scale studies have been conducted, including within families where the children present significant behavioural/management challenges (e.g. Weinblatt and Omer 2008; van Holen et al. 2016). Findings have been somewhat positive but were often from limited sample sizes or relatively uncomplicated family settings. This evaluation tested the feasibility and pilot outcomes for the CPV intervention, which works with families presenting with more complex needs than those in some of the studies mentioned above.

Working in a 'trauma-informed' manner has become increasingly prevalent, particularly in relation to trauma and adverse childhood experiences (ACE; CDC 2020). What a trauma-informed approach (TIA) means may vary, but a useful way to conceptualise the principles at the heart of trauma informed practice is accessibly summarised by the University of Buffalo Institute on Trauma and Trauma Informed Care. Rather than providing services to treat one or more particular aspects of trauma, a TIA seeks to be engaging and accessible, thus attempting to avoid worsening trauma by not acting in ways that would be harmful (University of Buffalo 2019). However, variance in how this approach is enacted–reflects one of the challenges noted by NICE relating to the literature on trauma-informed care (TIC). In 2018, NICE concluded that "*there is very little evidence demonstrating measurable impact of TIC or TIA. The evidence that does exist is of a low quality and come(s) almost exclusively from the US*." (NICE Guideline NG116, p.149). One year later, the Long-Term Plan for the NHS clearly advocated a TIA in the care and support of young people in the Health and Justice System (NHS England 2019, point 12, p.118). Despite this recommendation, there is still limited systematic evaluation of TIC (Asmussen et al. 2022).

When working with young people, RISE also use CBT, which has been shown to produce some of the largest effects on reducing reoffending in young people up to age 25 (Lipsey 2009; Koehler et al. 2012). When considering young people just up to age 18, reoffending outcomes have been more mixed (e.g. Ford and Hawke 2012; Martsch 2005). The most promise may be where other modes of support are implemented alongside CBT (Burraston et al. 2010). The use of CBT with young people alongside changes in parenting style via NVR, within a TIA, can be characterised as multi-modal.

Intervention

Activities address needs focused on NVR techniques designed to help adults with parental responsibility to find new ways to respond to violence from children and young people in their care. NVR is intended to achieve positive outcomes without relying on young people's engagement. Instead, it provides parents with skills and knowledge to deal with behaviour in a non-violent way, avoiding punishments and relying on natural consequences. Alongside violence towards parent/carers, behaviour of referred children typically manifests as poor engagement in school with subsequent poor attainment and increased risk of criminal activities. The intervention engages parents and children separately, in their homes, through a programme of up to 20 sessions. The programme is tailored to specific needs presented by the young people, with exercises selected by practitioners from a toolkit developed during the initial run of the programme, prior to commissioning by YEF. It should be noted that in several of the families referred for CPV, violence from children towards adults may have occurred in a broader context of intimate partner violence and abuse and/or violence from one or more parent or carer towards children. Reasons for early ending of the intervention may include young people and their families progressing sufficiently to engage with direct intervention from another service, as well as family-specific reasons for disengagement (considered in the pilot evaluation).

Referral process

Referrals were received from the London Boroughs of Croydon and Bromley. The programme set out to receive referrals from local authority social workers, schools, family intervention workers and early help teams, alongside the Child and Adolescent Mental Health Services (CAMHS).

Screening

All referrals were screened for suitability by RISE staff, following discussions with the referrer regarding the suitability of each family.

Participant inclusion criteria

Families living in Croydon and Bromley with children and young people aged 10–14 who are showing violence towards their parents within the family home and meeting one of the YEF inclusion criteria (such as at risk of offending behaviour, school exclusion, etc.)

Exclusion criteria

Not meeting inclusion/referral criteria outlined above.

Sample size

For quantitative analysis, ninety families had been recruited by the end of the feasibility phase. Their data were carried forward into the pilot evaluation (See Appendix: Data Audit-RISE Feasibility). Additional families were recruited after the feasibility data audit, and there were 107 families included in the baseline pilot data.

For qualitative analysis, there were 11 participants in the feasibility phase and 15 people who participated in pilot phase process implementation interviews. A mixture of service users, providers and referrers contributed to assessment of the implementation processes in each phase.

Recruitment and follow-up

Following recruitment into the programme (t0), the clients were followed up at one (t1), three (t2) and six months (t3). Where possible, data were also followed up to nine (t4) and 12 (t5) months after starting the intervention. This additional follow-up was possible due to the successful early recruitment during the feasibility study and ongoing contact with the intervention.

Aims and objectives

The overall aim for the feasibility and pilot evaluation was to investigate the potential of the CPV intervention to improve young people and their families' outcomes. The CPV evaluation progressed from feasibility to a pilot study, carrying forward quantitative data. The pilot study has a cohort design (N=107 cases) that assesses change over time in main outcomes and ongoing assessment of the extent of successful delivery.

RISE CPV evaluation objectives

> The overall objective is to assess potential improvement in emotion regulation, problem behaviour, and family functioning; distress related to trauma; and reduction in engagement in criminal behaviour by the children involved in the programme. Specific objectives are:

- To assess the potential effect size of the CPV intervention evaluated across the project's routine measures and those specified by YEF
- To evaluate progress to achieving goals set as part of the CPV programme
- To evaluate the methods for recruiting clients from the intervention's target population and retaining clients in the programme once enrolled
- To evaluate the potential to deliver a larger-scale randomised trial.

Core measures

YEF specified a standard set of measures to be used and compared across a range of commissioned interventions and evaluations. This is referred to as the core measures dataset and is described in more detail in the data collection section below. First, we summarise the broad approach. For the CPV programme, agreement was made during the feasibility phase to collect a limited range of outcome data.

Primary outcomes

Psychological wellbeing, emotional and behavioural measures:

- Strength and Difficulties Questionnaire (SDQ, Goodman 1997) (measured throughout the evaluation)
- SCORE 15 Index of Family Functioning and Change (Stratton et al. 2014, dropped during feasibility)
- The Impact of Events Scale (IES, Weiss 2007) and the Children's Revised Impact of Events Scale-Eight Items (CRIES-8, Perrin et al. 2005) (dropped during feasibility)
- Edinburgh Study of Youth Transitions and Crime (ESYTC, McVie 2007) – sweep 3 (dropped during feasibility).

Adherence to Intervention

- Adherence to the intervention was assessed by recording attendance at therapeutic interventions and follow-up assessments.

Service-user experience

Qualitative interviews were conducted with families to investigate their experience of participating in the intervention. Similar interviews were conducted with service providers, referrers and other frontline practitioners working with the families they had referred. Qualitative interviews allow an exploration of rich, in-depth information about interviewees' perceptions of RISE, but it is difficult to generalise from the findings. This could be noted as an evaluation limitation as experiences reported may not be relevant to, nor representative of, all stakeholders and service users involved with the project during either phase of the evaluation.

RISE specific outcomes

- The CPV programme uses goal setting as a therapeutic method, and progress on the goals was intended to form an additional outcome for this programme.

In addition, RISE captured a wider range of outcomes relating to the child and family experience specific to the CPV programme intervention:

- Routine monitoring of parenting skills development and incidence of child-to-parent violence was via a bespoke measure.
- Young people's satisfaction with life was measured via the Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS-Seligson, Huebner and Valois 2003).

Ethical review

The University's ethics and integrity policies and processes can be seen at: https://www.herts.ac.uk/research/research-management/ethics-and-research-integrity. In accordance with this process, the evaluation had full approval from the UH Health, Science, Engineering and Technology Ethics Committee (protocol numbers: LMS/SF/UH/04101-feasibility and LMS/SF/UH/04697-pilot). Following COVID-19 and changes in the initial deadlines for both phases of this evaluation, amendments were resubmitted for further extensions. Data collation was eventually permitted until November 2022 under approval 04697 (see Appendix: Ethics Approvals).

Safeguarding

The same process was adopted for feasibility and pilot studies: interview participants were made aware that there may have been situations, under the safeguarding framework, where there could have been a statutory obligation for members of the evaluation team to break confidentiality and provide information back to the organisation providing the intervention or other statutory bodies. Although it was made clear that the evaluation team would not process identifiable data, participants needed to be clear that for safeguarding reasons, anonymisation is not complete.

The initial intention was that evaluators would be following the safeguarding protocols provided by each grantee, working in close liaison with project managers from the grantee. Given the developments and dramatic changes to policy and process developed during the pandemic, the evaluators further developed our overarching practice working in continued consultation with project managers. No safeguarding concerns arose from the evaluation fieldwork, and none were recorded in the evaluation dataset (beyond those for which young people had initially been referred). The evaluation team subsequently were made aware that, during the evaluation period, three serious incidents had been managed by CPV workers and recorded by the YEF project management team. Practitioners raised concerns and worked on complex issues in supporting service users through multi-agency meetings.

Consent

The information in this section pertains to both the feasibility and pilot evaluation. Most of the administrative data being collated for this evaluation were shared, stored and processed under the principles of legitimate interest. Additionally, there were interviews undertaken (with service users, stakeholders and service providers) that proceeded on the basis of legitimate interest, supplemented by informed consent. When providing information and gaining consent from young people, a multi-stage process was designed to ensure that parents, primary caregivers and/or legal guardians would be informed. If they provided consent, then the team would contact the young person, who would then be presented with age-appropriate participant information and offered the opportunity to participate (which they could refuse). Evaluators were mindful that in some circumstances, parental interests could have conflicted with young people's rights. In such circumstances, the children's interests were prioritised.

When being invited to participate in interviews specifically for the evaluation, all prospective participants were provided with an Information Sheet and given time to read it fully before any interview. Any questions were satisfactorily answered, and if the participant was willing to participate, either written informed consent was obtained prior to the interview or verbal consent was obtained and recorded as part of an online interview process. During the consent process, it was made completely and unambiguously clear that the participant was free to refuse to participate in all or any aspect of the pilot evaluation, at any time and for any reason, without incurring any penalty or affecting their continued involvement in the intervention. Information was provided in accessible, age and cognitively appropriate ways; consent was treated as an ongoing process; consent and participation could be withdrawn without penalty; findings and data were anonymous where possible, confidential throughout and, where appropriate, depersonalised or anonymised according to principles both of the GDPR and UK anonymisation network framework. Please see appendices B and D for materials.

Data protection

The legitimate interest under which much of this evaluation proceeded rested on the fact that the intervention (and thus evaluation) seeks to ascertain whether or not there might be a public benefit from the potential reduction in harm to/from the young people, their families and wider communities. As data processors of the routine monitoring data and controllers of the bespoke (interview) data, we were (and are) registered and fully compliant with the requirements of the General Data Protection Regulations (GDPR) (Regulation (EU) 2016/679) and the Data Protection Act 2018. Our Cyber Essentials Certificate number is IASME-A-09513. This research was conducted in accordance with an agreed Memorandum of Understanding (MoU) and Data Sharing Agreement (DSA), which were informed by a comprehensive Data Protection Impact Assessment (DPIA). These were all agreed between grantee and evaluators, where possible drawing on YEF general principles as they developed.

Data transfer to the evaluator was in pseudonymised form and compliant with the DSA. Data storage was on secure servers. Access to the evaluation database was and is controlled and administered by UH Data Management, and access is via end-to-end encryption. The servers are protected by UH firewalls and anti-virus products and are patched and maintained (including back-ups) according to best practice.

The pseudonymised evaluation data will be electronically archived on secure servers for five years after the final evaluation reports have been completed. Access to the data will continue to be managed and only made available to members of the evaluation team, to YEF personnel or, where necessary, for statutory regulatory processes. Privacy notices and information about the routine monitoring data were provided by the grantee to their beneficiaries/service users.

Confidentiality

All data captured into the survey database remain anonymous to the evaluation team. Pseudo anonymity was achieved by providing each client with a randomly generated study ID, used in the dataset that is unrelated to their personal details. All reporting only provides summary data, which avoids the potential to identify individual clients. Where quotes are included from qualitative interviews, any identifying material has been removed or modified as appropriate.

By using a random ID to protect the identity of the beneficiaries and service users, the project team could provide the data required for the evaluation while maintaining a level of protection against disclosing the clients' identities. A relatively routine way to do this was adopted, which is for the organisations to retain a key that allows identification of the clients from the random code. If subsequent data linkage had been possible, then this key would also have allowed longer-term follow-up from public and institutional databases. Subsequent data linkage had originally been seen as desirable. It should be noted that grantees were commissioned and began running their interventions before privacy notices and data protection implications of potential archiving had been fully worked through within YEF. As such, the grantee initial agreements with referrers and with clients did not make it clear that data might have been used in that way. Accordingly, it was agreed that if found suitable for a randomised trial, this intervention would need to adopt different principles and that, from the evaluation perspective, this study will not be moving into an internal randomized controlled trial (where data might have been carried forward). This means that there will be no need to unmask the data because it will not be deposited in YEF's data archive.

Quality assurance

Evaluation staff reviewed the survey database for errors and missing key data points at regular intervals and via two specified data audits. The pilot evaluation database was also programmed to generate reports on errors and error rates. Essential study issues, events and outputs, including defined key data points, were monitored and documented. Qualitative data were assured via checks of transcript clarity and quality when first generated, then via inter-rater reliability checks between at least two members of the research team for each qualitative analysis.

Feasibility Study

Overview

Research questions

The key questions for the feasibility study were to better understand:

1. What factors support or interfere with the project's successful delivery?
2. What is the feasibility of the recruitment, retention and reach for the intervention?
3. What are service users' and referrers' experiences and views of the intervention?

Success criteria and/or targets

From the intervention perspective, intermediate outcomes for the child were intended to be: reduced violence, improved engagement with key individuals, increased emotional self-management and improved behaviour. Intermediate outcomes for parents/family were intended to be: increased de-escalation skills, reduction in feeling of helplessness, improved confidence, improved community support networks, reduced social isolation and improved wellbeing.

For the evaluation at feasibility, success criteria revolved around the extent of referrals, screening and throughput and whether routine and specified measures were being completed and collated sufficiently to progress to pilot evaluation (see data collection below).

Long-term outcomes were intended to be at a child's level: reduced offending, improved school attainment and, at a wider level, improved community response to reducing violence. These outcomes were beyond measurement at either feasibility or pilot phase of the evaluation.

Methods

Participant selection

Based on initial projections to YEF and anticipated CPV staff caseloads, it was anticipated that the parents or carers of approximately 90 referred children would be recruited over the duration of the YEF commissioned work. Approximately half this number might have been expected during the feasibility phase. For quantitative data, the entire cohort was analysed, where a 'case' was one child and at least one/parent carer. This would typically mean that each family could be considered a case. Three families had more than one referred child about whom outcome data were being recorded, meaning that the final cohort includes 104 families comprising 107 cases. For qualitative aspects of this evaluation, sampling was purposive for professional stakeholders and largely intended to be opportunistic for children and parent/carer interviewees, using the CPV workers as gatekeepers to facilitate access to parents/carers and potential child interviewees. By drawing on CPV workers as initial gatekeepers, this also ensured that no family would be invited to participate in an interview if the family context meant that an approach, at that time, may have been considered harmful or likely to worsen the family's circumstances._Relevant CPV workers obtained initial consent from parents for the evaluation team to contact them and/or the children for whom they had parental responsibility. Several of the adults with parental responsibility never responded to the invitations that were then sent. Each parent who had agreed with their worker being approached was contacted up to three times before being dropped from further contact.

Qualitative research was conducted with 11 participants (six from RISE, three referrers and two parents). Professional stakeholders were sampled purposively to capture management, practitioner and provider views and perspectives on how the interventions had been developed and delivered – most were frontline practitioners, both within RISE and from referrers.

Referrers and stakeholders were contacted by the evaluation team once initial consent to contact them had been obtained via CPV staff. Staff were invited to take part in a focus group (which took place with those who consented), and a separate interview was conducted with the manager. Quantitative data were uploaded into the survey database, and qualitative interviews and focus groups were run using video conferencing software and/or telephones.

Theory of change/logic model development

The logic model was developed by the project management team at the time of applying for funding from YEF and refined with evaluators during the feasibility phase. Table 1 summarises the logic model. Inputs and outputs were tested during feasibility and pilot phases of the evaluation. Shorter-term and some intermediate outcomes were assessed during the pilot phase. Longer-term outcomes are beyond the timeline of this evaluation.

NVR and/or the New Authority model concentrate on teaching parents and carers ways to de-escalate confrontation and violence. It is intended that rather than using punishments that could potentially be ratcheted up to little avail, families are encouraged to consider natural consequences, helping children and young people to consider more directly the outcomes of their actions and choices.

Intermediate intentions for the child were that there would be reduced violence; improved engagement with key individuals, such as in the family or potentially at school; increased emotional self-management; and improved behaviour. For parents and family, the intervention was intended to develop and improve de-escalation skills, reduce feelings of helplessness, improve confidence in parenting skills, improve community support networks, reduce social isolation and improve wellbeing.

Long-term outcomes were intended to be associated with reduced offending, improved school attainment and improved community responses to reducing violence. These outcomes are outlined in Table 1, but they could not be fully evaluated within the evaluation as most occurred beyond its scope.

Table 1: Theory of change: RISE Mutual CIC Child to Parent Violence

Problem statement	The programme seeks to change behaviours of 10–14 year-olds showing violence towards their parents. Behaviour manifests as poor engagement in school with subsequent poor attainment and increased risk of criminal activities.		
Inputs	**Outputs/Short-term outcomes**	**Mid-term outcomes**	**Long-term outcomes**
• Up to 20 sessions with families • Engage community and wider family to support the parents and the child • Train social workers, community members and referrers in NVR CBT For children might include: Anger management techniques; decision-making processes; dealing with and recognising emotions; empathy; perspective taking & goal setting Teaching NVR to parents might include: De-escalation skills to reduce risk; resistance and repair techniques; removing barriers (including punishments and rewards); building confidence; creating acceptance of the young person; helping build a relationship with the child before reinstating boundaries.	Whole family and community engagement, ensuring a consistent message. Training provided to teachers, youth leaders, sports coaches and other key individuals. Development of a community of support to resist the behaviour of the child.	Intermediate outcomes for the child were intended to include: • reduced violence • enhanced engagement with key individuals • improved emotional self-management • better behaviour. Intermediate outcomes for parents/ rest of the family were intended to include: • increased de-escalation skills • reduced feelings of helplessness • improved confidence • enhanced community support networks • reduced social isolation • improved wellbeing.	Longer-term outcomes related to the child were intended to include: • reduced offending • improved school attainment • improved community response to reducing violence and gang related activities. It was also intended, that key stakeholders – social workers, sports coaches and teachers – would be able to draw on these skills for other client work.
Impact	Improved connective parenting, consistency and acceptance will be further supported by enhanced community and wider family ties to better enable the young person to manage anxieties, anger and frustrations, thereby reducing familial, child and community/social harms, including violence and gang-related activities.		

Data collection

The CPV programme evaluation draws upon different data sources and methods. These include the use of routine monitoring data collected as part of project management information – mainly quantitative measures, with space for notes and comments on the database; core measures specified by YEF – quantitative measures relating to project participant outcomes; and qualitative data from interviews and a focus group with project participants and professional stakeholders.

The evaluation of the CPV programme was one of four family-based interventions being evaluated concurrently by these evaluators. To better understand the ways in which the CPV was intended to operate, evaluators also planned to run a workshop for all four grantees being evaluated by this team to share and develop learning during inception. Due to scheduling challenges and then onset of the COVID-19 pandemic, the combined workshop changed to a series of meetings and exchanges of materials between the evaluator and each grantee, with no cross-grantee sharing.

Interview protocols were designed to facilitate qualitative data collection from families, professionals and referrers. The interview protocols can be seen in Appendix: Feasibility Materials. They focused on understanding the implementation process, including factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; families' experiences and views of the intervention; and practitioner and provider perspectives on how the interventions had been implemented, developed and delivered.

Quantitative data were collated by the grantee and then uploaded via REDCap (the web-based Research Evaluation Data Capture system). It is both a secure system and one that is relatively straightforward to learn how to use when entering data. Descriptive statistics have been used for feasibility evaluation and inferential analyses, conducted within the pilot phase.

It should be noted that the RISE intervention and its evaluation were conducted under atypical circumstances. Commissioned in 2019, as part of the initial launch round of the YEF grants, intervention delivery was adversely affected by the first waves of the COVID-19 pandemic. Some staff were furloughed, and rather than working closely with families within their homes, some delivery was moved to remote means, mainly relying on video conferencing software. Where digital access was limited or other concerns such as privacy were being raised during video conferencing, telephone calls were also used. Evaluators also responded to COVID-19 lockdowns, infections, requirements for remote and then hybrid working, and implications for interviews (moving more fully to online than had been initially intended). Lastly, it should be noted that both evaluators and grantees needed to be responsive to emerging practices and changes from the commissioner, as YEF project management and evaluation teams formed, articulated and revised policies, guidance and reporting requirements.

Data collection methods

All interviews and focus groups were conducted remotely (either by phone or online). With participant consent, interviews were recorded for the purposes of transcription. Fieldwork for the feasibility study was undertaken between November 2020 and July 2021. Please note that despite several repeated attempts, it was not possible to gain young people as research participants. They were approached via their parents as agreed with the project and outlined above, but none consented to take part. It is disappointing that no young people agreed to take part in interviews with the evaluation team, although in this instance, parents and carers are the target of the intervention. In addition, given that this intervention concerns child-to-parent violence, further attempts to engage young people in research via the parents/carers and frontline staff might have caused more difficulties.

The majority of quantitative data collected comprises either data routinely collected within the CPV programme or the specified YEF core dataset. As far as possible, all identified data were collated by direct online entry to the REDCap system by members of the grantee team and stored securely on university servers. CPV staff received training on data collection and use of the REDCap online system from the evaluation team.

Data collection, data entry and queries raised by the RISE delivery team were conducted in line with the data management processes as agreed between the CPV team and the evaluation team. Data were routinely collected during the referral and screening process (as agreed with RISE). Once clients had been accepted onto the intervention, the agreed core data were collected at baseline (t0), and follow-ups with the clients were indicated at one (t1), three (t2) and six (t3) months (feasibility carried through to pilot, where possible) post recruitment.

Evaluation data

Routine monitoring data

The evaluation comprises analysis of aggregated and anonymised data collected by CPV staff relating to information about referrals into the service, the screening and assessment processes, and formalised reviews of parenting skills and child-to-parent violence. These data also enabled the profile of the source population to be characterised. By monitoring referrals, the evaluation team hoped to assess whether appropriate referrals were being made (as measured against the referral criteria) and the extent to which selection bias may have occurred in accepting clients into the programme. Where children were engaged, the CPV team routinely used the Brief Multidimensional Students' Life Satisfaction Scale (BMSLSS) (Seligson, Huebner and Valois 2003).

Key demographic data

RISE captured key client specific and demographic data, including age, ethnic heritage, gender, relationship to other grantee clients and index of deprivation on their CRM.

Core measures

The Strengths and Difficulties Questionnaire (SDQ) [family member and young person completed] (Goodman 1997) is a widely used and well-validated measure that has several versions, including for 11–17 year-olds, for parents and for teachers. It is used to evaluate antisocial or other behaviour problems. For all measures, in families where there was more than one adult with parental responsibility, it was agreed between them who would complete the measures. Where both parents are equally involved, nominating a key respondent is the preferred method of ensuring consistency. Although this was not monitored as part of the evaluation, each person had a unique identifier, so it might have been possible to test for differences between respondents had data been carried through to a trial.

The SCORE 15 Index of Family Functioning and Change [family member, and young person completed] (Stratton et al. 2014), a self-report outcome measure, is widely used in systemic, family-based interventions and has been validated for use by CAMHS. It is well manualised and has versions for use with younger children and for implementation within families. Although there were a few completions of this scale, it was agreed with the YEF project management team that RISE could drop the SCORE 15 from the evaluation of the CPV programme in favour of their bespoke measure of parenting skills and child-to-parent violence.

The Impacts of Events Scale, Revised (IES-R) (Weiss 2007) and the Children's Revised Impact of Event Scale – 8 (CRIES – 8) (Perrin et al. 2005) [young person completed] are freely available measures of post-traumatic stress disorder (PTSD) and trauma. The adult version is a self-report measure that was designed and revised in line with DSM-IV. It is widely used and allows adults first to identify a stressful life event and then report on the level of distress or intrusion ('difficulty') into their lives that the event has been associated with over the preceding week. The children's (CRIES-8) version is widely used as a pre-and post-intervention measure. It is also self-report, is aimed at children over eight years old who can read independently and is eight items long. Although there were a few completions of these scales at baseline, it was agreed with the YEF project management team that RISE could drop their use because measuring trauma was not directly relevant to the intervention. Although acknowledging that trauma may have been present, trauma was not a specified inclusion criterion, nor was the intervention directly targeting its affects.

The Edinburgh Study of Youth Transitions and Crime – sweep 3 (ESYTC) (McVie 2007) [young person completed] questionnaire used in sweep 3 (when children were aged 14) contains the original 15-items with an additional four items on bullying, harming or injuring animals, selling drugs and racial assault or harassment. No completed forms were provided to the evaluators, and it was agreed with the YEF project management team that RISE could drop it. Please see Table 2 for a summary of the methods adopted to test the research questions.

Analysis

Monitoring data were audited, and descriptive reports were generated that considered:

- throughput – referral routes, acceptance and withdrawal/completion rates
- screening – barriers and facilitators to acceptance on the programme
- completeness of routine and specified measures recording.

Qualitative interviews were analysed using deductive thematic analysis with key themes derived from the three research questions articulated above. Braun and Clarke's (2013, 2020) general framework was used as a tool to reduce and manage data without losing context and enabling the researcher to be immersed in it. Thematic analysis was designed to be versatile and adaptable. In this instance, it was adopted to identify key issues and themes that had been presented by interviewees in response to the semi-structured interview and focus group schedules. This allowed themes to emerge, framed by the research questions.

Table 2: Methods overview

Research methods	Data collection methods	Participants/data sources	Analysis	Research questions addressed	Implementation/ logic model relevance
Qualitative	Interviews and focus group conducted by the evaluation team, and comments field from REDCap database (populated by CPV staff)	Families Referrers Project staff	Thematic analysis	1–3	Experiential research into all stages of the logic model
Quantitative	Child and Adult SDQ; BMSLSS; CPV bespoke measure; notes field in REDCap database	Data entry into REDCap by RISE staff supported by the evaluation team. Whole cohort analysis.	Descriptive analysis via a data audit	1 & 2	Preparedness and/or ability to assess outcomes via use and recording of the YEF core measures and other routine monitoring data, i.e. readiness for pilot

Timeline

Table 3 provides a summary of the activities completed within the feasibility phase. It should be noted that this phase was extended due to the disruption caused by early waves of the COVID-19 pandemic.

Table 3: Timeline

Date Completed	Activity
07.02.20	Evaluation workshops initially intended to be for all four grantees to share and develop learning during inception, changed to a series of meetings and exchanges of materials between the evaluator and each grantee, here: RISE.
07.02.20	Ethics submission and finalised feasibility plan
17.03.21	REDCap training, database set-up
17.03.21	Feasibility data audit
16.12.21	Completion of feasibility analysis and preparation of slide stack (amended by YEF to delivery of draft feasibility reports).
28.02.22	Production of summary feasibility findings for RISE

Findings

Participants

Participant information from the feasibility assessment is summarised in Table 4.

Table 4: Participant characteristics

Referrals	
Screened	114 families
Enrolled	65 families
Bromley Family Services	58
Croydon Family Services	56
Age range	8–17*
Enrolled Child Characteristics	
Age range	9–18*
Male	41 (63%)
Female	23 (35%)
Asian heritage	2 (2%)**
Black heritage	10 (9%)
Mixed heritage	11 (10%)
Heritage not disclosed	6 (5%)
Other	8 (7%)
White	77 (67%)

* Eligibility criterion was 10–14 years, and one child had a birthday by the time of engagement
** Percentages rounded

Eleven participants took part in interviews and focus groups – two were parent/carers from the cohort described above. Additionally, five project delivery staff, one project lead and three referrers participated.

Intervention feasibility

Quantitative findings

RISE provided screening and enrolled participant data. RISE staff engaged with the evaluation team productively several times in order to set up the system and review effectiveness in entering data and in using the system. All families were given unique case numbers. Summary data collected at the audit point at the end of March 2021 can be seen in Appendix: Data Audit Feasibility.

The audit shows some solid data entry, including 100% completion of age, ethnicity, source of referral and referral IDs. Gender was recorded in all but one case, and 10 of the original 114 referrals were missing a date of referral (91% completed). The audit was not designed to explore how screening was conducted, but two items were intended to be recorded as part of screening: index of deprivation and referral ID. Index of deprivation was not being collated, although the first part of the postcode was uploaded and referral IDs were provided. At baseline, around 75% of potential parent surveys had been uploaded from the CPV bespoke measure and SDQ. Continuation data were also being entered, although it was too soon to tell whether the proportions would be sufficient for a trial. Several other elements of the data monitoring did not seem to be being used systematically, including the SCORE 15 and IES (seven adults at baseline), CRIES-8 and ESYTC (no children).

One of the challenges was in gaining the engagement of children. This was the case with both the intervention and the evaluation. Because of the nature of the antagonism of the young people towards parents and adults – the reason for referral and acceptance on to the project – the use of the child questionnaires has not normally been seen to be appropriate or possible by CPV staff. In consultation with commissioners, the project chose not to make use of Score 15, IES or CRIES-8. Due to the focus of the intervention not being on offending per se, the project also chose not to make use of ESYTC, and these measures were dropped before moving into the pilot phase.

Qualitative findings

Views and experiences of service users

Two interviews took place with parents. Two more had been agreed with the RISE worker, but they were not able to be contacted/did not respond to the evaluator to take part. However, evaluators were provided with some information from feedback forms; this was additional potential data that has been incorporated into separate testimonial boxes within the findings.

Interviews with the two parents resulted in very positive comments about the intervention. The flexible support to overcome difficulties as work progressed was particularly important. Parent/carers reported feeling being seen as “bad” parents by other professionals and staff they had seen before, but not by RISE staff. Within the RISE programme, they felt respected in terms of how they had been approached. They would recommend the programme to other parents.

The themes from the interviews were very similar, with frequent and serious aggressive behavioural difficulties from the children/young people identified. These could have significant, ongoing, negative effects on parents and other family members, and negatively affected their engagement with schools and with wider social networks. The parent/carers reported multiple problems from their child(ren).

Both interviewees were positive about initial engagement; planning and ongoing review of the work; updating and ongoing engagement on the progress of the work; and the reviewing of goals. Flexible support to overcome difficulties as work progressed was particularly important to the parents.

Interviewees said they “had tried everything” before but had not found previous input to be effective. Other agencies had not focused on how parents saw their own particular needs for help. They valued the regular support they needed over time to implement plans and constant working through, at regular intervals and sometimes short notice, the times when their child resisted the changes in their parenting styles. Frequency of contact, sometimes two to three per week by way of phone call/Zoom, as well as face-to-face meetings when possible after COVID-19, was seen to be key in this.

The goals, and the means to achieve them, had been clearly agreed and reviewed at regular intervals. Parent/carers reported that the programme had easy-to-follow strategies. The same comment was made in relation to the way the programme had helped them to find new ways to engage with schools, educational provision and other agencies. They felt that the way the intervention had been carried out with the RISE staff had encouraged and helped them to find ways to receive support from friends and family, as this was encouraged as part of the programme.

Matters were raised about how they and their children had experienced positive changes due to their engagement with the programme. These centred on changes in attitudes and behaviours from the children and were seen as being in response to the changes they had made as parents, in their relationship with the children as a result of the programme. They would recommend the programme to other parents. RISE also provided the evaluation team with feedback from their completion interviews (redacted examples are presented below).

Testimonials to project staff from two families:

X stated that he was amazed how well the programme had worked and that by implementing what are relatively minor changes to their own behaviour, that they have seen such a profound effect on AA's behaviour. Y has found the approach and intervention helpful in reducing AA's outbursts. She feels more in control of her own emotional responses towards him and stated that she has found the programme invaluable. Y also stated that she is feeling better and has been able to remain calm by taking time for herself and thinking more positively about how she can also come back to issues with AA at a more appropriate time.

Also, X was able to acknowledge how they had escalated behaviours in AA in the past and that by modifying their own behaviour, they had prompted change in AA's behaviour. This was manifested with AA's behaviour becoming less aggressive and confrontational the more Y and X managed to stay calm and not get annoyed, impatient or irritated with him.

In the post-intervention questionnaire, X stated that since beginning the intervention AA's problems are "much better" and that the intervention has been helpful in other ways, e.g. providing information or making the problems more bearable ("a great deal").

K reports feeling more confident, that she has improved her self-esteem and is reminded and assured by the programme that *"it's not all her fault".* She has the ability to express when she is frustrated to BB in a calm way and to remove herself from the situation in order to deal with it later. This has also shown BB how to manage his own emotions. K stated that positive affirmations towards BB – and that she is able to do this in a genuine way rather than through *''gritted teeth''* – works really well.

K reported that by staying calm, reminding him (BB) that Mum was here the whole time and celebrating *"wins",* this has been highly effective in building his self-esteem and rebuilding their connection. Minor things have had a significant impact, including random acts of kindness, such as taking him snacks, sharpening pencils for him and leaving notes.

K now consciously plans periods when she focuses on her own self-care, whether it be yoga, meditation, reading or gardening. K reports that this has been invaluable to her. K also stated that she is feeling better and has been able to remain calm by taking time for herself and thinking more positively about how she can also come back to issues with BB at a more appropriate time.

During the last session of the intervention, K stated that violence has reduced and has not taken place for several months. Targeted verbal abuse has also ceased, and [there is] no longer any deliberate destructive behaviour, with only occasional swearing. BB's suicidal ideation is also no longer verbalised, and Y believes it not to be present. K also joked that a house plant that BB would regularly destroy is now sprouting leaves. K stated that she was amazed how well the programme had worked and that by implementing what are relatively minor changes to her own behaviour, she has seen such a profound effect on BB's behaviour.

Stakeholder perspectives: *Referring professionals*

There were three interviews with referrers to the project. All three were the allocated family workers. There was little divergence between them in the positive feedback that they gave, in terms of the responses on initial referral, how the needs of the families were discussed, and in being kept up to date with what was happening, particularly where the referrer was still actively involved in supporting the plans for change.

A few points were made on how staff from the project were sometimes a little slow in getting back to them. However, referrers said that if there were issues in having to wait for allocation of the referral, for example, they had experienced the project staff making efforts to let them know what was happening, why there was a delay and when the family might be taken on. This was all seen as valuable in helping them to manage the families' expectations and concerns.

Referrers also mentioned that they had seen positive changes in families they had worked with and were very satisfied with what had happened for families in the intervention. They reported being part of discussions with RISE staff about the suitability of potential families and what the plans were for when they were on the programme. Interviewees stated that, on the whole, they had been kept up to date with what was happening with referred families and what this meant in relation to the work from staff in the local authority and on eventual handing back to them. Comments were made that one of the biggest changes being seen in the families was a move away from parents blaming the child for all that is going on to them reflecting on their own parenting. Also, parents had made use of the support in changing these attitudes and methods of handling behaviour that lead to improvements.

One referrer had found it helpful that RISE had come along at the beginning of the project to set out what the project could do for their families and the processes that would take place if a referral was accepted. Some of the referring staff said that they have found it valuable that RISE had sent final reports at the end of the project intervention to give guidance on what had worked well with the family and what might be worthwhile pursuing in the local authority member of staff's work with the family in the future.

All had reported that RISE had adapted its engagement strategies and intervention methods well in relation to the demands of COVID-19. The concerns reported by referrers were about when the project would end, as they see the issue of child-on-parent violence as one that has been increasing in recent years and places great demands on the parents and referrers, so the specific issue being dealt with by the project was very much welcomed.

The project team also provided an example of e-mail feedback from a referrer:

Positive feedback on the CPV intervention, sent by a referrer to RISE

"Dear XX,

It was good to speak to you today and hear about the work you do.

I would like to thank you for the amazing work you've done with Mum and her family. It's made an incredible difference to the family's quality of life.

The NVR strategies that you have given them have worked so well and Son has responded in such a positive way. Mum finds they shout less, get less stressed and the home is a more peaceful place. Something they never imagined could happen and everyone's mental health has improved.

Thank you so much and I look forward to the next family we work together with.

Best wishes, YY

Family Support and Parenting Practitioner"

Views and experiences of project staff

More of the families had more complex needs than had been expected, such as involvement in county lines, drug misuse, staying out overnight, autism spectrum disorder (ASD), attention deficit hyperactivity disorder or oppositional defiance disorder. Nearly all the children were reported as meeting criteria for one of these features, although it is not clear whether they were formally diagnosed with conditions such as ASD. Although not excluded from the intervention criteria, it had not been foreseen by RISE that such a high proportion of young people would present with additional mental health needs and/or be considered neurodivergent.

The focus in the programme on positives and building confidence in the parents was felt to be valuable. Although it was acknowledged that feelings of increased confidence could sometimes wear off after a few days/weeks for the parents, these can often be overcome with the support of staff drawing on suitable techniques and strategies.

RISE workers considered that their non-judgmental and supportive approaches were valued by parents, alongside the methods and techniques used, as they were not judging them as poor parents because of their problems. The group reflected on how important it is to engage with parents flexibly, especially as soon as possible after an incident – e.g. support via text.

When asked for views about what families might say if asked about what had improved from RISE's involvement, practitioners identified:

- improvement in parental confidence in themselves as people
- improvement in their abilities as a parent
- feeling less guilty about being a 'bad' parent and having no control
- valuing seeing small movements forward with their children.

In their experience of other agencies**,** delivery was characterised as requiring families to attend other agencies' premises at inflexible appointments. CPV staff felt that this was very unlikely to facilitate engagement, given the particular issues faced by young people and the busy, sometimes chaotic households staff are managing.

Significant time had been spent working with the referring teams and individual workers in the two referring agencies to set out the aims and methods for the CPV programme. At referral, designated time was spent to explain, from the outset, the nature of the CPV programme and what this would mean for the family and the referring worker. It was stated that if a young person fell outside the age category, RISE would not accept them, unless there were high risks involved. (The level of perceived risk may explain the wider age range subsequently found in monitoring data.)

There was a view that pre, post and follow-up implementation of the SDQ could be valuable, as used alongside the CPV bespoke measure. However, doing so could use up five sessions of the 20, which could be a problem in terms of finding time to do the "actual work". Staff were somewhat hesitant around their perception that parents who are very stressed/exhausted often need to vent, so workers are careful about when to introduce the measures to avoid risking a poor start.

All required data were entered into REDCap by the project lead, which they hope increases the standardisation of data recorded. It was stated that this was not too time consuming, and they found it useful. In addition, it was not too difficult or time consuming to learn to use REDCap, particularly with the support of evaluation staff. The project lead was able to liaise with the frontline workers so that they could give the information in the best way possible in order to record it to the best effect, e.g. baseline and other data. They also found it valuable to be able to use the REDCap system data for their other data needs, including the reports that they have to produce regularly for the YEF. At the point of the interview, parental SDQs were coming in regularly, but with children, not so consistently. This had been mentioned in their reporting back to YEF.

In one of the referring local authorities, as part of their referral assessment and planning process, there are three sessions for information gathering, and any additional questionnaires can become a problem, although not always. They are screening for eligibility and assess if the family is prepared to engage in the work required. Safeguarding enquiries have disrupted the work with families several times, as that must take precedence.

As intended, training events were held with staff in the two referring local authorities. There were regular training/briefings for staff in one of the referring local authorities and attendance at the online hubs. In the other authority, staff were already familiar with the concept of NVR from previous work with RISE, so less initial training was needed. Further training for both authorities was planned for autumn 2021 alongside ongoing one-to-one briefings for new social workers, teachers and supportive adults on referral/acceptance. RISE staff also gave a talk in February 2021 regarding NVR for the company Ment4, which was the membership organisation working with one of their cases, and to a school on another case. They attended and gave a briefing and talk about NVR in a nationwide British Association of Social Workers session.

The impact of COVID-19

COVID-19 was considered in the focus group, and there was a view expressed that the necessary amendments were working very well and there were some positives to the developments. Where amendments had been made, these were to the delivery mode and not to the content of the material delivered. Participants mentioned how the blended delivery mode seemed to be working well, and they could check in regularly with the parents/carers as part of their work. There would often be one home visit per month where it was possible and desirable and three contacts per month by telephone or online (via Zoom). Delivering more flexibly, according to family preference as well as CPV staff judgement, was something that the team were planning to retain. They felt that COVID-19 added to the risk for some families but reduced risk in others. In addition, COVID-19 sometimes meant retaining families on the programme longer than initially intended, e.g. for six to nine months.

Responses to COVID-19 were largely working well from the perspective of staff, referrers and parents, and there appeared to be some positives to the developments. Staff and parents were fairly positive; the staff could check in regularly with the parents as part of their work, and the parents could get rapid responses when they felt they needed to, through online and telephone contact. Please note that it was not possible to test quantitatively whether this was more or less effective than that which had been initially planned. This was because the project inception coincided with the pandemic, and records were not kept relating to the mode of delivery of particular sessions.

What worked well during the feasibility phase?

- There have been buoyant referral rates against expected numbers. By 30 July 2021, the project had accepted its total numbers for the whole commissioned period.
- Initial and ongoing engagement with families appears to be at a high level. Continuation rates for follow-up work at the three-monthly intervals was acceptable for the purposes of this evaluation and for moving into the pilot phase.
- The focus on positives and building parental confidence was seen to be important by staff and parents.
- For parents, the flexible support to overcome difficulties as work progressed was particularly important.
- Initial engagement with referrers and the joint work planning with programme staff were felt to be valuable.
- One of the biggest positive changes reported was the move away from parents blaming the child for all that is going on to reflect on their own parenting.
- There was agreement that RISE had adapted its engagement strategies and intervention methods well in response to COVID-19.
- Although increased confidence can sometimes wear off after a few days/weeks for the parents, this can normally be reinvigorated with the support of project staff and return to the strategies encouraged.
- Data capture was working smoothly with ongoing engagement between project and evaluation staff.
- The comments field of the survey database was felt to be very useful in providing context, particularly when data may look anomalous.

Lessons learnt

- Being non-judgmental and providing supportive approaches were important to staff and valued by parents.
- More families were presenting with more complex needs than had been envisaged.
- There had been a particular challenge in gaining the direct engagement of children with the project. ASD and associated needs were highlighted by several participants as being an important consideration here.
- On several occasions, safeguarding enquiries have impinged on the work with families.

Logic model development

The theory of change/logic model has largely remained the same since the inception of the programme. Change in delivery was made in response to COVID-19, where the programme of intervention had to be rearranged, sometimes necessitating the work with the families to be longer than initially intended, e.g. six to nine months could have been needed to deliver the same number of sessions. Changes were generally positively received and did not alter the underlying principles of the programme. The theory of change was carried forward into the pilot phase and is summarised below.

Theory of change

The multi-modal programme seeks to change behaviours of 10–14-year-olds showing violence towards their parents. Behaviour manifests as poor engagement in school with subsequent poor attainment and increased risk of criminal activities. Consistent with the principles of the New Authority (Omer 2011), treatment is highly individualised. The RISE therapist works with parents on developing strategies and setting boundaries to achieve change in the young person's behaviour. Parental skills develop gradually with intense support, moving from training and role modelling, enacted with therapist support, to independent practice. Parental barriers to managing their child's behaviour are addressed. As parents succeed in the home environment, efforts are made to address contributory factors such as deviant peers and investigating the possibility of reintegration into mainstream education.

The CPV programme spans up to 20 sessions. Work with parents is grounded in NVR (Omer 2004). When they engage, work with the children adopts a flexible skills-based approach using TIC alongside CBT techniques. Using CBT to support children displaying PTSD is within the NICE guidelines (NHS England 2019) and generally draws on the model developed by Meiser-Stedman (2002). NVR does not rely on young people's engagement but provides parents with skills and knowledge to deal with behaviour in a non-violent way, avoiding punishments and relying on consequences. It is seen as an alternative to provision where parenting courses are based on a punishment/ reward approach, encouraging parents to 'take control'. The CPV intervention focuses on improving connective parenting, consistency and acceptance, taking the approach that problems within the family can only be resolved through a consistent whole family approach, working with parents, young people and siblings (Weinblatt and Omer 2008). CBT and mindfulness techniques are taught to young people, supporting them to address anxiety and anger in a more productive manner.

Conclusion

Table 5: Summary of feasibility study findings

Research question	Finding
What factors support or interfere with the project's successful delivery?	Referrers were positive about RISE worker engagement, planning and progress and about being kept up to date with what was happening in the work and progress made in families they had worked with. Regular exchange of information was helpful in supporting delivery as it allowed for better planning of delivery for referrers and RISE. Many families had very complex needs, which required additional inter-agency collaboration. Although conducted successfully in most cases, the additional work could have interfered with timely delivery and/or led to mixed messages being received by families. Non-judgmental, supportive approaches were seen to be important by staff and parents and helped with delivery.
What is the feasibility of the recruitment, retention and reach for the intervention?	Most referrals were considered appropriate, i.e. they met the eligibility criteria set for the target group. Demand for the intervention was high, with promising enrolment and initial retention rates in line with the intended number of families for the feasibility phase. Intervention reach is good, and data entry was sufficient to allow data capture for the evaluation. Although most families had not been enrolled long enough to be confident in final data completion rates, it was expected that evaluation of 'distance travelled over time' would be possible as part of the pilot phase. Referrers were positive about the above areas.
What are service users' and referrers' experiences views of the intervention?	Parents made very positive comments about the very attentive and flexible support provided to overcome difficulties as their efforts to change progressed. Staff, referrers and parents mentioned how the blended mode – imposed in response to COVID-19 – seemed to be working well. The focus in the programme on positives and building confidence was seen to be very important by focus group and interview participants.

Evaluator judgement of intervention feasibility

In March 2021, an audit of the core measures collected by the project showed a good level of data entry of the agreed areas. Continuation rates for follow-up work at the three-monthly intervals was acceptable for the purposes of the feasibility evaluation and for moving into a pilot phase.

As the entry level of data was good, it should have been possible to assess outcomes regarding engagement and continuation with the families, including measurement of ‘distance travelled’ within responses to the SDQ. There was some concern expressed about the intrusion into intervention posed by the additional time taken to complete the SDQ alongside the bespoke CPV measure of parenting skills and child-to-parent violence, as it doubled the overall number of items to completed. However, the SDQ was generally seen favourably by practitioners.

Referral rates were high, evidencing the need for this service, something recognised within interviews with referrers. Initial analysis indicated that engagement and continuation with families seemed very good. Again, referrers confirmed this in interviews. Initial findings from the qualitative interviews with two parent/carers demonstrated satisfaction with positive comments concerning: initial engagement; planning and ongoing review of the work; updating and ongoing engagement on the progress of the work; and the reviewing of goals. Similarly, the referrers reported satisfaction with: How the RISE CPV team facilitate engagement between themselves and the families; in the planning and progress of the work; being kept up to date with what was happening in the work; and on advice for how to best maintain improvements in the family when the original referrer again picked up work with that family post-CPV intervention.

Arrangements for the evaluation team to enable ethical and effective access to parents and referrers were tested out in the feasibility phase to ensure these perspectives and views could be included in the evaluation. This aspect of the evaluation enabled judgements about the effectiveness of the intervention from their perspectives. Although children did not want to participate in the research, this was not seen as insurmountable for progress to pilot, particularly given that children’s participation in the intervention itself is voluntary and the initial focus is on parents’ interactions with their children.

Interpretation

It should be noted that in the context of uncertainty engendered by COVID-19, the decision had been taken by commissioners to extend the intervention delivery sufficiently to permit a before-after pilot phase, without relying solely on feasibility findings. There was therefore limited evaluator judgement required as to whether to proceed to pilot. The intervention was judged suitable for progress, using only the SDQ from the initial suite of core measures, supplemented by the routine CPV measure of child-to-parent violence and parenting skills. During the feasibility phase, the project worked with 90 families until end of July 2021. As 90 was the maximum aimed for over the whole project, evaluators were confident that sufficient rates of referral would allow for before and after pilot testing.

Implications for pilot study

A key focus for the (next) pilot phase of the evaluation was to assess the extent to which the project achieved its intended outcomes using the SDQ core measure and CPV bespoke measure in assessing change over time. Measuring progress towards families’ goals was considered an integral part of the work undertaken by the project, and this would also be considered as part of the pilot evaluation. It is acknowledged that data collection may introduce the potential to curtail exposure to the intervention via reduced 'dosage' and could be a threat to continued engagement. This is partly why all other YEF specified measures were dropped. Where children engaged, the BMSLSS was intended to be used as a routine measure and the SDQ as the core measure; no measure of offending was to be used in the pilot phase.

Pilot (Pre/Post-Test) Study

Study overview

The pilot phase evaluated six broad aims, designed to assess whether there were predicted improvements in children and young people's behaviour and wellbeing. This can be best thought of as a short-term assessment, exploring potential changes within young people and their families from before, during and shortly after completion of the intervention. The research design was quasi-experimental. In setting levels for retention and completion, a pragmatic approach was taken, in broad accord with best principles such as those articulated by Eldridge et al. (2016) or Thabane et al. (2010).

As with feasibility, the pilot evaluation was designed to assess the process of implementation from professional and referrers' perspectives as well as family members'. The aims and associated research questions are shown in Table 6. Please see link to the pilot protocol here: https://youthendowmentfund.org.uk/wp-content/uploads/2022/09/YEF-Rise-Pilot-study-plan-FINAL.pdf Additional information on data sources is provided in the section below.

Table 6: Aims and research questions

Aim 1: To evaluate improvement in core outcomes over time comparing baseline to 1, 3, 6 and 12 months	
Research question	**Measures**
Describe the client sample at baseline.	Participant demographic information fields requested and CRM
Describe the magnitude and direction of change in behaviour.	SDQ
Describe the magnitude and direction of change in family functioning.	CPV bespoke measure and BMSLSS
Where possible, describe and evaluate the effect of baseline status on change over time.	All measures listed for this aim
Describe progress towards achieving goals at six months for clients engaged in the programme.	Specified fields and notes in database.
Aim 2: Evaluate effect size	
Research question	**Measures**
Estimate the likely effect size of the CPV on behaviour.	SDQ
Estimate the likely effect size of the CPV on family functioning.	CPV bespoke measure and BMSLSS
Aim 3: Describe the referral and screening process	
Research question	**Measures**
Describe the flow of young people from referral, through evaluation, to engagement on the programme, including reasons for not progressing on the programme.	Referral fields in the database plus additional notes
Evaluate potential bias in selection by considering sample characteristics at different points in the referral process and, where possible, comparison across subgroups, e.g. referral sources.	Referral fields in the database plus additional notes
Aim 4: Client retention and data completion	

Research question	**Measures**
Do more than 66% of clients complete the intervention?	End of intervention form, end of study form and additional notes
For clients who complete the intervention, are more than 80% of the outcome measures completed?	End of intervention form, end of study form, SDQ, CPV bespoke measure and BMSLSS
Aim 5: To evaluate the potential for delivering a larger-scale randomised trial **Assessment to be made of the following success criteria:**	
Research question	
Referral: If bias in the referral process is identified, can this bias be addressed?	
Retention: At least 75% of young people and their families should be retained in the intervention, or evidence that retention can be addressed would be needed.	
Completion: At least 80% of outcome measures at baseline, 1, 3, 6 and 12 months, or evidence that completion can be improved in a larger-scale trial.	
Given the likely required sample size for a larger scale trial: a. What population size is required to achieve that sample size? b. Can likely delivery centres with a sufficient population be identified?	
Aim 6: To assess implementation process	
Research question	**Measures**
Has the intervention been implemented with fidelity?	Interview/focus group
Have service users felt engaged?	Interview/focus group
How responsive has the intervention been to service user, staff and volunteers (where appropriate)?	Interview/focus group

Success criteria and/or targets

The project's initial success criteria (as articulated in the proposal for funding) were complementary for children and adults and likely to be demonstrated within the period of the pilot evaluation. For young people, these included reduced violence, improved emotional regulation and engagement with others. For adults with parental responsibility, there was intended to be increased de-escalation skills; reductions in feeling of helplessness and social isolation; and improvements in wellbeing, confidence and community support. Please also see Table 1 above.

The main success criterion for the pilot evaluation is the potential to scale up the intervention to meet a sample size sufficient for both intervention and control arms. The sample size for a trial to evaluate effectiveness of the intervention has been estimated from evaluation of the potential effect size. Key criteria to assess evidence of promise were based on the research questions articulated in Aim 5 in Table 6 above.

Methods

Participant selection

Quantitative analyses were conducted on the entire dataset that had been uploaded to REDCap, i.e. both routine monitoring and core measures. Forms were collated and uploaded to REDCap by the CPV team and analysed by the evaluation team.

To assess the implementation processes, the evaluation team initially anticipated inviting up to five children and their parents, carers or legal guardians to participate in an interview to inform the pilot evaluation. Following the safeguarding concerns raised in feasibility and challenges in recruiting young people, they were dropped from recruitment to the pilot phase interviews. Professional stakeholders (up to five initially envisaged), including managers and delivery staff, were also sampled purposively by role. It was intended to conduct interviews – individual, jointly or within a group, as appropriate – with up to 15 participants associated with the CPV programme. Recruitment processes were the same as those articulated in the feasibility section above. Parent/carers, managers and frontline practitioners were invited to participate, including those who worked to deliver the CPV programme or were involved in referrals to it. Information about the participants recruited to the pilot evaluation can be seen in the findings section below.

Data collection

The evaluation draws upon different data sources and methods. These include the use of routine monitoring data collected by the projects, the core measure specified by YEF relating to project participants, and qualitative data from interviews and a focus group with project participants and professional stakeholders.

Data collection methods

As described above, for quantitative assessment, the outcome measures adopted in the pilot phase were the routinely used CPV bespoke measure and the BMSLSS; the SDQ was retained as a YEF specified core measure. Qualitative material was collated via interviews and a focus group. All interviews were conducted by the evaluation team and recorded, usually via video conferencing tools. In some instances, these were sound files only to conform to participant preference. Given the challenges of incorporating families' views into the implementation process elements of the evaluation, the evaluation team again asked the CPV team to provide examples of feedback that they had received. It is acknowledged that such data may be likely to be positively skewed; however, evaluators were sent both challenging and supportive examples and therefore felt it appropriate to use these comments, in a limited way, to bolster the data considered in the qualitative analysis. If an extract in the findings section below has been drawn from such feedback, it is marked clearly (e.g. Parent, x (project feedback)). Table 7 summarises the planned quantitative data collection schedule.

Table 7: Schedule of planned data collection and assessments

	Referral	Screening	Baseline (t0)	1 month follow-up (t1)	3 month follow-up (t2)	6 month follow-up (t3)	9 month follow-up (t4)	12 month follow-up (t5)
Demographics	X							
Programme-specific process	X	X						
SDQ			X	X	X	X	X	X
CPV parenting skills measure			X	X	X	X	X	X
Goal setting and attainment			x			x	x	x
End of intervention, or engagement form			To be completed if a client withdrew or when they completed the intervention.					

Please note that the data from baseline to t3 were originally uploaded during feasibility; they were carried forward to the pilot phase, when the additional two time points were added.

Data sources

To simplify description of the data, 'clients' encompasses the young people and/or families being considered for intervention, as appropriate. Quantitative data were captured separately for young people and their parents or carers. Please note that each client sub-set were recorded in both aggregated (total scores) and disaggregated (each item on the measure) ways to allow the evaluation to capture the different referral routes and their different potential experiences of the grantees' interventions. Each of the aims articulated in Table 6 earlier is presented here alongside the data source:

Aim 1: To evaluate the direction and magnitude of change in core outcomes over time, and for RISE to assess progress towards achieving goals

The key data sources were the SDQ data, and data from the CPV measure of child-to-parent violence and parenting skills, both of which were collected by the CPV staff and uploaded to the REDCap database. The data for goal setting and attainment has been extracted from the client notes held by RISE. Transcription and transfer of anonymised goal-related data for clients from RISE to the evaluation team was an ongoing process on a data format separately specified. It had been intended that the BMSLSS would also inform this aim. However, too few young people were engaged with the intervention or evaluation to test 'distance travelled' during the pilot phase.

Aim 2: To evaluate effect size

The effect sizes were estimated from the core dataset specified in Aim 1.

Aim 3: To describe the referral and screening process for the RISE programme

Data relating to screening and referral were requested, and where possible, these were incorporated into the REDCap database. Where the relevant data could not be captured in this way, the source data were the records held by the grantee. Again, transfer of anonymised data was an ongoing process on a data format separately specified.

Aim 4: To assess client retention and data completion

Attendance at therapeutic sessions and the client completion record were intended to allow evaluation of engagement in the CPV intervention, and the database record provides information on data completion.

Aim 5: To evaluate the readiness to delivering a larger-scale randomised trial

In addressing this aim, the evaluation team used all the data collected in a summary process to draw judgements after preceding aims had been evaluated.

Aim 6: To assess implementation process

The key focus of the pilot qualitative work was to understand, in more depth, matters that support or interfere with the intervention's delivery; the ongoing implementation processes of the intervention's recruitment, retention and reach; alongside service users' experiences and views of the intervention. Some replication from feasibility was deliberately built in to aid a richer understanding and to check whether challenges and successes were similar when the intervention had been running for longer. The interviews helped evaluators to further assess acceptability of and engagement with RISE by the young people and their families. Interviews with practitioners and referrers also informed the team's understanding of wider community engagement and assessment of whether and potentially how successfully processes might be managed and upscaled.

Table 8: Overview of intended methods

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Research questions addressed
Quantitative analysis	Routine monitoring data collected by RISE and concomitant core measure specified by YEF	Those referred, screened, accepted, discharged AND completing RISE programme. Includes progress against outcomes, as measured using YEF's core measures.	Descriptive and, where appropriate, inferential statistics	Aims 1 through 5
Qualitative analysis	Semi-structured interviews and a focus group	Purposive sampling of professional stakeholders (N=5) and opportunistic sampling of parents/carers (N=5) and children (N=5) accessing RISE programme.	Thematic analysis	Aims 1 through 6

Analysis

This section outlines the analytical strategy adopted within the pilot evaluation. Aims will be considered in turn, explaining how they have been assessed. The findings of those assessments will then be presented in subsequent sections of this report.

Aims 1 and 2: To assess the direction and magnitude of change in the main outcomes for the families in the programme. To assess the potential effect size of the intervention

As noted above, the CRIES-8 and ESYTC were not completed at any of the time points throughout the study. The Score_15 and IES-r for parents were only completed at baseline and, similarly to child-report outcome measures, they were not considered further during the pilot phase.

The analysis was intended to consider the SDQ, CPV parenting skills and child-to-parent violence data alongside progress against the goals set within the CPV programme for each client. The initial analysis is considered through descriptive statistics for the sample, as a whole, across all time points, including all demographic and other factors. The analysis describes change over time as a mean change from baseline (t or χ2 where appropriate) and estimated effect size (Cohen's $d_{z,}$ with confidence intervals) at 1 (t1), 3 (t2), and 6 (t3) months, and where possible at 9 (t4) and 12 (t5) months.

It was intended that sensitivity analysis would consider the influence of baseline characteristics and missing data. As the dataset is relatively small, any models would have had to constrain the number of variables included. The analysis would have sought to demonstrate gross effects of baseline variability and missing data (by replacement of missing values) and interpret any influence on the observed change over time. A particular method was not specified a priori, as the aim of the evaluation is exploratory (i.e. a pilot study). The methods applied would have been designed to evaluate particular questions, as they had arisen, rather than to undertake a more structured model-driven approach.

Goal attainment was intended to have been characterised as the graded progress against goals for each family. Where there is more than one goal for a client, identification of the main goal would have been used. Progress against the goals would have been characterised on the scale in a contingency table and summarised as a median with interquartile range. The intention to assess goals was for individual goals to be measured in a standardised way, using the Goal Attainment Scaling protocol outlined by Turner Stokes (2017).

Aim 3: Describe the referral and screening process

Analysis of the referral and screening process is descriptive. A flow chart is used to show the flow of clients from referral through screening to completion of the intervention. Focus is placed on why clients are not selected for the intervention at each stage. Descriptive analysis seeks to evaluate, through tabulation, the extent to which selection of clients is subject to bias, excluding particular groups of clients. Numbers of clients are small, but where possible, analysis uses χ2 to aid interpretation of the data.

Aim 4: Evaluate client retention and data completion in the programme.

For families starting the programme, retention to the end of the programme is important. Retention is defined as completing at least 75% of treatment sessions. This can be through missing sessions intermittently or regularly across the treatment period, or by withdrawing from the programme early.

The number of families failing to attend scheduled appointments is estimated, with the number and proportion of missed appointments and assessment sessions at each time point described. Adherence to the intervention (appointments) is estimated as an overall proportion of appointments missed for each family and the proportion of families attending at least 66% of treatment sessions. Characteristics of families that do and do not complete the programme have been tabulated and differences highlighted.

Data completion has been tabulated for each outcome. The choice of limits to define treatment adherence is a difficult challenge for evaluations, but most studies have limits between 66% and 75%. In general, limits can be defined by the intervention team, which makes a judgement about the minimum number of therapeutic sessions that should be attended to achieve a reasonable therapeutic effect. However, this is only informative where clients are required to attend a high proportion of available sessions to achieve the desired clinical outcome.

In practice, adherence determined in this way tends to have a biphasic distribution; that is, clients tend to attend therapeutic sessions or not, and attendance is either very low or greater than two-thirds. By using a 66% limit, the analysis allows for measurement error inherent in small samples without being too penalising (Midgley et al. 2018). This also means that if non-adherence is a significant issue, it can easily be detected and flagged.

Aim 5: Evaluation of success criteria

Readiness to progress to a larger-scale efficacy or effectiveness trial is assessed. A sample size is estimated more precisely following analysis in Aim 2. The progression criteria consider the potential to deliver a trial of suitable magnitude.

Progression to a larger-scale, efficacy or effectiveness trial considers four main criteria:

1. Bias in the referral and screening process and whether any bias can be addressed

Bias is evaluated by highlighting any differences between families that start therapy, compared to those that are referred but are not accepted on to the treatment programme. The reasons for not progressing will be listed.

2. Retention of clients in the intervention

Retention is an important secondary indicator of bias. Retention is initially evaluated by determining whether RISE were successful in retaining at least 75% of families that started the programme. Secondary analysis considers any apparent differences between families that do and do not complete the programme.

3. Sufficiently robust and unbiased data completion

Data completion for each of the outcomes has been tabulated. Data were defined as complete for scales where sufficient data for each outcome has been completed to evaluate a scale score. There is an allowable margin of missing data for each scale that allows for pro rata estimation of the scale score for a client. Where more responses are missing than the margin on any one scale, the data point (scale score for that client) is declared as missing.

4. Whether a trial of sufficient magnitude could be delivered

Analysis proceeds by tabulating the assessed outcomes from analysis of each of the first three aims and considering any mitigations identified in the qualitative analysis. This provides a summary statement of the success criteria, any bias in selection and any adjustments that can be made in future studies. The potential number of recruiting centres is estimated by considering how many young people and families could be recruited from each treating centre per year and the total number of treating centres required to achieve the required sample size.

Aim 6: Implementation process

Interview and focus group data were transcribed sufficiently for thematic analysis.[1] Due to the richness of the dataset, the evaluators have incorporated emerging themes more fully within this analysis and moved towards a more inductive analysis than initially outlined in the pilot protocol. Narrative fields from the REDCap database, containing information such as matters perceived to impede or facilitate positive outcomes, were also incorporated into the qualitative analysis. The evaluation of the CPV programme was one of four family-based interventions being delivered and evaluated concurrently by this team. This meant that emerging themes could be developed for each grantee, and it will be possible to conduct a secondary analysis across all four interventions subsequently.

Analysis was split into two sets: i) professional stakeholders (incorporating implementation practitioners, managers and referrers) and ii) families (incorporating those with parental responsibility for the referred children). The analytical method employed was reflexive thematic analysis (following Braun and Clarke 2020). This involves data immersion, multiple readings and reflection, designed to develop patterns of meaning through iterative development of themes and sub-themes. The first stage of the analytical process involved a close reading of all transcripts and then charting of data into pre-established broad organising concepts (e.g. recognised outcomes for families, perspectives on facilitators or barriers to intervention success). Iterations of themes and related sub-themes progressed through continual immersion in data extracted from the transcripts. Sub-themes were further refined through highlighting continuities and distinctions across extracts. Initial themes were shared within the research team to test for consistency and provide a degree of inter-rater development. This resulted in some shifting of sub-themes and reframing of

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[1] Transcripts were prepared that recorded everything said but did not note matters such as when there were elisions of speech, the length of pauses or other non-verbal aspects that may have been necessary for a conversation or narrative analysis but are not needed for thematic analysis.

themes. Analysis then continued, in this reflective way, to develop a thematic map and the findings presented below.

Timeline

Table 9: Timeline

Date Completed	Activity
16.12.21	Data sharing protocol renegotiation and transition to before-after pilot
24.02.22	Before-after pilot phase inception, including finalised pilot protocols and fieldwork completion
30.04.22	REDCap data download
30.06.22	Data analysis (pilot data), cleaning and preparation of data for archiving
30.09.22	Submission of draft final reports
30.11.22	Final report drafting, peer review and revision (feasibility and pre-post pilot).

Participants

For the implementation process evaluation, interviews were completed with five participants with parental responsibility, three referrers and seven managerial and practitioner professionals working as part of the RISE team. It should be noted there were 15 parents who had initially given consent to be contacted.

For the quantitative elements of the research, there were 170 family referrals, from which 107 young people and their parent/carer/guardian engaged with the project at baseline. For the evaluation, data completion was a little erratic, and most families do not have follow-ups at each interim three-month point. By 12 months, 94 records were uploaded to REDCap. From those who had completed the intervention, just under half of the parental forms had been completed on the CPV bespoke measure and SDQ. End-of-study forms indicate that 81 families had completed the intervention, 11 had not attended and five were listed as other. The most conservative way of calculating a retention rate therefore would be 81/107, or 76%, to the end of the pilot phase of evaluation.

Findings

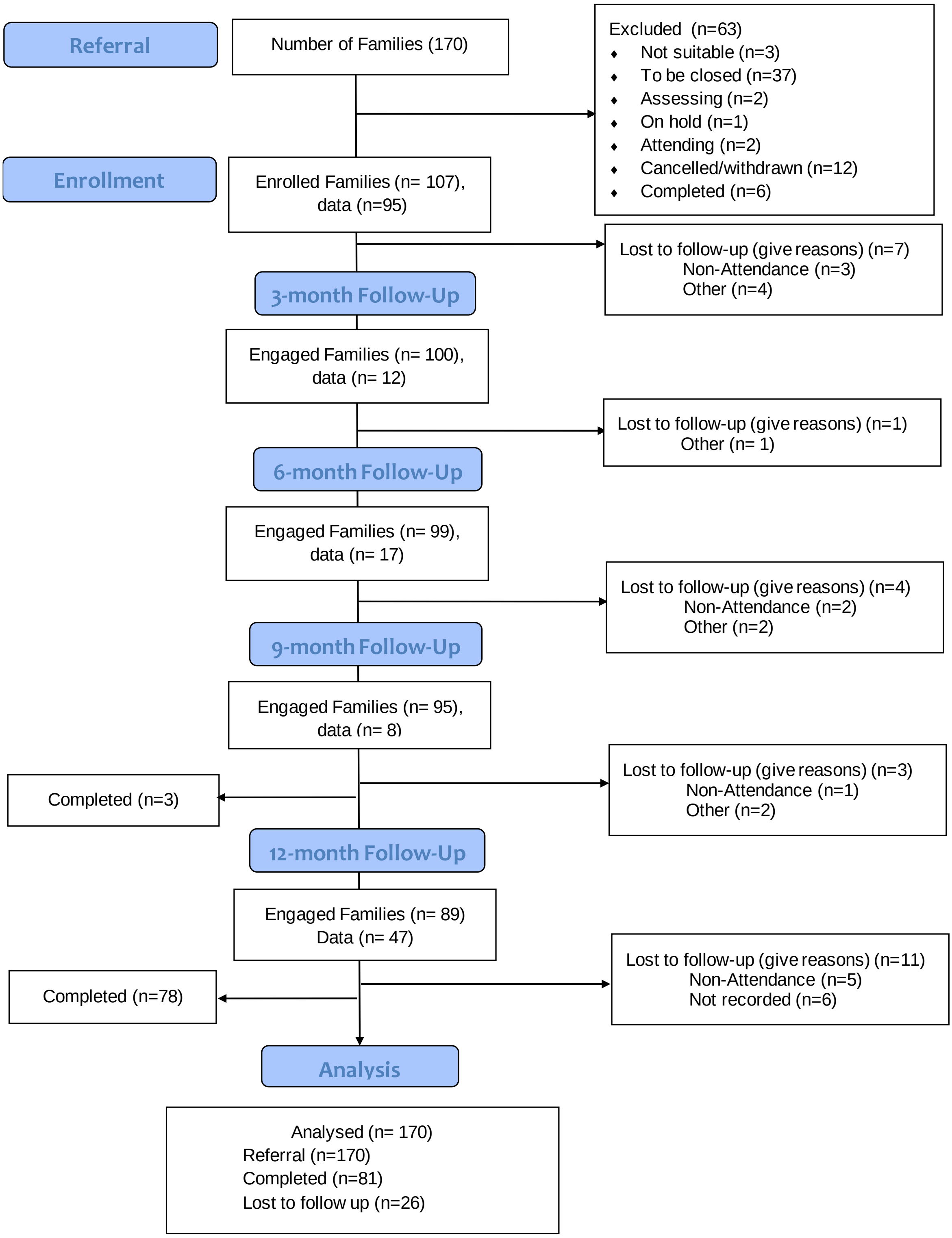
In this section, data are presented in the easiest order for interpretation and in ways that show how the analysis was built. All aims will be covered. Aim 3 is presented first, then Aims 1 and 2. For each aim, quantitative findings are presented, and then relevant qualitative themes are considered. The last aim evaluated, Aim 6, is entirely assessed through qualitative analysis.

Aim 3: The referral and screening process

Starting with Aim 3, the referral and screening process is evaluated first and is summarised in the flow chart (Figure 1) and Tables 11 and 12. Of the 170 families referred to RISE, 63 (37%) were not accepted into the service for support/not included in the study for YEF. As part of report preparation, the evaluation team were informed that a common reason for non-enrolment was that the children fell outside the targeted age range. Within the data provided via REDCap for the evaluation itself, three families were recorded as not suitable, 37 were recorded as to be closed (without any further information given), two were recorded as 'assessing' (but were not enrolled at the time of the evaluation and not recorded on the database for YEF), one was recorded as 'on hold', 12 were recorded as 'cancelled/withdrawn', two were recorded as attending (but were not included in the families followed up on the database for YEF) and six were recorded as intervention completed (but were not included in the families worked with during the evaluation for YEF). One hundred and seven families were enrolled in the programme.

Figure 1: CONSORT type flow chart of referrals and retention for RISE Child to Parent Violence programme

CONSORT 2010 Flow Diagram



For the majority of the referred families, the child was 13 years old, mainly male (108 young people, 64%) and White (110, 65%) or mixed race (19, 11%). Table 11 shows that there were very few differences between the families that were enrolled and those that were not. One difference is that the referred young person tended to be older in families that did not enrol (14 vs 12). It should also be noted that the referrals came from social workers, across the two operating areas (Bromley and Croydon). Time from referral to enrolment ranged from 2–14 days.

It appears that there is very little risk of bias in the referral and screening process. It is worth noting that 37 of the families that were not enrolled did not have a reason recorded as to why they were not enrolled and were recorded as ‘to be closed’. It is difficult to know whether there was anything different about these families, but some cases did have notes indicating that they could not be contacted or engaged and subsequent information regarding the likelihood that they fell outside the intended age range can also be taken as reassuring.

A limited additional perspective was gained from the implementation process interviews. One practitioner felt that it is good practice to persist with families who may be reluctant to engage, while acknowledging that sometimes, even when the families attend, the intervention may not be working for or with them:

> *"I have had a few experiences where I've had to close a case after the first session, when I can just see it's not going to work with the parent. That's been very rare, and that's maybe happened once or twice out of, I don't know, 30, 35 cases that I've had.* [It's] *usually them that ends it, though, and they've stopped talking to me;* [I] *never stop talking to them"* (Practitioner #5).

Aim 4: Client retention and data completion

Client retention and data completion (Aim 4) is outlined in Table 12. Under the principle of intention-to-treat, here data completion is considered in relation to the proportion of records at each time point in comparison to the number of families enrolled in the programme (n=107). At each time point, the number of families remaining in the programme is also highlighted. This may include families that have skipped data completion at one point and then returned to the evaluation subsequently. It should be noted that the COVID-19 pandemic was a significant factor in disrupting follow-up.

The number of families remaining on the RISE programme to 12 months is high, with 89 (83%) recorded as remaining on the programme. This includes several families that had not attended sessions. It is clear that by 12 months, 81 families (75.7%) had successfully completed the programme. It is worth noting also that there is almost no data collected from the children (n=1), and the maximum number of families providing data at follow-up is 17 (16%) at six months and 47 (44% of those enrolled) at 12 months. It is also noted that collection of data relating to goal setting was compromised by the needs of clinical practice and could not be reported here.

This indicates both a very low rate of data completion and the potential for significant bias. Tables 13 and 14 provide a comparison between the families (n=81) that were reported to have completed the programme (and have at least some data collected at follow-up) compared to those that were lost to follow-up and for which no data have been collected at follow-up. The baseline characteristics are reported. In general, the two groups are very similar, with the only apparent difference being the number of sessions attended. As might be expected, families that were lost to follow-up completed significantly fewer sessions than those that were retained and engaged in the programme. There remains the potential (outlined below) for significant differences in response to the programme between these groups. While data completion was compromised, client retention, defined by the programme, remained high. The programme reported that 89 (of 107, 83%) were retained in the programme to 12 months, with 81 (76%) families reported as having completed the programme.

Table 10: Data intended to be collected at each time point

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	X						
Gender	X						
Ethnicity	X						
Referrer	X						
Date of referral	X						
Family ID							
Index of Deprivation							
CPV (bespoke measure)							
Pre-Intervention Questionnaire							
BMSLSS			X	X	X	X	X
SDQ			X	X	X	X	X
Score 15			X	X	X	X	X
IES/CRIES8			X	X	X	X	X
ESYTC			X	X	X	X	X
Study End Form							X

Table 11: Demographic characteristics of families referred, unsuitable (referral only) and enrolled

		Overall	Referral only	Enrolled	Test of significance
n		170	63	107	
Child's age mean (sd)		13.13 (2.15)	14.22 (2.36)	12.49 (1.73)	t= 5.51, p<0.001*
Child's gender n (%)	Male	108 (63.53%)	39 (61.90%)	69 (64.49%)	χ^2= 0.23, p= 0.89
	Female	60 (35.29%	23 (36.51%)	37 (34.58%)	
	Prefer not to say	2 (1.18%)	1 (1.59%)	1 (.93%)	
Ethnicity n (%)	White	110 (64.71%)	45 (71.43%)	65 (60.75%)	χ^2= 4.97, p= 0.42
	Black	14 (8.24%)	3 (4.76%)	11 (10.28%)	
	Asian	3 (1.76%)	2 (3.17%)	1 (.93%)	
	Mixed	19 (11.18%)	7 (11.11%)	12 (11.21%)	
	Other	10 (5.88%)	3 (4.76%)	7 (6.54%)	
	Not provided	14 (8.24%)	3 (4.76%)	11 (10.28%)	
Borough	Bromley	89 (52.35%)	35 (55.56%)	54 (50.47%)	χ^2= 0.15, p= 0.70
	Croydon	77 (45.29%)	28 (44.44%)	49 (45.79%)	

note. * Indicates a significant difference at a .05 level

Table 12: Actual data collected at each time point

	Referral n= 170	Screening	Baseline (T0) Enrolled n = 107	3 months (T1) Still enrolled n=100	6 months (T2) Still enrolled n= 99	9 months (T3) Still enrolled n= 95	12 months (T4) Still enrolled n= 89
Age	170 (100%)						
Gender	170 (100%)						
Ethnicity	170 (100%)						
Referrer	168 (98.82%)						
Date of referral	170 (98.84%)						
Family ID	170 (100%)						
Index of Deprivation		0* (0%)					
CPV (bespoke measure-parents) (BMSLSS- children)			P: 95 (88.79%) C: 0 (0%)	P:12 (11.21%) C: 1 (0.93%)	P:17 (15.89%) C: 0 (0%)	P:8 (7.48%) C: 0 (0%)	P:47 (43.93%) C: 0 (0%)
Pre-Intervention Questionnaire			?				
SDQ			P: 94 (87.85%) C: 0 (0%)	P: 12 (11.21%) C: 1 (0.93%)	P: 17 (15.89%) C: 0 (0%)	P: 8 (7.48%) C: 0 (0%)	P: 45 (42.06%) C: 0 (0%)
Score 15			P:16 (14.95%) C:1 (0.93%)	P: 0 (0%) C: 0 (0%)	P: 0 (0%) C: 1 (0.93%)	P: 0 (0%) C: 0 (0%)	P: 0 (0%) C: 0 (0%)
IES			15 (14.02%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
CRIES8			0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
ESYTC			0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Study End Form			Non-attendance 3 (2.8%) Other 4 (3.74%)	Non-attendance 0 (0%) Other 1 (0.93%)	Non-attendance 2 (1.87%) Other 2 (1.87%)	Completed 3 (2.80%) Non-attendance 1 (0.93%) Other 2 (1.87%)	Completed 78 (72.90%) Non-attendance 5 (4.67%) Missing follow up 6 (5.61%)

*Deprivation not collected on REDCap first part of postcode on redacted information.

Table 13: Comparison of demographics between families who did or did not complete study measures

		Completed	Lost to follow up	Test of significance
n		81	26	
Child's Age m (sd)		12.56 (1.68)	12.65 (1.90	t=-.22, p=.83
Child's Gender n (%)	Male	50 (61.73%)	19 (73.08%)	χ^2=1.30, p=.52
	Female	30 (37.04%)	7 (26.92%)	
	Prefer not to say	1 (1.23%)	0	
Race n (%)	White	50 (61.73%)	15 (57.69%)	χ^2=6.36, p=.27
	Black	9 (11.11%)	2 (7.69%)	
	Asian	1 (1.23%)	0	
	Mixed	6 (7.41%)	6 (23.07%)	
	Other	5 (6.17%)	2 (7.69%)	
	Not provided	10 (12.35%)	1 (3.85%)	
Borough	Bromley	44 (54.32%)	10 (38.46%)	χ^2=.2.04. p=.15
	Croydon	34 (41.98%)	15 (57.69%)	
Number of sessions attended m, sd		14.71 (4.26)	5.37 (5.23)	t=7.11, p<.001*

note. * indicates a significant difference at a .05 level

Table 14: Comparison of mean scores between families who did or did not complete study measures

		Completed		Withdrawn		Test of significance
		n	Mean (sd)	n	Mean (sd)	
Parent	SDQ	70	23.7 (5.07)	24	23.83 (6.44)	t=-0,10, p= 0.92
	Score-15	12	45.58 (13.49	4	51.25 (13.84)	t=-0.72, p= 0.48
	IES-r	11	29.45 (18.60)	4	30 (21.37)	t=-0.05, p= 0.96
	CRIES-8	0	-	0	-	-
	Child-to-Parent violence	69	44.06 (13.09)	25	40.76 (15.73)	t= 1.02, p= 0.31
	Parenting Skills	70	8.06 (1.68)	24	8.92 (1.77)	t= -2.13, p= 0.04*
Child	SDQ	0	-	0	-	-
	Score-15	1	35 (-)	0	-	-
	CRIES-8	0	-	0	-	-
	ESYTC	0	-	0	-	-

note. * indicates a significant difference at a .05 level

Additional insight into data completion was gained from the interviews, where data capture was sometimes mentioned as a barrier to engagement. Although one professional indicated that data capture can be “useful for getting to the root of the problem and examining all the issues” with families (Staff member #1), the professional also acknowledged the challenges in engaging young people meaningfully in the evaluation of the intervention:

> “[We] *clearly haven’t done so many of the questionnaires with the child,* [as it] *interferes with engagement, and it’s just so boring for them.* [By] *the time we even start the work with the child, we may have been working with the parents for three or four months, so there’s no real baseline because the work with the family, the work with the parents, has already started to affect the child.* [So] *in that sense, it doesn’t really work because there is no real baseline, and they still don’t want to sit in a room with us, because we’re boring. And we have really started working with them, and they are starting to engage*, [so] *it’s just not practical”* (Staff member #1).

A similar view was expressed by another practitioner:

> *“I found the questionnaires quite challenging, to be honest.* [It] *got easier as we’ve gone along. But I’ve got the odd example where there’s a family that maybe because things have got better quite quickly, [...] we haven’t needed that many, like maybe eight or 10 sessions and we’d normally book in and do that final questionnaire, the SDQ at the end. [...] Things are so improved, and I’m really struggling to get her to do the questionnaire, so I've tried to arrange an appointment with her.* [As] *far as she's concerned, the problem has kind of gone now, and her daughter isn't being aggressive anymore. But, from my point of view, I really want that questionnaire done, because I want to capture the fact that her daughter was really aggressive, and she isn’t now. […] Yeah, and also they are quite long, so she knows it won't just be like a five-minute questionnaire to do over the phone; she knows it would take a bit longer than that"* (Practitioner #6).

It was acknowledged that the sensitivity of the measures does not always adequately reflect the scale of change, nor do families themselves always see the impact in the same way as professionals:

> *"Sometimes, I mean, we’re working with these families for six, eight months [...] and then sometimes you're filling out at the end, and obviously, [...] you can’t affect the answers, you've got to be clinical. [...] And so we've got to clinically not lead these people and ask them questions and go, ‘So, how much improvement do you think there's been?’ And they go, ‘Oh, a little bit.’* [However]*, they've not done anything for three months, and you're saying a little bit. I mean, come on, we have transformed your life and you’re saying a little bit"* (Referrer #1).

A similar view was expressed by Practitioner #6. In the extract below, they highlight the importance of making additional notes when trying to address the lack of sensitivity of the measures:

> *"So any comments I have to send to* [colleague] *in an email, because there are things, and I'm sure I raised it last time, about the questionnaire. One, well, two particular questions that stick out: one of the answers in one section happens almost every day, […] emotional abuse, such as name calling, sometimes a parent might say, well, he called me* X*, we've all got the letters – like, 20 times a day – at the point of referral. Now, he might call me a X almost every day.* [It’s] *a colossal improvement, but it doesn't show up unless you put the comments. And the other thing that does really spring to*

> *mind […] how is it worded? Like, has your child suffered emotional difficulties in one or more of these areas? And then it gives four areas, and you might get a point of referral, and it's like, yeah, massive difficulties in all four of those areas, but then after the intervention, they've got difficulties in one area. So, again, you've massive improvement, but unless there's a comment, you don't see it"* (Practitioner #6).

Aims 1 and 2: The direction and magnitude of change in the main outcomes and the potential effect size

The mean scores for each of the outcome measurements are presented in the following tables for each of the time points: SDQ (Tables 15 and 16) and the CPV parenting skills (Table 17). Only two children (out of 107), completed any of the child outcome measures across all time points, and their data are thus not considered within inferential analyses. Seven (6.54%) families were marked as withdrawn from the study at the baseline time point for non-attendance or non-engagement (n=3, 2.8%) and other reasons (n=4, 3.74%).

Where data have been reported, the families indicate a slight improvement for the child. The SDQ total scores at baseline are reported as very high and are reduced, but still high by 12 months. The impact scores of the SDQ remain very high over time.

Similarly, the families report an improvement between baseline and 12 months, in both parenting skills and reduction in child-to-parent violence. The CPV bespoke assessment scores fluctuate with a slight improvement at three months and nine months for the child-to-parent violence sub-scale and an improvement at six months for the parental skills scale. However, the very low completion rates of these measures at three, six and nine months follow-up make them difficult to interpret.

Change in the scores for the SDQ and CPV bespoke measure were evaluated at each time point compared to baseline (see Tables 18 and 19). For both outcomes, the number of families providing data was well below 75%, making adjustment for baseline status meaningless. Similarly, no attempt was made to evaluate the effect of missing data (sensitivity analysis), as any attempt to impute missing values would overwhelm the data reported. Further commentary on these issues is reported below.

For both the SDQ and the CPV bespoke measure, the scores fall significantly by three months, which is maintained through six, nine and 12 months. We note that the reported effect sizes[2] are medium to large and indicate a fairly robust treatment response. For the SDQ, a significant improvement in scores is reported at three months, with a 3.4 point decrease in the parent reported SDQ total score (t=2.85, p=0.02) with a large effect size d_z=0.90, which is maintained to 12 months with a 4.95 point decrease in total score (t=5.77, p=0.01) and a large effect size d_z=0.92.

Similarly, for the CPV bespoke measure, there is a significant improvement by three months, with a 23.62 point decrease in child-to-parent violence total score (t= 4.65, p= 0.002) with a very large effect size d_z= 1.64, and also a 19.93 point decrease in child-to-parent violence total score at 12 months (t= 9.43, p<0.001) with a very large effect size d_z= 1.49. Although there is still a decrease in scores at six months (13.59 point

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[2] It is generally recognised that an effect size d>0.7 is large. However, repeated measures designs, where the evaluation is changed over time generally, show larger effects than comparisons between groups in parallel group designs (intervention compared to control groups).

decrease) and at nine months (24.38 point decrease), the mean score is higher in both than at three months. Considering the low completion rates at three, six and nine months, this may be due to differences in the families completing the measure at these time points rather than a worsening of behaviour. There were no cases where measures were completed across all time points; the majority of families completed measures at three of the possible five data points.

The parenting skills section of the CPV also shows a slight improvement by three months, which becomes significant at 12 months, with a 1.32 point increase in total scores ($t=-4.43$, $p=.001$) yielding a large effect size $d_z= 0.77$. While the reported change over time is fairly large and statistically significant, the proportion of missing data makes interpretation difficult. It should be acknowledged again that the COVID-19 pandemic was a significant factor in preventing completion of outcome measures during the pilot period.

An analysis of missing data is not helpful, as imputed scores will overwhelm observed scores. The profile of families reporting data and completing, compared to those that did not, does not show many significant differences at baseline (as reported above). The main change observed is in the reported parenting skills, with those that did not complete the programme indicating a slightly higher mean parenting ability at baseline compared to those that completed the programme (8.1 vs 8.9). It remains possible that families that did not provide data at follow-up may not have perceived as much benefit from the programme as those families that did provide data. The outcomes therefore need to be treated with caution.

Table 15: Mean score and standard deviation for total SDQ score across each time point

Note: The four-band solution for cut-off scores of SDQ (rounded to nearest whole number) has been used. *=Slightly raised above average **=High ***=Very high

	Baseline n=94			3 months n=12			6 months n=17			9 months n=8			12 months n=45		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	23.73*** (5.41)	11	35	22.67*** (5.12)	16	33	20.06*** (6.16)	10	31	19.5*** (7.69)	9	30	18.78** (6.53)	3	35
	Baseline n=0			**3 months n=1**			**6 months n=0**			**9 months n=0**			**12 months n=0**		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	-			18** (0)	18	18	-			-			-		

Table 16: Mean SDQ impact score and standard deviation across each time point

	Baseline n=92			3 months n=12			6 months n=16			9 months n=7			12 months n=43		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	5.73*** (2.68)	0	10	5.75*** (1.76)	3	9	4.19*** (3.53)	0	10	3.57*** (3.46)	0	10	4.4*** (3.08)	0	10

Note: The range is 0–10 for parent scores. The four-band solution for cut-off scores of SDQ (rounded to nearest whole number) has been used. *=Slightly raised above average **=High ***=Very high

Please note that the SDQ has different scoring scales for each subscale categorised in different bands. For the parent total, it is: close to average 0–13, slightly raised 14–16, high 17–19 and very high 20–40. For the parent impact score, it is: close to average 0, slightly raised 1, high 2 and very high 3–10. For the child total score, it is: close to average 0–14, slightly raised 15–17, high 18–19 and very high 20–40. For the child impact score, it is: close to average 0, slightly raised 1, high 2 and very high 3–10.

Table 17: Mean and standard deviation scores for the total and average CPV bespoke measure scores across each time point

		Baseline n =94			3 months n=11			6 months n=17			9 months n=8			12 months n=47		
		m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max	m (s.d)	min	max
Parenting skills	Total score	8.28 (1.74)	3	12	8.18 (2.56)	3	12	9 (2.12)	3	11	7.75 (1.83)	5	10	9.53 (1.6)	4	12
	Average score	1.38 (.29)	.5	2	1.36 (.43)	.5	2	1.5 (.35)	.5	1.83	1.29 (.31)	.83	1.67	1.59 (.27)	.67	2
Child-to-parent violence	Total score	43.18 (13.83)	12	74	23.9 (16.82)	7	52	31.88 (14.54)	12	62	27.5 (13.94)	12	51	23.41 (12.96)	0	55
	Average score	1.88 (.6)	.52	3.22	1.04 (.73)	.3	2.26	1.39 (.63)	.52	2.7	1.2 (.61)	.52	2.22	1.02 (.56)	0	2.39

Note: Total score between 0–12 for parental ability and between 0–92 for violence, Average score between 0 and 2 for parental ability and between 0–4 for violence

Table 18: Estimation of outcome and treatment effects (comparison to Time 0), months three and six

Outcome measure	Total n	Baseline			3 months			Comparison 3 months - baseline					6 months			Comparison 6 months- baseline				
		n	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	n	m	sd	N	diff	t (p)	d_z	CI (95%)
Parents																				
SDQ	176	94	23.73	5.41	12	22.67	5.12	10	3.4	2.85 (.02*)	.90	.70 - 6.10	17	20.06	6.16	17	3.41	2.62 (0.02*)	.63	.65 - 6.17
Parenting skills	177	94	8.28	1.74	11	8.18	2.56	10	-.6	-0.92 (0.38)	-.29	-2.08 - .88	17	9	2.12	17	-.59	-0.88 (.39)	-.21	-2.01 - .83
Child-to-parent violence	172	94	43.18	13.83	11	23.9	16.82	8	23.62	4.65 (.002*)	1.64	11.60 – 35.35	17	31.8	14.54	17	13.59	4.63 (.001*)	1.12	7.37 – 19.81

note. * indicates a significant difference at a .05 level

Table 19: Estimation of outcome and treatment effects (comparison to time 0), months nine and 12

Outcome measure	Total n	Baseline			9 months			Comparison 9 months - baseline					12 months			Comparison 12 months- baseline				
		n	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	n	m	sd	N	diff	t (p)	d_z	CI (95%)
Parents																				
DQ	176	94	23.73	5.41	8	19.5	7.69	8	5.25	3.09 (.02*)	1.09	1.23 – 9.66	45	18.78	6.53	39	4.95	5.77 (<.001*)	.92	–.21–- 6.69
Parenting skills	177	94	8.28	1.74	8	7.75	1.83	8	-.75	-1.21 (0.27)	-.43	-2.22 - .71	47	9.53	1.6	47	-1.32	-4.43 (<.001*)	-.69	-1.92 - -.72
Child-to-parent violence	172	94	43.18	13.83	8	27.5	13.94	8	24.38	6.43 (.001*)	2.27	15.42 – 33.33	47	23.41	12.96	40	19.93	9.43 (.001*)	1.49	15.65 – 24.20

Note: * indicates a significant difference at a .05 level

Changes in family functioning over the course of the intervention were highlighted through interviews. It was noted that the programme put parental wellbeing at the forefront, which facilitated positive change for families.

> *“*[It] *is not judgemental, but this is the one course that is looking at you, looking at your wellbeing as a carer, a grandmother or a grandfather, or a parent, they're looking at your wellbeing foremost, and how they can help you to deal with your children's problems, rather* [than] *approaching it from the child's point of view"* (Parent/carer #3).

Parents and carers recognised that the intervention led to marked improvements in their child’s emotional wellbeing and general behaviour:

> "[He] *has calmed down. He used to be quite overexcited with certain things, quite anxious about certain things.* [At school], *they had a lot of concerns about him doing DT class, for example, where there are lots of tools, and safety of him and safety of other children, and concerns that he may not be able to handle those things [...] So they were quite concerned about all that, and we haven't heard any of that at all this year"* (Parent/carer #2).

> “*We haven't had any outbursts of that kind that we used to have at all, and he still gets anxious, and he still gets upset sometimes when things don't go his way; but, at the same time, talking to him helps"* (Parent/carer #4).

> "[Young person] *tries to do a little bit more for herself. Whereas at one time it was, ‘Oh, can you do this? Can you do that?' And, of course, I was doing it"* (Parent/carer #1).

Alongside these recognised changes, one service user highlighted a reduction in conflict within their home:

> *“Today, I can say that I am GRATEFUL this programme has helped me to understand my children more, to control situation that could have led to arguments, fights or even violence. My daughter also noticed the changes this program has helped us to achieve. Thank you so much; my family and I are grateful”* (Parent/carer #1; project feedback).

Two professionals from referral agencies conveyed feedback they had received from families regarding the impact of the intervention on reducing conflict:

> *“I think what really worked well is really the reduction of conflict and violence in the family. It most definitely has worked, and I think that happens when parents take it onboard"* (Referrer #2).

> *"I had to speak to the family members to say, well, what is the current situation, and how do you feel being supported from the different networks? And the first one they mentioned, it was RISE, that they feel that the support is very good. [...] And there was no other incident of the young person either becoming violent to other family members, so there was a lot of improvement"* (Referrer #3).

> *"*[A] *parent consistently reported that there was a decrease in events and an increase in her feeling able to manage these incidents, which is a positive outcome"* (Referrer #2; project feedback).

Parent/carers and professionals emphasised how the intervention led to more harmonious relationships between young people and their families. A parent/carer highlighted that homelife had become a "calmer, more nurturing, mutually respectful and loving environment" and that programme involvement had led to an improved relationship with their child (#5; project feedback).

One other parent/carer spoke of reconciliation with their children through drawing on learnt techniques from the programme:

> *"Just having reconciliation and approaching children with more respect, I think, we found was very useful for us. Because the more respect we gave and treated them like equals, they were responding better, rather than barking orders at them"* (Parent/carer #2).

A professional highlighted an example of the intervention significantly improving relationships between the young person and whole family:

> *"I do have a particular family, probably with a child with the most challenging behaviours.* [The parents] *really got onboard and said, right, this is it; they literally said this weekend, that's it, we're going to do this, and we're going to do it wholeheartedly. […] And it all happened during lockdown, where the whole family – and he's got a little brother – where the whole family was just there all the time, so it was a particularly challenging time for them, and yet it worked. At one point, him and his brother couldn't be left in the room on their own because he would just fight him and beat him up, and it was awful.* [They] *actually do things together now, and they play together, they'll watch TV, do a film, play games, she said, which is just a miracle as far as she's concerned"* (Referrer #2).

Another referrer provided an example where a young person, who would have gone missing from home, began to spend more time with their family as there was less tension and improved relationships following the intervention:

> *"*[A] *young person used to go missing quite a lot, but after the relationship was improving and the episode significantly decreased.* [He] *was also communicating with*

> *professionals because we were trying to manage risks and the like. It's only that sometimes our young person* [felt] *a lot of pressure around, within the community around, and that is due to exploitation.* [The family] *were no longer fearful of his behaviour or threats of violence because the relationship has improved.* [Parent] *was able to spend more time with him, use the strategies to calm the young person, and the relationship was even becoming stronger, which was quite positive, and the young person also was enjoying that time with the family"* (Referrer #3).

Aim 5: Evaluation of success criteria

1. Bias in the screening and referral process [Green]

The referral and screening appear to be largely unbiased. There is very little observed difference between families that are enrolled on the programme and those that are not. The families that are not enrolled tend to report fewer problems. This indicates a robust process that is generally acceptable to the target population. Therefore, the lack of bias indicates that, on this criterion, the CPV intervention is suited to undertaking a trial.

2. Retention of families in the programme [Green]

The programme reported the number of sessions attended and the number of families completing the programme. The proportion completing the programme was high (76%). While there is potential bias in reporting by the programme delivery team, there was little indication that this was the case, and there can be confidence that a high proportion of families enrolled on the programme will complete it. Again, this criterion indicates that the delivery of the intervention is sufficient to support a trial.

3. Sufficiently robust and unbiased data completion [Red]

Data collection was a significant problem. While it is acknowledged that the COVID-19 pandemic affected intervention delivery and evaluation data completion, the maximum proportion of data completion at any time point was 44% of those initially enrolled, which is very low and compromises the internal reliability of any study design. There was no indication that there was a significant difference between families that did or did not complete the measures. It is also possible that families that did not complete did not perceive as much benefit from the programme, but the quantitative data to support this conclusion is limited. Although limited in scope, some of the qualitative findings indicated that the measures were sometimes seen as being too onerous, particularly when families were being asked to fill them in them after they had successfully completed the intervention. Measure completion remains a significant risk to a future larger-scale trial.

4. Can a trial of sufficient magnitude be delivered? [Amber]

The programme produced a significant treatment effect for families that did report outcome data, indicating that there is good evidence that the intervention could be effective in a randomised trial with at least a medium effect size. Assuming that the primary outcome would be the CPV bespoke measure, for which there is most data and the largest effect – an effect size for parallel groups of $d=0.5$ ($\alpha=0.05$, $1-\beta=0.9$) would require sample size of $n=86$ per group (total $N=172$) assuming that a control condition produces little or no improvement and does not account for any clustering. This would need to be considered in the context of completion of the intervention (73%) and data collection, which would significantly increase the required sample size. In general, the estimation of the required sample size con only be fully realised following considerable co-design of the trial intervention and control conditions, where all the relevant factors can be specified with some degree of certainty.

The programme recruited a substantial number of families to the intervention over a year (n=107), indicating that families are willing to engage. How many of these families would have been willing to take part in a randomised trial, with random allocation, was not tested. There remains the potential to complete an appropriately powered trial given the potential to recruit to the programme, but it is possible that either the current programme would need to increase capacity or additional sites would need to be identified.

The primary risk to a trial must be the lack of measure completion. The impact of the COVID-19 pandemic needs to be considered, but even under these circumstances, the level of data completion is very low. A number of issues would need to be addressed to recommend progression to a full trial.

I. Can sufficient evidence be gathered to indicate that data completion can be significantly improved?
II. Can a suitable control intervention be identified that is not subject to too much heterogeneity?
III. Evidence would need to be gathered to indicate that families would be willing to be randomised.

If these issues can be addressed, it is possible that a trial of sufficient magnitude can be delivered.

Aim 6. Implementation process assessment

Implementation fidelity

A practitioner highlighted that the principle of the intervention is to explore with parents how they respond to the presenting difficulties in the home. This exploration itself is seen as beginning to enable parents or carers to try different approaches:

> "[All] *the other things that they're doing non-verbally are actually so much more important sometimes; the verbal things are important, but, actually, their action is also really important. Things that they're completely unaware of, that they are doing in the home. And that's why I think NVR is so unique [...]. It teaches the practitioner to think on their feet, but it also teaches the parent to embody that and then eventually use those techniques to do it themselves."* (Practitioner #5).

The programme teaches parents and carers to consider practical strategies to increase their child's emotional wellbeing, such as positive affirmation techniques. This was seen as increasing young people's self-esteem, helping to foster better relationships with their caregivers:

> *"I think one thing that works really well, and when it comes to sort of praise, which is really, really important for the two reasons of, one, increasing connection and the parental presence, but also rebuilding self-esteem. Because there is a big connection with self-esteem, when a child's self-esteem is really low, they don't think they deserve certain things and things like that"* (Practitioner #6).
>
> "[One family] *felt like RISE were giving them practical support and practical strategies, in terms of managing violence in the home. And indirectly, what also took place with one of these strategies is that it built the relationship between the family, of parents and the young person. Because one key element I picked with the programme is that they offered what we call use of affirmation, when the parents are responding to a child's needs and in terms of communicating. So that also became quite key, like, one day I arrived visiting, and the maternal grandmother was starting to implement those, like being affirmative, talking positively about the young person, and he was so happy that day and he was engaging, and that also promoted him spending more time at home"*(Referrer #3).

A parent/carer highlighted that when principles on reducing conflict are carried forward, there is the potential to maintain positive family relations beyond the intervention:

> *"I think the programme [...] was obviously meant for my oldest and, in general, has helped. Understanding the principles has helped in many ways, actually, towards our younger son, as well as towards each other, in a way"* (Parent/carer #2).

One adult with parental responsibility described learning about alternate approaches as seeming “counterintuitive”. However, the programme provided opportunity to rethink the responses to their child’s behaviour and enabled them to become more comfortable:

> “*From the very beginning, in a way, when you think you do not address the issues which are very stick rather than a carrot, or whatever you can call it. You would think it is counterintuitive with the children will start taking advantage of it or will make more of it…. in a way, you think you feel pressured to be strict with your children in certain ways, because that's what is expected of parents.* [We] *would respond with the equal amount of whatever the force he is bringing, and it ends up escalating rather than deescalating; and just take it away, that thing, and address his real concern, as opposed to feeding into whatever anxiety he's feeling, by doing more of what he wants or what he thinks he wants"* (Parent/carer #2).

Three parent/carers highlighted that a key outcome for them was that they were enabled to take a different approach with their children:

> *"Early help is brilliant support as well, but on a different level. Whereas the NVR was more for the behaviour and how to deal with it, and things like that.* [It] *was just some of the advice and the routines that she* [practitioner] *was trying to go through with me. Some did, some didn't* [work]*; it was just good advice, and I thought, ‘Yeah, I've never thought of trying that before’”* (Parent/carer #1).*"One of their points was, really, that we had to feel that we were safe, and how we can feel safe when* [young person] *has quite lost it. And this was kind of, if you like, removing yourself from the situation, don't try and speak with him and calm him down now, it's not going to work”* (Parent/carer #3).*"I think not taking things away from him when he's being naughty, or when he's in one of his full-blown* [outbursts]*. It's not to [be] like, right, I'm taking your PlayStation, I'm taking that, because that just adds fuel to the fire and that would just escalate, and escalate, and escalate. [...] That's one of the things, is to try and step back"* (Parent/carer #4).

The programme supports parents and carers to consider practical NVR, de-escalation techniques and affirmation strategies to encourage positive behavioural change:

> *“*[We] *had a box, and when he’d done something good, you write it on a piece of paper and put it in the box. [...] And it was absolutely the slightest thing that he might do well [...]. Sort of the type of things you might not consider he's doing well, and you might think it's a normal child. That's what a normal child would do, but even if he wasn't being disruptive, if he wasn't being violent, and if he wasn't sort of smashing things up for a while, well, that's a positive, and even that can go in the box. The tiniest thing and get as many things in that box as possible that we can open and read, and he could feel then that he has done quite well"* (Parent/carer #3).

There was potential for tension around the age of children referred. This is because the choice of range from 10–14 was made to fit the funding source. Theoretically, the provision could have been applied to older or younger children’s families. In the absence of alternative provision, practitioners may have found it hard to stick to the age range commissioned. During interviews, one practitioner suggested that they needed to be stricter on implementation of the age thresholds for children at referral to ensure quotas are manageable:

> "[We] *screen out more for the age group, so we've tried to get a bit stricter.* [I] *think, initially, we were probably maybe a little bit overly flexible. So, we would get somebody that's nine or 15, and we would sort of think that they really need help, like, this family they need some intervention, and it feels wrong to turn them away, so let's do what we can. I think then we realised that the referrals were coming through so quickly, that then that invariably meant that we had to turn away people, because we'd reached the full quota. We reached the full quota really early on, actually"* (Practitioner #1).

The same practitioner also suggested broadening the referral criteria to consider presenting degrees of violence, thereby initiating intervention as part of a preventive course of action. Refining screening to better prioritise according to need and manage demand may be seen as positive learning, developed by the team, aiding professional judgement on which families most require the intervention and for whom it is likely to be most impactful (with an eye on service need):

> "[Even] *when there was no physical violence, some of the more complex families I've worked with haven't really had much in the way of physical violence to the parent. But very destructive behaviours: self-harm, absconding, running away all night, drugs, alcohol, violence to siblings, that kind of thing. So even though, on the face of it, it might look like there's no physical violence, or really emotional aggression necessarily, not even necessarily name calling to the parent, the destructive behaviours, NVR is still so helpful with them because of the focus on connection"* (Practitioner #1).

For future evaluation, one professional suggested that the implementation and evaluation reporting timelines are clearer:

> "[It] *would have been really helpful* [to have] *an updated timeline on when things were agreed with* UH*, with us, and YEF, over the reports and what it meant. Because there was a huge confusion over feasibility, pilot, times, and then we're like, well, we already have all the people [...]; but if we'd all been on the same page, it would have been a lot less confusing"* (Staff member #1).

Professionals from referral agencies had several suggestions for programme development. First, one referrer suggested closer communication between the programme team and referrers before the family assessments occur:

> "[In] *my case, what probably could have been helpful is having a three-way conversation, like initially before the assessment. So, then that way I can understand where we're starting off. I can help the family understand it a bit better because, obviously, from my experience, I didn't really know much. So, when I got the first feedback from* [a parent/carer]*, I got off on the wrong foot, so it might alleviate some of that initial misunderstanding"* (Referrer #1).

In line with a parent/carer's suggestion, one referrer suggested that the programme integrates one-to-one support with the young person to work on specific developmental areas:

> "[An] *area of improvement that is needed because, first of all, most of the direct sessions were between parents, were mostly for parents and how parents were responding, rather than also on the young person. But I believe that there were some joint sessions that could be one or two, that could have taken place with the young person.* [...] *But I think there's also maybe a need to look into how to help the young persons to work around a certain area [...]* [For example,] *I think it's around self-care, like it looks on how do parents take care of themselves to just have their wellbeing? So, I think if it's also extended to young persons to find out how best can they self-care, and how can they also safely express their emotions"* (Referrer #3).

Another referrer suggested the need for timely clarity around funding as it creates uncertainty as to whether the programme can be offered to new cases:

> *"Hurry up and get the money to RISE, so they can continue doing their great work. [...] I've got so many, honestly, since last June when we could put our last families in, it's just so difficult. The job is getting so much more complex, complicated, harder. And every one of us, and there's, I don't know, probably about 25 of me around the borough, we've all got 15 cases and we've all got probably most of the cases have SEN, so RISE is absolutely needed. Now that we've had them, I can't see how life goes on without them, kind of thing"* (Referrer #2).

This suggestion was echoed by another professional so that the service can fund the professions in place to undergo direct work with new families.

> "[The] *only thing I would say is, again, in regards to kind of future funding and stuff, it would be helpful to know that sooner rather than later.* [The] *staff are […] not accepting any more referrals because they've hit the numbers, and they need to have them completed by March, which is difficult for them.* [The] *referrals aren't even going to our admin, so it is quite a straight cut-off.* [However], *they've still got social workers coming up to them and asking for advice, and it's a case they're happy to give advice, but they'd really like to say, 'Oh, refer them', but they can't"* (Staff member #1).

Two professionals would like to see greater emphasis on cohesive multi-agency working for any subsequent implementation of the programme:

> "[One] *of the issues that we had is the fact that there are so many different agencies [...] involved from the start, and yet there was no overarching framework put in place.* [That] *whole system was indicative of the fact that, again, no one had understood the fact that we've got four, five different agencies involved"* (Staff member #1).

> "[The programme] *can be expanded to schools. Working with the schools, especially, we have got some children who are excluded, and they go to people at the referral units and the like for different reasons, some of them, because the teachers struggle to manage behaviour within the mainstream settings. But whenever those concerns come up, they can start to look into what RISE can offer, in terms of helping them, in terms of strategies to manage that behaviour. That's what I would say, that it's very relevant and we need the support"* (Referrer #3).

Service user engagement

Other interviewees highlighted that the programme gave a 'voice' to parent/carers experiencing CPV, despite previous reticence to speak about their experiences:

> "[Everything] *was just thrown at me from all angles at once, but then I chatted to* [Practitioner], *and I just found she was just someone I could really open up to and talk and tell her exactly what was going on" (*Parent/carer #1).

> *"We weren't holding back on anything, and we didn't have to, we knew we didn't have to. Sometimes on social workers, when you're talking to them, you need to hold back sometimes, because I think with a lot of the other types of help was there, they always looked on things as the child's perspective [...] RISE were sort of here for us"* (Parent/carer #3).

Alongside the support from individual practitioners, the opportunity to speak to those with shared experienced enhanced the engagement of parents and carers:

> "[Anyone] *who was on the course used to go to the coffee morning and just exchange things, really.* [We] *found that quite useful.* [You] *realised that you're not alone, that you're not the only one that's going through it all, I suppose, isn't it, really?"* (Parent/carer #4).

> *"I think many a time there is a level of stigma with the word 'violence' itself, I find. So, you don't want to go to anybody saying, my child gets to be aggressive sometimes. [...] It's a taboo subject sometimes, as a parent, I feel, because you think as if you are not good enough a parent"* (Parent/carer #2).

> *"What I found was that everyone was very similar, so had very similar problems to us.* [The] *behaviour and the way things were happening at home was sort of so similar, and it helped us then, of course, we discussed things, we discussed what was working and what wasn't"* (Parent/carer #3).

A practitioner also emphasised the importance of bringing families together for that shared understanding with others:

> "[We] *were able to have some of our families [...] come to an establishment to then do the intervention as a group.* [There's] *been the tearful moments, there's been laughter, but I think it's been very valuable for the families because they can see that they're not the only ones in that situation.* [From] *my experience, working with families, especially at the beginning, they truly believe that they're alone, even though they have a lot of professionals around them, because no one really understands what they're going through"* (Practitioner #3)

A recurring theme among interviewees related to perceived benefits arising from a network of support being built around families involved in the programme. One referrer characterised supportive, non-judgemental relationships with professionals as the cornerstone to engaging and working with referred families:

> "[I] *would say in each and every setting the family members, be it children or all clients we work with, they should feel respected and not judged. So those are the key attributes that any professional should have when working with them.* [When] *you acknowledge what they are doing well and then they feel appreciated, and then you can also articulate the concerns, what you're concerned about in terms of the family members"* (Referrer #3).

One practitioner spoke directly of the "therapeutic alliance"[3] to describe the nature of a positive relationship with involved families that facilitates positive outcomes:

> *"NVR* [is] *about what can we do from here? What things might enable a parent to bring about change.* [If] *their own needs aren't met, they can't meet the needs of the child. So, I think that is a nice starting point, really, because they can see that we're not coming in and saying you should have done this, you should have done that. It's more [...], how can we meet your needs, particularly when there has been trauma?* [I] *think we've kind of demonstrated that we definitely do build a rapport with those*

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[3] The notion of a therapeutic alliance is common in counselling and clinical psychology. In this context, it may be useful to read Ackerman and Hilsenroth (2003).

> *parents in a really good therapeutic alliance, and it's a good starting point and we kind of need that in order to make progress"* (Practitioner #1).

Parent/carers appreciated the one-to-one support and encouragement from practitioners in helping alleviate the difficulties they were experiencing:

> "[Over] *the last few years, she's* [young person] *been going through quite a bad time with mental health, and she became quite violent towards me. […] Early help introduced me to* [practitioner] *from the NVR, and she was absolutely fantastic. She's been so much help, support, advice; […] without her, I wouldn't be where I am today"* (Parent/carer #1).
>
> "[The practitioner] *really helped my husband; giving him confidence that he doesn't have to rely on one person, or one individual to address* [his] *concerns. So I think, in a way, it really helped to have that one-to-one support for me and* [husband] *to be able to talk it through those individual concerns, ideas or whatever our inputs were.* [He] *wasn't beating around the bush; he was very frank, which I really appreciated, because he was sort of holding a mirror to us and saying, 'Let's do this'"* (Parent/carer #2).

A practitioner referred to the importance of having faith in the parent or carer and persisting with them to facilitate change:

> "[If] *we persist with the parent, often we get there in the end with NVR, even when the journey seems like it's never going to work. And I think there's that going back to [...] not having expectations, encouraging the parents to not have expectations from the child that they're going to be really favourable, but persisting anyway, carrying on doing it. […] I don't know how many other ways I can try and explain the importance of the parent not withdrawing and reconnecting to the child. But having a little bit of faith, actually, that often the message is going into the parent, it's just it takes a little bit of time sometimes. So, yeah, persistence, I think, is something that I've kind of taken from this"* (Practitioner #1).

One service user emphasised the impact of such faith and persistence from their allocated practitioner. During those difficult times where the parent/carer felt unable to sustain the learnt approach, they highlighted how they never felt they had "let the worker down" (Parent/carer #5), nor were they being judged. Instead, the practitioner would support the parent/carer by looking at the issues that were particularly difficult and offering close support and encouragement to keep trying or suggested adaptations to elicit different responses from their child.

Professionals also acknowledge the importance of relationships that are built via the programme in instances when relationships with statutory services may be strained:

> *“Often, there's cases where parents, their relationships with professionals are almost completely broken down, but because we are independent and we don't have what they might regard as a hidden agenda, it enables us to do much more meaningful work, which is based around creating meaningful, trusting, open relationships"* (Practitioner #6).

> "[In] *some cases, we've got the families that are resistant to services because they feel that, or they feel blamed, or they feel that when professionals come to them, they have got this, I would say, like negative perception of family functioning. But once the relationship is built; [...] then they started to be motivated to implement the strategies"* (Referrer #3).

A parent/carer also spoke of a beneficial ongoing relationship with a RISE practitioner beyond the lifespan of the programme:

> *"RISE do keep in contact with us. They've always said that if ever we feel we need their help, they're there, but they drop in perhaps once every three months, and we have a short meeting like this, just to update […], have a bit of a chat and seeing how things are going, perhaps gives us a bit of advice, adjusting things or remembering something"* (Parent/carer #3).

Interviewees also emphasised the importance of a supportive professional network being built around involved families:

> *"I think it's important to get everyone onboard because he's* [young person] *got care workers as well who take him out and we get a bit of a respite for a few hours. But it's important for them to also hear what RISE are doing, and they were quite open to it.* [In] *meetings, we had with the social worker, our care workers and RISE [...]. We had teachers in on that as well”* (Parent/carer #3).

> *“*[I] *mean, there's a lot of professionals involved with the family, and the fact that he's* [CPV practitioner] *involved with the* [social care] *meetings is really helpful [...]; he reinforced what the other professionals were saying, and they reinforced what he was saying as well. So, it's just having that extra person in the family side, as well"* (Referrer #1).

> "[We] *have gone into schools to work with some children, and we always speak to the teachers and things, because it's like a whole wraparound, like, multiagency thing. So, we have gone into schools"* (Staff member #1).

A parent/carer involved in the programme underlined the importance of increasing awareness of the intervention so that families can see there is an effective avenue of support accessible to them:

> *"I think awareness probably will be the key, and more people understand why some other people seek help. It might be useful to bring down that taboo.* [Going] *through the NHS, you might just say there is a long queue; there are people with a lot more issues, where children are running away from home, you are just not in that list.* [If] *there is anything we can improve on, it's about bringing that awareness of help that is out there, and different kinds of help that we can go through"* (Parent/carer #2).

On the other side of this, the parent/carer also highlighted a need to consider the impact of the programme on families and relationships built once the intervention has been completed. The same participant emphasised the importance that an intervention considers how families experience the full trajectory from joining to exiting the programme:

> *"[I think] you're quite anxious when a programme like that is not there anymore, obviously, because we had to be released or offloaded from the programme"* (Parent/carer #2).

Difficulties engaging young people came through in the interviews with families. Some service users expressed a keenness for the intervention to extend direct work with their children. Although one parent/carer (#5) indicated that they understood that the aim of the programme was to support parents to respond differently to their children, they also felt direct work with a young person would help them self-regulate their feeling and behaviours and facilitate better outcomes for the family. Another service user suggested that sessions with young people should run in parallel to sessions with parents and carers:

> "[We] *weren't doing things or changing our behaviour and saying, we do this now because we're doing this course with RISE; we didn't do that. It was sort of in the background, and it was for us to know, and not him. And it was suggested that perhaps RISE could have a few sessions with* [young person] *and they'd never, it never actually happened. It would have been interesting on our point of view, just to see how that would go and what they would do with him. That's something perhaps they might consider.* [We] *ran out of sessions. We were taking up too much time, and we talked too much!"* (Parent/carer #3).

Intervention responsivity

Despite the limit on total number of sessions, across the interviews, the dominant theme was that the programme of support is flexible and responsive to the needs of involved families. Practitioners worked to promote positive outcomes, regardless of circumstances, and stayed in touch post intervention. Families also sometimes compared the CPV intervention's responsiveness to other parental support services, which they had found to consist of demanding, inflexible, pre-timetabled sessions.

One practitioner stressed that the intervention is relatively unique as it places the needs of parents and carers at the forefront, allowing for the direct work to be tailored accordingly:

> *“*[So] *much of an intervention is focused on the child's needs, which, of course, we are looking at, but the parents, a lot of the time, in other interventions, get missed… and about providing them with their needs so that they can fulfil the child's need. And there's a lot of expectations placed on them that are quite often risky for them, and also there's just too much at one time. So, I think that relationship works really well, because we're just spinning it around a bit and going, ‘Let's look at you as a parent in your own right. You're a person, you have needs, and if they're fulfilled, you can fulfil the needs for the child.’ And I think, having an understanding and flexibility as well with them builds up a lot of trust and reassurance and kind of like a weight lifted off their shoulders.* [It] *does seem to be like an approach that's kind of your last chance saloon type affair, where things just haven't worked, like the traditional sort of parenting programme approaches haven't worked"* (Practitioner #2).

Practitioners emphasised that they are enabled to work alongside families, be flexible and tailor the intervention according to need:

> *“The NVR, just it requires the practitioners themselves to think on their feet, and really bring that kind of family-centred approach. That I haven't found another intervention that does that for a family, or another intervention, even CAMHS. I mean, a lot of it just becomes about, let's tick this box, let's tick this box, hopefully this will work, hopefully this will work. NVR, it kind of throws that out of the window and says we will find the way, but maybe it's going to require the practitioner and the family together to mould something different. Whatever that is, that's going to work for the family, we can find that solution"* (Practitioner #5).

> *"*[There is] *flexibility for us to put more input into those other families where they really need it.* [I] *think that's really helpful because [...] there's an awful lot of parallels in the work. We're modelling flexibility, negotiation, compromise and all sorts of things that we want to see in our parents, that I think we are hopefully modelling quite well ourselves"* (Practitioner #6).

Practitioners provided examples of the ways in which programme delivery has also been tailored to the needs of parents:

> *"*[I've] *got some cases where they’ve been subjected to such terrible domestic abuse. Maybe this is more so with me because I'm a man, but they're not comfortable with me going to the home. So I've had joint visits with the social worker at children's centres, but then it's made it a lot easier for me to do online meetings, especially when people have got three, four children, and invariably one is off sick. And, yeah, it makes*

> *it a lot easier, but, obviously, to have that opportunity to be able to go and see them in schools as well"* (Practitioner[4]).
>
> *"I've got families that only want home visits, so I've tried my best to do only home visits, with text messages and that kind of thing, and to keep communication going in the middle. Whereas others that are quite happy to just mainly have a video call, with a few home visits. I think that's worked really well, because* [with] *a home visit, you get a sense of the dynamic in the household, and you maybe get to meet the child, you pick up on an energy that you perhaps don't get on a video call. But the video call makes us very efficient, and we can see more families in a day that way"* (Practitioner #1).

Such flexibility allows practitioners to be creative in delivery with families with different accessibility needs:

> "[A] *practitioner can then become creative with resources. I know a lot of us create our own activities and resources that we work, and we share together. And also because it's so flexible, you can adapt it to different cultures as well. I've got someone that doesn't speak any English, so she does, but it's really hard sometimes without her husband. And so now we've had to do it, just me and her, sometimes I'm like drawing pictures and stuff, but it's fun, like we have fun with it. And NVR allows you to be creative and do that, and I don't think any other programme has that much flexibility that I've had experiences with"* (Practitioner #4).

A parent/carer acknowledged that the CPV programme was adaptable to their child's additional needs:

> "[It] *works very well for children with autism;* [it] *works with the way their mind works. So, a lot of their concerns and anxieties come out in different forms, and just applying the de-escalation strategies, irrespective of what that concern is, actually helps them […]. Obviously, we had to modify some of the things and how it works for my son, because sometimes having very much things in his face doesn't work. So, writing down sometimes what we feel made him very annoyed, so we didn't use that technique. But something else, sitting down and having a talk and having him have a talk, having the family having a talk with him.* [Having] *the school involved, rather than just taking it on ourselves and thinking* [we] *are responsible, and we need to solve this, but reaching out for as much help we can get"* (Parent/carer #2).

A referrer also lauded the programme's capacity to adapt in light of the COVID-19 pandemic:

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[4] Identifier removed here to help prevent identification of individual practitioner.

> "[I] *think everything that we've said about how flexible and everything it is; […] that's something that we've been able to really adapt to well. It doesn't seem, for me,* [that] *the intervention that we've provided to families had to suffer […] because of the way that we work and how adaptive it is. So, I think that's been a really big, massive success because we've had this funding and this work with these families over such a difficult period of time, and it has been hard. But I still think the level of service that we've given has been the same, as if that hadn't have happened and we were in [...] say, a normal world"* (Referrer #3).

Evaluation feasibility

The pilot evaluation allows us to draw conclusions about each of the key aims, albeit with some caution around the completeness of data recording and that the evaluation was limited to a before-after intervention design, carried out in two boroughs, with one delivery team.

Aims 1 and 2: The direction and magnitude of change in the main outcomes and the potential effect size:

In general, where data have been reported, adults report a significant improvement for the child across the SDQ and CPV measures. The reported effect sizes are large to very large and indicate a robust treatment response. Although in the desired directions and showing statistically significant positive changes, there are still high levels of distress indicated on the measures. It should be noted that from baseline to 12 months, the effect is substantial, but at the interim time points, change is somewhat faltering (substantial drop in distress at three months, going up again at six and nine months of the evaluation). It should also be noted that there were substantial gaps in the dataset and that the 12 months dataset was more complete than at interim points. Also, no sensitivity analyses could be conducted, given the large amount of missing data. From the characteristics that could be observed, it was possible that those families that did not complete the programme may have had slightly higher levels of parenting skills at the outset and so found the programme less useful. This was the only difference observed, and it remains possible that families that did not provide data at follow-up were not responding as well to the programme as those families who did provide data. It is also acknowledged that the COVID-19 pandemic was a significant factor in preventing completion of outcome measures during the pilot period. The outcomes therefore need to be treated with caution.

Aim 3: The referral and screening process

Of the 170 young people referred to the CPV intervention, 107 were initially enrolled in the programme. For the majority of the referred families, the child was 13 years old, predominantly male (n=108, 64%) and White (n=110, 65%) or mixed race (n=19, 11%). Referrals came from Bromley or Croydon. For most young people, referral to engagement was rapid. In general, it appears that there is very little risk of bias in the referral and screening process, although parents with older children were less likely to enrol.

Aim 4: Client retention and data completion

The number of families remaining on the RISE programme to 12 months is high, with 89 (83%) recorded as remaining on the programme. This includes several families that had not attended sessions, yet it is clear that by 12 months, 81 families (76%) had successfully completed the programme. It is worth noting also that the maximum number of families providing data (parents only) at follow-up is 17 (16% of those enrolled) at six months and 47 (44% of those enrolled) at 12 months. It is also noted that collection of data relating to goal setting was compromised by the therapeutic needs of the intervention and could not be scaled to allow comparison.

Aim 5: Evaluation of success criteria

Using the traffic light system drawn on above, it can be concluded that two of the success criteria were met (green), one was missed (red) and one may be possible to meet (amber). Specifically, no evidence of bias in the screening and referral processes was found, and retention of families in the intervention was good. However, data completion rates were disappointing, meaning that it cannot be said that there were sufficiently robust, unbiased processes for measure completion. These three success criteria lead to the conclusion that whether the fourth one could be met – to deliver a trial of sufficient magnitude – would depend on whether data completion could be improved. It would also depend on the identification of a suitable control condition, if the measures used could be kept to those found helpful in this evaluation (rather than the full YEF core measures set) and whether families would be willing to be randomly allocated to control or intervention.

Aim 6: To assess implementation process

There are three main questions to be answered in interpreting the qualitative aspects of the evaluation. These relate to implementation fidelity, service user engagement and programme responsiveness.

Implementation fidelity

There were many ways in which it can be said that the programme was delivered with fidelity. The techniques used included: NVR, de-escalation and emphasising the role of natural consequences. These all come through as being implemented with families and appreciated by them. The exact number of sessions delivered is in line with being ‘up to 20’. For those families that completed the intervention, the mean number of sessions attended was 14.71. Additionally, it should be noted that some families reported ongoing touchpoints. Although not part of the formal intervention, these touchpoints may be acting as a way to enhance the chances of success and minimise likelihood of relapsing into old habits.

There is more of a question over the ways in which the intervention engaged with children and the extent of their involvement. Although intended to work with parents in the first instance, the logic model and intentions were that, where possible, young people would receive direct support as well. The parent/carer interviews and feedback indicate that there were occasions when the family would have liked direct support for the young person – whose behaviour was at the centre of the referral – but it had not been provided. The dearth of core measure data from young people and their lack of engagement in interviews was problematic for the evaluation as their experiences have not been considered directly. It is important to note however that the levels of distress in the children that are being observed by parents and practitioners can be seen in both the quantitative and qualitative findings. These perhaps provide some route to seeing why young people have not been more directly included in the intervention's implementation, particularly if considered alongside the safeguarding concerns raised by practitioners and other agencies.

Practitioners' understanding of the distress experienced by young people and the adults with parental responsibility for them also partially explains the other key breach of implementation intentions, namely the ages of children accepted into the programme. The quantitative data show that, at referral, children whose families were subsequently accepted onto the programme range from 9–17 and not 10–14. The qualitative findings indicate that this was generally because the team did not want to turn away families whom they felt would benefit from the intervention and were in distress, with high safeguarding needs identified. It should be noted that the CPV team also met the target number of families within the feasibility phase and subsequently had to start refusing referrals. The demand is clearly there, and it is unclear whether the age boundaries imposed were more closely aligned with the commissioner's requirements than an integral part of the intervention's logic model.

Service user engagement

As already noted, assessment of children's responses was not possible due to their low engagement with the core measures or with the interviews conducted within the evaluation process. Obviously, this is disappointing, but the key criterion for engaging with a family is whether the parents or carers were prepared to engage with the intervention team, not whether the child at the centre of the referral was themself prepared to engage.

It is reassuring, therefore, to see the high rates of family retention overall and the high rates of successful completion of the programme. The interviews and feedback show that families greatly appreciated the support and empowerment facilitated through the intervention. Qualitative findings indicate transformations that are recognised and appreciated. From the adult perspective, we can say that service user engagement was high.

Programme responsiveness

Relationships between families and practitioners were generally seen as being positive. It was clear that families felt listened to and that they appreciated the new skills and techniques they were being taught. They also appreciated that they were being treated as individuals when it came to looking at how to advise them about their particular family in their particular context. In a complementary manner, families also appreciated the opportunities provided to meet other parent/carers. These helped them not to feel so isolated and to recognise that there were other families going through similar situations to their own. In one instance, this was directly contrasted with families' experiences of other services, where they had felt that they had been denied assistance because their needs did not fit the criteria specified. It is perhaps worth noting that another way to interpret this finding might be that the other service had been closely following implementation criteria with the effect that a family in need felt dismissed.

When considering lessons learnt during the evaluation and what could help or hinder the development of positive outcomes within the CPV programme, the thoughtful reflection from practitioners, managers and referrers demonstrates their willingness to respond to the needs of individual families and to assess ongoing development of the intervention. It was clear, however, that the major problem signalled was one of resourcing. They felt that need and effectiveness were being demonstrated by the transformations experienced by families, observed by referrers and reported back from schools.

Evidence of promise

Having addressed the research aims above, this section will consider the implications of the findings to the logic model (Table 1), continuing from the material initially considered in the implementation fidelity sub-section above.

Starting with the inputs planned, it can be seen that the number of sessions attended were broadly delivered. Also, the interviews show that the wider family was being engaged. It is harder to tell from this evaluation how much the wider communities had been engaged, and it is acknowledged that this would have been particularly difficult during the period of the evaluation as it coincided with COVID-19. The ongoing pandemic may also have had an influence on the intention to train social workers, community members and referrers in NVR. However, it was clear in the feasibility phase that training had been run specifically for the local authority that was new to work with RISE, that training had been provided to other agencies working with the families and that NVR processes were considered in the initial and ongoing discussions with the allocated family workers. The interviews with referrers indicate their understanding of the process. In at least one instance, this was something that developed once they had been trained and more properly understood the nature of the intervention being offered.

The biggest gap in the input section of the logic model is in relation to work with children that, as already discussed, could not be assessed within this evaluation. One area that could have been included in the input model relates to the informal follow-ups conducted by the practitioners. For example, a quarterly drop-in to families, for a year, post completion might be considered a formal part of the process, worth incorporating into the logic model.

The outputs/short-term outcomes would also have been affected by the pandemic, but there is evidence that the mid-term outcomes were being demonstrated. Specifically, those that were being assessed on the SDQ and CPV bespoke measure, particularly in relation to parenting skills. The scores for parenting skills subscale go up at 12 months, whereas those for the others (child-to-parent violence and SDQ) go down at 12 months; in each case, this is the desired direction. It may also be worth repeating that there is some indication that those parents who had greater difficulties in parenting at baseline measurement are more likely to have stayed with the intervention through to completion. The remaining intermediate outcomes, particularly for adults with parental responsibility, were harder to assess from the quantitative data but come through as themes in the qualitative implementation process assessment. Longer-term outcomes could not be assessed within this evaluation.

Overall, the evaluation team are cautiously optimistic that the logic model was a fair reflection of the work with adults observed in the evaluation. Although significant modification would not be a necessary part of a randomised trial, it would be advisable to better specify the balance of inputs intended, particularly in relation to children and wider community engagement. If a trial were to be conducted, then the measures used might also be considered in the context of the envisaged mid-term outcomes.

Readiness for trial

As discussed in the findings and evidence of feasibility sections, it may be possible to conduct a trial, but the intervention is not quite ready. In particular, it would be important to be sure of:

1. Whether sufficient evidence could be gathered to indicate that data completion can be improved (on the more limited, agreed measures used in the pilot phase and potentially dropping the SDQ as well)
2. Whether a suitable control condition could be identified that is not subject to too much heterogeneity
3. Whether families would be willing to be randomly allocated to intervention or control arms of a trial.

Conclusion

Table 20: Summary of pilot study findings

Research question	Finding
Core outcomes over time	Where practitioners succeeded in managing to facilitate completion of the measures, reported changes over time tended to be large, in the desired directions and statistically reliable. Although their efforts were clear, there remains a challenge to interpreting data, given the large proportion of missing data. It should also be noted that several of the core measures were dropped during the feasibility phase. Some caution should therefore be applied to the findings, although it is also acknowledged that the COVID-19 pandemic was a significant disruptive factor to completion of outcome measures during the pilot period.
Effect size	Within the parameters of a before-after evaluation, within a relatively modest cohort, reported effect sizes were large or very large, on both the SDQ and CPV bespoke measures, indicating a positive effect of the intervention. However, IES-R, CRIES-8, SCORE-15 and ESYTC were dropped from the pilot evaluation.
Referral and screening	Referral and screening processes seemed to be working appropriately, and there was little risk of bias.
Retention and data completion	Retention in the intervention was high, with 76% of enrolled families completing the programme. It should be noted that this does not match the proportions of recorded data, which represented less than half of the baseline families by 12 months, with no meaningful recording of measures from young people. Therefore, it can be concluded that family retention was high but data collation was compromised, both by COVID-19 and therapeutic decisions made about pursuing data completion.
Potential to move to a randomised trial	There remains the potential to complete an appropriately powered trial, but several issues would need to be addressed to recommend progression to a full trial: i. Can sufficient evidence be gathered to indicate that data completion can be improved? ii. Can a suitable control condition be identified that is not subject to too much heterogeneity? iii. Evidence would need to be gathered to indicate that families would be willing to be randomised. If these issues can be addressed, and if YEF would be happy to sacrifice the core measures dropped from the pilot evaluation, then it is likely that a trial of sufficient magnitude can be delivered.
Fidelity of intervention	Implementation fidelity with adults was very good and is the main focus for the intervention and evaluation. It should be noted that the ways in which young people felt about the intervention could not be assessed due to their limited engagement with the intervention and non-engagement in the evaluation.
Service user engagement	The grantee's files show a very high retention rate, and the implementation process interviews indicate that adult service user engagement was commendable and sustained. However, it was clearly difficult to gain service user engagement in completing the core measures, and young people were not substantively engaged.

Intervention responsiveness	Intervention responsiveness was good, with families, practitioners and referrers all demonstrating that the intervention team listened to families and tailored support accordingly, working alongside other agencies.

Evaluator judgement of intervention and evaluation feasibility

RISE Mutual CIC's Child to Parent Violence programme is a well-regarded intervention, appreciated by families, referrers and those that work within the team. The intervention is available to parents more directly than children but, through the techniques and skills implemented, demonstrated the ability to make profound change for the children as well as wider families. There are some challenges for sustainability and a potential future trial, particularly relating to data completion and the engagement of young people, but there is promise here that the intervention can make a positive, sustained impact on young people's lives. Under the conditions outlined above, it is possible that both intervention and further evaluation are feasible.

Interpretation

This section begins by referring back to the background section of the introduction to this report. It then moves on to consider the transferability and generalisability of the findings presented.

The first point tied to initial intentions for the intervention relates to the inclusion criteria of the CPV programme. Although the majority of referred children fit squarely into the criteria, there were some accepted into the intervention from a wider age range than initially envisaged, both younger and older. In terms of delivery, the sessions focused on adults were based around models of NVR and were generally implemented with success by those parents that stayed in the programme and from whom the evaluation team have data available.

It should be noted that the stated ambition is to work with young people when they are ready to engage and that the initial focus is on adults with parental responsibility. The findings from this evaluation indicate that, in most instances, the young people do not engage sufficiently for meaningful evaluation of the efficacy of that aspect of the intervention's work.

One novel aspect of this intervention and evaluation is that it provides evidence on the use of NVR/New Authority within families with complex needs. This is also why the CPV programme is designed to take a trauma-informed approach. Rather than providing services to treat one or more particular aspects of trauma, a TIA seeks to be engaging and accessible, aiming to avoid a situation where trauma may have been worsened by not having acted in ways that are appropriate (University of Buffalo 2019). As the formal measures of trauma were dropped from the evaluation, there is no quantitative data that can inform assessment of this approach. The implementation process findings indicate that families find practitioners to be approachable, accessible and trustworthy, all of which are consistent with trauma-informed work, although not unique to that approach. Families were positive about the practitioners and responded well to the intervention. This would have been much harder and less likely to succeed if the intervention itself were triggering or potentially retraumatising. It seems fair to conclude that the intention of acting appropriately and accessibly is met. Similarly, although not specifically explored by the interview protocols, it is noteworthy that no iatrogenic or negative consequences were reported as having arisen from engagement with the intervention.

When considering the transferability and generalisability of the findings, there are some limitations as well as future implications to be considered. The first limitation is the difference between retention rates and data completion rates. Given the lack of data directly from children, it is impossible to assess whether CBT-based techniques were being implemented with them and, if so, to what extent this was helpful. Even from adults, data completion rates would have to be improved before a full trial could be comfortably started. It would also have to be agreed exactly which were the best measures to use.

It may be useful to consider the use of the core measures in light also of the findings from the implementation process. It should be noted that the intended way of working with young people relied on first establishing a parent/carer relationship and improving parental management techniques, potentially for several months before the practitioner would try to establish engagement with the child/young person. This then meant that the first potential set of measurements using the core measures with young people would either need to be taken at baseline on initial familial enrolment or, if taken when first working with the young person, could not be considered a baseline measure. If the former were attempted, it is hard to envisage much success, given the nature of the referrals and inclusion criteria. This does not mean that the use of the core measures would be impossible with young people. For example, the SDQ is routinely used by several CAMHS as part of their delivery of CBT with young people and their families. It does, however, indicate that attempting to measure the full extent of initial challenges faced by young people would probably be best not advised at familial enrolment but evaluated in the context of the ongoing intervention with parents/carers.

Another potential limitation relates to the recruitment of participants within the implementation process interviews. As this element of the assessment is qualitative research, generalisability is not really a relevant criterion. The similarity and consistency across many of the themes considered are reassuring, but it should be noted that the views expressed by those who participated may not be consistent with those that would have been found from a different set of participants, had they been recruited. This is particularly noteworthy given the lockdowns and other responses to COVID-19 that may become a decreasing part of intervention reality.

Although the findings indicate no significant causes of bias in recruitment or retention to the intervention, some caution needs to be exercised regarding the data completion rates. It is possible that those who did not complete the measures differed in some way that was not accounted for in this design. Lastly, this evaluation did not consider the nature of what a control condition might look like. For most of these families, there is no ‘treatment as usual’. It would therefore be necessary to consider what a control condition might look like and who would provide it. For a randomised trial, a control could range from treatment-as-usual (not preferred) and a standardised set of common routine interventions (i.e. standardised normal treatment) to a more active comparison (but untested and therefore not preferred). As indicated, all these choices have significant impact on the likely effect size for group comparisons. These questions cannot be addressed without some co-design.

Future research and publications

Allowing for the caveats above, the evaluators believe that a trial may be possible, broadly adopting similar principles to this design. Additionally, secondary analyses or separate publication of the findings across all four grantees evaluated by this team may provide further insight to theory and practice. One area that might be considered across grantees is to consider whether the multiplicity of measures could be streamlined and assessed in the context of the other measures to which families would have been exposed. Another area might relate to the expectation, common to at least two of the grantees, and possibly all of them, that YEF would continue to fund projects beyond the period of evaluation and/or trial. Sustainability of funding is an increasingly worsening problem for the grantees, and the impact of funding uncertainty on children and families could be considered more fully than in this report.

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Appendices:

Appendix A Ethics Approvals

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 01/04/2020

Protocol number: **LMS/SF/UH/04101**

Title of study: A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Prof Brian Littlechild (CI) Dr
David Wellsted (CI)
Ms Helen Munro-Wild (CI)
Prof Joanna Adler (PI) from LMS.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 01/04/2020 To: 30/10/2020

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair

DATE 30/09/2021

Protocol number: **LMS/SF/UH/04697**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From:

30/09/2021 To: 31/03/2022

Please note:
Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair

DATE 16/03/2022

Protocol number: **aLMS/SF/UH/04697(1)**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Joanna Adler David Wellsted
Brian Littlechild

Modification: detailed in EC2. (Extension to November, 2022).

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Appendix B: Feasibility Interview Materials

Information Provided to Potential Interviewees

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEETS

1 **Title of study**

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Rise Mutual CIC

Information for a Child/Young Person Potential Interviewee

SOME INFORMATION ABOUT THE RESEARCH

1 We'd like to ask you if you'd be interested in taking part in some research. But before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you'd like.

Thank you for reading this.

2 **What's the research about?**

One of the projects you've been seeing –Rise Mutual CIC - is working to prevent young people aged between 10 and 14 from getting caught up in crime and violence by offering them (and sometimes their parents) the best possible support, as early as possible. Researchers from the University of Hertfordshire (UH) are talking to people who are getting this support to see if they think it's helpful.

3 **Do I have to take part?**

No. It is completely up to you whether to take part or not.

4 **How long will my part in the study take?**

One of the researchers will ask you some questions about the project and the support they've been giving you. This shouldn't take more than 30 minutes.

5 **What will happen to me if I take part?**

A UH researcher will arrange with an adult who looks after you, or a member of staff at the project, a good date, time and place for you to meet and talk about the support you've been getting. With your permission, the researcher may want to record your chat with a small voice recorder. This will make things easier and quicker as they won't have to make notes of what you're saying. If you'd rather they didn't record it that's fine – please just tell them when you meet. After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

6 **Will anyone get to see or hear what I say?**

We won't record or use your name in the research. All the information about you will be held safely and securely by UH. What you tell us is confidential (so no-one else will see or know what you've said).

7 **What happens with the information I give you?**

We will use what you and others tell us to say whether the support that the project offers is useful and helpful to young people. We can also make suggestions about how things can be improved so that young people get more or better help. But nobody will be told what you have said about the project.

8 **Can anything we talk about be shared with others?**

If you tell the researcher from UH that you or another person is at risk in some way then by law we would have to share that information with the project, and possibly other people too, in order to protect you or the other person.

9 **Who has reviewed this study?**

This study has been reviewed and approved by the UH, Science, Engineering and Technology Ethics Committee.

The UH protocol number is **LMS/SF/UH/04101**

10 **Who can I contact if I have any questions?**

If you have any questions about the research then you can telephone or email one of the UH researchers: either Brian (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this research, then please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and thinking about taking part in this study.

Information for a Parent/Carer/Guardian Potential Interviewee

1 Title of study

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Rise Mutual CIC

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 What is the purpose of this study?

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 How long will my part in the study take?

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of Rise Mutual CIC.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a ‘thank-you’ for taking part in the research. You’ll have to sign a piece of paper just to say you’ve received this.

7 How will my taking part in this study be kept confidential?

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 30th October 2020). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 What will happen to the data collected within this study?

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 Factors that might put others at risk

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 Who can I contact if I have any questions?

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University’s Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Information for a Practitioner/Stakeholder Potential Interviewee

1 Title of study

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Rise Mutual CIC

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish.

Thank you for reading this.

3 What is the purpose of this study?

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you in any way. If you have any concerns about taking part, please discuss this with your manager and/or supervisor.

5 How long will my part in the study take?

If you decide to take part in this study, then you will be invited to speak with a researcher from UH to answer some informal questions about your views and experiences, and this will take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and participate in an interview (or possibly a focus group) in order to answer a set of questions about the work of the YEF-funded project.

The interviews/focus groups will be conducted by an independent researcher from UH.

The researcher will ask you about your views on the work you and others are doing with children and/or families receiving YEF-funded support. We are interested in your opinions and there are no right or wrong answers. With your permission, the interview will be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020).

7 How will my taking part in this study be kept confidential?

Participant confidentiality will be respected. We will use an anonymity code rather than your name and your organisation will not be identified. Anonymised data will be kept for up to five years after which it will be securely destroyed. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 30th October 2020). Audio files will only be stored on computers belonging to UH and will only be available for the purposes of data analysis. All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 What will happen to the data collected within this study?

We will use the data collected to assess the feasibility of the YEF-funded projects. UH is the data controller for the study. This means we are responsible for looking after your information and using it properly. No personal data (e.g. names) or details of your organisation will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

The data collected as part of the study will be stored electronically, in a password-protected environment, for up to five years, after which time it will be destroyed under secure conditions. All such data will be anonymised prior to storage. Any data collected in hard copy by UH (e.g. copies of consent forms) will be stored in a locked cupboard until 30th October 2020, after which time they will be shredded.

9 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 Factors that might put others at risk

Please note that if, during the study, any unlawful activity becomes apparent that might or had put others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent for Family Participation: Feasibility Interview Phase

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

Rise Mutual CIC

(UH Protocol number **LMS/SF/UH/04101**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial box

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number}**) for the interview phase of the above study. I have had the opportunity to consider the information about the interview, ask questions and have had these answered satisfactorily. ☐
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights being affected. ☐
3. I understand that the information collected about me and my child will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

______________________	______________________	______________________
Name of Parent/Carer/Guardian	Date	Signature
______________________	______________________	
Name of child	Your relationship to the child	
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Consent form: Stakeholders/Practitioners

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project Rise Mutual CIC

(UH Protocol number **LMS/SF/UH/04101**)

1 I confirm that I have been given a Participant Information Sheet giving details of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to me. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it. I understand that this study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that a voice recording will take place and I have been informed of how this recording will be used.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant………………………………………..…Date…………………………

Signature of (principal)
investigator……………………………………………………Date…………………………

Name of (principal) investigator *[BRIAN LITTLECHILD / TIM MCSWEENEY]*

………………………………………………………………………………………………

Topic Guide for use with Families

- How did you first hear about the project?

- What did you find valuable/attractive in what you were told about the programme at the start of it?

- What did you see as the main challenges you and/or your family had when you were first referred to the programme?

- What hopes had you about how the programme and how it might help you/your family when you were accepted?

- What were your concerns, if any, about engaging with the programme?

- What help/support had you tried before, if anything, and had any of these things been successful in any ways at all? Has your involvement in this programme been any different in terms of positive changes for you/your family?

- What has worked well while you have been on the programme - for you? For your family?

- What have you found most difficult or unhelpful on the programme so far?

- How far do you think things have changed in a positive way as a result of your involvement with the programme (so far)?

- What have you found most challenging in terms of keeping up with the demands of the programme, and in making changes whilst on the programme (so far)?

- What other factors do you think have affected for you/your family - whether things have got better (or not) since you started the programme? For example, other help and support you have received, what is happening at school, with friends/acquaintances etc.?

- What has changed least in relation to 1) the challenges you/or family were facing when you started the programme 2) in relation to what you had hoped for as a result of at taking part in the programme?

- Have other members of your family experienced any changes from your involvement in programme so far? If we were to ask others involved with yourself and your family, such as school staff etc., what do you think they might say as to whether there have been improvements in the challenges you are experiencing?

- Have you looked at your/your family's progress with the challenges you were experiencing when you came onto the programme with your worker, and if so how did you do this, and in what ways did you think there had been improvements (or not)?

- If we were to ask your worker, what do you think they would say 1) the main things that have been positive in terms of change for you/or family, 2) things maybe still need to be worked on rather more?

Topic Guide for use with Stakeholders/Practitioners

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?

- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?

- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?

- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?

- How have you reviewed progress with them, and the outcomes so far of your interventions?

- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.

- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?

- If we were to ask them what the main areas of positive change had been, and why, what you think they might say?

- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?

Thank you….

University of Hertfordshire UH

Debriefing

If you have been affected by any of the issues we have discussed during the course of the research then please consider approaching a member of the project team for advice and support. Alternatively, the following sources of advice, support and information may be useful.

1. Childline

Call free on 0800 1111 or get in touch online at https://www.childline.org.uk/get-support/

2. Samaritans

The Samaritans are available 24 hours a day, 365 days a year to support you with whatever you're going through.

https://www.samaritans.org

Tel: 116 123

Email: jo@samaritans.org

3. Ask to speak to one of your school teachers

4. Contact your local GP or NHS Direct

NHS 111 can help if you have an urgent medical problem and you’re not sure what to do.

Call 111 on your phone or go to https://111.nhs.uk/

5. Emergency services

In an emergency, contact the emergency services.

Tel: 999

University of Hertfordshire School of Life and Medical Sciences Risk Assessment Form

Ref No:	
Date:	
Review Date:	

For assistance in completing this form, please see the Guidance Notes at the end

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Name: Dr Tim McSweeney Email address: t.mcsweeney@herts.ac.uk Ext no: 5284
Title of Activity	A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.
Location of Activity	It is envisaged that fieldwork for the study will be undertaken either on the premises of the service being evaluated (ASSIST in Northamptonshire, Family Support, Brandon Centre and RISE Mutual, all of whom deliver service in London), or remotely over the phone or online (e.g. using Zoom software). Where necessary and appropriate, some interviews with parents and carers may be undertaken in public spaces (e.g. cafes).
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable.	The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The feasibility study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.
Personnel Involved	Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI), Ms Helen Munro-Wild (CI) and Prof Joanna Adler (PI) from LMS.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED

☐ Animal Allergens
☐ Biological Agents (see COSHH)
☐ Chemical Compounds (see CoSHH)
☐ Compressed/liquefied gases
☑ Computers
☐ Electricity
☐ Falling Objects
☐ Farm Machinery
☐ Fire
☐ Glassware Handling
☐ Hand Tools
☐ Ionising Radiation
☐ Office Equipment
☐ Laboratory Equipment
☐ Ladders
☐ Manual Handling
☐ Non-ionising Radiation
☐ Hot or cold extremes
☐ Repetitive Handling
☐ Severe Weather
☐ Sharps
☐ Slips/trips/falls
☑ Stress
☐ Travel
☐ Vacuum systems
☐ Pressure systems
☐ Vehicles
☑ Aggressive response, physical or verbal
☐ Workshop Machinery

The above is not an exhaustive list – all other hazards should be listed here.

Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity Extensive Damage or Loss Major Long Term Environmental Impact	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification: 1-4 Trivial 5-7 Tolerable 8-12 Moderate 13-16 Substantial >20 Intolerable	→	1	2	3	4	5
	Likelihood	Almost Impossible	Unlikely – possible exposure every 1-3 years	Harm is possible	Harm is likely to occur	Harm will occur or is very likely to occur.

ASSESSMENT OF RISK CLASSIFICATION			
Hazard	Likelihood Score	Severity Score	Risk Classification
Stress	3	1	3 (Trivial)
Emotional discomfort or distress	3	1	3 (Trivial)
Aggressive response, physical or verbal	3	1	3 (Trivial)

EFFECT OF RISK CLASSIFICATION	
Risk Classification	Action
Trivial	No further action required. Activity can begin.
Tolerable	No additional controls required. Current controls must be maintained and monitored.
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.
Substantial	Activity cannot begin without major risk reduction.
Intolerable	Activity must not begin.

RISK CONTROL MEASURES

Are the local code of practice and/or local rules adequate to control the risks identified?

Yes

Please list.
Please list all additional measures required.

Local Code of Practice and Local Rules applicable:

All LMS health and safety rules will be followed including ‘LMS Health and Safety Codes of Practice’, the ‘BPS Code of Ethics & Conduct (2009)’ and ‘BPS Code of Human Research Ethics (2014)’.

Additional Measures: All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences).

The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected on service premises, online (via video conferencing) or over the phone.

As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	Children at risk of involvement in crime and violence, their parents, carers or guardians, and professionals working with them.
Health Surveillance Measures (including symptoms and signs of exposure)	It is possible that some respondents may experience distress, or become aggressive (verbally) as a consequence of recalling their experiences of crime and/or violence.
Exclusions	Respondents must be consenting service users of the YEF funded project or a professional stakeholder linked to the delivery of these interventions.

	SIGNATURES			
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	Staff	Tim McSweeney		26/02/2020
Supervisor (if Assessor is a student)	N/A			
Local Health and Safety Advisor / Laboratory Manager	Health and Safety Lead (Psychology)Staff	John Bain		27/02/2020

GUIDANCE NOTES.

This Risk Assessment is the legally required written record of the Risk Assessment for an activity. It must include all known risks and hazards involved in the activity, to the best of the assessor's knowledge. Both the Risk And CoSHH Assessments must be signed off by signatories prior to work starting. No changes may be made to this document without being countersigned by all signatories.

The purpose of this Risk Assessment is to identify risks arising from specific activities and substances and put into place safe working practices to minimise these risks.

Copies of this Risk Assessment must be available at all times during the period of the activity.

For clarity and help in filling this form in, please read the following notes:

ACTIVITY INFORMATION

Name of Assessor - contact details must be included here.

Title of Activity – this should be brief but specific to the details here.

Location of Activity – any rooms, buildings or venues where this activity will be carried out must be included.

Description of Activity – a brief description of the activity proposed. This MUST include any materials used, classes of substances used (e.g. micro-organisms) equipment used and analytical and preparatory processes and techniques if they are being used. Do not forget to include by-products of any activity.

Personnel Involved – anyone who will be present in the area during the activity. This should be groups of people where possible, e.g. undergraduate students.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED

This is a list of the more common hazards likely to be encountered within Life and Medical Sciences. Tick those that will be encountered during the proposed activity. Any additional hazards must also be included here.

HAZARD ASSESSMENT

This table is the heart of this assessment. By looking at the severity of the consequence of being exposed to a hazard and measuring that against how likely this may happen you can calculate how much risk is involved.

Severity x likelihood = risk.

If the proposed activity has a high risk (i.e. a high number) then control measures will need to be put in place.

RISK CONTROL MEASURES – Refer and list the local codes of practice, guidelines and local rules of the area where the activity will be carried out for *minimum* safe practices.

Additional Measures– this details the measures that can reduce the risk. For example – using volatile solvents in a fume hood, or arranging for interviews to be conducted in a public place.

ASSESSMENT of RISK CLASSIFICATION

Hazard – this is a list of all hazards encountered in the activity as identified earlier.

Likelihood Score – this is a measure of how likely it is that a hazard will occur. Identified from the Hazard Assessment table

Severity Score – this is a measure of how severe exposure to any given hazard can be. Identified from the Hazard Assessment table. Use the highest score for each hazard.

Risk Classification – this is the result from the Hazard Assessment table and will be one of the following words – trivial, tolerable, moderate, substantial or intolerable.

EFFECT OF RISK CLASSIFICATION – this table indicates whether the proposed activity can begin and if other controls must be put into place.

HEALTH SURVEILLANCE ISSUES – this looks at how hazards can specifically affect health of people coming in contact with the proposed activity.

Persons at Special Risk – this must include anyone who has a special health issue with hazards involved – e.g. pregnant women, specific allergic reactions, asthmatics, immune-suppressed individuals etc.

Health Surveillance Measures – this must include symptoms of exposure to hazards involved. For example, chemicals and drugs can cause dizziness and drowsiness. Outside working can involve extremes of temperature i.e. summer and winter working.

Exclusions – this should include a list of anyone who should not take part in this activity, e.g. pregnant women, or anyone with a pacemaker.

SIGNATURES – all required signatures must be completed before work can commence.

Assessor – this is the person who has filled in the Risk Assessment.

Supervisor – an academic member of staff with responsibility for the assessor if the assessor is a student.

Local health and safety advisor – a named person who is familiar with the area specified for the activity to take place. A list of current local health and safety advisors for each Department is given below (removed for publication of Appendices):

DEFINITION OF TERMS

HAZARD - a potential source of harm

HARM – personal injury or damage to property

RISK – a combination of the likelihood of harm arising from a hazard and the severity of that harm.

RISK ASSESSMENT – identification of hazards and a classification of the risk they produce.

RISK CONTROL – physical control and/or the safe system of work required to reduce the risk to acceptable levels.

Appendix C: Feasibility Data Audit

RISE provided referral/screening and participant data.

Table 1: Data Intended to be Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	X						
Gender	X						
Ethnicity	X						
Referrer	X						
Date of referral	X						
Family ID	?	?	?				
Index of Deprivation		?					
CPV (assessment)		?	?				
Pre-Intervention Questionnaire		?					
SDQ			X	X	X	X	X
Score 15			X	X	X	X	X
IES/CRIES8			X	X	X	X	X
ESYTC			X	X	X	X	X
Study End Form							X

Data Collected

Screened: 114

Enrolled: 65

Followed up (actual):

3 months: 5
6 months: 4
9 months: 2
12 months: 10

Table 2: Actual Data Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	114 (100%)						
Gender	113 (99%)						
Ethnicity	114 (100%)						
Referrer	114 (100%)						
Date of referral	104 (91.2%)						
Family ID	114 (100%)	114 (100%)					
Index of Deprivation		0* (0%)					
CPV (assessment)			49 (75.4%)	4 (8.9%)	3 (16.7%)	2 (40%)	7 (70%)
Pre-Intervention Questionnaire			?				
SDQ			49 (75.4%)	P: 4 (8.9%) C: 1 (2.2%)	3 (16.7%)	2 (40%)	7 (70%)
Score 15			7 (10.8%)	0	0	0	0
IES			7 (10.8%)	0	0	0	0
CRIES8			0 (0%)	0	0	0	0
ESYTC			0 (0%)	0	0	0	0
Study End Form							10 (100%)

*Deprivation not collected; however, first part of postcode collected (e.g. BR7 6), 2 missing

Enrolment dates: not always completed

Follow up time assumed based on

- Date of enrolment (n=54),
- Date of assessment if missing (n=9)
- Date of first SDQ (n=2)

Based on enrolment date, numbers with long enough follow up are:

- 3 months: 45
- 6 months: 24
- 9 months: 5
- 12 months: 0

20 participants with enrolment Dec 2020 onwards (i.e. too soon for 3 month follow up).

41 participants with enrolment September 2020 onwards (i.e. too soon for 6 month follow up).

60 participants with enrolment June 2020 onwards (i.e. too soon for 9 month follow up).

65 participants (all) with enrolment March 2020 onwards (i.e. too soon for 12 month follow up).

<u>Referral/Screening Data: 114 young people screened</u>

Referral Data to be collected:

- Age (*Age (Service User)*)
    - 100% Complete
    - Service users aged 8-18 years (Eligibility criteria was 11-14 years)
- Gender (*Gender (Service User)*)
    - One case without Gender completed – seems to be two service users (siblings).
- Ethnicity (*Race/Ethnicity (Service User)*)
    - 100% Complete
    - 2 Asian (1.8%), 10 Black (8.8%), 11 Mixed (9.6%), 6 Not disclosed (5.3%), 8 Other (7.0%) 77 White (67.5%).
- Referrer (*Contract Provider Account*)
    - 100% Complete
    - Bromley Family Services (58) and Croydon Family Services (56)
- Date of Referral (*Referral Received Date (Audit)*)
    - 91% Compete (104 cases, 10 missing)
    - Range 07/02/2020- 19/02/2021

Screening data:

- Family ID (*Case Number*)
    - All given unique case numbers
- Index of Deprivation (*Address 1 (Service User)*)
    - Not collected; however, first part of postcode collected (e.g. BR7 6), 2 missing
- CPV (assessment) (*Course Status Reason*)
    - 6 (5.3%) completed (age 10-15, all male)
    - 59 (51.8%) enrolled (age 9-18, 23 females, 35 males, 1 blank (siblings?))
    - 4 (3.5%) removed from course (all with notes completed)
    - 45 (39.5%) Missing:
        - 19 of these have closed notes completed
        - 18 of these referrals were December 2020 onwards (dates not always completed) with no closed notes
        - 8 prior to December 2020 with no closed notes

Closed notes for 23 screened (19 with no course status reason complete, 4 removed from course).

<u>Participant Data: 65 cases (arm 1, parent)</u>

Date of baseline assessment missing for 6 cases.

4 participants (cases CAS-02314-W4Z3, CAS-02689-D0P9, CAS-02942-L3V4, CAS-03056-X6Q3), marked “enrolled” in screening data, missing in participant data.

2 participants (cases CAS-3047-R1N5 and CAS-3118-B0D0) missing “course status reason” in screening data, entered into participant data.

1 set of duplicate case numbers (CAS-03112-D3T6) – one female age 13 and one male age 10. Only female appears in screening notes (siblings?).

Note to say participant ID 65 is a duplicate – deleted.

Cases are mostly completed for parent arm, so parent demographics are completed.

One baseline child case opened, but no questionnaires completed.

Age missing for 22 in participant data but completed for 21 of those in screening data. 10 participants have different ages in screening and participant data, differing only by +/- 1 year.

Participant 8 (case ID CAS-02647-J3Z7) is shown as Male in participant data and Female in screening.

Baseline

- SDQ
    - 49 complete (75.4%), 7 of those have missing enrolment dates
    - 17 missing (26.2%), 5 missing enrolment dates
- CPV Assessment
    - 49 complete (75.4%)
    - 17 missing (26.2%)
- Score 15
    - 7 complete (10.8%)
    - 59 missing (90.8%)
- IES
    - 7 complete (10.8%)
    - 59 missing (90.8%)
- CRIES8
    - None (child survey)
- ESYTC
    - None (child survey)

3 months

20 participants with enrolment date December 2020 onwards (i.e. too soon for 3 month follow up).

4 parents and 1 child followed up out of possible 45 (questionnaires completed). One parent too soon for 3 month follow up but has record opened and notes added:

- SDQ:
    - 4 parent questionnaires (8.9%)
    - 1 child questionnaire (2.2%)
- Score 15: all missing
- IES: all missing
- CRIES8: all missing (child survey)
- ESYTC: all missing (child survey)
- CPV: completed for 4 (8.9%) (not due)

6 months

41 participants with enrolment date September 2020 onwards (i.e. too soon for 6 month follow up).

4 followed up out of possible 24:
- SDQ: completed for 3 (16.7%)
- Score 15: all missing
- IES: all missing
- CRIES8: all missing (child survey)
- ESYTC: all missing (child survey)
- CPV: completed for 3 (16.7%) (not due)

9 months

60 participants with enrolment date June 2020 onwards (i.e. too soon for 9 month follow up).

2 followed up out of possible 5, although 1 unexpected as followed up (just) before 9 months:
- SDQ: completed for 2 (40%)
- Score 15: all missing
- IES: all missing
- CRIES8: all missing (child survey)
- ESYTC: all missing (child survey)
- CPV: completed for 2 (40%) (not due)

12 months

65 participants (all) with enrolment date March 2020 onwards (i.e. too soon for 12 month follow up).

10 followed up (although none have assessment dates 12+ months).

- SDQ: completed for 5, partially complete for 2 (70%)
- CPV Assessment: completed for 7 (70%)
- Score 15: all missing
- IES: all missing
- CRIES8: all missing (child survey)
- ESYTC: all missing (child survey)

- Study end form: 10 (100%) completed (2 non-attendance, 3 completed with comments, 5 completed without comments)

Appendix D: Pilot Interview Materials

Please note that the pilot materials were not substantively different from those adopted during feasibility. Minimal changes related to the transition from feasibility to pilot phase of the evaluation. One example of each set of amendments is included here for completeness with the changes highlighted.

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC6: PARTICIPANT INFORMATION SHEETS

Parent/Carer/Guardian Information Sheet

NB: Changes to the versions for children and young people and for stakeholders and practitioners were in line with those below. Otherwise, they were the same as versions shown in Appendix B.

1 **Title of study**

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Rise Mutual CIC

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 **What is the purpose of this study?**

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the pilot study are to better understand the factors that support or interfere with the project's successful delivery and, service users' experiences and views of the intervention.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 31st March 2022) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 How long will my part in the study take?

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of Rise Mutual CIC.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 31st August 2022). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a ‘thank-you’ for taking part in the research. You’ll have to sign a piece of paper just to say you’ve received this.

7 How will my taking part in this study be kept confidential?

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 31st August 2022). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 What will happen to the data collected within this study?

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04697**

10 Factors that might put others at risk

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 Who can I contact if I have any questions?

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707 284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707 284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent Form: Pilot Interview Phase

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

Rise Mutual CIC

(UH Protocol number **LMS/SF/UH/04697**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial box

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number}**) for the interview phase of the above study. I have had the opportunity to consider the information about the interview, ask questions and have had these answered satisfactorily. ☐
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights being affected. ☐
3. I understand that the information collected about me and my child will be used to support other research in the future, and may be shared anonymously with other researchers. ☐
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

______________________	______________________	______________________
Name of Parent/Carer/Guardian	Date	Signature
______________________	______________________	
Name of child	Your relationship to the child	
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Please note that for the pilot phase, there were no changes to the topic guide used with families and the debrief remained the same as in the feasibility phase. Changes to the topic guide adopted with professionals have been highlighted below.

Topic Guide for use with Practitioners/Stakeholders

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?
- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?
- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?
- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?
- How have you reviewed progress with them, and the outcomes so far of your interventions?
- What's the most reliable and appropriate way of measuring the intervention's outcomes?
- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.
- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?
- To what extent do you think the project achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap)?
- If we were to ask them (the families) what the main areas of positive change had been, and why, what you think they might say?
- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?
- Do you think the intervention is ready for full scale efficacy testing (e.g. using a randomised trial)?

Thank you….

Ref No	
Date	
Review Date	
	OFFICE USE ONLY

SCHOOL OF LIFE AND MEDICAL SCIENCES
UNIVERSITY OF HERTFORDSHIRE

Life and Medical Sciences Risk Assessment

The completion of this is an integral part of the preparation for your work, it is not just a form to be completed, but is designed to alert you to potential hazards so you can identify the measures you will need to put into place to control them. You will need a copy on you when you carry out your work

	General Information			
Name	Dr Tim McSweeney	Email address	t.mcsweeney@herts.ac.uk	
Contact number	*Ext 5284*			
Supervisor name (if student)		Supervisor's e-mail address (if student)		
Supervisor's contact number				

	Activity	
Title of activity		A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.
Brief description of activity		The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The pilot study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the pilot study are to better understand: the extent to which the intervention achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap); views on the most reliable and appropriate ways of measuring the intervention's outcomes; whether the intervention is considered ready for full-scale efficacy testing (e.g. using a randomised trial); how, if at all, have aspects of design

		or delivery changed and adapted (e.g. in relation to enhancing participant recruitment, retention or outcomes); and, service users' experiences and views of the intervention.
Location of activity		*Online using REDCap (Clinical Trials Database system*
Who will be taking part in this activity		Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI) and Prof Joanna Adler (PI) from LMS.

	Types of Hazards likely to be encountered			
X Computers and other display screen	☐ Falling objects	☐ Farm machinery		☐ Fire
☐ Cuts	☐Falls from heights	☐ Manual handling		☐ Hot or cold extremes
☐Repetitive handling	☐ Severe weather	☐ Slips/trips/falls		X Stress
☐Travel	☐ Vehicles	X Aggressive response, physical or verbal		☐ Workshop machinery

Other hazards not listed above		Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.

	Risk Control Measures
	List the activities in the order in which they occur, indicating your perception of the risks associated with each one and the probability of occurrence, together with the relevant safety measures. *Describe the activities involved.* *Consider the risks to participants, research team, security, maintenance, members of the public – is there anyone else who could be harmed?* *In respect of any equipment to be used read manufacturer's instructions and note any hazards that arise, particularly from incorrect use.*

Identify hazards	**Who could be harmed?** *e.g. participants, research team, security, maintenance, members of the public, other people at the location, the owner / manager / workers at the location etc.*	**How could they be harmed?**	**Control Measures – what precautions are currently in place?** *Are there standard operating procedures or rules for the premises. Are there any other local codes of practice/local rules which you are following, e.g. Local Rules for the SHE labs? Have there been agreed levels of supervision of the study? Will trained medical staff be present? Etc*	**What is the residual level of risk after the control measures have been put into place?** *Low Medium or High*	**Are there any risks that are not controlled or not adequately controlled?**	**Is more action needed to reduce/manage the risk?** *for example, provision of support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects*
Computers and other	Research team.	Prolonged periods of computer use.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice'.	Low.	No.	No.

display screen.						
Aggressive response, physical or verbal.	Research team, other people at the interviewees' location.	Being subjected to an aggressive response, or physical or verbal abuse in reaction to some of the issues and topics being discussed.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice', the 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'.	Low.	No.	No. The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected online (via video conferencing) or over the phone.
Stress.	Participants and research team.	In response to some of the issues, views or experiences reported during the course of an interview.	All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences).	Low.	No.	All fieldworkers are experienced, trauma-informed researchers. As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

List any other documents relevant to this application		The 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'.
	Signatures	

Assessor name	Tim McSweeney	Assessor signature		Date	*16/09/2021*
Supervisor, if Assessor is a student		Supervisor signature			

Local Health and Safety Advisor Lab Manager	Jon Gillard	Local Health and Safety Advisor/ Lab Manager signature			*16/09/2021*