EVALUATION REPORT

The Child and Adolescent to Parent Violence and Abuse (CAPVA) programme

Efficacy Trial report

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YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people from becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activities.

And just as important is understanding children and young people's lives. Through our youth advisory board and national network of peer researchers, we'll ensure they influence our work and that we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together we need to look at the evidence and agree what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart, it says that we will fund good work, find what works and work for change. You can read it here.

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About the evaluator

This independent report, funded by the YEF, has been produced by a multi-disciplinary team based at the University of Hertfordshire. The evaluation was led by Professor Joanna R. Adler as principal investigator with Dr Caroline Cresswell, trial manager; Professor David Wellsted, quantitative methodology lead; Amanda Busby, statistician; Dr Silvana Mengoni, implementation process senior adviser; Dr Fiona Mae Creevy, senior research assistant; Dr Karen Irvine and Megan Smith, governance; Yifei Jiang, Emily Lione, Sudipta Chowdhury, Dr Andrew Laughland, Dr Hannah Allcott-Watson and Natalie Hall, database development and management; Dr Jane Fry, health economist; and Dr Amanda Ludlow and Professor Shivani Sharma (Aston University), EDI leads.

The evaluation team brought expert insight and competence in the field of youth violence and crime, considerable experience conducting research involving vulnerable and at-risk children and families, and in the design and management of clinical research trials.

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

Acknowledgements

The evaluators are immensely grateful to all the families that agreed to participate in this evaluation; to the site leads and staff within local authorities who made it possible; to the management and practitioner teams at RISE,[1] with whom collaboration is always constructive; to the experts by experience and members of the YEF youth advisory board; to the project and evaluation staff at YEF; and to the members of the independent trial steering committee. Individuals have not been named here to maintain confidentiality in findings and to protect their personal circumstances. However, they brought critical friendship, rich insights and much-appreciated support in very difficult, as well as rewarding, phases of this evaluation.

[1] RISE Mutual is a Community Interest Company, Respect accredited, specialising in the design and delivery of whole-family interventions, created to educate and empower, with the aim of preventing potentially harmful behaviour and repeat victimisation.

RISE's work is guided by a mission to develop and deliver innovative approaches that support individuals and families to make meaningful change in their lives. Within this context, the Child and Adolescent to Parent Violence and Abuse programme is designed to address child and adolescent-to-parent violence and abuse through a non-violent, trauma-informed, whole-family approach.

Executive summary

The project

The Child and Adolescent to Parent Violence and Abuse (CAPVA) programme is a parenting intervention that aims to improve the behaviour of children aged 9 to 17 who are showing violence towards their parents, carers or guardians. Delivered by RISE Mutual Community Interest Company (CIC) (RISE), the CAPVA programme uses non-violent resistance techniques to guide parents' and carers' responses to violent and abusive behaviour from the children in their care. Families receive up to 20 sessions delivered by trained practitioners. The programme begins by working with parents and carers, using techniques to de-escalate conflict, resist violent and abusive behaviour without using punishment or coercion, and rebuild positive relationships with their children. Where appropriate, practitioners also work directly with children, using trauma-informed care alongside Cognitive Behavioural Therapy techniques and mindfulness to support changes in behaviour. The programme is tailored to the needs, risks and vulnerabilities of each family.

In 2023, the YEF published a feasibility and pilot study of the programme. The YEF decided to commission an efficacy trial because the programme addressed an important evidence gap relevant to the YEF's mission and demand; enrolment and retention during the (non-randomised) feasibility and pilot study were promising. It was considered suitable for evaluation through a rigorous randomised controlled trial (RCT). The pilot evaluator similarly concluded that the programme had the potential to be evaluated in a large-scale RCT.

Following a period of co-design between the grantee, evaluator and the YEF, the efficacy trial started in April 2024. The evaluation aimed to involve 376 families and assess the impact of the CAPVA programme on child-to-parent violence and abuse as its primary outcome. However, mobilisation and recruitment took substantially longer than planned. By August 2025, 41 families had been referred; following screening and eligibility assessment, 18 families had consented to participate in the study. Recruitment was progressing too slowly for the trial to reach the sample size needed to robustly answer its research questions within the commissioned timeframe. Recruitment was affected by delays in involving local authorities, high staff turnover, complex referral processes and concerns that families allocated to the control group would receive little or no support. Despite additional support and contingency plans, the YEF decided to terminate the trial in September 2025.

As part of the evaluation, baseline data on violence and children's perceived strengths and difficulties were collected from the parents and carers of 17 children, with seven families also completing follow-up measures. Data collection took place between February 2025 and March 2026. Following the early termination of the trial, these data were used to assess the acceptability and potential utility of the measures rather than the programme's efficacy. The evaluators also interviewed 12 RISE and local authority stakeholders to understand the challenges experienced in delivering the trial and inform potential future research.

This report documents the evaluation activities undertaken and draws out lessons and options for future research. Key learning includes:

- **Future trials should invest more time and resources in mobilisation, engagement and communication**. Local authorities should be involved from the design stage, with sufficient time to engage senior leaders and frontline practitioners. Roles and responsibilities should be agreed early, administrative burden minimised and the purpose of randomisation and what participation involves clearly communicated to practitioners and families. The team should listen and respond to concerns on an ongoing basis and adapt where feasible.

If further impact evaluation is considered, there are several potential design options:

- **Retain an individually randomised trial.** An RCT remains a viable option for establishing the impact of CAPVA compared with business as usual, with greater investment in mobilisation, local authority involvement and communication about randomisation.
- **Randomise at a higher level.** Instead of allocating some families to the intervention group and some to business as usual, allocation could occur at the level of teams, services or local authorities. This design would require a larger sample of participants than the individually randomised trial.
- **Consider a stepped-wedge trial.** CAPVA could be introduced sequentially across participating local authorities, with the order randomised so that all areas eventually receive the programme. This would require sufficient sites and careful planning of implementation and recruitment.
- **Consider a quasi-experimental design.** If randomisation proves infeasible, families receiving the CAPVA programme could be compared with similar families in areas not delivering the programme. This could provide evidence of impact but may be considered less robust than a well-conducted RCT.

Introduction

The Youth Endowment Fund (YEF) launch grant round in October 2019 included funding for several grantees (intervention providers) who were working with young people at risk of offending and their families. Under that launch round, the University of Hertfordshire (UH) was commissioned to provide four feasibility-pilot evaluations, including an initial evaluation of the RISE Mutual Community Interest Company (CIC) (RISE) Child and Adolescent to Parent Violence and Abuse (CAPVA) programme (Adler et al., 2023). The YEF decided to re-commission the grantee (RISE) to deliver the intervention for an efficacy trial and, following a tender process, UH was reappointed as the evaluator. Thus, in April 2024, a randomised controlled trial (RCT) was commissioned to test the efficacy of the RISE CAPVA programme. In parallel, it was also intended that a cost analysis and an implementation process evaluation (IPE) would be conducted, permitting concurrent triangulation of findings. The trial protocol was registered (ISRCTN-90520639, 2024) with an expectation of final reporting around autumn 2027.

Following delays to mobilisation, slow referral rates and disappointing numbers of families consenting to participate, the trial was terminated early by the YEF. Alongside the necessary activities to wind down the trial, the YEF commissioned the evaluators to reduce the planned analyses and conduct additional research to produce a learning report. Accordingly, this document presents a reflection on the early closure of a trial. It assesses the acceptability of measures and makes recommendations for future research, but it does not assess outcomes or the impact of the intervention. Within this report, the originally commissioned efficacy study will be referred to as the "terminated trial", and the work commissioned for learning from the termination will be referred to as "additional activity".

Background to the terminated trial

Ibabe (2020) defines CAPVA as "Young people/children who consciously direct physical, psychological, emotional, financial, or sexual aggression toward one parent or caregiver, repeatedly over time" (p. 7). An earlier, alternative definition is also useful: "Parent abuse is any act of a child that is intended to cause physical, psychological or financial damage to gain power and control over a parent" (Cottrell, 2003, p. 3). Both definitions focus on adolescents, although the commissioned age range for the terminated trial was a little wider, as it reflected the range of children typically worked with by RISE (nine to 17).

In attempting to assess the prevalence of CAPVA, a particularly useful exercise was undertaken by Brennan et al. (2022). Their research informed the dimensions on which statistical analyses were planned for the terminated trial. Brennan et al. (2022) drew on Metropolitan Police Service (MPS) data that reflected the start of the COVID-19 pandemic within London and pooled data from the 2012 to 2020 waves of the Crime Survey for England and Wales (CSEW). Data came from 322,990 people, of whom, 5,246 reported violent incidents. Of all violence reported to the CSEW, 1.2% (133 incidents, reported by 102 respondents) could be identified as CAPVA cases using the relatively limited filters available in the dataset. It was noted that less than half (40%) of the CAPVA incidents recorded in the CSEW were reported to the police. Prevalence fluctuated within the MPS data, and it was not clear what the final effects of lockdown would be at the time of publication. The lowest recorded number of CAPVA offences across London per year was 577 (2020) and the highest was 846 (2018).

A gendered dimension to CAPVA incidents was also found in both the action taken and the target of that action. The majority of recorded incidents were by males: 71% in the CSEW and 81% recorded by the MPS. In the CSEW, 78% of reported victims were female (overwhelmingly, the mother). Families from the global majority (ethnically minoritised) were over-represented when compared to national and local prevalence, comprising 53% of reported CAPVA. Analyses showed no association between indicators of deprivation and incidence of CAPVA. However, this could only be tested at the borough level, and in London, there is likely to be more variation within boroughs than between them (data taken from chapter six and annex three, Brennan et al., 2022).

Harms from CAPVA "can be physical, emotional and psychological, material and financial, and legal" (Baker and Bonnick, 2021, p. 12). Although increasingly recognised in policy and practice (Holt, 2022), much of the research around CAPVA has concentrated on how it feels to live with CAPVA within families (Holt and Lewis, 2021). It is also pertinent to note that under the Domestic Abuse Act 2021, children and young people (CYP) could be liable to prosecution for CAPVA once they reach 16. This may also decrease the likelihood of parents reporting CAPVA. Referred families may be experiencing sharp impacts of trauma, crime, health, poverty, disadvantage and further intersections with race, ethnicity, disability and gender.

The implications for evaluation design were considered in some depth as part of the co-design phase of the terminated trial and were reported in the trial protocol (Adler et al., 2024). Some examples of inclusive practice were that gender and ethnicity of the referred CYP were included within the terminated trial's randomisation processes; that the design of the terminated trial included additional focus on neurodiversity; that joint training was run for full programme delivery and evaluation teams on minoritised families and exclusion, which was itself jointly delivered and designed; and that routine consideration was made of potentially excluded groups within trial management group meetings with sites and within evaluation team meetings. Similarly, when delivering the programme, RISE use nuanced, tailored approaches, including considering gender norms within their work and working within and/or managing cultural expectations (see Delivery).

The RISE CAPVA intervention aims to change behaviours of CYP showing CAPVA by first engaging with their parents/carers and working with them before any direct intervention with CYP. The intervention is based on the principles of nonviolent resistance (NVR); see Theory of change: Child and Adolescent to Parent Violence and Abuse programme. One published randomised trial compared NVR against business as usual (BAU) within support provided to foster families (Van Holen et al., 2016). Although underpowered and without statistically significant effects, reductions in abusive behaviours were reported. More recently, Fongaro et al. (2023) conducted an RCT comparing NVR against parental counselling with psychoeducation. That study did not assess the frequency or severity of violent or abusive behaviours but rather focused on parental stress. When compared to psychoeducation, NVR had similar outcomes on the Child Behavior Checklist (Achenbach and Rescorla, 2001) and Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) parent-completed measures but was not as effective at reducing parent-reported stress by the end of the programme. The study's acknowledged limitations include that although the authors found improved outcomes over time for families with NVR, they did not make any longitudinal between-group comparison against treatment as usual. Parental stress could be a useful proxy rather than directly testing reductions in violence. Nonetheless, it might be expected that if effective, counselling would help parents manage better, even if their children's behaviours did not improve. It is therefore important to also attempt to assess CAPVA

incidence directly. The terminated trial was intended to be better powered than either of the two mentioned above, to specifically test for reductions in CAPVA, concomitant impacts on families and the communities around them, and CYP school attendance and attainment.

Differences between the feasibility–pilot study and the terminated trial

The feasibility-pilot evaluation found relatively large reductions in CAPVA and improvements in problematic behaviours (Adler et al., 2023). The feasibility-pilot trial was not compared against alternative provision; therefore, it involved no randomisation. These elements (control group comparison and randomisation) constitute the major changes between the feasibility–pilot phase and the terminated trial. Other changes made between the initial evaluation and the terminated trial included the incorporation of additional neurodiversity, trauma and inclusion expertise within the evaluation team. Also, a dedicated researcher was employed to ensure that the validity of the design was maintained, rather than relying entirely on intervention practitioners, social workers and/or families for data collection. Relatedly, each family received a bespoke link to complete the measures required for analysis. The materials could be completed by families on their own or with the assistance of the research team. The database software (Research Electronic Data Capture [REDCap]) survey tool was set up to facilitate this process, and it ensured that no one other than the evaluators had direct access to the database. Conversely, in the feasibility–pilot evaluation, some areas of that database had been set up for certain RISE practitioners to upload data directly.

As part of the initial contracting for the terminated trial, a co-design phase was actively engaged in by the evaluators and grantees, with additional assistance from the YEF youth advisory board (YAB). Two key challenges considered during co-design related to BAU and the safe engagement of CYP in the evaluation. BAU varied between boroughs and might also have varied depending on families' needs. For example, some families may have been awaiting intervention from Child and Adolescent Mental Health Services (CAMHS) and others from educational liaison services. In some boroughs, competing models were being used to address CAPVA, such as those that target the CYP rather than the parents/carers first (e.g. Respect, n.d.). In others, there was no specific CAPVA intervention.

A scoping exercise was undertaken to identify BAU in each of 10 potential local authorities intended as delivery sites.

Table 1 demonstrates the wide variation in potential support that was identified. In boroughs where there was no routine activity identified, it was agreed that a lead professional would be allocated (as would happen in the intervention group), and the families would be provided with advice about safety measures. These safety measures were frequently used within RISE practice and further refined as part of the co-design phase.

To limit potential backwards identification, local authorities have not been named in the table below. The table is presented first by activity within sites that were eventually part of the study, then within sites that were not part of the study. Given that half the sites initially proposed did not come on board, additional sites were sought during the mobilisation and initial phases of the trial. They were not included within the control group scoping exercise, so those additional sites are not included here.

Table 1: Business-as-usual scoping

Site type	Examples of usual practice (for control group)
Referrals received sites (four local authorities)	<u>Clinical services:</u> A lower severity/risk level Child and Adolescent Mental Health Service (CAMHS) intervention. <u>Community organisations:</u> Domestic abuse provider.
	Minimum – lead professional and study safety measures.

	<u>Multi-agency safeguarding arrangements:</u>
	• Child-to-parent abuse is included within local authority safeguarding children, domestic abuse procedures.
	• Professionals used the referral and assessment guidance to consider the threshold of support/services:
	  ○ Family support service and/or
	  ○ Targeted youth support and/or
	  ○ Social, emotional and mental health pathway
	• If the threshold was met for a child causing harm, then a family assessment would be completed and an intervention formulated: e.g. joint working, referral to further support/interventions or direct work.
	• Practitioners could request a practice consultation with the Violence Against Women Group Workforce Development Team and/or Young People and Domestic Abuse Lead.
	  ○ An open-ended offer of risk assessment, intervention suggestions and resources, safety planning, and signposting using theoretical bases, including nonviolent resistance (NVR), youth work and systemic family intervention
	<u>Children's social care:</u>
	• ADHD parenting programme
	• Incredible Years – school-age programme.
	• Strengthening Families, Strengthening Communities (SFSC) (including Community Languages programme)
	• Mellow Parenting – Growing Together family programme
	• Cygnet Parenting for parents of children with autism
	• Domestic Abuse, Recovering Together programme
	• NVR – 12 weeks (alternative provider, not RISE)
	• In care/edge of care: Adolescent Multi Agency Support Service or Adolescent Support Intervention Project
	<u>Onward referral</u>
	• Community organisations
	• Youth Justice Service
	• CAMHS

	Family Solution Service delivered by the Edge of Care team (around 12 sessions skills-based and sustainability focused) Early help Whole family assessment, formulation and delivery of parenting skills/sessions alongside potential onward referral or signposting to limited services
Onboarded; no referrals (one local authority)	Minimum – lead professional and RISE safety measures.
Not onboarded; five initial potential study sites	Children's social care: • One-to-one support from a social worker • One-to-one support from early intervention (within children's social care) • Parenting group programmes (delivered through early intervention). • Borough family support offer – to promote the emotional wellbeing and mental health of children, young people and their parents/carers. Clinical services CAMHS (may refer to from within children's social care)
	Children's social care: • Families in Focus early intervention (children aged 4–16) • NVR delivered one-to-one with parents, not as part of a targeted programme (staff in other teams are also trained) • SFSC • Triple P online parenting programme focused on teenagers Community organisations (providers anonymised) • Twice-yearly NVR group with occasional casework • Teen parenting programme (eight-week rolling programme) • Systemic intervention, via CAMHS and/or social work • Early help community (short-term team and early help front door) Youth justice service • Youth justice parenting practitioner • Violence Reduction Unit group support for parents, not focused on CAPVA specifically • Family group conferences
	Community organisations: Three different interventions targeting intimate partner violence and abuse Children's social care Strengthening Families Strengthening Communities. SFSC
	Minimum – lead professional and RISE safety measures

Given the wide variation in BAU, considerable attention was paid to alternative potential design choices, including the possibility of implementing an active control, which was discussed in depth by the YEF, RISE

and UH. Several tensions arose, the most notable being between trying to run a real-world test of efficacy against what would otherwise happen, keeping families safe, meeting the required design standards of the funder and the challenge of identifying what an active control would be and how it might be implemented across sites. It was also expected that all families referred for CAPVA would have been assigned a social worker or an early help practitioner and/or that many would have a youth worker. The minimum BAU considered for the control intervention in the terminated trial was therefore taken as practitioner support from the local authority, with the provision of a safety protocol that was an enhanced version of the suggested steps routinely provided by some RISE practitioners. The "safety sheet" was implemented as part of the initial screening and assessment for suitability.

In both the feasibility–pilot and terminated trial, screening for suitability and the initial screening processes were undertaken by RISE with the minimum possible changes to usual practice. For the terminated trial, some materials were modified to incorporate supplementary information required by the YEF (e.g. specific categories for ethnicity rather than a free-text box) and to aid study recruitment. For the terminated trial, it was also required that, as part of the initial referral, practitioners would need to provide families with clear, specific information about BAU. This meant that whether families were subsequently randomly assigned to the control arm or intervention arm of the trial, they should have known what to expect from the support that would be offered to them.

The intervention began with parents/carers (see the next section), and assessments of violence were made by them. They were thus the primary respondents for the terminated trial. Nonetheless, young people's voices were intended to be heard more directly within the IPE than had been possible in the feasibility–pilot trial. The safe engagement of CYP was considered in a participatory session run with representatives of the YEF YAB, who continued to provide advice to the study during the mobilisation phase. Key considerations included:

1. Ensuring the age appropriateness and readability of all study materials, written, verbal and visual
2. Drawing on and creating bespoke, accessible materials for adults and CYP to make clear who was conducting the evaluation, who was delivering the intervention, what to expect from the terminated trial and why it would be helpful to sign up, even if subsequently assigned to BAU
3. Acknowledging the adultification (e.g. Davis, 2022) that referred CYP may have experienced and responding appropriately to neither patronise CYP with tone or the content of materials nor worsen or reinforce responses to them that do not acknowledge that they are still children
4. Checking with practitioners and social workers prior to inviting CYP to participate directly in research for the terminated trial
5. Gaining informed consent in a process that was intended to start with gatekeepers (as in 4), followed by parents/carers and then young people themselves under 16. Where potential participants were 16 or 17, they would still be seen as vulnerable, and although their parents/carers would not have been approached prior to their invitation to research, the practitioners working with them would still have been asked for a safeguarding-informed view
6. Providing safety measures routinely to all families at screening/assessment for suitability (as above)
7. Routinely recording and reviewing adverse events, including ways for families (adults and CYP) to self-report

8. Monitoring data monthly, including checking potential safeguarding instances associated with the evaluation

An additional design change by the evaluators was intended to increase the likelihood of participation and make the study as engaging as possible for CYP. This involved greater use of creative participatory methods, e.g. designing images to be used as research prompts. Although not ultimately implemented, an IPE was designed, with materials developed in line with all these considerations and ethical requirements. Other data collection tools also differed between the feasibility–pilot and terminated trial (see Methods).

Overview of this report

The mobilisation and delivery phases of the evaluation coincided with a national restructuring of children's social care (CSC) based on the principles of child-centred engagement and fewer points of transfer between teams (Department for Education, 2024). This involved major reorganisation for local authorities, which was still ongoing when preparing this report. Therefore, engagement with local authorities was extremely challenging. The evaluators and grantees had realistic expectations and previous experience working within local authorities, but pre-existing relationships were strained by ongoing staff churn and absence. It rapidly became clear that the contracted mobilisation phase had not been long enough. During the delivery phase, the YEF liaised closely with evaluators and the grantee to explore the reasons for referral rates being below those required, and an action plan was developed, enacted, reviewed and revised as part of quarterly monitoring processes. The evaluators and grantee worked closely together over several months to try to improve recruitment rates. They were supported in doing so by the trial management group and trial steering committee. Examples of additional activities included producing additional materials that addressed queries about RCTs from potential referrers, attending multiple meetings, running virtual roadshows and joining local authority activities and training sessions. On-boarded sites also shared what was working well and what was more challenging. The YEF also provided support in developing additional actions and plans to improve referral rates.

Ultimately, the decision was taken in September 2025 to terminate study recruitment forthwith. Families in the pipeline for referral were encouraged to make decisions as speedily as possible, and by the end of October, no more families could join the (terminated) study. Delivery of BAU was continued without change, but delivery to the intervention arm had to be completed by February 2026. This meant that the frequency of intended engagement with families was increased for the last-recruited families assigned to the intervention arm to meet minimum postulated treatment requirements.

Given the early curtailment and very low numbers involved, no efficacy assessments are made in this report. Where families completed follow-up measures, descriptive data will be presented and an assessment made of acceptability and the potential utility of measures. The YEF recommissioned the evaluator to conduct interviews and/or focus groups with key stakeholders to inform this report. This was tightly specified and designed to balance the desire to understand better what went wrong and what could be avoided in the future with the need to account for resources.

Intervention

The CAPVA programme run by RISE is intended to change the behaviours of young people (aged 9–17) showing violence towards their parents and carers. It does this first by seeking to change the ways in which parents and carers respond to young people's behaviours. Behaviours of concern manifest as moderate through to severe violence, typically targeting parents, carers, siblings and other family members. Behaviours may be different when aimed at different family members; hence, the experiences of mothers may not mirror those of fathers. RISE's CAPVA intervention applies a whole-family approach in line with the understanding that long-lasting change will be better facilitated if all members of the family understand NVR. Typically, low engagement in school is also observed, with subsequent poor attainment and increased risk of criminal activities beyond the home.

As part of routine assessment for suitability for the CAPVA programme, a robust assessment and suitability process is conducted with all families to explore previous patterns of behaviour and violence, including levels of coercive control. Some families referred to RISE may not appear to be in crisis due to physical violence being absent by the point of referral, or less frequent and/or intense. In such cases, screening frequently finds that families who have previously attempted to implement boundaries have seen increases in violence. As a result, they may have adopted complementary patterns of escalation (see Table 2 below). These families are assessed as suitable to embark on the intervention, despite physical violence not being a key feature at the time of referral.

For the CAPVA programme, RISE routinely assesses vulnerabilities and risks in one or two sessions with parents/carers (see Intervention screening below), which include:

- Self-harm and/or suicidal ideation
- Mental health difficulties and disabilities (undiagnosed or diagnosed)
- Substance misuse
- Violence and harmful behaviours outside the home – in what settings and towards whom
- Vulnerability factors – e.g. exploitation risk and absconding
- Previous intimate partner violence or abuse (IPVA) or current concerns

The identification of vulnerabilities and risks inform how the intervention can be tailored for individual families (for examples see intervention delivery). Baseline assessment is also made of family functioning and how the CAPVA affects the family and systems around the family.

The CAPVA delivery team works with other practitioners assigned to the family (e.g. the social worker and/or youth worker allocated) to ensure they also understood the principles being adopted and that the CAPVA intervention is delivered using a trauma-informed approach (Asmussen et al., 2022) that is inclusive of cultural and diverse needs. RISE practitioners are trained in cultural and trauma-informed approaches, recognising that families possess diverse worldviews shaped by their cultural backgrounds. For instance, families' distinct norms may differ according to gender roles or belief systems, necessitating a personalised approach in delivery. Practices in managing difficult child behaviour are well established as being impacted by cultural norms (Fox et al., 2002). As NVR does not follow a sanction/reward perspective, CAPVA practitioners explore these beliefs in more depth with families to help challenge any practice that is incompatible with NVR principles.

Theory of change: Child and Adolescent to Parent Violence and Abuse programme

The CAPVA programme delivery centres around the NVR approach and is consistent with the principles of the New Authority (Omer, 2004, 2011). Four overarching elements have been characterised within NVR interventions: presence, self-control, social support and structure (Shimshoni et al., 2021). The underlying concepts and principles drawn on within NVR are summarised in Table 2 and have been derived from Omer and Lebowitz (2016).

The model was further developed within the UK by Partnership Projects (Jakob, 2016), including making more formal acknowledgement of trauma. The NVR practices adopted by RISE's CAPVA practitioners are intended to create a safe family environment for trauma management by facilitating change processes in the larger system around the family. This includes, but is not limited to, helping parents/carers request support from others instead of delegating their authority to critical, potentially prescriptive or coercive other adults. Other elements are drawn from clinical practice, including that neuropsychological and physical responses to trauma become entwined and that "the body keeps the score" (van der Kolk, 2015). Techniques are then used that include helping parents/carers identify their own physiological responses to other adults as a measure of emotional safety in communication.

Other principles from Jakob (2016) include providing and preparing the groundwork for compassionate and appreciative witnessing to take place. An example of compassionate witnessing would be enabling and facilitating parents/carers to name the violence, share their own distress and share their understanding of harm caused to everyone in and around the family. A potential forum for this is within a supporters' meeting. Appreciative witnessing could involve exploring, with the parent/carer, accounts of the NVR actions they may take. RISE practitioners might facilitate and encourage parent/carers to give these accounts of parental agency to potential supporters. If others around the family see an adult increase their parental agency, they are subsequently more likely to become safe supporters (Jakob, 2016).

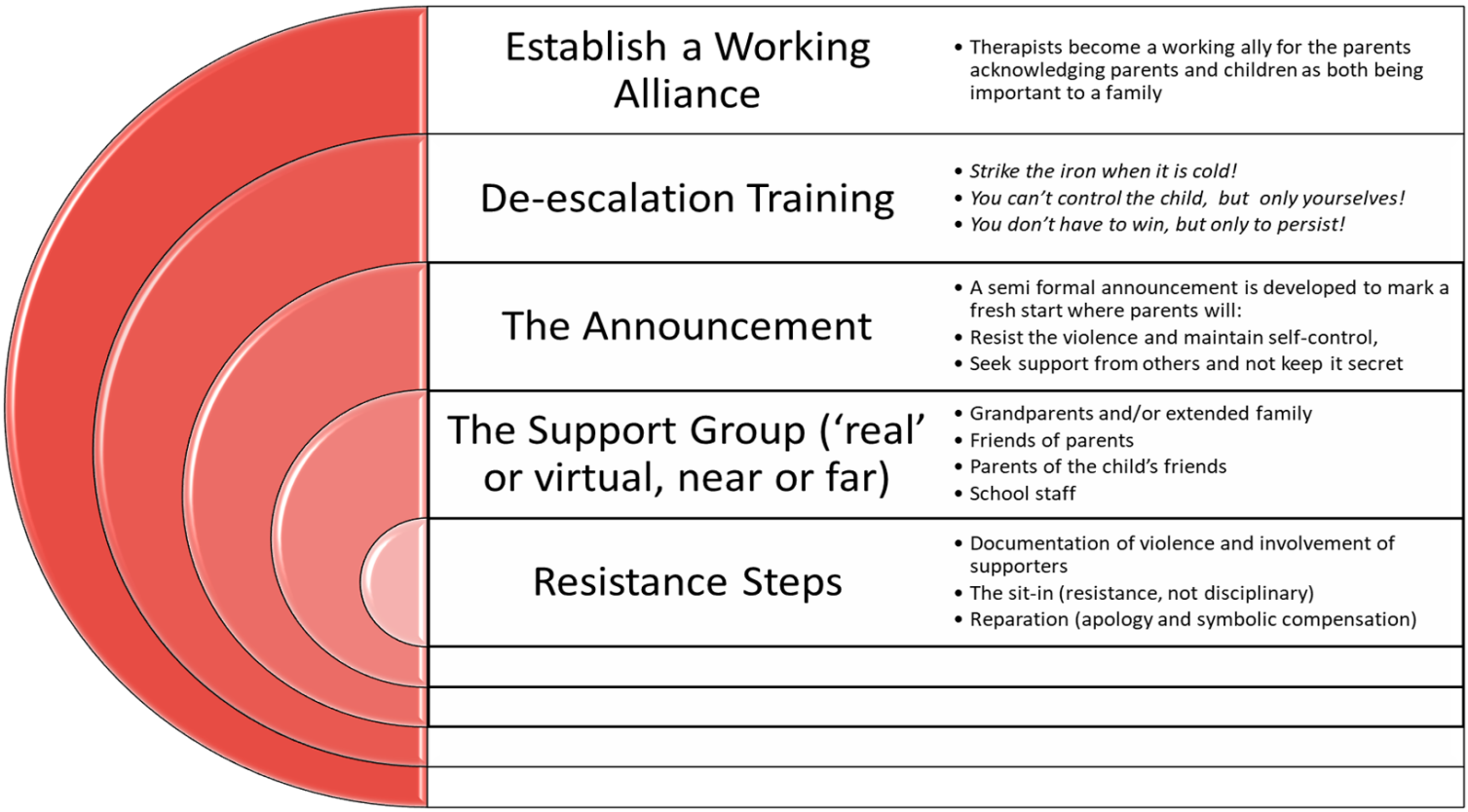
The UK adaptation of NVR also draws on the idea of "erasure" (Dolberger et al., 2016, cited in Jakob, 2021), where people may become disconnected from their previous values, potentially losing some of their sense of self. Alongside this, families may lose touch with support networks and develop distorted images of how others perceive them. This kind of fracturing or disconnect is posited as being part of sustained psychological injury. Some trauma-focussed NVR methods include practitioners helping parents/carers to understand their traumatic responses and traumatic triggers; learning about parents'/carers' self-calming strategies; learning about parents'/carers' interpersonal calming resources; and teaching grounding techniques. The key underlying concepts are summarised in Table 2.

Table 2: Underpinning concepts (Omer and Lebowitz, 2016, pp. 693–695)

Parental feelings of helplessness	Even if they are coercive or violent themselves, parents with children who are violent often feel helpless and may be tempted to vent their frustration in ways that can be inconsistent and perpetuate the child's aggression/domination.
Escalation	Two forms of escalation are characterised within the model: *complementary escalation* is seen as being when parental submission increases a child's negative behaviours, and *reciprocal escalation* is when "hostility begets hostility" (p. 693). De-escalation skills training is therefore a central part of intervention.
Reconceptualising power and control	Violence should be resisted in ways that are "rigorously nonviolent" (p. 693), with an emphasis on resisting rather than controlling children's violence. This is designed to restore control by diminishing the sense of helplessness articulated above and reframing care so parents "don't have to win, but only to resist" (p. 694).
Presence	Omer and Lebowitz provide the example of "choosing to be physically present in situations and locations where the child is at risk for destructive or high-risk behaviours" (p. 694), thereby maintaining authority while helping to reduce risk. Parents and carers learn to be present "while rejecting authoritarian practices based on fear or physical force" (p. 694). This helps establish authority without being authoritarian and minimises the likely negative reactions to fear and shame that the young person may be feeling. Improved, appropriate presence will also help the parents/carers be less fearful and less likely to retreat from the child.
Support, openness and transparency	Parents and carers are encouraged to draw on support from friends and family beyond the home. Being open is also designed to reinforce parents' and carers' own commitment to reducing their use of violence. Supporters act to reinforce parental approaches and can validate children's feelings while still challenging inappropriate behaviours, helping to make clear what is tolerable and what is unacceptable.
Respect and reconciliation	Acts of respect and reconciliation acknowledge that neither is the child an opponent nor is their behaviour unremittingly bad. This principle centres on the idea that there are things that can be celebrated about a young person's life even when they sometimes behave dangerously towards others. *The most common conciliatory steps are verbal or written messages of appreciation, small symbolic gifts, proposals of pleasurable joint activities, offers of small unrequested services, reminders of positive events from the past (without contrasting them to the more bleak present)* (p. 695)

Omer and Lebowitz (2016) also outline the typical treatment stages within NVR; these have been summarised in Figure 1 below.

Figure 1: The interlinked steps to nonviolent resistance within Child and Adolescent to Parent Violence and Abuse (Omer and Lebowitz, 2016, p. 695-696



The theory of change and associated approaches taken by CAPVA practitioners have been summarised in a logic model (Table 3), which is slightly revised from that originally developed within the feasibility–pilot evaluation (Adler et al., 2023). Rather than solely considering a delivery span, intervention duration was reframed to consider the number of sessions delivered. Similarly, a minimum number of sessions for therapeutic efficacy was postulated, rather than minimum time alone. Other changes reflected the development of intervention work that could be delivered online as well as face-to-face post-COVID-19 and that, for the terminated trial, the YEF was willing to fund delivery to a wider age range of CYP, more consistent with usual practice at RISE.

In practice, the time allowed for completion of the usual number of intervention sessions was taken to be between nine and 11 months. In rare cases, families were expected to complete the intervention in as few as six months, typically when they engaged in the minimum possible, adult-only dosage of 12 sessions. Sometimes, the full 20 sessions can run for around a year; this includes the last one or two, optional sessions, which involve practitioner follow-up after completion of the main intervention.

In planning the terminated trial, time was allowed for a likely pause between the suitability assessment and delivery of the rest of the sessions to allow for engagement in the trial, completion of baseline outcome measures and allocation to the BAU or intervention arm of the terminated trial. As noted above, once the trial was terminated, delivery for the final recruited families was condensed into around four months.

Table 3: Logic model: RISE Child and Adolescent to Parent Violence and Abuse (CAPVA) programme

Problem statement	The programme seeks to change behaviours of 9–17-year-olds who are violent towards their parents/carers. Behaviour manifests as violence and abuse within the family home, and/or poor engagement in school, with subsequent poor attainment and increased risk of anti-social behaviours.		
Inputs	**Deliverables and Short-term outcomes**	**Mid-term outcomes**	**Long-term outcomes**
• Up to 20 sessions with families (including up to two for initial screening and assessment and up to two for optional follow-up) • Engage community and wider family to support the parent/carers and the children and young people (CYP) • Brief social workers, community members and referrers in nonviolent resistance (NVR) Teaching NVR to parents might include: Teaching de-escalation skills to reduce risk, teaching resistance and repair techniques, removing barriers (including punishments and rewards), building confidence, creating acceptance of the CYP and helping build a relationship with the CYP before reinstating boundaries. Trauma-informed Cognitive Behavioral Therapy for children might include: Experiences of trauma, anger management and self-regulation techniques, decision-making processes, dealing with and recognising emotions, empathy, perspective taking and goal setting	**Deliverables** • Two family assessment sessions occurred prior to programme delivery. Over somewhere around nine to 10 months, parents/carers engaged in at least 12 face-to-face CAPVA sessions, with six involving CYP (if no engagement, parents/carers could receive sessions). Engagement in a minimum of 12 sessions (post-screening/assessment) was posited to induce a reasonable therapeutic effect. • Throughout the delivery phase, bi-monthly one-off online NVR training workshops were provided to key individuals supporting the family/CYP (e.g. teachers, youth leaders and sport coaches). • Briefing meetings were held with a lead professional allocated to a family. **Short-term outcomes** Short-term outcomes anticipated for the family and their network: • Whole-family and community engagement with a consistent understanding of NVR principles within the network.	Intermediate outcomes for the CYP include: • Reduced violence • Enhanced engagement with key individuals • Improved emotional self-management • Better behaviour Intermediate outcomes for parents, carers and/or the rest of the family include: • Improved 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 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 – could draw on acquired 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 CYP to manage anxiety, anger and frustration, thereby reducing familial, child and community/social harms, including violence, abuse and anti-social behaviours.		

Intervention referral

Intervention mobilisation was set for two months from September 2024. Referrals were intended to start by the end of October 2024, with delivery continuing until October 2026. The first local authority where all permissions and documentation were approved sufficiently for them to be deemed fully onboarded were theoretically able to have made referrals to the study from November 2024. As well as likely uncertainty about referring into a new trial, the final sign-off for this local authority to refer coincided with the launch of the CSC reorganisation and the nationwide lead-in to that year's 16 days of activism and was followed immediately by the winter/school vacation period. In this event, the first referrals came in February 2025. Families were considered eligible for inclusion if they had a child or adolescent in the household aged 9–17 referred due to medium- to high-risk situations where they had used verbal, financial, physical and/or emotional means to exert power and control over a parent/carer. The manualised exclusion criteria include: where a parent has a history of child abuse towards the child; where there is evidence of violence between the parents/carers such that they could not engage in joint parenting sessions, whether there was domestic violence between the parents/carers at the time of the referral and whether the perpetrator was living at home (RISE, 2024).

Project and evaluation teams developed presentation materials to support practitioners and jointly delivered briefings on the intervention to referring boroughs. Both teams were also available to prospective families to clarify information on suitability criteria for referrals and the reasons for the study. Supporting materials included information about the underlying principles and purposes of the RCT design drawn from sources created for relevant local authority staff (Chalmers, 2017; Hanson and Pergamit, 2022) and underpinned by the clinical trial literature (Freedman, 1987; Horn and Weijer, 2015).

Mobilisation and engagement activities included talking through what was proposed, covering potential concerns about the evaluation, the intervention and the reasons for an RCT (e.g. Rosen et al. 2006). Slides, notes and videos were developed to be as accessible as possible, drawing on materials previously developed for practitioner/teaching audiences (e.g. Chalmers, 2017). This was covered in the ethics section of the terminated trial protocol (Adler et al., 2024), and where more technical detail was needed, that protocol itself could also be shared, alongside a developed FAQ on the UH website. Such activity began in the co-design phase, developed through inception and mobilisation, and was renewed as part of action planning. It was informed by previous research into the acceptability of randomised trials; Macintyre and Petticrew (2000) provide a useful summary of the kinds of areas that were considered.

Examples of the key topics raised are provided below; in each case, the first bullet summarises the topic, and examples that were provided of explanation/mitigation are considered in the indented bullets underneath. Please note that in any meeting, not all examples would be needed, but the topics outlined here would have been explained more fully in instances when they were needed.

- Families randomly allocated to BAU would not be offered any support beyond that already available in their area:
    - There may still be increased protection of CYP via the additional close monitoring of them for the evaluation;

    - Although an active control was considered, there was no established effective intervention to compare against the intervention (Council for International Organizations of Medical Sciences [CIOMS], 2016).
- The BAU support may be very limited or even non-existent:
    - At a minimum, the allocation of a lead professional was required so that the family would always have a point of contact within the local authority. If there was nowhere to refer, local authority staff may otherwise have closed the case.
    - A set of safety measures that families may have chosen to enact was formalised and provided as part of screening to all families screened, whether or not they were subsequently found to be suitable for the trial and whether or not they consented to join the trial.
- Families randomly allocated to BAU were being denied an intervention that works:
    - The intervention was not something to which anyone was routinely or statutorily entitled (Chalmers, 2017; The Abdul Latif Jameel Poverty Action Lab [J-PAL], 2016).
    - Concern about withholding treatment is only relevant if one knows that the intervention is effective and that it causes no harm (Chalmers, 2017; J-PAL, 2016; Rosen et al., 2006).
    - "We need evidence from impact evaluations to know if a program works. Without this evidence, providing the program to everyone may be wasting resources and people's time. It is also possible that the program may even be harming participants" (Hanson and Pergamit, 2022, p. 9)
    - Explanations were provided about equipoise (Freedman, 1987; Rosen et al., 2006), explaining how the study was a way to help resolve "disagreement in the professional community as to the preferred treatment" (Horn and Weijer, 2015, p. 1).
- "Anything is better than no intervention at all":
    - The comparison group was supposed to experience what they would usually experience anyway (with some added safety enhancements), i.e. nothing was being stopped that would otherwise be offered. (NB: it was still possible to acknowledge frustration felt by practitioners when they could not see an obvious way to help families.)
    - Scarcity was considered as well as part of an attempt to reframe considering "withholding" an intervention into considering the study as a way to "provide" an intervention to half of a potential cohort rather than to none of it.

Information for referred families (potential evaluation participants) was produced in accessible and creative ways that conformed to ethical requirements (e.g. full and plain English versions of participant information sheets, Appendix D, and videos about the study as a whole and to explain randomisation, Appendix E). Supporting information was also available on a study webpage hosted by UH. These materials were shared with referrers to support the recruitment process and to ensure participants were fully informed. The referral form also asked for confirmation of how study information had been provided to families.

It was expected that 8–10 boroughs would make referrals, generally from within CSC and/or a borough's clinical services (local authority service users). Referrals followed the usual RISE processes as far as possible: referrals were received by RISE and triaged according to the inclusion and exclusion criteria by the CAPVA programme team leader. An allocations meeting was held, and the team leader subsequently allocated families to practitioners for screening and suitability assessments (see the next section). For the trial, an additional amendment was that the RISE practitioner triaging referrals also contacted eligible families to

remind them of the purpose of referral, i.e. to potentially join a study where they could be allocated to either control or intervention.

Intervention screening

To determine suitability for the intervention, and thus the terminated trial, RISE practitioners interpreted the screening tool (RISE, 2024) alongside data received on the family through a referral report and other sources of information (such as multi-agency meeting minutes and/or reports from statutory services, including CSC, the police and CAMHS). The data used to assess suitability alongside the screening tool included the frequency and severity of family violence. During assessment, these data were considered by the practitioner to assess which areas on the screening tool required further exploration with each family.

Referral information does not always fully reflect family dynamics and the complexities of their circumstances, yet the practitioner needed to explore these areas and assess such information alongside the screening tool. So, additional information was sought as part of the initial screening. The practitioner made a reflective judgement, based on the referral data and the parental responses to the screening tool. The practitioner then set out a therapeutic plan based on their clinical judgement; this plan mapped out the focus of each session, who the practitioner might work with, in what ways they may need to individualise the work and when they may begin work with the CYP. Judgements made from the point of screening to formulating a therapeutic plan were discussed with the lead practitioner: practitioners completed a post-assessment suitability and intervention planning report for the team leader to review and sign off. Under usual conditions, families would then have been contacted regarding their suitability, and practitioners would begin arrangements for the sessions. Practitioners would also confirm the start date and intervention plan with referrers. For the terminated trial, this step was revised to allow families to receive further information about it (including what would happen to them if they were randomly allocated to the control or intervention arm), decide whether to join the terminated trial, provide consent to join the terminated trial, complete baseline outcome measures and for random allocation to be made.

Intervention delivery

Wherever possible, delivery followed routine practice. So, the intervention was delivered by CAPVA practitioners or, for more complex cases, an advanced practitioner (AP). Practitioners were required to have completed Foundation Level 1 training in NVR, and APs completed advanced NVR training at levels 2 and 3. All training was provided by Partnership Projects – an established training provider for NVR practitioners.[2] The intervention was delivered to families by CAPVA practitioners trained to lead NVR sessions and support families in developing the skills and knowledge necessary to apply NVR techniques. All CAPVA practitioners have experience in delivering trauma-informed work with families, in work on IPVA interventions and/or in casework. Practitioners may hold qualifications in social work, advanced NVR, probation work, or Cognitive Behavioral Therapy (CBT) or family therapy. APs are similarly qualified to CAPVA practitioners but may hold additional qualifications in forensic and/or clinical psychology. An AP will have experience of delivering and

[2] For further information visit www.partnershipprojects.uk.com

quality assuring interventions to people with complex issues. The AP oversight role involves direct work with families, acting as a mentor to the assigned CAPVA practitioners and conducting specialist risk and practice reviews. All practitioners delivering the intervention were line managed by the team leader to ensure practice standards were achieved and to provide additional governance.

RISE practitioners worked with parents/carers first to develop strategies to raise parental presence and reduce the risk of violence using de-escalation and resistance techniques. Refusing demands and resetting boundaries were focused on subsequently. This combination of approaches was designed to facilitate change in CYP' behaviour. Parental skills are intended to develop gradually with intensive support, moving from training and role modelling, enacted with therapist support, to independent practice. Barriers to managing CYP' behaviour were addressed. As parents and carers succeeded in supporting change within the home environment, efforts were made to address contributory factors, such as peers who may have been offending, and to investigate the possibility of reintegration into mainstream education.

In their usual practice, CAPVA practitioners often see parents/carers present with constraints to how they care for their children; one example being a negative internal representation or image of the child (Jakob, 2019). Under the NVR model, it is intended that practitioners work with parents/carers to see an improving child, focussing on the child "as they are in the present" and coaching parental resistance methods to potentially dismissive behaviour from the child. This is designed to protect parents/carers from triggering negative interpretations in CYP.

If they subsequently engage, then work with CYP adopts a flexible, skills-based approach using trauma-informed care alongside CBT techniques and mindfulness. Using CBT to support children displaying Post Traumatic Stress Disorder is within NICE guidelines (2018) and generally draws on the model developed by Meiser-Stedman (2002). NVR does not rely on CYP engagement but provides parents/carers with skills and knowledge to deal with behaviour in a nonviolent way, avoiding punishment and relying on consequences. It is seen as an alternative to parenting courses based on a punishment/reward approach, encouraging parents/carers to "take control". The CAPVA intervention focuses on improving connective parenting, consistency and acceptance, taking the stance that problems within the family can only be resolved through a consistent, whole-family approach by working with parents/carers, young people and siblings (Weinblatt and Omer, 2008).

The CAPVA programme can be delivered in the home, community or family hubs, and practitioners can attend other locations as needed to support the family. One or more parents/carers can participate, and work can be individual, joint, whole family or a combination of these delivery modes. Delivery to any one family spans up to 20 sessions, which include two screening and assessment meetings preceding formal delivery and two optional follow-up sessions. At least 12 programme sessions are with parents/carers, and up to six sessions are with the CYP, including a joint session. For a minimum treatment effect, at least 12 programme sessions should be completed at a frequency of one every two weeks, at most. CAPVA practitioners employed techniques to encourage CYP engagement; however, should a CYP not engage, the remaining sessions can be used to continue to support the rest of the family (RISE, 2024). As already noted, the trial termination required delivery to be implemented more frequently, i.e. asking parents/carers in extremely challenging circumstances to engage more often in any one month. Additional concerns were

raised, and safeguarding was considered alongside the necessary ethical amendments, which were subsequently approved.

Intervention tailoring

The intervention is highly individualised, with sessions tailored for families according to the identification of any needs, risks and vulnerabilities during screening. For example, work with some families may involve using different principles of the NVR model at different times, depending on their needs; one family may need to focus on self-care as a starting point to raise their own parental presence, while another family – whose patterns of escalation are symmetrical – may need to start with self-control and anchoring functions before they are able to de-escalate effectively (see Theory of change for the rationale behind this approach).

For work with a parent who is a survivor of IPVA, the CAPVA practitioner assumes a strengths-based approach to recognise the developed strengths and/or acts of resistance relating to times when the IPVA was prevalent. Accordingly, practitioners may identify that the parent worked hard to care for their child(ren)'s physical and emotional safety and their basic needs and to maintain as safe, stable and nurturing an environment as possible during the abusive relationship. Helping survivors to recognise these strengths involves helping them to identify the steps they took, even if the perpetrator thwarted their efforts or they had not previously acknowledged their own efforts.

When it has been assessed that substance misuse is present but the parent may be able to function adequately to begin the intervention, practitioners explore the positive intentions of the parent and their use of drugs or alcohol as self-medication. Solution-focused methods will be used to explore alternatives to substance misuse when a parent is coping with trauma that has been triggered by the child's violence. For example, practitioners will support parents/carers to understand their own triggers and trauma responses to develop self-calming techniques early on, help reduce anxiety and develop self-efficacy.

Where CAPVA is present, CYP may sometimes use self-harm and suicidal ideation as forms of coercive control that can result in an escalation or withdrawal from parents/carers. Practitioners apply the same methods regardless of whether the child is seen as saying such things coercively, demonstratively or genuinely. Practitioners support the parents/carers to respond with increased vigilant care while encouraging them to inform their child of the vigilant care actions they will be taking and why. Practitioners also respond to identified risks outside the home for the young person, such as exploitation, by focusing on increasing support networks and vigilant care among parents/carers.

Terminated trial objectives

The trial protocol was lodged on the YEF website (https://youthendowmentfund.org.uk/wp-content/uploads/2021/04/REVIEWED_RISE-RCT-Trial-Protocol-v1.4-July-2024.pdf) and registered on ISRCTN (ISRCTN-90520639, 2024). The statistical analysis plan was intended to be finalised after approximately 25% of referrals had been received. It remains unpublished, as insufficient referrals were made to finalise it.

Primary research question:

1. What is the efficacy of the RISE CAPVA programme in reducing child/adolescent to parent violence and abuse when compared to BAU?

Secondary research questions:

2. Does the RISE CAPVA programme lead to:

    a. Reduced problematic internalising behaviours?
    b. Reduced problematic externalising behaviours?
    c. Reduced family conflict?
    d. Improved family relationships?

3. Are there variations in outcomes (CAPVA and other behaviours) by intervention recipient type, specifically parent-only delivery of the intervention compared with whole-family engagement?
4. Are there variations in outcomes (CAPVA and other behaviours) by family ethnicity (broadly defined)?

Additional activity research questions:

1. What were the reasons this trial could not be delivered as planned?
2. What are considerations for YEF to deliver a similar trial in the future?
3. What would it take for local authorities to be involved in a similar trial again?

Ethics, reflexivity and trial registration

The trial was registered at https://www.isrctn.com/ISRCTN90520639 and the protocol published on the YEF website at https://youthendowmentfund.org.uk/wp-content/uploads/2021/04/REVIEWED_RISE-RCT-Trial-Protocol-v1.4-July-2024.pdf. Ethical permission for the trial itself and all amendments thereafter were granted from the UH's Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (HSET-ECDA). The original in-principle protocol number was: LMS/SF/UH/05788. Once the protocol and measures were finalised, this was then amended to 0233 2024 Oct HSET. Subsequent amendments were made each time a new site was brought on board. A final set of amendments was made around early termination and the introduction of a learning report (0233 SFa HSET 2025).

Participant-facing information was designed to satisfy university, professional, statutory and regulatory body ethics requirements and to be accessible (e.g. Appendix A, Appendix F, Appendix H). Thus, for the trial, participant information sheets were produced in full (Appendix C) and summary (Appendix D) versions; a recruitment video and consent video were produced (Appendix E); a webpage was hosted (https://www.herts.ac.uk/research/centres/psychology/applied-psychology-research-group/rise-capva-efficacy-study; and additional supporting information was provided to local authorities for use by referring practitioners. The information included how to contact RISE and/or UH study staff for advice. Where support for a translator was needed, this was provided as part of initial screening by RISE. As part of the referral form, practitioners were asked to indicate where they had used the video, provided participant sheets, et

cetera. This was also checked as part of the initial screening by RISE. More in-depth consideration of the ethical sensitivities of this research can be seen in the protocol (Adler et al., 2024).

Participant wellbeing was considered as part of the termination process. Phone calls were made and emails sent to all families explaining that the trial was being terminated early, with advice on where to seek additional support and a reminder about the UH team availability (Appendix N). Communication was additionally supported by WhatsApp to ensure families were carefully informed about what the early termination would mean for the study and for follow-up (Appendix O). In one case, a family in the control group did not understand that they had been part of the study, even though they were not receiving the RISE-provided intervention, so the underpinning principles of the study were explained again as part of wider support offered. When practitioners were recruited to the interviews for the additional activity, this recruitment was done via email requests with participant information sheets, supported by telephone/WhatsApp (Appendix P). If they were happy to take part in an interview, initial consent was gained via a Qualtrics form (Appendix R) and a suitable time for the interview was agreed.

When conducting and reporting the additional activity and the terminated trial, the evaluators were mindful of positionality and assumptions that could have been brought into the research process. It is a large team, including people with direct and related experience of CAPVA; several people are parents/carers; some are from minoritised backgrounds; and many team members actively sought work with vulnerable people. That young people's voices could not be heard within the research and that the whole trial was being terminated was obviously upsetting and, for some colleagues, directly led to termination of employment. At RISE and UH, staff had been trained and employed directly to support the study. When planning, implementing, analysing and reporting on the interviews conducted for the additional activity, this context should be understood as part of reflexivity. Bracketing techniques (Tufford and Newman, 2012) were employed, and conducting deductive analysis helped maintain the necessary distance.

Data protection

The original principles for data protection were considered in some depth as part of the trial protocol (ISRCTN-90520639, 2024) and conformed to research guidance provided by the Information Commissioner's Office (ICO 2023 a, b, c) and to YEF guidance (2023). The main variation from that protocol is that data will not be archived. The evaluation proceeded under legitimate interest and public task, with UH acting as both a controller and processor of data. Data processing information agreements were generated, and data-sharing agreements were in place with each recruiting site before referrals commenced. Data processing and privacy notices can be seen as part of the participant information sheets (Appendix C).

Within the original protocol, it was indicated that data deletion requests would be considered as they were made. Two participants withdrew from the study, and one specifically asked that their data be deleted. As can be seen from the participant information sheets and consent forms, the intended usual practice was that if somebody withdrew from the study, data would be retained up to the point of their withdrawal. However, one family first withdrew from the intervention delivery and then made it clear that they wished to withdraw from the study as a whole and requested that their data be deleted. Given the specific request, baseline responses from the family were withdrawn from the database, a file note was placed within the database and only their referral information up to initial consent was retained.

During a trial management meeting, it became clear that several referrals had been made by practitioners who were employed by CAMHS and that no local authority–based lead professional had been identified within the screening of those families. As part of the baseline safety requirement was to allocate a lead professional within the local authority, this constituted a protocol breach. Additionally, if families came from CAMHS, they were more likely to be NHS patients. The trial had been conceptualised to run with allocated local authority professionals not within the NHS. As such, Health Research Authority ethical approval was not obtained; therefore, there was an ethics breach as well as a protocol breach.

Following the clinical trial unit's standard operating procedures, the university's data protection officer, HSET-ECDA chair, pro-vice chancellor for research, chair of the trial steering committee and the YEF were consulted promptly. Five families were identified where it was clear that the case was not being held within an onboarded local authority. In all but one case, the CYP were under CAMHS care, with the practitioners being situated within CAMHS. These five families were withdrawn entirely from the trial. None of their data was retained, as these data should not have been collated without relevant permissions. These five families are not included anywhere in the numbers reported in this document. The protocol breach was formally logged; each relevant lead practitioner, local authority site lead and/or CAMHS team and their research and development officers were promptly informed; and, where requested, additional information was provided. Letters that included the UH team contact details were prepared for each lead professional to personalise and send out to the families themselves. Where families had been allocated to the intervention arm, it was agreed that the YEF would continue to pay RISE to deliver the intervention to completion for these families, but outside the study. This was largely on safety grounds, as sudden discontinuation might have left the family with escalating violence without the skills/knowledge intended to help ameliorate the violence.

Methods

Terminated trial design

Table 4 Terminated trial design summary

Trial design, including number of arms		Two-armed randomised controlled trial with allocation to business as usual/intervention post-consent and concurrent triangulation via the implementation and process evaluation.
Unit of randomisation		Family
Stratification variables (if applicable)		Gender of the referred child: male, female or non-binary Age of the referred child: under 12 or 12–17 years Ethnicity: Asian, Black, Mixed, White or Other
Primary outcome	Variable	The extent and severity of child-to-parent violence
	Measure (instrument, scale, source)	Abusive Behaviour by Children Indices (ABC-I; Simmons et al., 2019a)
	Variable(s)	Problematic internalising and externalising behaviours

Secondary outcome(s)	Measure(s) (instrument, scale, source)	Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) parental report: emotional, conduct, hyperactivity, peer problems and impact subscales.
Baseline for primary outcome	Variable	The extent and severity of child-to-parent violence and abuse at randomisation (implemented post-screening and post-consent)
	Measure (instrument, scale, source)	ABC-I parental report, full scale (Simmons et al., 2019a)
Baseline for secondary outcome(s)	Variable	Perceived strengths and difficulties of the young person assessed by parents/carers (implemented post-screening and post-consent)
	Measure (instrument, scale, source)	SDQ parental report.

Additional activity design

Alongside terminating the project early, the YEF were keen to learn what might be done differently in potential future research. Although the timeline was always ambitious, it was particularly disappointing that sites involved in the feasibility–pilot study and several of those that had previously worked with RISE declined to take part in the RCT. The evaluation team had provided reflections for the YEF on potential challenges as part of an unpublished options paper produced in August 2025 under the action plan. The additional commissioned evaluation/research was tightly specified and limited in scope to individual or group interviews conducted with RISE staff, site leads from local authorities that had taken part in the study and local authority staff who had taken part in early negotiations from areas that did not come on board. Although other activity was proposed, it was not commissioned. This means that in the research conducted for the additional activity, referring practitioners', young people's and parents'/carers' voices are missing.

Although families were not invited to interviews, it was agreed that those who had consented to participate in the terminated trial would still be invited to complete follow-up measures. As part of those surveys, four items were added to assess study design and measure acceptability. Given the very low numbers and curtailed delivery, it would be inappropriate to assess efficacy, outcome or impact from the follow-up data.

Equity, diversity and inclusion

It was expected that the local authorities would have diverse communities within them, ethnically, religiously and culturally, with variation in levels of deprivation (e.g. Ministry of Housing, Communities and Local Government, 2019). Referred families were expected to have been disproportionately drawn from groups minoritised within their local area and nationally and to have been experiencing socioeconomic disadvantage. Service users might have histories of being viewed through culturally insensitive lenses by practitioners and evaluators. Such factors are related to systemic disparity stemming from institutional racism and a lack of representation within settings like CSC (Ethnicity Facts and Figures Service, 2023). Being

mindful of these issues helped guide both teams to stop inappropriate practices and continue to implement inclusive approaches, and the project leads for equity, diversity and inclusion brought experience in both research and organisational leadership. The evaluation team was informed by the evolving landscape of support intended to further inclusion in research, such as that by the National Institute for Health and Care Research (National Institute for Health and Care Research, 2020; Parekh et al., 2019). As part of mobilisation, jointly convened sessions were run between UH and RISE, and cultural inclusion was also considered during trial management group meetings.

Participants

Terminated trial participants

The intention was that at least 188 families would complete outcome measures from each arm (control: BAU provision and intervention: RISE CAPVA programme) over two years. In the feasibility–pilot phase, 107 families were recruited over 12 months from three local authorities. Most recruited families came from two of those three local authorities, neither of which eventually joined the terminated trial. The two local authorities that did not join the trial had well-established relationships with RISE and seemed highly motivated during the feasibility–pilot study. It is likely that concerns over randomisation underpinned their reluctance to take part in the subsequent trial. In the remaining local authority, clear distinctions were drawn between services to ensure that families who had participated in the feasibility-pilot study could not be invited to the terminated trial.

Projections for referral and recruitment across 10 sites were included in the trial protocol (Adler et al., 2024). They were informed by previous referral and delivery rates to RISE and by the high demand evidenced within the feasibility–pilot study. If 10 sites had been onboarded, it is likely that the potential pool for referral would have been sufficient. Specifically, the protocol projected 705 CYP referrals and 470 recruited families over the two-year recruitment window, including 100 referrals in the first quarter alone. It should be acknowledged that the required rates of referrals and recruitment to the trial were ambitious. This was highlighted within the co-design phase, and required delivery timescales were pushed to the limit of the commissioner's operating model, from 18 to 24 months. Seven local authorities were fully on board by April 2025, with an eighth brought on in August 2025. At the point of termination, 41 families had been referred by staff from six local authorities. For more information about referrals from the six active local authorities, please see Table 6. Following screening, eligibility assessments and information provision to them, 18 families consented to take part in the trial, of which one withdrew prior to randomisation, and 17 were randomised: eight families allocated to the intervention and nine families to BAU (see Table 6).

Additional activity participants

Seven families completed the acceptability measures, four from the intervention arm and three from BAU. Twenty-eight people were approached to participate in stakeholder interviews, and 12 took part. People who were invited to participate in the additional activity came from five potential sample groups:

- RISE management (five people were invited, four participated)
- RISE practitioners (six people were invited, three participated)

- Site leads from local authorities that were onboarded and made referrals (eight people were invited, three participated)
- Site leads from local authorities that were onboarded but did not make referrals (two people were invited, neither participated)
- Potential site leads from local authorities that were not onboarded (i.e. people involved in mobilisation but where the local authorities ultimately did not engage in the study) (seven people were invited, two participated)

Intended outcome measures (terminated trial)

All referred families were screened for suitability by RISE practitioners (see Intervention screening). Screening was conducted alongside initial assessment. Where families agreed to join the trial, individual links were provided for baseline measurement. This was after consent but prior to randomisation and the delivery of any (more) programmed sessions with families.

Baseline measures

At baseline for the trial, parents and carers were asked to complete the Abusive Behaviour by Children Indices (ABC-I; Simmons et al., 2019a) and Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997); see primary and secondary outcomes below.

Primary outcome

The primary outcome was child/adolescent-to-parent/carer violence and abuse, assessed pre- and post-intervention, measured using the ABC-I (parent report) for those in the intervention arm compared to those receiving BAU at completion of the intervention/BAU.

Secondary outcomes

For the secondary outcomes listed below, information was intended to be collected via the parent-report versions of measures. Again, this was pre- and post-intervention – comparing those in the intervention arm to those receiving BAU at completion of the intervention/BAU.

- *Reducing problematic internal behaviours:* the internalising behaviour score of the SDQ (sum of the emotional and peer problems scales)
- *Reducing problematic external behaviours:* the externalising behaviour score of the SDQ (sum of the conduct and hyperactivity scales)
- *Reduced family conflict:* routine measures from the RISE CAPVA manual (RISE, 2024)
- *Improved family relationships/family functioning:* the SDQ impact supplement

Monitoring data and measures

Demographic and family status data

In line with YEF guidance on demographic data collection and the requirements of the trial design, age at referral and age at the start of delivery (years), sex, gender, looked after status and ethnicity (Asian, Black,

Mixed, White, other) were collected for all CYP in participating families. Free school meals eligibility was recorded as a proxy measure of socioeconomic status. Additional variables collated for both CYP and adults included whether English was an additional language and child and parental neuro-nontypicality (suspected and/or confirmed). For data archiving, the CYP' name, address and full birthdate were required and held with restricted access. Given the early termination of the trial, no data will be deposited for Ministry of Justice or Department of Education archiving.

Family status data incorporated demographic factors, e.g. family make-up, ages, ethnicities, income and indices of deprivation (based on postcode). Family status was recorded in collaboration with the family and, where necessary, supported by referrer data:

1. Family involvement with social services, youth offending services and other statutory and non-statutory services, including the removal of children from a family during the evaluation
2. Recorded incidents of abuse and/or neglect
3. CYP' school/alternative provision attendance
4. New access to health services (physical or mental) requiring admission or extended outpatient engagement
5. Eligibility for free school meals (a common proxy measure for socioeconomic disadvantage)
6. Family adherence to intervention ('length-of-treatment'), captured through a log and evaluated as attendance at scheduled sessions (log completion was terminated early)
7. Differences between intervention recipients (parent-only or whole-family engagement), captured through a log and evaluated as attendance at scheduled sessions (log completion was terminated early)
8. Adverse events: a process for reporting, recording and responding to adverse events, for completion whenever occurring while the family was actively participating in the terminated trial or wind down/additional activity phase:

The trial's tools were designed to facilitate the self-report of adverse events (Appendix K). Family members could still discuss adverse events with a practitioner, but practitioners were asked to direct the participants to complete the relevant REDCap self-report form (Appendix L). This was to avoid potential duplication of adverse event reporting and to encourage information provision directly by the person concerned. Practitioners and the evaluation team were available to support completion, if needed.

The information provided to participants included a plain English definition of what should be recorded as an adverse event and how an adverse event would differ from events routinely being observed. A prompt for adverse events was added to data collection requests as well as a (participant-specific) ongoing log that participants could access. To further ease this process, specific examples were provided, and the form had a free-text field.

Submitted adverse events prompted an automated email to the trial email address to say PIDXXXX had reported an adverse event for review. That email address was monitored only by those members of the team with governance and/or trial leadership roles. Typically, the trial manager went into the database, reviewed the information, responded and/or escalated the matter in consultation with the principal

investigator and governance leads. An automated email was also sent to the participant to acknowledge submission of an adverse event; this included signposting links for external support.

Characteristics of referred young people

In the feasibility–pilot study, clinical/diagnostic labels were semi-regularly applied to CYP, but it was unclear whether there was evidence of formal screening. There seemed to be an expectation of neurodivergence without clarity about what this might mean for individual CYP and/or the intervention. To assess some of the most relevant behaviours associated with neuro-nontypical young people, the Extreme Demand Avoidance eight-item measure (EDA-8; O'Nions et al., 2021) and the Glasgow Sensory Questionnaire (Robertson and Simmons, 2012) parent-report short version (Smees et al., 2022) were used. These were offered as optional baseline measures to be completed post-screening and post-consent by the parent or carer. As these measures were only implemented once, they could also be completed after randomisation, if preferred. They were requested to help assess potential intersectional needs/comorbidities so that advice could be provided around likely service need and management techniques that may be helpful if/where need was identified.

Additional measures

Activity logs were designed as part of the cost reporting exercise. On termination, these were immediately stopped, and no cost data will be reported. For more information about the elements involved in the cost reporting exercise, please see the protocol (ISRCTN-90520639, 2024).

For additional explanatory information regarding family functioning, the evaluation also drew on practitioner assessments of family conflict that are routinely collected as part of the RISE CAPVA programme. The family conflict assessment was amended to include the Clinical Global Impressions Scale (CGI; Guy, 1976; Busner and Targum, 2007) to capture practitioner insights into families' potential change over time. In the BAU arm, the CGI was also requested pre- and post- delivery but without the family conflict scale used by RISE.

Selection of measures and links to the logic model

It was recognised that young people may have been particularly hard to recruit to the study and to engage in any intervention directly. It was also recognised that CYP may feel shame and stigma around the behaviours triggering referral. So, burdens on CYP were minimised by seeking as little additional data collection as possible – beyond that required for the intervention. Conversely, it also felt important to hear from them about their experiences and to amplify the voices of those CYP who may have wanted to participate in the evaluation, whether or not they engaged directly with the intervention. On balance, it was agreed that no outcome measures would be requested, but additional efforts were made to incorporate CYP within the IPE (subsequently cancelled by the early termination).

During the feasibility–pilot study, RISE was using a measure of CAPVA designed under the EU Daphne strand within the Responding to Child to Parent Violence project (RCPV). Although tested as part of RCPV, the measure had not met the necessary validity tests for commissioner-approved continued use in the terminated trial. Through the co-design process, it was decided that the ABC-I (Simmons et al., 2019) be adopted as the measure of violence.

The main secondary outcome measure was selected to help assess both the impact of the NVR techniques adopted by parents/carers and the direct work undertaken with children and adolescents, particularly the CBT-informed trauma support. The SDQ (Goodman, 1997) provides a total score to assess problem behaviours (difficulties), alongside subscale scores. Of the five standard subscales, the terminated trial was designed to draw on the four needed for internalising (emotional and peer problems subscales) and externalising behaviours (conduct and hyperactivity subscales), alongside the supplemental impact subscale.

The main addition to acknowledge diversity of neurotypes is the EDA-8 (O'Nions et al., 2021). This is a short test used mainly for research purposes to help screen for oppositional defiant disorder (ODD) and pathological demand avoidance (PDA). ODD and PDA may present similarly disruptive challenges for parents/carers, but they should be managed differently. This is partly why additional attention was paid to the relatively high proportion of neuro-nontypical CYP likely to be referred to the CAPVA programme. The assessment of sensory difficulties is also relevant here and was measured using the shorter parent-report version of the Glasgow Sensory Questionnaire (Smees et al., 2022).

The protocols for practitioner logs of activity included the CGI (Guy, 1976), slightly modified to reflect that the intervention is a programme of activity, not a drug. These short questions are designed to capture practitioner insights into the severity of families' needs, whether there is any improvement and the extent to which they ascribe any change to the intervention. Additionally, lead professionals were asked to notify the research team (via a link to REDCap) of any change in circumstances, such as changes in participant details, changes in the lead professional or an adverse event.

Scales were used in their validated forms, with two slight amendments to the ABC-I: the ABC-I asks respondents to report what has happened in the previous 12 months. However, as support provided likely lasted less than 12 months and varied between families, trial participants were asked to report on activity "over the past three months". Also, the word "check" was changed to "tick".

Data collection

All data collection was completed between February 2025 and March 2026. Data checking was completed in May and June 2026.

Data collection – terminated trial

For baseline and follow-up outcome measures, parent/carer participants were sent an email link, automated via the trial database software's survey tool. All measures were completed online, and responses were captured on REDCap. Baseline surveys were sent post-consent and pre-randomisation, and follow-up surveys were automatically sent to participants either at completion of the intervention or by 11 months following the suitability assessment. It was estimated that completion of the CAPVA intervention (without optional follow-up) would typically take around 10 months, so this was matched in the control arm. If people dropped out of either arm for support (but agreed to stay in the study) or finished early, they were still sent the post-intervention measures at approximately 10 months following the suitability screening. In practice, this was taken as 10 months plus or minus a month, as requests for outcome measure completion began at nine months post-screening and were repeated weekly for up to two months, with offers of assistance from

the evaluation team research assistant. Monitoring and additional data were also collected on REDCap using a combination of surveys designed for practitioner completion (e.g. demographic data) alongside information provided directly from families (e.g. family status information).

Participant information documents and videos provided families with the contact details of the trial manager and/or senior research assistant (SRA), who worked closely with delivery teams to support participants in completing materials. Depending on their preference, participants completed the surveys independently or with support from CAPVA practitioners or with support from a member of the evaluation team.

Compliance and adherence thresholds were considered and outlined in the protocol, but because no outcome assessments were made, they are not tested within this report nor commented upon further.

Data collection – additional activity

Semi-structured interview schedules were tailored for four groups: RISE management, RISE staff involved in referral/screening for eligibility and intervention delivery, local authority stakeholders who were onboarded and local authority stakeholders from areas that were not onboarded as study sites. The participant information sheets/consent and interview schedules were adapted accordingly and can be seen in appendices S to V.

Potential participants were offered the opportunity to take part individually or jointly, according to participant preference, and for participation to be online or face-to-face, again according to participant preference. All participants took part individually via an online session, which was recorded on Microsoft Teams and then transcribed to prepare redacted transcripts for analysis.

Sample sizes

Terminated trial

The registered protocol contained the logic and decisions behind the proposed sample size for the terminated trial (ISRCTN-90520639, 2024). Based on the previous literature and findings from the feasibility–pilot study and allowing for the lack of a counterfactual within that feasibility–pilot study, the evaluation team initially proposed a minimum detectable effect size (MDES) of 0.3. This was considered to be outside the commissioner's preferred rigour requirements, and it was agreed that an MDES of 0.29 would be adopted. Allowing for an effect size of 0.29, with power $1-\beta=0.8$, the required sample size was n=188 families per arm.

Unfortunately, the funders concluded that the necessary sample size was unlikely to be recruited within the available time for them to fund delivery and evaluation. Tests of acceptability of measures and descriptive data are presented below from 17 families; 18 originally consented, but one withdrew.

Additional activity

The evaluators were commissioned to conduct research with key informants, with a commissioner preference for joint interviews/focus groups wherever possible. The response rate to the invitations to

participate was higher than expected, but although focus groups/joint interviews were offered, no participants chose these options, so 12 people participated in individual interviews.

Randomisation

Family allocation to BAU or the intervention was randomised for the terminated trial and continued through the wind-down process. Following referral from the relevant local authority, families (starting with parent/carers) were screened by RISE practitioners for eligibility for the trial over a maximum of two sessions that included information about the trial. To determine inclusion in the trial, RISE practitioners used their clinical judgement in interpreting the screening tool (see Intervention screening). For the evaluation, one parent was the nominated respondent to complete outcome measures. Families that were assessed as suitable for the RISE CAPVA intervention, consented to take part in the trial and completed baseline assessments (in that order) were then randomised with a one-to-one allocation ratio to either the RISE CAPVA intervention (the intervention arm) or to the control group (the BAU arm).

Brennan et al. (2022) provide a rationale for why it was important to consider potential effects of age, gender and ethnicity. Older or adult children tended to be reported to police more than younger children, boys were more likely to be reported for incidents than girls, women were more likely to be recorded as victims than men and families from minoritised communities were more likely to be recorded in the MPS dataset. These British findings are consistent with those from elsewhere, including in Canada, where Cottrell (2003) highlighted the importance of puberty as being a potential phase when violence starts or becomes more problematic.

Therefore, allocation was made by minimisation with Taves' method (Scott et al., 2002), using the child's age (under 12, 12–17), gender (male, female, non-binary) and ethnicity (Asian, Black, Mixed, White, Other) as factors. The randomisation was achieved using an R script running on the REDCap server to query the data of existing participants in the REDCap evaluation database and randomise the newest participant (Jin et al., 2020; Jin et al., 2026). Once a family consented to take part in the trial and completed baseline assessments, REDCap triggered an alert to the evaluation team members with necessary access permissions. An allocation for that family was automatically generated. The allocation code, along with the family study ID, was emailed to the agreed-upon specified point of contact within RISE and/or each borough and the trial manager. The specified point of contact informed the families of trial arm allocation by telephone.

Statistical analysis

Given why the trial was terminated, it would be inappropriate to attempt an analysis of the primary or secondary research questions, efficacy, outcome or impact. This report mainly provides descriptive data and an interpretation focused on the potential utility of the measures and an understanding of who agreed to participate in the research.

Implementation and process evaluation (additional activity)

The IPE for the terminated trial was designed with an intention to begin fieldwork around six months after the first families began receiving the intervention or BAU. This meant that it should have been implemented

from when the YEF was considering options for the trial: extension, continuation as planned or termination. The IPE was paused while the decision was made, and, when termination was selected, it was never implemented. This section focuses on the process evaluation conducted specifically for the additional activity.

Research methods

Four questions were added to the family surveys at follow-up to capture participants' views around the acceptability of the CAPVA study. These optional questions included three statements for participants to record the strength of acceptability and a final question to capture the overall experience of the study (Appendix J). They were implemented alongside the follow-up surveys via REDCap.

With practitioner groups, semi-structured interviews were conducted by the SRA. The SRA had joined the study after the co-design phase and was one of the team members directly affected by the early termination of the study. The SRA was not involved in the mobilisation phase, so was also well positioned to maintain neutrality/as much independence as possible when seeking narratives about events before the commencement of the SRA role.

Within each of the four subgroups outlined in the participant section, interview protocols were tailored according to the nature of the respondents' interactions with the study. For local authorities that were not onboarded, interviews were opened by asking participants about their impressions of the CAPVA study, moved on to asking for reasons why they felt that their local authority did not support the study and what differences they would like to see to try to engage the local authority in potential future work and then checked whether there was anything else they wanted to share or to ask.

For site leads from local authorities that were onboarded, the protocol was a little longer. It began by seeking to understand a bit more about how the interviewees saw their roles within the study, moved on to understand more about their experiences as site leads, sought their views on the CAPVA study overall, including whether they might take part in future research, and moved to the closing questions, checking whether there was anything else they would like to share or ask.

Interviews conducted with RISE staff were organised in two subgroups: practitioners and management. Within each subgroup, there were participants who had been involved in the evaluation from the feasibility–pilot phase through the co-design of the study to its eventual termination, alongside others who had joined partway through the process, including after co-design was completed. For the practitioner interviews, the interviewer started by asking them about their role within the CAPVA study and whether they had needed to adapt their existing work to support the study. Initial expectations were considered before moving on to their experiences during the CAPVA study. They were asked what worked well and what was challenging about specific stages of the study, whether there were difficulties they identified/addressed, what they thought could be done differently to avoid similar issues in future studies, what the highlights of their involvement in the CAPVA study were and what advice they might give to somebody else involved in similar research. As with the local authority staff, interviews closed with questions checking whether there was anything else they would like to share or ask.

RISE management interviews again began by considering interviewees' roles within the study and their expectations of the evaluation. Interviews then moved on to considering how they felt the research was received among the wider staff in RISE, e.g. whether there were concerns and what was done to address them. The interview then moved on to consider their experiences liaising with the local authorities, including RISE managers' views on how the study was received by various local authorities, what steps were taken to encourage engagement and what challenges were faced. It then moved on to recommendations they may have for future evaluations. Then, as with the practitioners, they were asked about the highlights of their involvement in the CAPVA study, and interviews closed with questions checking whether there was anything else they would like to share or ask.

Qualitative analysis

Interviews were conducted on Microsoft Teams and recorded according to the preference of the participant. In most cases, this was audio and video recording throughout the interview. Recordings were transcribed, adopting intelligent verbatim practices (McMullin, 2021). Where editorial decisions were made to clarify intention, these are signified with square brackets within the text that follows. Pauses, elision of speech and/or nonverbal communication were generally not included in the transcript. Each transcript was read and re-read, and the initial analysis was conducted deductively within the subgroups (onboarded local authorities, non-onboarded local authorities, RISE practitioners and RISE management). Common themes were then considered across all four subgroups, leading to draft themes.

The SRA conducted interviews; professional transcription was undertaken by a transcription agency regularly used by the clinical trials unit under the terms of a nondisclosure agreement. Transcription was checked by the SRA and principal investigator, and the initial analysis was undertaken by the SRA. The draft themes were considered by three members of the research team and then reflected upon within a full research team reflection and learning session, and final variants are presented in the IPE findings. For transparency and accountability, the qualitative research process has been mapped to the template for the standards for reporting qualitative research (O'Brien et al., 2014; see Appendix W).

Timeline

Table 5: Timeline

Dates	Activity	Staff responsible / leading
November to January 2023	Co-design	UH: PI and TM RISE: CEO, BDRO and SM
January to April 2024	Contracting, inception and governance	YEF: CEO UH: legal
11 June 2024	Finalisation of protocol	UH: PI and TM
September to October 2024	Mobilisation	UH: TM RISE: PM LAs: site leads
18 November 2024	First site ready to make referrals	UH: TM RISE: PM
10 February 2025	First referrals made	UH: TM RISE: SM, PM, HoS LAs: site leads
31 October 2025	Termination cut-off date for baseline measure completion	YEF
27 February 2026	Completion of additional activity interviews	UH: SRA
17 April 2026	End of quantitative data collection – terminated trial	UH: SL, SRA, PI

Key: BDRO = business development and research officer, CEO = chief executive officer, HoS = head of service, LA = local authority, PI = principal investigator, SL = statistics lead, SM = service manager, TM = trial manager, UH = University of Hertfordshire, YEF = Youth Endowment Fund

Terminated trial analyses

Participant flow, including losses and exclusions

By the time of termination, 41 families had been referred from six local authorities:

- ***N=41 referred to the study:*** n=1 referral was incomplete, and n=1 referral was received after the end of the study.
- ***N=39 triaged:*** n=4 were not eligible, n=3 were lost to follow-up (LTFU), n=6 withdrew after this stage, n=4 did not proceed for other reasons (no lead professional, n=3; already receiving RISE intervention, n=1).
- ***N=22 screened:*** n=3 ineligible, n=1 withdrew post-screening.
- ***N=18 consented:*** n=1 withdrew post-consent.
- ***N=17 randomised:***
    - N=8 treatment: n=1 subsequently withdrew
    - N=9 BAU

The data presented in Table 6 show the number of referrals and family status by the end of the fieldwork, broken down by de-identified local authorities.

Table 6: Participants at each stage of the study by site

	LA 1	LA 2	LA 3	LA 4	LA 5	LA 6	Total
Not triaged						2	**2**
Triaged: no lead	1					2	**3**
Triaged: ineligible	1	2		1		1	**5**
Triaged: withdrawn	1		1			4	**6**
Triaged: lost to follow-up			2			1	**3**
Screened: ineligible		1		1		1	**3**
Screened: withdrawn			1				**1**
Consented: withdrawn		1					**1**
Randomised: withdrawn				1			**1**
Randomised: progressed	1	3	5		3	4	**16**
Total	**4**	**7**	**9**	**3**	**3**	**15**	**41**

Key: LA = local authority

In line with the protocol, Table 7 presents the number of families/CYP referred and recruited, reported by age, sex, ethnicity, de-identified referring site and parent experiencing CAPVA. The mean age (standard deviation) of referred families' CYP: 13.0 (2.6) years; the mean age (standard deviation) of consented families' CYP: 12.6 (1.9) years. A CONSORT flow diagram is presented in Figure 2.

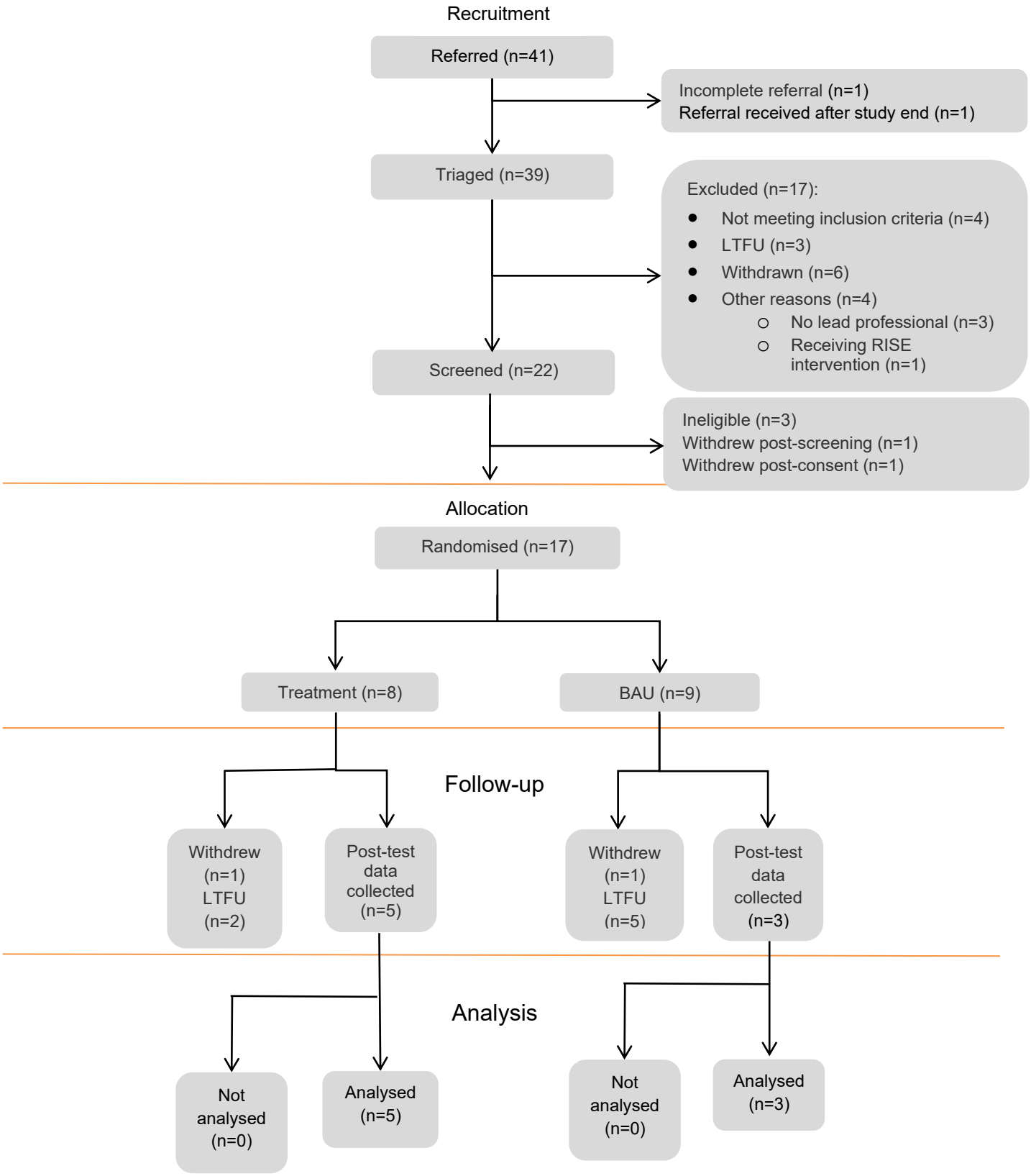
Table 7: Summaries of referred and consented participant children and young people

		Referred families		Families who consented	
		N	%	N	%
Age (years)	8	1	2%	-	-
	9 to 11	11	27%	5	28%
	12 to 14	16	39%	10	56%
	15 to 17	13	32%	3	17%
Sex	Male	29	71%	11	61%
	Female	12	29%	7	39%
Ethnicity	Asian	6	15%	5	28%
	Black	9	22%	2	11%
	Mixed	7	17%	3	17%
	White	16	39%	7	39%
	Other	3	7%	1	6%
Borough	LA 1	4	10%	1	6%
	LA 2	7	17%	4	22%
	LA 3	9	22%	5	28%
	LA 4	3	7%	1	6%
	LA 5	3	7%	3	17%
	LA 6	15	37%	4	22%
CAPVA relationship	Mother	34	83%	16	89%
	Father	5	12%	1	6%
	Other	2	5%	1	6%
Total		**41**		**18**	

Key: CAPVA = Child and Adolescent to Parent Violence and Abuse, LA = local authority

Notes for Table 7: Age is at initial referral, rather than when referral to the study was made. Values differed for one CYP. Sex is reported, but there was no difference between gender and sex for all CYP. More granular ethnicity data are available; only top-level data have been reported due to low numbers.

Figure 2: Participant flow diagram (two arms)



Key: LTFU = lost to follow-up, BAU = business as usual

Participant characteristics at baseline

As reported above, 18 participants consented; one withdrew prior to randomisation (i.e. no baseline data recorded). So, 17 families were randomised: nine were allocated to BAU and eight to the treatment group. One family (assigned to the treatment group) subsequently withdrew from the study and requested deletion of their data. Baseline family characteristics data (collected prior to consent) are presented in Table 8.

Table 8: Baseline characteristics by treatment group

		Treatment (n=8)		BAU (n=9)	
		N	%	N	%
Age (years)	9 to 11	3	38%	2	22%
	12 to 14	3	38%	6	67%
	15	2	25%	1	11%
Sex	Male	5	63%	6	67%
	Female	3	38%	3	33%
Ethnicity	Asian	4	50%	1	11%
	Black	0	0%	2	22%
	Mixed	1	13%	2	22%
	White	2	25%	4	44%
	Other	1	13%	0	0%
Borough	LA 1	0	0%	1	11%
	LA 2	3	38%	0	0%
	LA 3	2	25%	3	33%
	LA 4	1	13%	0	0%
	LA 5	1	13%	2	22%
	LA 6	1	13%	3	33%
CAPVA relationship	Mother	7	88%	8	89%
	Father	1	13%	0	0%
	Other	0	0%	1	11%
Total in household	2	1	13%	2	22%
	3	1	13%	1	11%
	4	5	63%	5	56%
	5	0	0%	1	11%
	6	1	13%	0	0%
Total in household 17+ years old	1	2	29%	2	25%
	2	3	43%	4	50%
	3	2	29%	2	25%
Total in household <17 years old	1	2	25%	3	33%
	2	4	50%	6	67%
	3	2	25%	0	0%
Support for parent/carer within the household	Yes	2	29%	3	33%
	No	5	71%	5	56%
	Unknown	0	0%	1	11%
Social care involvement	Yes	7	88%	7	78%
	No	1	13%	2	22%
Legal status	Early Help	2	25%	3	33%
	Child in Need	3	38%	2	22%
	Child Protection Plan	1	13%	0	0%
	Edge of Care	0	0%	1	11%
	Voluntary Care Order	0	0%	1	11%
	Interim Care Order	0	0%	0	0%
	Full Care Order	0	0%	0	0%
	Child Arrangement Order	0	0%	0	0%
	Special Guardianship Order	0	0%	0	0%
	Other status	1	13%	2	22%
	Unknown	0	0%	0	0%

Free school meals	Yes	4	50%	2	22%
	No	2	25%	4	44%
	Unknown	2	25%	3	33%
Education status	Mainstream	7	88%	9	100%
	Not in education, employment or training	1	13%	0	0%
English additional (CYP)	Yes	4	50%	1	11%
	No	4	50%	8	89%
Health concerns	Yes	2	25%	5	56%
	No	5	63%	2	22%
	Unknown	1	13%	2	22%
Neurodivergence	Yes	4	50%	6	67%
	No	3	38%	2	22%
	Unknown	1	13%	1	11%
Criminal activity (risk/engaged)	Yes	2	25%	2	22%
	No	4	50%	7	78%
	Unknown	2	25%	0	0%
Alcohol use	Yes	0	0%	2	22%
	No	5	63%	7	78%
	Unknown	3	38%	0	0%
English additional (parents/carers)	Yes	5	63%	2	22%
	No	3	38%	7	78%
Between-parent violence	Yes	0	0%	1	11%
	No	7	88%	7	78%
	Unknown	1	13%	1	11%
If violence, perpetrator at home	No	0	0%	1	50%
	Unknown	1	100%	1	50%
Health concerns (parents/carers)	Yes	4	50%	4	44%
	No	3	38%	5	56%
	Unknown	1	13%	0	0%
Neurodivergence (parents/carers)	Yes	0	0%	1	11%
	No	5	63%	8	89%
	Unknown	3	38%	0	0%
Alcohol use (parents/carers)	Yes	1	13%	0	0%
	No	6	75%	8	89%
	Unknown	1	13%	1	11%
Referral origin	Another service	5	63%	4	44%
	RISE	3	38%	5	56%
Referral service	Police	2	40%	2	67%
	Education	3	60%	1	33%
Youth offending service	No	8	100%	9	100%
Statutory support organisations	Yes	1	13%	2	22%
	No	7	88%	6	67%
	Unknown	0	0%	1	11%
Non-statutory support organisations	Yes	2	25%	4	44%
	No	6	75%	5	56%
Other support orgs	Yes	0	0%	3	38%
	No	7	88%	5	63%
	Unknown	1	13%	1	13%

Key: BAU = business as usual, LA = local authority, CAPVA = Child and Adolescent to Parent Violence and Abuse programme, CYP = children and young people

Notes for Table 8:

- Some data were missing, e.g. total under 17 in the household has only eight values for the BAU group. When this occurs, percentages are calculated out of the number who answered rather than all participants in that group.
- The legal status variable was a "tick box if applicable" type, so percentages are out of eight (treatment) or nine (BAU), as applicable.
- It is possible that some families were receiving support from more than one agency/organisation in more than one of the support categories listed.

None of the CYP had been referred to youth offender services, but families were supported by various organisations. Only five of the young people referred had been classed as neurotypical. In line with the decision to explore neurodiversity (i.e. both neurotypicality and neuro-nontypicality) more directly within the terminated study, Table 9 and Note: CYP = children and young people, BAU = business as usual, ADHD = attention deficit/hyperactivity disorder, ASD = autism spectrum disorder, CAMHS = Child and Adolescent Mental Health Services, EHCP = Education and Health Care Plan, ASC = Autism Spectrum Condition (a discontinued diagnostic label)

Table 10 present free text about both the CYP and parents/carers where "neurodivergence" and/or any health-related concerns were reported as part of the referral and initial screening process. Any information that might identify a CYP or family has been removed, but these statements are otherwise as entered into the REDCap database, with no alterations to typographical errors.

Table 9: Free text for young person's health and "neurodivergence" specifics

Health concerns specifics (young people)	Treatment group
Due to her emotional dysregulation [CYP] will often feel depressed, ashamed and has in the past expressed suicidal ideation.	Control/BAU
[CYP] experiences low mood, he has previously had suicidal ideations due to being bullied.	Control/BAU
ADHD, unaware of danger, anxiety, dysregulation and anger.	Control/BAU
[CYP] is exhibiting depression symptoms such as not washing, staying in her bedroom, isolating herself from others and keeping her soiled dirty period pads in her bedroom.	Control/BAU
There are concerns around [CYP]'s emotional wellbeing has she has reported low mood.	Treatment
Emotional	Treatment
Neurodivergence specifics (young people)	**Treatment Group**
…[date of assessment and provider] was confirmed by them to be on the autistic spectrum. We trust their assessment, it has made a lot of sense. We are currently reading up on pathological demand avoidance. [CYP] regularly expresses high anxiety, has a need for control and becomes dysregulated when demands cannot be avoided. She may comply with the demand, but might equalise by causing emotional or physical distress.	Control/BAU
[CYP] is waiting to be assessed by CAMHS.	Control/BAU
It is suspected that [CYP] may have ADHD, although no formal diagnosis	Control/BAU
ADHD and has EHCP	Control/BAU
[CYP] has diagnosed dyslexia and she has had two autism assessments that have come back as inconclusive.	Control/BAU
[CYP] (and possibly [another family member]) may have some undiagnosed neurodiversity (ADHD or ASC), and although [CYP] has been referred to the … Social, Emotional and Mental Health [team] twice these referrals have not led to assessment or intervention.	Treatment

Mother shared that [CYP] has communication processing difficulties because of her autism	Treatment
[CYP] has exhibited behaviours that may suggest underlying neurodiversity, such as: Emotional dysregulation Aggression and impulsivity Difficulty with peer relationships Possession of sharp objects and threats Escalating behavioural concerns despite therapeutic input While there is no confirmed diagnosis mentioned, these patterns could indicate suspected neurodiversity, such as ADHD, ASD, or other behavioural or developmental conditions.	Treatment
CAHMS has said he has severe speech and language	Treatment

Note: CYP = children and young people, BAU = business as usual, ADHD = attention deficit/hyperactivity disorder, ASD = autism spectrum disorder, CAMHS = Child and Adolescent Mental Health Services, EHCP = Education and Health Care Plan, ASC = Autism Spectrum Condition (a discontinued diagnostic label)

Table 10: Free text for parental health and neurodivergence specifics

Health concerns specifics (parents/carers)	**Treatment group**
Mother has [multiple inflammatory health conditions].	Control/BAU
Mother is stressed and suffers with low mood. No formal diagnosis to my knowledge.	Control/BAU
Emotional and physical burnout, anxiety due to [CYP]s behaviour and previous relationship that ended [x] years ago.	Control/BAU
[parent] is on the waiting list for bereavement counselling	Control/BAU
[parent] has a history of anxiety and Depression …mentioned stress at home/finances again in a [previous] GP consult …Currently [parent] has said that she does not want any additional support around her emotional wellbeing.	Treatment
The parental relationship between [parent] and [parent] seems to be difficulty and [CYP] appears to be caught up within this conflict and is already struggling with processing her own emotional needs. There have also been reports of Domestic Violence between [parent] and [parent] ….	Treatment
[CYP]'s mother has a history of mental health difficulties. [A described] incident highlights the emotional strain and vulnerability within the family. There are no known physical health issues reported at this time.	Treatment
Suffers with depression and anxiety	Treatment
Neurodivergence specifics (parents/carers)	**Treatment Group**
ADHD	Control/BAU

Key: CYP = children and young people, BAU = business as usual

Related information was requested via two optional surveys, completed by eight participants (four from each group). Neither was used for diagnostic purposes but rather to help present information that may help in the management of young people and/or indicate additional clinical assessments that could be of help. Table 11 first presents the findings on extreme demand avoidance. The EDA-8 scores are then summarised (Table 12 and Table 13), and potential sensory issues are identified in Table 14.

Table 11: Extreme demand avoidance (EDA-8)

		Not true	Somewhat true	Mostly true	Very true
1. Obsessively resists/avoids demands	Treatment	-	1 (25%)	-	3 (75%)
	BAU	-	-	-	4 (100%)
2. Driven by need to be in charge	Treatment	-	1 (25%)	-	3 (75%)
	BAU	1 (25%)	-	2 (50%)	1 (25%)
3. Tells others how to behave but not applicable to them	Treatment	-	1 (25%)	2 (50%)	1 (25%)
	BAU	2 (50%)	-	-	2 (50%)
4. Difficulty complying with demands unless presented carefully	Treatment	-	1 (25%)	1 (25%)	2 (50%)
	BAU	-	-	2 (50%)	2 (50%)
5. Unaware of differences between them and authority	Treatment	-	1 (25%)	-	3 (75%)
	BAU	1 (25%)	2 (50%)	1 (25%)	-
6. Rapid mood changes	Treatment	-	1 (25%)	-	3 (75%)
	BAU	-	1 (25%)	-	3 (75%)
7. Uses outrageous behaviour to get out of things	Treatment	1 (25%)	-	2 (50%)	1 (25%)
	BAU	-	-	2 (50%)	2 (50%)
8. Has bouts of extreme emotion to small events	Treatment	1 (25%)	-	2 (50%)	1 (25%)
	BAU	1 (25%)	-	2 (50%)	1 (25%)

Key: BAU = business as usual

Table 12: Summary of total extreme demand avoidance scores

	Median (IQR)	Mean (SD)
Treatment	21.5 (13.5, 22)	17.8 (7.8)
BAU	16.5 (13.5, 19.5)	16.5 (3.5)

Key: BAU = business as usual, IQR = interquartile range, SD = standard deviation

Scores over 19 could indicate the need for more in-depth measurement of extreme demand avoidance but do not necessarily suggest a PDA-profile.

Table 13: Extreme demand avoidance (EDA-8) score distribution

EDA-8 scores	Treatment	BAU
6	1 (25%)	-
13	-	1 (25%)
14	-	1 (25%)
19	-	1 (25%)
20	-	1 (25%)
21	1 (25%)	-
22	2 (50%)	-

Key: BAU = business as usual

Three in the treatment group and one in the BAU group had scores above 19, indicating a potential need for follow-up.

Another innovation for the terminated trial, in comparison to the feasibility–pilot trial, was the addition of the Glasgow Sensory Questionnaire. Children with additional sensory difficulties may try to mask these, for example, while in school, thereby increasing frustration and potential outbursts associated with ongoing discomfort and unmet sensory needs.

Table 14: Glasgow Sensory Questionnaire

		Never	Rarely	Sometimes	Always
2. Gag on certain foods	Treatment	1 (33%)	-	2 (67%)	-
	BAU	2 (50%)	1 (25%)	1 (25%)	-
6. Find noises annoying	Treatment	1 (33%)	-	1 (33%)	1 (33%)
	BAU	1 (25%)	2 (50%)	-	1 (25%)
8. Complain of bright lights	Treatment	2 (67%)	1 (33%)	-	-
	BAU	2 (50%)	1 (25%)	-	1 (25%)
9. Listen to a song repeatedly	Treatment	1 (25%)	1 (25%)	2 (50%)	-
	BAU	2 (50%)	-	1 (25%)	1 (25%)
10. Seem ill/dizzy when reaching up/down	Treatment	2 (50%)	-	-	2 (50%)
	BAU	4 (100%)	-	-	-
12. Like to spin	Treatment	3 (75%)	-	1 (25%)	-
	BAU	2 (67%)	-	1 (33%)	-
15. Dislike having a haircut	Treatment	3 (75%)	-	-	1 (25%)
	BAU	1 (33%)	1 (33%)	-	1 (33%)
16. Not feel pain when hurt	Treatment	2 (50%)	1 (25%)	-	1 (25%)
	BAU	2 (67%)	1 (33%)	-	-
17. Borrow perfume	Treatment	1 (50%)	-	1 (50%)	-
	BAU	1 (50%)	-	1 (50%)	-
18. Seem bothered by flickering/fluorescent lights	Treatment	1 (25%)	2 (50%)	-	1 (25%)
	BAU	3 (100%)	-	-	-
19. Like lining things up	Treatment	2 (50%)	1 (25%)	1 (25%)	-
	BAU	1 (25%)	1 (25%)	2 (50%)	-
21. Complain about strongsmelling shops	Treatment	2 (50%)	1 (25%)	-	1 (25%)
	BAU	2 (50%)	1 (25%)	1 (25%)	-
22. Complain about clothes labels	Treatment	2 (50%)	-	-	2 (50%)
	BAU	3 (100%)	-	-	-
23. Hate texture of foods	Treatment	2 (67%)	-	1 (33%)	-
	BAU	3 (75%)	-	-	1 (25%)
24. Complain about smells in restaurants	Treatment	2 (50%)	1 (25%)	-	1 (25%)
	BAU	4 (100%)	-	-	-
25. Dislike loud noises	Treatment	1 (25%)	1 (25%)	-	2 (50%)
	BAU	2 (67%)	1 (33%)	-	-
28. Complain of weak taste	Treatment	3 (75%)	1 (25%)	-	-
	BAU	4 (100%)	-	-	-
30. Complain of dizziness during sport	Treatment	2 (50%)	1 (25%)	1 (25%)	-
	BAU	2 (50%)	-	2 (50%)	-
33. Like listening to certain sounds	Treatment	2 (50%)	2 (50%)	-	-
	BAU	3 (75%)	-	-	1 (25%)
34. Like to run more than average	Treatment	2 (50%)	1 (25%)	-	1 (25%)
	BAU	3 (75%)	1 (25%)	-	-
35. Chew and lick non-food objects	Treatment	2 (67%)	1 (33%)	-	-
	BAU	2 (100%)	-	-	-
36. Seek out strong smells	Treatment	2 (50%)	-	1 (25%)	1 (25%)
	BAU	3 (75%)	-	1 (25%)	-

		Never	Rarely	Sometimes	Always
39. Go outside with no coat when it's cold	Treatment	2 (50%)	1 (25%)	-	1 (25%)
	BAU	-	-	1 (50%)	1 (50%)
42. Flick fingers in front of eyes	Treatment	4 (100%)	-	-	-
	BAU	3 (75%)	1 (25%)	-	-

Notes and Key for Table 14:

Key: BAU = business as usual

Note: The scale was completed by the same eight participants, four from each group, as the EDA-8. Item numbers reflect that this is the short form of the questionnaire designed for parent completion.There is no set cut-off; the survey works by building a profile for practitioners to use in addressing potential sensory differences rather than imposing a clinical threshold to be met. High scores may, however, indicate that a young person is struggling and that their profile should be investigated further.

Table 15: Summary of Glasgow Sensory Questionnaire scores by group

	Median (IQR)	Mean (SD)
Treatment	28 (12.5, 43)	27.8 (21.2)
BAU	30.5 (15, 36)	25.5 (15.7)

Key: BAU = business as usual, IQR = interquartile range, SD = standard deviation

Table 16: Glasgow Sensory Questionnaire (GSQ) scores by participant per group

GSQ scores	Treatment	BAU
2	1 (25%)	-
3	-	1 (25%)
23	1 (25%)	-
27	-	1 (25%)
33	1 (25%)	-
34	-	1 (25%)
38	-	1 (25%)
53	1 (25%)	-

Key: BAU = business as usual

One participant in the treatment group was rated with a notably higher total Glasgow Sensory Questionnaire score than others.

Outcome measures at baseline

As originally conceptualised, the primary measure was to be an indicator of abusive behaviour and the secondary outcome measure related to strengths and difficulties faced by CYP, each rated by their parents/carers. Although tests of change over time cannot be reliably made, data are still presented, largely to assess these scales' potential value for future research.

Abusive Behaviour by Children Indices baseline values

Data for seven participants in the treatment group and nine in BAU, as described above, are presented in Table 17. Scoring was conducted using the guidance originally provided in Simmons et al. (2019a). Please see the protocol (Adler et al., 2024) for consideration of the potential limitation regarding cultural specificity of the indices raised by Simmons et al. (2019b).

Table 17: Question-level responses to the Abusive Behaviour by Children Indices (baseline)

		Never	Once	A few times	Monthly	Weekly	Daily
1. Swore at parent	Treatment	-	-	-	-	2 (29%)	5 (71%)
	BAU	-	-	1 (11%)	1 (11%)	5 (56%)	2 (22%)
2. Insulted/ humiliated	Treatment	-	-	-	-	6 (86%)	1 (14%)
	BAU	-	-	2 (22%)	1 (11%)	4 (44%)	2 (22%)
3. Attempted to intimidate	Treatment	-	-	-	1 (14%)	5 (71%)	1 (14%)
	BAU	-	1 (11%)	1 (11%)	3 (33%)	3 (33%)	1 (11%)
4. Stole money/ possessions	Treatment	5 (71%)	2 (29%)	-	-	-	-
	BAU	1 (11%)	2 (22%)	2 (22%)	3 (33%)	-	1 (11%)
5. Threatened to hurt self/others	Treatment	-	1 (14%)	4 (57%)	-	1 (14%)	1 (14%)
	BAU	2 (22%)	-	2 (22%)	3 (33%)	1 (11%)	1 (11%)
6. Broke (or threatened) objects	Treatment	-	-	2 (29%)	1 (14%)	4 (57%)	-
	BAU	-	-	1 (11%)	2 (22%)	4 (44%)	2 (22%)
7. Prevented medical care	Treatment	6 (86%)	-	1 (14%)	-	-	-
	BAU	5 (56%)	1 (11%)	1 (11%)	1 (11%)	1 (11%)	-
8. Threatened with object	Treatment	2 (29%)	2 (29%)	3 (43%)	-	-	-
	BAU	4 (44%)	2 (22%)	1 (11%)	2 (22%)	-	-
9. Physically aggressive	Treatment	-	-	4 (57%)	3 (43%)	-	-
	BAU	1 (11%)	-	3 (33%)	2 (22%)	3 (33%)	-

Key: BAU = business as usual

Totals for the three subscales are presented in Table 18. These are reported in more detail subsequently and with consideration of gender before moving on to the SDQ.

Table 18: Abusive Behaviour by Children Indices subscale scores (baseline)

	Median (IQR)	
	Treatment	**BAU**
Verbal aggression (Q1+Q2)	24 (16, 24)	16 (16, 24)
Coercive behaviour (Q3+Q4+Q5+Q6)	120 (88, 200)	104 (72, 192)
Physical aggression (Q7+Q8+Q9)	80 (32, 96)	112 (64, 144)
Total	224 (176, 264)	256 (142, 336)

Key: IQR = interquartile range, BAU = business as usual

Physical aggression

Table 19: Types of aggression (baseline)

	Treatment	BAU
Threw something	4 (57%)	5 (56%)
Pushed	5 (71%)	8 (89%)
Grabbed	5 (71%)	3 (33%)
Hit/slapped	3 (43%)	6 (67%)
Punched	3 (43%)	2 (22%)
Kicked	4 (57%)	5 (56%)
Strangled	0 (0%)	1 (11%)
Used a weapon	0 (0%)	1 (11%)
Burned/scalded	0 (0%)	0 (0%)
Other	2 (29%)	0 (0%)

Key: BAU = business as usual

Participants could select as many options as applicable.

Percentages are out of seven (treatment group) and nine (BAU).

Table 20: Other types of physical aggression (verbatim-baseline)

Other types of physical aggression (ABC-I)	Treatment group
Spat	Treatment
Thrown things	Treatment

Key: ABC-I = Abusive Behaviour by Children Indices

Table 21: Injury types (baseline)

	Treatment	BAU
No injury	3 (38%)	2 (22%)
Minor injury	4 (50%)	6 (67%)
Major injury	0 (0%)	0 (0%)

Key: BAU = business as usual

Abusive Behaviour by Children Indices reported by gender

N=10 male, n=6 female

Table 22: Abusive Behaviour by Children Indices question-level responses (baseline) by gender

		Never	Once	A few times	Monthly	Weekly	Daily
1. Swore at parent	Male	-	-	1 (10%)	-	4 (40%)	5 (50%)
	Female	-	-	-	1 (17%)	3 (50%)	2 (33%)
2. Insulted/ humiliated	Male	-	-	1 (10%)	1 (10%)	7 (70%)	1 (10%)
	Female	-	-	1 (17%)	-	3 (50%)	2 (33%)
3. Attempted to intimidate	Male	-	1 (10%)	-	4 (40%)	4 (40%)	1 (10%)
	Female	-	-	1 (17%)	-	4 (67%)	1 (17%)
4. Stole money/ possessions	Male	2 (20%)	4 (40%)	1 (10%)	3 (30%)	-	-
	Female	4 (67%)	-	1 (17%)	-	-	1 (17%)
5. Threatened to hurt self/others	Male	1 (10%)	1 (10%)	5 (50%)	2 (20%)	1 (10%)	-
	Female	1 (17%)	-	1 (17%)	1 (17%)	1 (17%)	2 (33%)
6. Broke (or threatened) objects	Male	-	-	1 (10%)	2 (20%)	6 (60%)	1 (10%)
	Female	-	-	2 (33%)	1 (17%)	2 (33%)	1 (17%)
7. Prevented medical care	Male	8 (80%)	1 (10%)	-	1 (10%)	-	-
	Female	3 (50%)	-	2 (33%)	-	1 (17%)	-
8. Threatened with object	Male	4 (40%)	3 (30%)	2 (20%)	1 (10%)	-	-
	Female	2 (33%)	1 (17%)	2 (33%)	1 (17%)	-	-
9. Physically aggressive	Male	1 (10%)	-	4 (40%)	4 (40%)	1 (10%)	-
	Female	-	-	3 (50%)	1 (17%)	2 (33%)	-

Table 23: Abusive Behaviour by Children Indices subscale scores by gender (baseline)

	Median (IQR)	
	Male	Female
Verbal aggression (Q1+Q2)	22 (16, 24)	20 (16, 24)
Coercive behaviour (Q3+Q4+Q5+Q6)	112 (72, 128)	156 (80, 224)
Physical aggression (Q7+Q8+Q9)	80 (32, 112)	88 (64, 160)
Total	208 (152, 264)	260 (224, 328)

Key: IQR = interquartile range

Wilcoxon Mann–Whitney test to compare the two: p=0.3021

Strengths and Difficulties Questionnaire baseline values: parent or carer report

Table 24: Strengths and Difficulties Questionnaire subscale scores (baseline)

	Treatment		BAU	
	Median (IQR)	Mean (SD)	Median (IQR)	Mean (SD)
Emotional difficulties	6 (2, 8)	5.3 (3.4)	6 (4, 6)	5.6 (2.1)
Conduct difficulties	5 (5, 8)	6.0 (1.8)	6 (6, 7)	6.3 (1.9)
Hyperactivity	8 (6, 9)	7.1 (2.1)	7 (6, 10)	6.8 (3.2)
Peer difficulties	4 (3, 5)	4.0 (1.8)	3 (2, 4)	3.6 (2.5)
Prosocial*	5 (2, 6)	4.7 (2.6)	7 (4, 8)	5.8 (2.9)
Internalising score	10 (6, 12)	9.3 (3.7)	8 (6, 10)	9.1 (3.8)
Externalising score	13 (11, 17)	13.1 (3.4)	14 (11, 16)	13.1 (4.6)
Impact	6.5 (3, 10)	6.3 (3.5)	6 (3, 8)	5.8 (2.8)
Total	24 (19, 27)	22.4 (6.1)	19 (18, 26)	22.2 (7.3)

Key: IQR = interquartile range, SD = standard deviation, BAU = business as usual

**Higher scores indicate fewer difficulties*

Table 25: Strengths and Difficulties Questionnaire (SDQ) comments (verbatim at baseline)*

Baseline SDQ other comments	Treatment group
Unable to control anger, blames everyone else, lying and steeling, low self confidence	Control/BAU
her behaviour varies a lot depending on whether or not she is anxious or worried about something.	Control/BAU
Some areas were difficult to answer as she has not been in school regularly over the last 2 years so spends a lot of time alone or online with friends apart fo when she anttends [club].	Control/BAU
lack of empathy, impulsiveness, anger outbursts.	Treatment

Key: BAU = business as usual

**As before, no corrections are made to typographical errors entered into the database by participants.*

Table 26: Strengths and Difficulties Questionnaire (SDQ) difficulties: presence, duration and burden (baseline)

		Treatment	BAU
Difficulties present	No	1 (14%)	0 (0%)
	Yes, minor	2 (29%)	0 (0%)
	Yes, major	2 (29%)	8 (89%)
	Yes, severe	2 (29%)	1 (11%)
Duration of difficulties	6–12 months	1 (17%)	0 (0%)
	1+ years	5 (83%)	9 (100%)
Burden of difficulties	Only a little	0 (0%)	1 (11%)
	Quite a lot	3 (50%)	2 (22%)
	A great deal	3 (50%)	6 (67%)

Key: BAU = business as usual

Note: Difficulties percentages out of n=7 (treatment group) and n=9 (BAU). Duration and burden percentages out of n=6 (treatment group) and n=9 (BAU), since one in the treatment group reported no difficulties.

Outcome measures at follow-up

Please note that no assessment should be made of programme efficacy based on the data presented here. They are indicative of measure usefulness, not intervention outcome.

Abusive Behaviour by Children Indices follow-up values

Data were collected for the treatment group (n=5) and BAU (n=3). Note that two families from the treatment group and six (two-thirds) from the BAU group were LTFU.

Table 27: Abusive Behaviour by Children Indices question-level responses (follow-up)

		Never	Once	A few times	Monthly	Weekly	Daily
1. Swore at parent	Treatment	-	-	2 (40%)	1 (20%)	1 (20%)	1 (20%)
	BAU	-	-	1 (33%)	-	1 (33%)	1 (33%)
2. Insulted/ humiliated	Treatment	1 (20%)	-	3 (60%)	-	1 (20%)	-
	BAU	-	1 (33%)	-	-	1 (33%)	1 (33%)
3. Attempted to intimidate	Treatment	1 (20%)	1 (20%)	2 (40%)	-	1 (20%)	-
	BAU	-	-	2 (67%)	-	1 (33%)	-
4. Stole money/ possessions	Treatment	5 (100%)	-	-	-	-	-
	BAU	2 (67%)	-	1 (33%)	-	-	-
5. Threatened to hurt self/others	Treatment	3 (60%)	-	2 (40%)	-	-	-
	BAU	1 (33%)	-	2 (67%)	-	-	-
6. Broke (or threatened) objects	Treatment	1 (20%)	1 (20%)	3 (60%)	-	-	-
	BAU	-	-	3 (100%)	-	-	-
7. Prevented medical care	Treatment	4 (80%)	-	1 (20%)	-	-	-
	BAU	1 (33%)	-	2 (67%)	-	-	-
8. Threatened with object	Treatment	4 (80%)	-	1 (20%)	-	-	-
	BAU	2 (67%)	-	1 (33%)	-	-	-
9. Physically aggressive	Treatment	2 (40%)	2 (40%)	1 (20%)	-	-	-
	BAU	-	-	2 (67%)	1 (33%)	-	-

Key: BAU = business as usual

Table 28: Abusive Behaviour by Children Indices subscale scores (follow-up)

	Median (IQR)	
	Treatment	**BAU**
Verbal aggression (Q1+Q2)	6 (4, 16)	16 (3, 32)
Coercive behaviour (Q3+Q4+Q5+Q6)	32 (20, 40)	40 (40, 88)
Physical aggression (Q7+Q8+Q9)	16 (0, 16)	64 (64, 96)
Total	44 (26, 104)	139 (136, 168)

Key: IQR = interquartile range

Physical aggression

Table 29: Abusive Behaviour by Children Indices: types of aggression (follow-up)

	Treatment	BAU
Threw something	1 (20%)	2 (67%)
Pushed	3 (60%)	2 (67%)
Grabbed	1 (20%)	2 (67%)
Hit/slapped	1 (20%)	3 (100%)
Punched	1 (20%)	2 (67%)
Kicked	2 (40%)	1 (33%)
Strangled	0 (0%)	0 (0%)
Used a weapon	1 (20%)	0 (0%)
Burned/scalded	0 (0%)	0 (0%)
Other	0 (0%)	0 (0%)

Key: BAU = business as usual

Percentages out of n=3 for the BAU and n=5 for the treatment group.

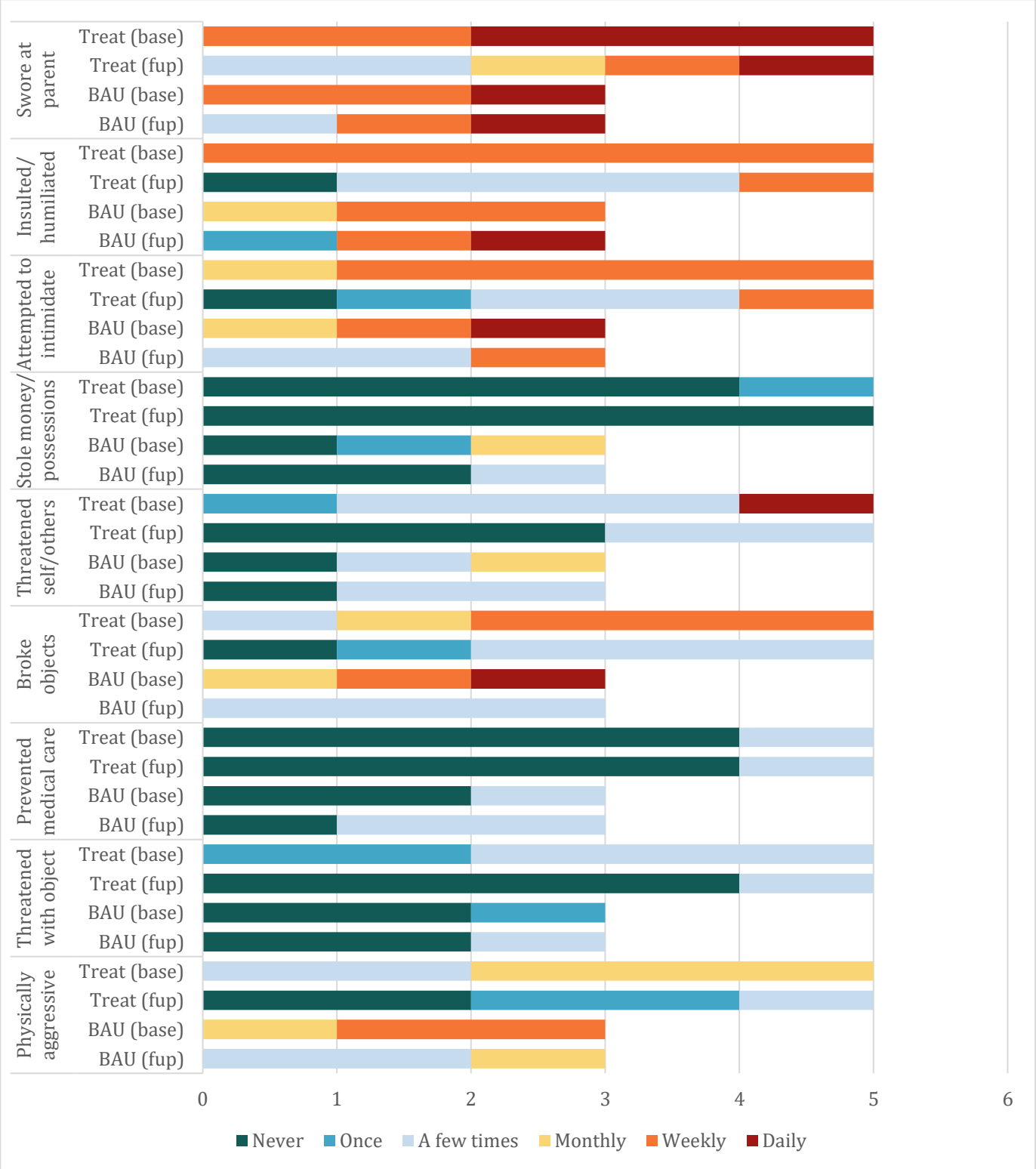
Injury types

All eight families reported “no injuries” at follow-up.

Measures at follow-up for those with baseline values

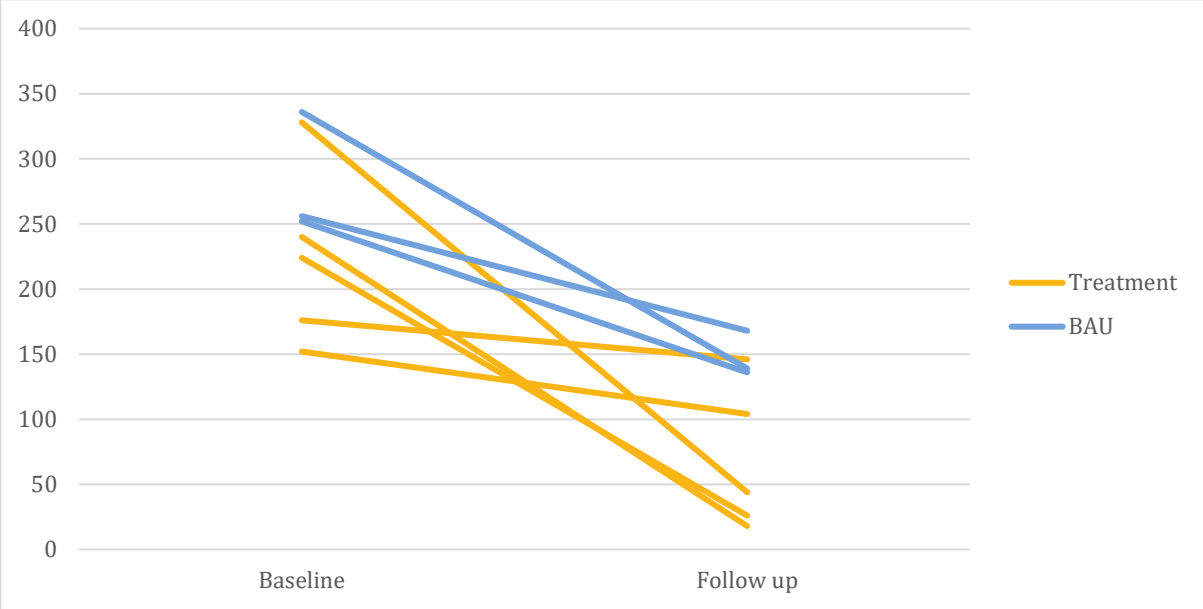
The ABC-I is scored in a manner that allows consideration of both the frequency and severity of particular behaviours. These are reported over time here, but again, they are not presented as a test of efficacy (see Figure 3 and Figure 4).

Figure 3: Results of Abusive Behaviour by Children Indices questions at baseline and follow-up, by treatment arm (n=5 treatment, n=3 BAU)



Key: BAU = business as usual

Figure 4: Total Abusive Behaviour by Children Indices scores at baseline and follow-up (for those with values at both time points)



Key: BAU = business as usual

Regression model results have not been reported because low numbers (n=8) and the unusual scoring of the ABC-I system (non-normality) mean that assumptions for regression are not met. Figure 3 and Figure 4 are presented descriptively only and should not be read as an indication of programme impact.

Strengths and Difficulties Questionnaire scores at follow-up

The SDQ was completed by five families in the treatment group and three in the BAU group.

Table 30: Strengths and Difficulties Questionnaire subscale scores (follow-up)

	Treatment		BAU	
	Median (IQR)	**Mean (SD)**	**Median (IQR)**	**Mean (SD)**
Emotional difficulties	6 (3, 6)	4.8 (3.4)	6 (6, 7)	6.3 (0.6)
Conduct difficulties	4 (4, 4)	4.2 (1.8)	5 (3, 5)	4.3 (1.2)
Hyperactivity	6 (6, 7)	6.2 (1.5)	5 (2, 9)	5.3 (3.5)
Peer difficulties	2 (1, 6)	3.2 (2.6)	4 (2, 8)	4.7 (3.1)
Prosocial	5 (4, 6)	5.0 (1.6)	8 (4, 10)	7.3 (3.1)
Internalising score	7 (4, 12)	8.0 (5.4)	10 (8, 15)	11.0 (3.6)
Externalising score	10 (10, 11)	10.4 (1.8)	10 (5, 14)	9.7 (4.5)
Impact	7 (6, 9.5)	7.8 (2.4)	12 (9, 12)	11.0 (1.7)
Total	20 (14, 22)	18.4 (6.4)	20 (13, 29)	20.7 (8.0)

Key: IQR = interquartile range, SD = standard deviation, BAU = business as usual

Table 31: Strengths and Difficulties Questionnaire (SDQ) comments (verbatim, follow-up)

Follow up SDQ other comments	Treatment group
complains about his mental state like depression, difficulty going to sleep and anger. also experience derealization.	Treatment
No	Control/BAU

Key: BAU = business as usual

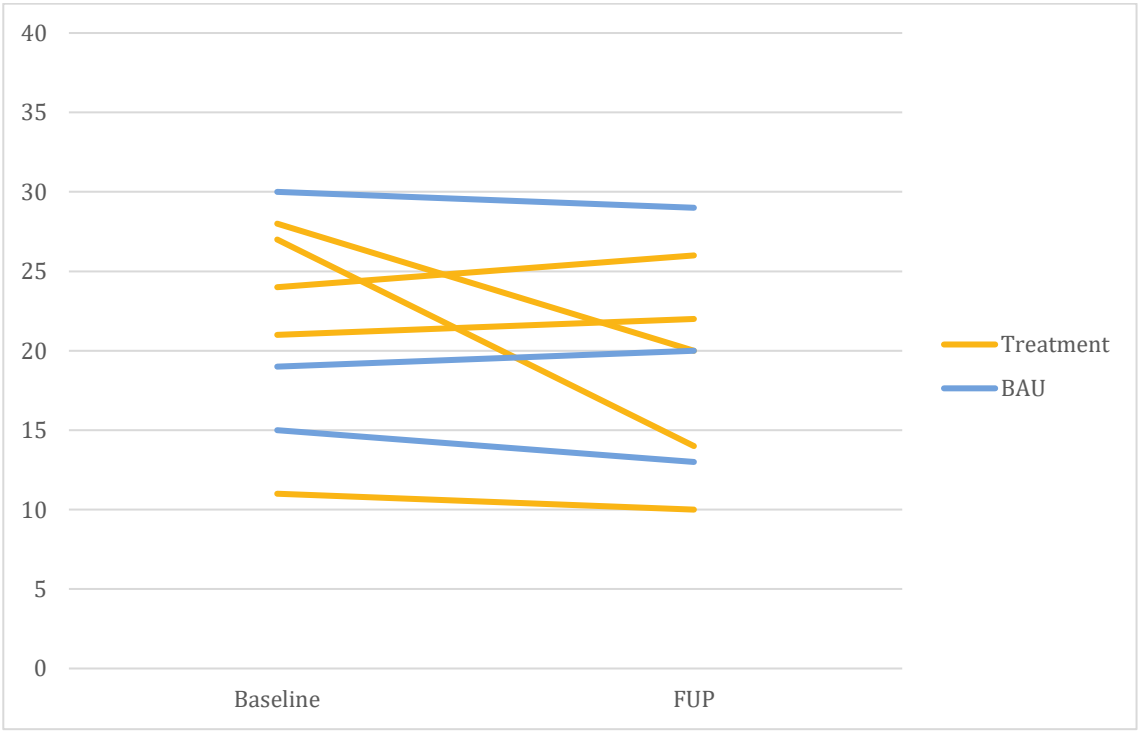
Table 32: Strengths and Difficulties Questionnaire difficulties: presence, duration and burden (follow-up)

		Treatment	BAU
Difficulties present	No	1 (20%)	0 (0%)
	Yes, minor	0 (0%)	1 (33%)
	Yes, major	1 (20%)	0 (0%)
	Yes, severe	3 (60%)	2 (67%)
Duration of difficulties	6–12 months	4 (100%)	3 (100%)
	1+ years	-	-
Burden of difficulties	Only a little	1 (17%)	1 (11%)
	Quite a lot	2 (33%)	1 (11%)
	A great deal	1 (17%)	1 (11%)

Key: BAU = business as usual

Difficulties percentages are out of n=5 (treatment group) and n=3 (BAU). Duration and burden percentages are out of n=4 (treatment group) and n=3 (BAU), since one in the treatment group reported no difficulties.

Figure 5: Total Strengths and Difficulties Questionnaire scores at baseline and follow-up (for those with values at both time points)



Key: BAU = business as usual, FUP = follow-up

Figure 5 should be treated with the same caveats as the ABC-I, in terms of assumption violations and low numbers. Results are descriptive only.

Additional outcome measures

The family conflict questionnaire is used by RISE practitioners as part of routine engagement with families. Data for this measure are thus available only for the treatment group. The data extracted from REDCap indicated that although there were data from five families at both time points, four had completed measures at both time points (Table 33).

Table 33: Family Conflict Questionnaire (both time points)

	Session	None	Mild	Moderate	Marked
1. Physical conflict	First	-	2 (40%)	1 (20%)	2 (40%)
	Final	2 (40%)	1 (20%)	2 (40%)	-
2. Verbal conflict	First	-	1 (20%)	1 (20%)	3 (60%)
	Final	-	2 (40%)	2 (40%)	1 (20%)
3. Psychological intimidation	First	-	2 (40%)	1 (20%)	2 (40%)
	Final	2 (40%)	2 (40%)	1 (20%)	-
4. Resistant or defiant behaviour	First	-	1 (20%)	2 (40%)	2 (40%)
	Final	-	1 (33%)	1 (33%)	1 (33%)
5. Conflict outside of home	First	1 (20%)	2 (40%)	2 (40%)	-
	Final	1 (20%)	3 (60%)	1 (20%)	-
6. To what extent does this cause conflict between child and others in the home	First	1 (20%)	2 (40%)	2 (40%)	-
	Final	2 (40%)	3 (60%)	-	-
7. Extent of family conflict present	First	-	1 (20%)	1 (20%)	3 (60%)
	Final	1 (20%)	3 (60%)	1 (20%)	-

The CGI was provided to practitioners in both groups, and completion was requested before and after support was provided to families. This scale is usually used to measure a drug's or other clinical treatment's perceived efficacy. Wording was maintained as far as possible but was modified to reflect that efficacy was being assessed before and after a family-based intervention.

The severity scale was completed for five participants from the treatment group only. It is measured in the first RISE session on a seven-point scale, from 1 "no CAPVA" to 7 "extreme CAPVA". At baseline, the scores were:

- 3 "mild" for two families,
- 4 "moderate" for one family, and
- 5 "marked" for two families.

The improvement scale was completed at follow-up, and in this instance, it was again completed for five participants (treatment group). Four families had measures for both baseline severity and improvement at the final session (the same families for which practitioners had completed the family conflict questionnaire).

Improvement was measured in the final session on a seven-point scale, from 1 “very much improved” to 7 “very much worse”.

Positive results were recorded:

- 1 “very much improved” for two families,
- 2 “much improved” for three families.

The therapeutic effect was recorded for the same five participants as the improvement scale. This was measured on a four-point scale, from 1 “marked improvement, complete or near complete cessation of CAPVA” to 4 “unchanged or worse”.

Therapeutic effect results:

- 1 “marked improvement” for four families,
- 2 “moderate improvement” for one family.

Measures of side effects were also completed for the same five participants as the improvement scale and therapeutic effect. However, there was an error in the database, and one of the items was repeated, overwriting the option for the most significant potential negative side effect. This still left the more moderate negative option, which was not chosen. From the options that were available, side effects were rated as:

- 1 “none” for three families,
- 2 “do not significantly interfere with family functioning” for two families.

Investigations were conducted, and the team tried to understand how the error had not been picked up. Multiple people tested the database before it was released, and it appeared surprising that nobody had noticed the repeated option and that it had not been reported as a glitch when in use by the practitioners. The assumption made is that the error had slipped through, as drop-down lists were provided, and it would only have been if somebody had looked for the most negative variant that they would have noticed a repeat of a more positive option.

Total efficacy used a combination of the therapeutic effect and side effects (Guy, 1976). The practitioners assessed that:

- Three families scored 1 (best score possible),
- One family scored 2,
- One family scored 6.

Measure utility

The conversion rate from referral through to consent is much lower than the 80% desired by the YEF, at around 45%, but this may not be surprising, given that parents/carers are likely to want both the violence to stop and to continue to parent their child. Vulnerable families reaching out for help are likely to find taking part in research alongside their support particularly challenging. Additionally, the majority of referred CYP were reported to be neuro-nontypical, either formally labelled as such or suspected. Some children

were reported to have sensory difficulties, with one CYP reported as very high scoring on the Glasgow Sensory Questionnaire. Four CYP met the threshold for additional follow-up regarding extreme demand avoidance.

Many children might fit a PDA profile, and it is important to be mindful of taking a suitable approach to support them. Challenging behaviours are frequently not defiance but can be better seen as anxiety. How such behaviours are managed can make all the difference. Strategies for managing PDA have been developed by the PDA Society within the PANDA framework. This approach shifts the focus from firm control to collaboration, relieving the underlying anxiety that triggers demand avoidance (PDA Society, 2025). Several of the strategies suggested would fit well within the NVR model:

- Reduce direct demand by avoiding firm instructions such as “do this now”, and use softer, indirect language.
- Offer choice and flexibility, e.g. “Shall we do this first?” Be willing to adapt plans.
- Pick your battles (prioritise).
- Adjust expectations (break activities into small tasks, add more breaks between activities or understand that some days are more of a challenge than others).

The ABC-I shows that, at baseline, significant violence of multiple types was being experienced by families. Although results on this measure are not normally distributed, it does seem well suited to future research, as it is a sensitive test of change over time. Conversely, the SDQ seemed more resistant to change, as the best predictor of follow-up seemed to be how CYP had been rated at the outset. It should be noted that the SDQ is a widely used tool, and it is reasonable to assume that people are used to completing it. It may be that the scale, therefore, becomes less useful in studies where families have grown accustomed to filling it out in a particular way. That said, it has been used in other studies where change has been demonstrated; it may be that for future research, the most salient measures for the person experiencing CAPVA are the level and frequency of abuse.

Additional measures were recorded for the treatment group only; they were all positive, and nobody reported difficulties using the measures. It should be noted, however, that an obvious criticism of the CGI is that it is completed by the practitioner who is implementing the support. Without comparative data from the control/BAU group, it is difficult to assess whether it should be recommended for future research.

Although numbers are very low, the measures seem to have been generally acceptable to those who completed them (also see Table 34 and Table 35). That must be noted in the context of the low response rate and low conversion from referral to consent. It is possible that potential streamlining of materials may enhance participant engagement. It is likely that the SDQ is not sufficiently salient for this kind of research and could be dropped. Although complicated to score, the ABC-I inbuilt weightings may be sufficiently sensitive to change to recommend keeping the measure in future research.

Of the families who completed forms, more CYP were identified as being neuro-nontypical than neurotypical. Provided that these screening measures remain optional, there is useful theoretical and practical information to be gained from understanding the likely sensory and demand needs of the referred young people. The RISE family conflict scale is used in routine practice and was modified to include items from the CGI impression scale. Their combined use seemed suitably sensitive to be recommended for future

research, where the family conflict scale continues to be used routinely. It would not seem sensible to suggest their combined use in other circumstances, as it may increase research burden unnecessarily.

Implementation and process evaluation findings

This section first reports the measures of acceptability made at follow-up, then considers adverse events before moving on to the findings from the semi-structured interviews. In reporting acceptability measures, data are presented in full, as extracted from REDCap.

Additional activity: acceptability measures

Although the numbers completing the acceptability measures are low (as reported in Table 34 and Table 35), the findings are generally positive. Participants could respond to acceptability questions using a 5-point Likert scale, from "I really disagree", the most negative, to "I really agree", the most positive (Appendix J).

Table 34: Acceptability of measures

		Treatment	BAU
Helped me understand	I really agree	2 (50%)	1 (33%)
	I agree a bit	2 (50%)	2 (67%)
	I'm not sure/in the middle	-	-
	I disagree a bit	-	-
	I really disagree	-	-
Time was fair	I really agree	3 (75%)	2 (67%)
	I agree a bit	1 (25%)	-
	I'm not sure/in the middle	-	1 (33%)
	I disagree a bit	-	-
	I really disagree	-	-
Captured family situation	I really agree	2 (67%)	2 (67%)
	I agree a bit	-	-
	I'm not sure/in the middle	1 (33%)	-
	I disagree a bit	-	1 (33%)
	I really disagree	-	-

Key: BAU = business as usual

Table 35: Acceptability: free text comments

Acceptability	Treatment group
It doesn't quite capture the degree of tie verbal abuse or the impact on siblings and how that relationship is relevant too.	Control/BAU
The study has been enormously helpful. Having the time to sit down with my husband the the practitioner to become a team in our approach was what we needed. We were able to look at how our own behaviour and parenting styles were impacting our child's behaviour. Becoming more aligned has brought much more clarity for us all.	Treatment
Helped to identify differences in parenting across care givers and brought clarify and empathy for each other. Therapeutic. At times suggestions could seem frustrating / non achievable, such as implementing boundaries and structure. Hands on, in person support would help implementation easier and give the professional opportunity to identify areas of need and how we can tweak our approach to work best for us and our child.	Treatment
Having a person that is understanding. It was useful to have the sessions in person and material to use	Treatment

Key: BAU = business as usual

Note for Table 35: comments are as typed; no errors have been corrected.

Terminated trial: adverse events

There was only one confirmed adverse event reported over the duration of the study. This was in the BAU group. It was logged as "adverse event recognised"; event risk: "low risk, action taken"; causality: "not related". The report relates to the kind of behaviour that was expected prior to referral to this study. *"[XX} received police referral. Parent locked herself in room due to child's behaviour and called police. In the lead-up, child pushed parent. No report of injury. Child later locked mother out of the house for 3 hrs."*

Additional activity: interview findings

Findings can be usefully considered in three main interview themes that are quite close to the focus of the sections of the interview schedules:

1. Participants' hopes for the study, concerns and the mobilisation phase
2. The different elements of delivery
3. The study's closure, interviewees' reflections and suggestions

Participants' hopes for the study, concerns and the mobilisation phase

The intervention delivery team (comprising RISE management and practitioners) was aligned in hoping that the evaluation would primarily seek to establish a credible, objective evidence base, which demonstrated "*how much NVR can impact families"* (RISE Practitioner #1), with a report that showed they had been *"objectively reviewed"* (RISE Management #3). By evidencing outcomes on families experiencing CAPVA, the evaluation could also be instrumental in securing future funding: "I *mean, my hope was that it would have even more robust evidence base, that it would be maybe more highly regarded in terms of certain academic worlds, certain funders"* (RISE Management #2). Securing future funding could enable RISE to extend its

geographical reach and support more people experiencing this form of family abuse. Additionally, this may contribute to raising awareness of the programme and highlighting the complexities of CAPVA, ultimately so that "*we can stop more violence"* (RISE Practitioner #4).

These sentiments were reiterated by local authority interviewees, who also expressed their hopes that evaluating the RISE CAPVA programme would provide an academic report detailing the efficacy of the intervention: *"I guess it was independently scrutinising and verifying what we [the local authority] think we know already"* (Local Authority Staff #5), thus supporting local authorities in seeking funding for CAPVA programmes: "F*rom a commissioning perspective, it will help me out"* (Local Authority Staff #1) because *"the research would be able to show the value of the programme"* (Local Authority Staff #4).

This meant that the evaluation was considered potentially beneficial to several local authorities that were *"really keen to get involved…especially something so close to our hearts, really, like the child-to-parent violence. We see a huge relevance, and we see it on an increase"* (Local Authority Staff #1). Local authority staff participants #2 and #3 were also "*supportive",* seeing an evaluation as "*beneficial".* However, initial enthusiasm for the CAPVA study diminished when the practical details of the RCT were discussed further. RISE staff, liaising with local authorities to help secure their participation in the evaluation of the RISE CAPVA programme, described the local authorities' reactions to an RCT as increasingly challenging*, "and two or three boroughs pulled out very quickly"* (RISE Management #7), although the barriers were not perceived as being insurmountable:

> *...and there were some people [local authority staff] who were like, "Yeah, that's really good"…referrers who understood CAPVA a bit more…or felt maybe more confident in supporting the families that they had, should they get BAU. Probably generally more okay with it than people who maybe would normally refer in, tick a box, send it over and close the case.* (RISE Management #5)

Some local authorities already had a positive working relationship with RISE, which was (or previously had been) commissioned to provide a CAPVA service to their local authority. The study could create an additional ethical dilemma, particularly if seen as a replacement for a previously commissioned service, *"so what you're saying is, we've already got really good embedded CPV [Child to Parent Violence], but now some of these kids may not get a service because they're part of the test group"* (Local Authority Staff #5). RISE staff also wondered whether local authorities were concerned that an RCT may expose their BAU model to scrutiny*, "for them potentially to be criticised over the lack of service provision within their business as usual"* (RISE Management #2).

Mobilisation meetings were supported by increasing information and attendance at other events from RISE and UH. As delays ensued, these were also supported by evaluation and project staff from the YEF. Nonetheless, an RCT remained an intractable difficulty for some potential areas due to perceived ethical, safeguarding or legal concerns when comparing a specialist CAPVA programme with the varied non-specialist support available as BAU.

> *…I don't feel that an RCT is appropriate…For perpetrators of domestic abuse…if they are not going to be offered anything, but they're still assessed as posing a risk; I see that as poor practice, as dangerous practice and as unprofessional practice…But we also felt that there was a risk to*

> *the local authority in being a part of it [the study] because if something had gone wrong and it had come back that we…That this man hadn't been offered an intervention [the CAPVA programme] because he was part of a[n] RCT, that opens a potential legal world of pain for us, and it's a real safeguarding risk.* (Local Authority Staff #2)

It is worth noting that in this extract the practitioner situated child/adolescent violence within wider IPVA work, e.g. the reference to CYP as "perpetrators of domestic abuse" and a potential referred individual as a "man".

Concerns surrounding participant randomisation were not confined to the local authorities, as RISE management #2 also expressed their initial apprehension, where despite having *"done a lot of work around the ethics of an RCT…How do practitioners feel at the prospect of speaking to individuals and then them being randomised and only some receiving the intervention?"* Some RISE staff were able to reconcile the perceived ethical issues with anecdotal reports from participants triaged by the RISE team and then randomised to the control group:

> *...the measures [safety sheets] that we'd [UH and RISE] put in place for the potential of that family going to BAU [were] really beneficial for them. And if we weren't doing the RCT, they wouldn't have had that at all.* (RISE Management #5)

Nonetheless, there was ongoing ethical uncertainty regarding whether participants allocated to BAU would receive any support, particularly when, "*our local authority doesn't provide any in-house programmes for perpetrating any interventions, so if they weren't going to be offered the CAPVA intervention, they would be offered nothing"* (Local Authority Staff #2). Despite attempts to combat resistance to an RCT, there was a common perception that the intervention worked, and anybody allocated to BAU was being denied support.

> *...how do you judge the efficacy…? We don't know if it's a ten or a one in comparison to nothing...because you're likely going to see some improvement, but it doesn't say how great...I think that the RCT thing, predominantly, was the main issue.* (Local Authority Staff #3)

One local authority interviewee's perspective on BAU seemed to epitomise the general frustration: *"If the intervention could be done by business as usual, I wouldn't need CPV in the first place"* (Local Authority Staff #5).

Site leads felt that lead professionals, usually social workers, found explaining the randomisation process to potential families challenging, particularly the difference in support between the intervention and control groups: "S*ocial workers who were on the front line didn't necessarily fully understand...how the research was going to be conducted"* (Local Authority Staff #4). It was difficult to explain what might happen prior to randomisation, and it might be harder after an allocation had been made, when they needed to tell the family whether they had been allocated to BAU or RISE. This contributed to a general sense of uncertainty about whether practitioners, and consequently families, really understood the study and *"there was some confusion about how it benefited our families overall"* (Local Authority Staff #5).

Interviewees reported that the mobilisation phase was too short and that this increased pressure on everyone involved in the study from the outset, ultimately contributing to the study's early closure because "*it takes so much effort to mobilise these contracts"* (RISE Practitioner #6). When local authorities did agree

to take part, RISE interviewees were disappointed by the complexity of the site initiation process and how long "*the logistics of the sign-up"* took (RISE Management #3), particularly signing agreements to comply with statutory requirements and practices that are normative for clinical and/or social care trials. *"Also, senior managers backed off when they got challenged by other leaders or directors"* (RISE Management #7).

Practically, interviewees from the local authority and RISE delivery team were unsure of who was authorised to sign the study paperwork within the local authorities, creating miscommunication and delays. *"And I think that was probably something I never anticipated, how difficult a process that was for something that I thought was quite simple"* (RISE Management #5).

> *So, I think there [were] a lot of issues with [paperwork]…and with understanding what that meant on our side...because my understanding at first was that I could be able to sign those. But then through more investigation, it became clear that I didn't have…the authority to do so".* (Local Authority Staff #4)

The first stage of study delivery, the promotional work, could not begin until the local authority sites had been officially brought on board, with all initiation documents signed, and the delays *"had a real, big impact on when we were doing that promotional work"* (RISE Management #5). This was particularly difficult when it came to two of the local authorities involved in the feasibility–pilot study:

> *As I said, no one could have had better evidence of the efficacy of our work than the people [local authorities] who we did the feasibility study for, and they hadn't signed after nine months…. We were so hamstrung from the beginning before we could present ourselves to the frontline staff; that was massively a problem".* (RISE Practitioner #4)

The different elements of delivery

The key elements considered in the terminated trial's delivery were study promotion; referrals; family recruitment, including the triage and screening stages; intervention delivery as part of the study; and communication throughout the study. Interviewees commented on what worked well and the challenges encountered at each stage.

<u>Study promotion</u>

RISE interviewees felt that their organised approach to contacting local authority staff worked well, "*that there was a really good plan and structure in place"* (RISE Practitioner #6), namely, attending local authority team meetings, the co-design of promotional materials to produce accessible documents, the video, a Padlet created to host all materials and engagement at roadshows*. "And it was all digitalised, and people could just click on…And people love the Padlets".* (RISE Management #3). Local authority staff acknowledged the time it takes for the local authority to adjust to new concepts and appreciated how promotional materials were presented, although some formats were less well received than others: "*I'm not necessarily sure that everyone really understood how the Padlet worked"* (Local Authority Staff #4).

The main challenge identified at the study promotion stage was that the study coincided with the national restructuring of CSC. This seemed to add to the high turnover of staff within CSC, leading to confusion about whom to contact to promote the study to the referring teams *"because there was so much happening*

internally" (RISE Management #2). A particular challenge was *"making sure we were in front of the right people all the time"* (RISE Practitioner #6) and ensuring that there was sufficient engagement to account for staff churn; *"when we did the road shows and then the follow-up meetings, they just weren't enough and frequent enough…because the turnover was so high with some of the social workers"* (RISE Management #7). The high turnover of local authority staff and the difficulty in "selling" the study to local authority practitioners who may be far removed from site leads were seen as ongoing challenges:

> *I think maybe I underestimated, personally, probably the amount of convincing that needed to be done. Where I just thought, "Oh, well, this is a free service for these, for CAPVA. I know there's a need, so what's the problem?*" (RISE Practitioner #6)

Local authority site leads were tasked with cascading information to their teams but expressed concerns about communicating the study information all the way through the various teams, eventually arriving at the practitioners working directly with families. Similarly, it was clear from RISE participants that the study promotion stage was a long (ongoing) process, initially aimed at senior managers not directly responsible for referring families into the study. *"Then when we have to promote to service managers who don't make referrals, then we have to promote to team leaders, who don't make referrals, then finally, we might, way after the launch, get into the team meetings"* (RISE Practitioner #4). Local authority staff also acknowledged the difficulties in approaching CSC and the additional complexities resulting from the restructuring process, which "*made the whole thing really challenging...Even trying to…understand who were the team managers to be able to reach out to for…RISE to come into their team meetings became extremely difficult"* (Local Authority Staff #4). This was despite the terminated trial being viewed as ***"****nothing out of the ordinary; nothing I wasn't expecting"* (Local Authority Staff #1).

<u>Referrals</u>

Several challenges were mentioned regarding the referral form; these were the length of the form, the amount of information required, the time it would take to complete it and the lack of information received by the triage team: *"But just with all the paperwork that was involved in the referrals, I think that potentially also created a block"* (Local Authority Staff #4). This was despite the form not actually being very much longer than that which RISE usually used:

> *Just as an example, our old referral would have ethnicity, and they would put in what it was. We had the options, so it made it look very extensive, but actually, the questions were the same...And then it was just…the checklist on, have they explained to the family that this is a study?"* (RISE Management #5)

The referral stage highlighted that the local authority referrer did not necessarily have to be (or remain as) the lead professional, although a local authority practitioner still had to be identified and willing to act as the lead professional for the family in the study. The requirement for a lead local authority professional to maintain involvement with the family throughout the delivery phase applied even when the family was allocated to the intervention arm, meaning that the local authorities were the risk holders. This is RISE's usual practice and was an expectation carried into the terminated trial. However, some referrals *"did not detail who the lead professional would be because often the referrer didn't actually know those answers"*

(RISE Management #2). CAMHS referrals were not accepted as part of the study, and this proved challenging for referrers and the delivery team: *"I think it would have been good if we could have also taken referrals from CAMHS. We could have utilised some of the good relationships that we already have with CAMHS in some of those boroughs"* (RISE Practitioner #6).

The randomisation process, and potentially the objections to an RCT, were perceived to be the main contributors to the low number of referrals "*because when I started, [the question] was, 'Why are we having such a low referral?" And they [social workers] said that's that [the randomisation]* (Local Authority Staff #1).

> *We just could not drum [up] enough referrals, I think, which is odd because the CPV, it's been a very high uptake…. Maybe the rationale needs to be simpler, like it needs to be stupidly, simply, blunt…. I'm not sure if I fully got it. I'm not sure if I fully agreed with how it was going to benefit us, selfishly, as a borough. Maybe we could have made that simpler, or maybe someone could explain to me why it is the case.* (Local Authority Staff #5)

Yet the lack of referrals did not coincide with a perceived lack of need for CAPVA support, as *"those same boroughs that were either reluctant to make referrals, or referrals were non-existent, are begging us to deliver the programme"* (RISE Practitioner #4).

<u>Family recruitment (including triage and screening stages)</u>

The main challenge reported by local authority staff during the family recruitment stage concerned conversations that local authority practitioners would be required to have with families to explain the study. In some cases, it was unclear whether the local authority practitioners fully understood the rationale for an RCT and what support families could expect if randomised to BAU or RISE:

> *There may have been the challenge for some of the social workers again to understand how the research would be conducted, about the control group…and to be able to explain that to families with the understanding that there's no guarantee that they would be part of the CAPVA group itself.* (Local Authority Staff #4)

This was even more challenging when the site lead themselves felt ambivalent. "*It's more trying to explain to the staff group the long-term benefits, the broader benefits for our families of CAPVA, partly because I'm not sure I was convinced"* (Local Authority Staff #5). The requirement for a lead professional to remain involved with the family during the study should have been the same as routine delivery for RISE. Yet staff reported that maintaining contact with a lead professional can be challenging; aside from the study, "*the other problem was, which we have in our own programmes as well, is when they see how effective we are – and lots of them do – they want to signpost and close"* (RISE Practitioner #4). The requirement for a lead professional to be in place throughout may have therefore felt like additional work, as "*there were questions raised about this [the study] being an extra, an added, more added to someone's workload when there wasn't a guaranteed intervention at the end of it"* (RISE Practitioner #6).

In contrast, local authority site leads did not feel that adapting their existing role to fit in with the study requirements had any impact on their work, as there was *"not a lot of work really involved from my perspective"* (Local Authority Staff #1), or *"it's not different to what I do anyway with promoting our services"*

(Local Authority Staff #4). As the study progressed, the challenges for the local authorities appeared to relate to the identification of BAU support for families randomised to the control group, "*and it was only when we were with about the fourth or fifth borough…they mapped everything out [BAU support], and it was really good in terms of comms"* (RISE Management #7).

During the screening process, RISE identified that potentially not all families had watched the study video or fully understood that they had been referred to a study. Therefore, at their initial contact, prior to a potential first screening session, RISE reported emailing the study's safety sheet and video to all referred families: *"one of our screening practitioners had said that she'd spoken to a couple of people when it had got to screening, and they had no idea, really, that it was a study",* even though the referrer had confirmed that the study information had been shown to the family (RISE Management #5).

<u>RISE CAPVA programme delivery</u>

RISE staff commented positively on the speed of the randomisation process and the subsequent high engagement levels of those participating in the intervention group: *"Their motivation is quite high because they've done both screening assessments, they've done the measures, and it was only then that they then come on the programme. So, I think they'd committed to so much already"* (RISE Management #5). According to RISE interviewees, the high engagement rate and commitment by participants indicated positive benefits for the families. For example, "*the family wanted to stay for the full 20 sessions, so they obviously found it in some way useful"* (RISE Practitioner #6), or:

> *I built a good relationship with the parents. I think it is really important to this progress…[the parent] was really willing to engage with the programme…really willing to change and to improve the relationship at home. [The parent] took all the strategies into practice…was fully engaged every week…really was committed.* (RISE Practitioner #1)

RISE Practitioners emphasised that delivering the RISE CAPVA programme was their specialism outside the study, although the terminated trial created additional demands: *"Once you've got a family, you're there to stop the abuse. So, I mean the study didn't help us in any shape or form"* (RISE Practitioner #4).

<u>Communication throughout the study</u>

Some of the local authority boroughs commented on their positive working relationship with RISE: *"It's always an easy process…And they [RISE staff] did their absolute best to try and make this work, if I'm really honest"* (Local Authority Staff #4). Good working relationships were mirrored in RISE interviews. Processes that they normally adopted and those adapted for the study embedded multiple routes for communication between teams, as "*all the different local authorities could come together and discuss any issue, share good practice...and with any borough that was a bit hesitant, I was able to speak to them and talk about boroughs who had a good process"* (RISE Management #3).

One of the more challenging areas of communication revolved around the various additional meetings required for multiagency working:

> *So, there's that ongoing attendance from the practitioners to go to TAF [Team Around the Family] meetings or child protection meetings and CiN [Child in Need] meetings. There's a lot of multiagency working…and the professional network around the family [does] become quite involved in what we're delivering*. (RISE Management #5)

It was clear from the RISE practitioners' perspective that communication with the lead professional could be difficult and that they weren't always being invited to relevant meetings: *"But we always, always attend Child in Need meetings and child protection meetings and stuff like that, which is often the only time we will have contact with the lead professional, if the lead professional turns up"* (RISE Practitioner #4). The turnover of CSC staff exacerbated the difficulties in continuity and challenges for the CAPVA practitioners:

> *If we're involved six months, even if the case is staying open and you haven't had to fight to keep a lead professional, even if it was steadily on a Child in Need programme, you can have four or five different social workers.* (RISE Practitioner #4)

Practitioners were asked to identify what could be done differently to avoid similar issues in future studies. They reiterated that communication challenges encountered during the study were not unique to the evaluation but reflected difficulties routinely experienced in their day-to-day practice. "*Maybe it's something that we need to address first before we start the programme with the families"* (RISE Practitioner #1). Local authority staff felt that initial meetings provided insufficient clarity or reassurance about the rationale for using an RCT, and they expressed different opinions regarding how their questions were received and addressed:

> *I got the answers, but it was an explanation, and it was very dry and…matter-of-fact…So, how would you explain to people who have got them concerns? And it…basically repeated what the study does. So, I've been provided with answers, but they didn't, they didn't answer my concerns, in a way.* (Local Authority Staff #1)

> *In layperson's terms, the study and all the terminology and so on was helpful. I think potentially…sometimes I did feel overwhelmed by some of the paperwork and the understanding of things…. However, the [evaluation] team always put time in to explain it and to clarify things. So that was always a positive.* (Local Authority Staff #4)

Upon reflection, it was suggested that clear procedures, prior to mobilisation, for onboarding local authority sites could have expedited the onboarding process:

> *And I think it could have been a much smoother process if it [onboarding process] had been clarified from the beginning that it needs to be a senior manager who is signing and so on. Could have just smoothed it out a little bit.* (Local Authority Staff #4)

Once the study was underway, communication between the evaluators and the local authority sites was smooth: *"I think it was all right, and there's no problems there, and it was quite straightforward. I mean, it's emails, calls, meetings; they're fine"* (Local Authority Staff #5). Communication between the delivery team and the evaluators was viewed favourably by RISE management staff, who were *"just really impressed with the way everyone was really trying to make it work"* (RISE Management #3), with RISE Management #7 going further: "*I think the highlight would be that working in*

partnership with Hertfordshire University and the YEF to consolidate and home in on our treatment model really did help us, and to think about how to effectively evaluate". However, communication between the boroughs was not always smooth, given the mixed attendance/engagement at trial management group meetings. This meant missed opportunities to compare working practices or gain insight into positive working practices and ways to overcome study challenges:

> *I think it would have been helpful to have more consistency from all boroughs in the meetings…so, to be able to have those catch-ups and to understand on a wider scale what the issues were. Because then, like some boroughs had really good ways of…managing those…. I think there were times when I'd go to the meeting and no one else [from other local authorities] would be there.* (Local Authority Staff #4).

The study's closure, interviewees' reflections and suggestions

The immediate cessation of referrals "*came as a shock"* (RISE Management #7) to many involved in the terminated trial, and the curtailed timeline created additional challenges for the RISE practitioners who were delivering the intervention and felt unable to "*pace things and meet families fully where they were"* (RISE Management #2).

Interview respondents spoke about issues that had impacted the delivery of the study and provided suggestions for future studies. This included selecting local authorities, considering their needs, more closely involving local authorities in design, recognising the variety of local authority operational practices, allowing sufficient time for onboarding sites and launching the study, considering the practicalities and time constraints when employing and training new practitioners to deliver the CAPVA intervention, creating a specialist team solely to promote the study, identifying or developing BAU specifically for families experiencing CAPVA and reconsidering the study design.

Recognising that "*each local authority and even teams within the local authority work differently, have different resources, have different capacity, have different needs"* (RISE Management #2) and considering how this could be accommodated within a research study was seen as important. Strategic selection of local authorities most in need was highlighted by RISE Management #3, who suggested that "*if there was maybe some work done in terms of which boroughs most need CAPVA or which boroughs are most struggling, I think that might have helped".*

Closer working with local authorities may have been beneficial, as expressed by RISE Management #7: "*the design phase, we should have got involved with the local authorities then".* When working with local authorities, study teams need to allow plenty of time and adopt a flexible approach "*because things take a while to get a head of steam, I think, in local authorities, particularly in statutory social work teams"* (Local Authority Staff #5). Local Authority Staff #4 also highlighted the need for "*more time to, or more meetings to understand like the nitty-gritty of it".*

The mobilisation phase was seen as a lengthy and "*complicated process"* (RISE Practitioner #6) by the delivery team and the site leads. It was felt that a simpler process with an agreed launch date would have helped "*to get the onboarding to happen at the same time".* (RISE Management #5). The timeline was a problem for RISE practitioners, who noted that "*the short-termism of contracts makes it difficult to recruit*

people and retain people" (RISE Practitioner #4). It was challenging to recruit and then train people who could promote the study; as RISE Practitioner #6 highlighted, "*It's just a lot, a lot to condense into a small amount of time".* Recommendations were suggested to reduce the pressure on the RISE CAPVA practitioners to promote the study, enabling them to focus on the programme and instead having "*a few people who are just designated to that role of…knowing the study inside out and going around to teams and speaking to them constantly"* (RISE Practitioner #6).

BAU was seen as a significant hurdle, with suggestions to develop specific "*alternative resources"* (Local Authority Staff #1) for the comparison group. Some people not getting "*that specialised service [RISE CAPVA programme]"* (Local Authority Staff #5) created tension for practitioners, particularly when they were already used to working with RISE and/or in areas where some services were referring to the terminated trial and others directly to RISE. RISE and local authority interviewees concurred that a future evaluation should consider using an evaluation method other than an RCT. Some respondents were unclear about why an RCT design was chosen and felt that it could never work for this research question, with a quote from Local Authority Staff #2 summing up concerns: "*I don't feel that a randomised control[led] trial is safe or professional or appropriate in this situation".*

Interviewees highlighted that alternative models to the traditional RCT would need to be considered in future, as "*different methods of evaluation might be able to work on the ground"* (Local Authority Staff #3). The BAU condition was not felt to be an appropriate control group, with interviewees highlighting that it was too variable across different local authorities. It was not viewed as a comparable intervention, with Local Authority Staff #2 stating, *"If you want to say, 'Does this intervention work?' You have to assess it against another [CAPVA] intervention, rather than against nothing because any intervention is going to work".* That extract also reinforces the possibility that there was limited, if any, recognition that an intervention might have no effect at all, or indeed might be harmful, despite attempts to explain these concepts clearly to local authority site leads and other staff. Comparing the RISE CAPVA programme against another intervention was felt to be more able to explore "*the difference it's making"* (Local Authority Staff #3). Alternative comparisons were also suggested, such as "*a historical experimental model or a quasi-experimental model or a geographical"* (RISE Management #7).

Reflecting on the CAPVA study, interviewees maintained that there was a need for a CAPVA intervention embedded in local authorities, both because of an "*increased need"* (RISE Management #2) and because of a perception of programme efficacy:

> *So, I could see when we started the programme, and the risk was medium. And I think when we finished, it was, I could say…I can't say no risk at all, but it was really, really low risk, but no violence at all, no aggression.* (RISE Practitioner #1)

In line with this, local authority staff who had participated in the study as site leads believed that their local authorities would consider taking part in another evaluation of CAPVA if one was to be commissioned in the future. They were keen to learn and support families, with Local Authority Staff #5 reflecting, "*Anything we can do to help, I think we would"*.

Summary of implementation and process evaluation findings

Initial enthusiasm from RISE and local authority staff often centred on the hope that an evaluation would demonstrate the effectiveness of the programme. Additionally, there was a perception that the study itself would result in enhanced awareness of both CAPVA and ways to address it. The clear expectation was that this would lead to additional funding and provision of services. Enthusiasm waned once details of the study emerged and questions persisted concerning the evaluation method.

Key concerns voiced included:

- RCTs were seen as fundamentally unethical.
- An RCT design raised additional safeguarding concerns.
- A real-world efficacy trial was ultimately viewed as not suitable within the study, given the wide variety of BAU support available – a concern not assuaged by the ongoing involvement of a lead professional and the provision of the safety sheet for all families.

These concerns were common across local authorities, although they were somewhat ameliorated within the senior teams of those local authorities that were onboarded.[3] The findings of these interviews echo discussions in trial management groups centring on concerns about an RCT in general and of the study in particular; challenges were clearly present by the time referrers were being asked to explain the study to potential participating families and worsened with the high staff turnover.

Findings from both acceptability measures and interviews indicate that there is an acknowledgement of need in the families experiencing this violence. There is also willingness to engage in research to test the efficacy of the intervention. It should be noted that families responding to acceptability measures will have been those that consented to take part in the study and then agreed to respond after they knew that the trial had been discontinued. This is nearly all those that were assigned to the intervention arm of the trial. Although referred families that chose not to take part in the study were asked why they did not wish to take part (Appendix G), no answers were forthcoming.

Turning to the practitioners, it was clear that there was considerable goodwill and several constructive suggestions were made about ways to conduct future research. The interpretation will discuss these ideas and elucidate recommendations associated with the process aspect of this research. A summary of recommendations will be provided in the conclusions and recommendations section.

Implementation and process evaluation interpretation

To successfully deliver an RCT requires several key features to be present. Of most relevance to this report are the principle of equipoise and the belief among practitioners that an RCT was not ethical in this context (Donovan et al., 2014). This belief was successfully countered in several sites, as demonstrated by their engagement with the study (see also Intervention referral). Nonetheless, resistance to an RCT persisted, and

[3] It should be noted that these concerns were present despite extensive attempts to counter resistance to RCTs (see Intervention referral)

questions remained in onboarded sites as well as in local authorities that were not onboarded. This resistance could be understood as being based on conclusions reached, not in the absence of discussion about the value of RCTs but despite such discussions.

Equipoise assumes that the intervention being tested does not have sufficient evidence to show that it is more effective than the comparator/control. Yet the test intervention must sustain sufficient belief among key staff that there is at least the possibility that it will not cause more harm than the control condition. The challenge comes when key staff believe that the test intervention is a better alternative intervention for study participants, despite the lack of definitive evidence, creating an ethical and moral dilemma for staff who have an imperative to offer the best treatment available to the people they support. This challenge can be further compounded when no alternative intervention suitable for a control is easily available. An additional layer of complexity might occur when the services involved may not be familiar with research in action, the need for random allocation (often to interventions with perceived differences in value) and how research governance is designed to protect study participants from harm.

Difficulties engaging services and interviews with staff indicate that common areas of resistance to an RCT were present in this study. These are not unique to the CSC and have been documented in education (e.g. Oakley, 2006), international development (e.g. de Souza Leão and Eyal, 2019), medicine (e.g. Benson et al., 1991), public health (Macintyre, 2011; Macintyre and Petticrew, 2000) and social care (Dixon et al., 2014). Resistance to an RCT had been foreseen, and sustained attempts were made to counter it (see also Intervention referral). Although somewhat successful, it must be acknowledged that even among the practitioners working to provide the intervention, some ambivalence remained, and, in at least one onboarded local authority, key staff were sceptical that the study design was ethical. This was on the basis that the RISE intervention was perceived to be better than the support being provided, thereby rendering the trial unethical, in their view.

BAU as the control condition: In co-production, the study team spent considerable time considering what the control intervention might be. Given that the services involved were receiving referrals for CAPVA, it was assumed that most, if not all, would have some viable alternative intervention to offer. As the study sought to recruit from a range of different social care services, all of which have limited funds to support new initiatives and many of which would be unlikely to agree to implement a specific, potentially costly intervention that would otherwise not be incurred to support a clinical trial, the most plausible solution was considered to be BAU. BAU is defined here as the intervention that these families would normally have been offered in the absence of the terminated trial.

A significant challenge was that many staff did not believe that BAU was a viable alternative treatment option for families that were in desperate need of support. This placed the staff in an impossible moral position of telling families that they would, in effect, not be receiving appropriate support if they were allocated to the control condition. These staff also tended to believe that the RISE CAPVA intervention would be superior to any currently available intervention, compounding their dilemma in recommending the trial to families referred to them.

While staff might have accepted a situation where they could have offered an alternative, despite believing that RISE CAPVA was superior, the default design was challenging. The staff did accept the idea that evidence

(despite believing that the intervention was superior) was needed to persuade services to invest in scaling up delivery of the RISE CAPVA intervention to this group of families. Yet relying on BAU was not seen as a viable alternative to the RISE CAPVA programme by key staff on the ground. The lack of an alternative provision may have reflected the routine difficulties practitioners felt in supporting this group of families that the terminated trial brought into sharp relief. One of the barriers to recruitment was thus the perception that the study design lacked equipoise. That perception seems to have been a key contributor to low referral rates and therefore early termination of the study – with a reversion to BAU without any additional safeguards that had been provided by the study (the safety sheet and requirement for an ongoing lead professional within the local authority).

Ongoing concerns about BAU were first flagged within the feasibility–pilot evaluation, and during co-design, work was undertaken to identify what happened in boroughs for a real-world comparison. The potential provision of an active control was considered but ultimately rejected. Nonetheless, safeguarding concerns were at the forefront when developing materials, and this was why the safety sheet, with practical tips on what could be done by parents and carers facing violence from their child/the child in their care, was formalised as part of the minimum requirement for engagement. It was also the key reason for ensuring that a lead professional maintained involvement.

Some local authorities developed leaflets to document the usual support they offered to families experiencing CAPVA, which were positively received by RISE's screening team and assisted staff in explaining to families the support available from the local authority if a prospective participating family was randomised to the control group. Over the course of the terminated trial, most RISE staff and some local authority staff recognised the benefits of referring families to the study, even if they were randomised to the BAU group. Discussions with RISE staff during the screening sessions and support from the family's local authority lead professional to view and discuss the study video and safety sheets were documented positively and would not have been possible without the terminated trial.

Additional challenges reported by the interviewees included:

- The complex and time-consuming mobilisation process to bring local authority sites on board
- Difficulties with the ongoing promotion of the study
- Completion of the referral form and the identification of a lead professional and/or BAU
- Local authority staff's concerns over difficult conversations with families in explaining the study and ongoing communication challenges for RISE to reach "front-line practitioners".

The uncertainty over which local authority staff member had the authority to sign the onboarding paperwork and the time it took to mobilise a local authority study site were complicated by the national restructuring process involving CSC, which, in turn, exacerbated the high turnover of staff, notably among social workers.

Some issues, although relevant, were not specific to the study. Completion of the referral form was thought to be problematic, although local authority interviewees (especially those who had worked with RISE previously) were unperturbed. Concerns with identifying a lead professional were raised during the referral and triage stages, but interviewees reported more issues with retaining the lead professional once a family had been randomised to a group.

The study relied heavily on local authority referrers and lead professionals speaking to parents/carers first and explaining the study (and the randomisation process). Local authority interviewees discussed practitioners' difficult conversations with families as an additional pressure, despite the various support materials provided and the routes for practitioners and potential participants to reach the evaluation team. This is less surprising given the finding that both RISE and local authority staff felt it was unlikely that frontline practitioners had fully understood the terminated trial. It is difficult to see how initial information about the study could have been otherwise provided, as, without consent to share their details, nobody outside the local authority could talk to the family, and consent could not be obtained unless the study was explained to them.

The ongoing involvement of the lead professional became more of a challenge than initially understood by the evaluators. Lead professionals were considered a routine part of RISE delivery and BAU. This would typically be a family social worker, although other lead professionals were expected. It became apparent that the grantees experienced regular challenges in maintaining lead professionals' involvement with families, as the perceived preference was characterised as being to refer onwards and then close the case. This can be noted both as a challenge and a potential enhancement that was provided within the BAU arm of the terminated trial: if there was routinely nowhere to refer to, cases may otherwise have been closed.

Following the early closure of the trial and a move to wind down, the scope of remaining evaluation activity was kept tight. Consequently, local authority lead professionals (frontline practitioners) were not invited to interview. This means that this report cannot consider their views about holding the cases, nor can it consider how initial referrers felt about the terminated trial. For example, some practitioners may have tried to push the study in the hope that a family would have a chance of gaining some intervention that they otherwise would certainly not have been able to access, whereas others might have tried to steer families in different directions in the knowledge that families might be randomised to the control group. Local authority staff interviewees (who were involved in the evaluation) did concur that referral rates were lower than expected – given the increasing number of families reporting CAPVA. This suggests that referring to a study, not an intervention, is likely to have been an issue. Another limitation is that none of these ideas could be discussed directly with the families, as they were also left out of the additional activity commissioned.

To those outside the terminated trial's management, the YEF's decision to cease funding and close the study early was sudden, swiftly implemented and unexpected. The very tight timeframe for closure meant that programme delivery had to be adapted, with the frequency of sessions being increased and the minimum number of sessions overall being seen as the target for some families rather than the minimum threshold postulated for therapeutic effect. Nonetheless, by the end of the delivery phase (February 2026), all intervention arm families had completed the minimum session number, usually more.

To summarise, the primary objection to the RCT was that families in the control group were unlikely to receive an intervention that was specific to the CAPVA they were experiencing, as BAU often did not provide that support. Local authorities that felt unable to support the CAPVA study and that decided not to participate in the RCT cited the evaluation as unethical and a potential safeguarding risk for families. Generally, local authorities that did participate in the study still felt uneasy at the prospect of an RCT and the fact that some families experiencing CAPVA would not receive the intervention if randomised to the

control group. This is despite the reality that, if the local authority did not offer a CAPVA intervention as part of its BAU, there would be no opportunity for families to receive any CAPVA intervention.

The number of sites, individual teams within local authorities, challenges reaching potential referrers, the need for local authority lead professionals, the national restructuring of CSC, the high turnover of local authority staff and the variation in BAU complicated the mobilisation and promotion stages, delaying the onboarding of local authority sites and the recruitment of families. Even so, interviewees concurred that there was a need for a CAPVA intervention embedded within local authorities because reported cases of CAPVA were increasing.

Despite their concerns, the site leads interviewed felt that their local authority would participate in another study to evaluate CAPVA. Recommendations were suggested by most interviewees (from RISE and local authorities) for a more successful future evaluation and included ensuring that there was a clear control/BAU referral route, moving away from an RCT, taking more time prior to mobilisation, mobilising all boroughs at once, ensuring early local authority involvement in mobilisation and reducing the number of boroughs involved, with a related suggestion of targeting support to those local authorities most in need of a CAPVA intervention.

An obvious control group: suggestions were made to ensure that each local authority borough had a BAU model to support families experiencing CAPVA, preferably a model that incorporated some form of CAPVA/CPV/behavioural change intervention. However, this may be impractical for many boroughs due to financial and resource constraints. Therefore, interviewees concurred that other evaluation methods should be explored when considering a future evaluation of CAPVA.

Moving away from an RCT: this evaluation was intended to be a real-world test of a relatively novel intervention against BAU. An RCT is often seen as the best way to do this, since this design is considered the gold standard for studying causal relationships, as randomisation eliminates much of the bias inherent in other study designs, but it is not the only approach possible. The YEF has distinct approaches to efficacy trials and seeks to compare interventions funded across the whole work of the endowment, requiring the use of as many of the same measures as possible (e.g. the SDQ). There is also a commendable desire to ensure that findings are as robust, transparent and accountable as possible.

In clinical settings, RCTs are still seen as the best way to achieve these aims, and, increasingly, RCTs are becoming more common within social care and other policy domains. Ethically and professionally, the conditions for conducting an RCT were met, most notably the condition of equipoise, i.e. uncertainty as to whether the intervention would be more or less effective than BAU and/or whether it might also have unforeseen negative consequences. The feasibility–pilot phase had not tested randomisation, and this was flagged in its report as a potential area of concern (Adler et al., 2023). When designing the terminated trial, it was recognised that there may be some resistance to an RCT. The nature of an RCT was considered in great depth during the co-design phase, and materials were provided explaining the principles under which an RCT can run. These were sent to RISE for initial discussions with potential local authorities and were used by both teams as the study progressed. Videos and promotional materials were developed for families and for practitioners; RISE and UH staff attended meetings, training sessions and roadshows. The YEF YAB fed into the design of bespoke materials, both for promotion and the research itself.

Several of the RISE managers and practitioners interviewed for the additional activities were part of the co-design phase. Yet these interviews show that for some, within RISE and the local authorities, there was a fundamental belief that persisted despite all attempts to the contrary: anybody placed in a control group was being denied an intervention that worked. For practitioners working in RISE, the potential dissonance of being told that efficacy testing involves the assumption that the intervention they were delivering may have been no better or potentially even worse than alternatives must have been difficult, and the necessary neutrality for being involved in a study was thus challenging. For local authority staff faced with uncertain alternatives for families in real need, it is understandable that they may have felt it was the intervention or nothing. That this reflected usual practice may have been little comfort for practitioners trying to do their best for families. So, should an active control have been implemented and/or should the baseline for BAU have been higher than the lead professional and safety sheet?

The lack of perceived equipoise: there are two ways to address the lack of perceived equipoise. The first is to address the design of the study, and the second is to improve engagement with key staff on the ground to address their concerns directly. The main concern of most staff was that BAU was not sufficiently robust to stand up as a viable alternative in comparison to the RISE CAPVA intervention. It remains an open question whether a standardised alternative to BAU could have been agreed that would not have been a significant barrier to engagement by services that are hard pressed for resources. Without a change to the design of this kind, it is not clear that any training would have changed the perceptions of the relevant staff sufficiently for them to agree to recommend the study to families.

Alternative study designs:

Cluster randomised controlled trial designs*:* an alternative to modifying the control intervention is to move to a cluster design, where the families referred for support receive the intervention based on whether the service is allocated to deliver the intervention or control (Andrade, 2022; Kim, 2023). While this removes the moral and personal dilemma for staff managing families referred to them, the services would still need to be persuaded to engage in the study, given that they may not be allocated to the intervention. This problem could be somewhat addressed by offering training for the intervention to non-intervention services after the study has completed. Alternative cluster designs, such as a stepped-wedge design, allow all services to implement the intervention at different times (depending on the step sequence to which they are allocated).

Quasi-experimental designs: alternative designs could include cluster trials without any randomisation. While this might be appealing to local authorities, the ability to randomly allocate families at some level (e.g. clusters) remains plausible, negating the need to consider this type of design. Additionally, the lack of randomisation could lead to selection bias and may increase the chance of unmeasured confounding variables being non-uniformly distributed throughout the clusters.

A concern relating to designs beyond individual studies is that they are considered to provide evidence that is less robust by the so-called levels of evidence principle (Critical Appraisal Skills Programme, 2024). This distinction persists in the face of considerable evidence that traditional randomised trials provide evidence with limited relevance to real-world settings and is partly why a process evaluation had been specified and

embedded within the terminated trial. Other authors have developed a range of experimental methods, including pragmatic trials (Capili and Anastasi, 2025) and hybrid designs (Curran et al., 2012).

The IPE suggests that another trial based on individual family randomisation is highly unlikely to succeed, given the level of scepticism found. A pragmatic alternative would be to move towards cluster-based randomisation, which, if designed well, could provide robust evidence for the effectiveness of the intervention. For studies such as this, where the intervention for a family is discrete, a stepped wedge RCT could be a viable alternative. As with most cluster designs, this may require larger sample sizes than for an individualised RCT. However, developments such as simplified consent (which is recommended) make recruitment into a study more straightforward, with potentially fewer families declining to participate (Health Research Authority, 2020).

Local authority early involvement in mobilisation: including local authorities from the design phase and throughout a future study would be another way of improving mobilisation. The two areas that referred most consistently during the feasibility and pilot phases of this evaluation declined to take part in the terminated trial despite ongoing good relationships with RISE and significant input from all parties to try to make it work for those local authorities. Nonetheless, some steps could still be considered to engage local authorities early in potential future research.

In most potential areas, preliminary meetings could identify named primary and secondary senior managers, site leads to oversee paperwork and teams supporting families on the ground, thus proactively managing potential changes in site leads or lead professionals. Initial meetings could delve into the common questions raised during the interviews and have processes in place to determine (a) who is responsible for a specific task, (b) how long a process will take, (c) how many people are required in each local authority/team, (d) who the main contact(s) is/are for the delivery and evaluation team and (e) what information practitioners need to relay to families. Determining the answers to these questions before the start of the study could aid clarity and consistency across boroughs, reducing confusion and saving time.

Targeted support: some of the interviewees suggested focusing future research in a more targeted manner, identifying specific areas for implementation within and/or across local authorities. From an evaluation perspective, this kind of a targeted approach feels difficult to recommend, as the initial literature search and previous scoping exercises indicated that although the extent of CAPVA is hard to assess accurately, it seems to occur across local authorities, often within pockets of deprivation, but not always (Brennan et al., 2022). Also, low referral rates were the reason for the early termination of this trial, and restricting the potential referral population feels counterintuitive. Nonetheless, evidence of need may be increasing, and focusing study delivery could be further considered in future research.

Re-situating the research within violence against women and girls: another potential way to narrow the focus would be to consider whether a study could be situated within domestic abuse, rather than family support. This would be contentious, and several families would potentially resist this conceptualisation of their children. However, it is noted that practitioners were talking about the intervention in these terms within the interviews. This acknowledges that at 16, CYP can be held legally accountable for domestic violence under the Domestic Abuse Act, 2021, and that CAPVA is abuse within the home/family. It would mean that research would only be possible with over-16-year-olds, but that would also permit young people

to consent for themselves about whether to engage in the intervention and/or research. Yet where early intervention can be made, it is generally more successful, and this suggestion would mean that CYP under 16 would be much harder to incorporate within research; thus this suggestion will not be carried forward into the final recommendations.

Conclusion and summary of recommendations

In answering the three questions posed for the additional activity, a summary of the critical findings and main recommendations made within this report are provided below.

1. What were the reasons this trial could not be delivered as planned?

The terminated trial mobilisation phase coincided almost exactly with the launch of the national restructure of CSC, and timelines had not been mapped against the associated activity. Another powerful reason that the study failed to recruit was the lack of perceived equipoise between the treatment alternatives. Some staff were unwilling to recommend the study to families, limiting the scope for recruitment into the study. Yet it should also be noted that at the time of termination, after 10 months of persistent engagement, relationships with several local authorities were developing smoothly. The evaluation team saw consistent engagement from senior leads attending trial management groups, and some practitioners were making multiple referrals. Although this came later than desired, it does suggest that progress was being made.

2. What are considerations for the YEF to deliver a similar trial in the future?

Understanding the complexity and embedding the necessary time to mobilise complex research in environments where staff are not used to supporting research would help raise the chances of success. However, providing training to the staff on the importance of individually randomised trials and the protections in place through governance and ethical scrutiny was insufficient to persuade them to change their view on the ethical and moral concerns they identified. Taking longer over each stage feels necessary but not sufficient. The preferred alternative is to move towards a cluster randomised approach, which, with careful design and consideration, could produce robust evidence on the effectiveness of the RISE CAPVA intervention.

3. What would it take for local authorities to be involved in a similar trial again?

The onboarded local authorities would have continued with the trial as originally constituted. For others, moving away from an individually randomised trial seems to be the critical point. There are multiple areas that could also bolster future studies that have been posited within this report and are now provided as a summary, concluding list of recommendations, across all three of the additional research questions:

1. If substantive changes are proposed between the pilot and efficacy trial, extend the pilot or build in an internal pilot to the trial.
2. Take longer over mobilisation, assess trial timelines against wider policy plans and scale up gradually.
    a. Take a strategic, jointly agreed approach to mobilisation – clarifying responsibilities, prioritising early engagement with senior service leads and ensuring shared oversight, including dedicated project management capacity within all study partners.

    b. Minimise the additional administrative burden for practitioners “on the front line”, and, wherever possible, try to map materials to practices and/or assessments that will be familiar.
    c. Ensure that capacity within research sites is clearly considered and supported as far as possible.
    d. Drop the SDQ, unless it is already being used by the relevant services, but keep other measures, focusing on the ABC-I for outcome measurement, keeping the sensory and EDA measures as optional for management/intervention support. Consider adding/keeping the CGI where practitioner assessments are already being made.
    e. Employ at least one person for screening only for the study, to be employed by the study team but trained by RISE. As much early information as possible for referring practitioners and families should come from the study team and inform them about the study as a whole.
3. Identify a broader group of team managers, below site leads and across different recruitment pathways, as soon as possible to better support consistent cascade into practice and strengthen referral routes;
    a. Assist any potential research sites in identifying necessary signatories and gaining in-principle approval as part of initial research planning.
    b. Involve sites in early co-design, ideally as part of research grant application processes.
    c. The study team should keep logs of referring and/or assigned lead professionals, ensuring the delegation of duties logs initiated by site leads are supplemented and updated as promptly and as completely as possible.
4. Reconsider whether a lead professional is always needed, given the preference to refer and close cases. It should be noted, however, that this would have consequential implications for organisational risk and potentially require additional legal review.
5. Consider a direct comparison against current alternative provision, but only where such provision can be clearly identified, conceptualised and acknowledged as such within sites, i.e. if BAU is minimal, do not attempt a comparison.
6. Build in direct contact from the study team with families who have consented to take part, helping to encourage engagement and reinforce that both arms of a study are important. Encourage as much joint communication as possible, seeking to hear from as well as talk with families, potentially facilitating/drawing on existing family engagement groups.
7. Consider a wider range of research sites, for example, specific CAMHS. Although this would add complexity and require gaining NHS approvals, it would permit drawing on CAMHS research and development teams, where service staff are more familiar with research.
8. Design and implement a cluster randomised study.

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Appendices

All participant facing documentation created specifically for the terminated trial or additional activity is included within the appendices. Contractual information, site on-boarding documentation and standardised measures (e.g. the SDQ) are not included. Materials are presented here with the wording used during the evaluation activity. Any references to a "learning report" refer to this document.

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Appendix A: CAPVA Study Family Recruitment Leaflet

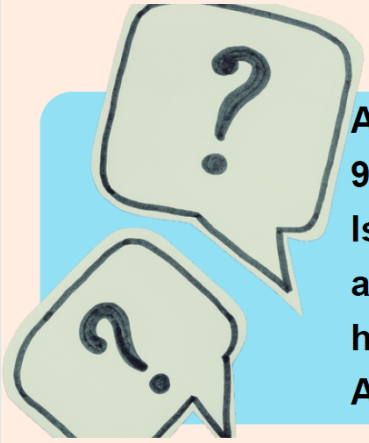
University of Hertfordshire UH

CAPVA STUDY
UNIVERSITY OF HERTFORDSHIRE

RISE TRANSFORMING LIVES

COULD YOU BE PART OF RESEARCH?

We are looking for parents or carers to take part in a study about child to parent violence and abuse. It aims to find out what support does and doesn't work, to help your family and other families in the future.



Are you a parent or carer for a child aged 9-17?
Is your child struggling with their feelings and behaviours and causing harm in the home?
Are you interested in taking part?*

Have any questions? Please get in touch!



Email a member of the study team: CAPVAstudy@herts.ac.uk



Phone or email the trial manager: 01707 286466 or c.cresswell@herts.ac.uk.

* **If "yes", please tell your family's practitioner. If they work for one of the boroughs supporting the study, they will send a study referral form on your behalf.**

To find out more,scan the code or visit www.go.herts.ac.uk/RISE-CAPVA-efficacy-study

Appendix B: Information Sheet for Local Authority Referrers

University of Hertfordshire UH

CAPVA STUDY
UNIVERSITY OF HERTFORDSHIRE

RISE TRANSFORMING LIVES

SCAN ME

The RISE CAPVA Study
Information Sheet for Local Authority Referrers

Randomised Controlled Trial (RCT) of the Child and Adolescent to Parent Violence and Abuse (CAPVA) programme run by RISE Mutual CIC.



What is the study about?

The RISE CAPVA Randomised Control Trial (RCT) will evaluate how well a new programme works to reduce Child or Adolescent to Parent Violence and Abuse (CAPVA) when compared to usual support for CAPVA.

The RISE CAPVA programme (delivered by RISE Mutual CIC) works differently from other types of support and by comparing it to usual support we aim to find out what works best for families experiencing CAPVA.

The RISE CAPVA Study is being evaluated by the University of Hertfordshire (UH) and is funded by the Youth Endowment Fund.

What does the study referral process look like?

The study will be receiving referrals from 8-10 local authorities until January 2026.

A practitioner in contact with a family experiencing CAPVA will explain the study using UH recruitment material and gain their verbal consent being making the referral.

If a family is eligible and decides to take part they will be randomly allocated by computer to either of the study groups below. It's like a roll of a dice!

RISE CAPVA group

Families will receive:

- **Up to 18 CAPVA programme sessions.**
- **Sessions teaching non-violent resistance (NVR) techniques to help change young people's behaviour.**



or

Business as usual (BAU) group

Families will receive:

- **The support normally available in their area.**
- **Support of a lead professional**
- **A RISE Safety Sheet containing NVR techniques.**

But why will only half receive the programme? By randomly selecting participants to one of two study groups, we will be able to evaluate whether the CAPVA programme makes a difference to families above and beyond the usual support available.

What do LAs need to do before they can refer families to the RISE CAPVA Study?

Please see the step-by-step guide below.

1 LA Site Lead and 'Capability & Capacity'

What is a site lead? They are usually a service lead within children's social care who acts as the main point of contact with UH and RISE. They help raise awareness of the study in the LA, identify referral pathways and cascade study information to practitioners. They will arrange for a senior lead to confirm LA Capability & Capacity (C&C) to deliver the study.

What is needed? A signed site lead statement and confirmation of C&C.

2 LA & RISE Sign Information Sharing Agreement (ISA)

How will we make the referral? The study referral form will be emailed to RISE, who will process the data for the study's purpose. The referral form contains a family's personal data and information about their service status and difficulties.

What is needed? A signed ISA by the LA and RISE.

3 Online Study Site Initiation Session

What is this? A site initiation will delivery training in study processes (e.g. informed consent and safety of participants) and timelines.

What is needed? A site initiation and training confirmation document is signed.

4 Delegations of Duties Log

What is this? The delegation of duties log lists those involved in supporting study processes (e.g. the site lead and a team manager in a referral team). They will be added to the UH SharePoint Investigator Site File (ISF) containing useful study documents.

What is needed? A delegations of duties log is signed and the site lead confirm ISF access.

5 UH Ethics Documents

What is this? The site lead and others with delegated duties will have access to documents confirming ethical approval has been received from the UH ethics committee.

What is needed? A review and approval of UH ethics document signed by the site lead.

6 The LA is 'activated' - referrals can be made to the study

A letter confirming activation is emailed to the site lead and RISE.

If you have any further questions about the study set-up process in your local authority, please contact the trial manager, Dr Caroline Cresswell, via telephone 01707 286466 or email c.cresswell@herts.ac.uk.

The CAPVA Study Participant Information Sheet for Parents & Carers (full version)

Full title of study: Randomised Controlled Trial (RCT) of the Child and Adolescent to Parent Violence and Abuse (CAPVA) programme run by RISE Mutual CIC

1. Why am I invited to take part in this study?

Introduction

You are being invited to take part in a study about child to parent violence and abuse (CAPVA). This study will involve comparing different types of support that are provided to families experiencing CAPVA. You are receiving this invitation as a practitioner has spoken to you about the study and a referral has been made about your child or the child in your care. This study is designed to understand what does and doesn't work, to help your family and other families in the future.

The study is funded by the Youth Endowment Fund and is comparing support provided by RISE Mutual CIC (RISE) with different types of support offered by your local authority. The research is led by the University of Hertfordshire (UH).

Before you decide whether you want to take part in this study, it is important that you understand what the study is about and what to expect if you join it. Please take the time to read the following information carefully and discuss it with others if you wish. We know this document is quite long. It is important that you have all the information you need before deciding to take part.

Questions 1-14 explain what is involved in taking part in the study. Questions 15-22 focus on confidentiality, what happens to your data, how it will be protected and how to contact the research team. Our contact details are on the last page, and we will be happy to answer your questions.

If you wish to view video and summary versions of this information beforehand, please visit:

www.go.herts.ac.uk/RISE-CAPVA-efficacy-study or scan the QR code below:

You are invited to take part because you are a parent or carer of a child aged between nine and 17 who is struggling with their feelings and behaviours. We want to know how best to support families whose children are being violent or abusive. A practitioner within your local authority has spoken with you and referred you to the study, as you may be eligible to take part.

2. Who is funding this study?

The study is funded by the Youth Endowment Fund (YEF), a charity established in March 2019 with a purpose to prevent children and young people becoming involved in violence. To fulfil this purpose, YEF fund projects and evaluations to find out what works in supporting children, young people, and their families, who are impacted by violence. Please visit https://youthendowmentfund.org.uk/ to read more.

3. What is the purpose of this study?

The main purpose of this study is to evaluate the CAPVA programme developed by RISE by comparing it with the support that is usually available where you live. The CAPVA programme run by RISE works differently than some of the other types of support offered. Before the RISE programme is used more widely, it is important to understand whether it is helpful and what it is like for families who engage with it. So, this study will test whether the CAPVA programme leads to reductions in challenging behaviours from young people.

It will also be important to understand whether support from RISE is more effective than other kinds of support that are offered. So, we need to compare the RISE programme to the other types of support available through your local authority. For the study, we refer to the other types of support as 'business as usual' or BAU.

Half the eligible families who agree to take part in the study will be randomly allocated to the usual support, the BAU group. In the BAU group, families will receive the support normally available in their area. The other half will be randomly allocated to receive the CAPVA programme. Following up with families from both groups, for around a year after initial referral, will let us find out if the support they receive makes any difference.

4. Why will only half of those taking part receive the RISE CAPVA programme?

Some previous research shows that the RISE CAPVA programme is promising. However, there has been no research that compares it to existing practice. It is important not to invest money in any programme without understanding whether it is going to make a real difference and without being sure that differences are for the good. By having two groups, with each group randomly selected to either attend the CAPVA programme or to receive the usual support, we will be able to see whether the CAPVA programme makes a difference to families.

We know it can feel disappointing to sign up for a study like this and then find out that you are in the group that will not be offered a new form of support. It is important to remember that you will

be offered the support that other families in your area would normally be getting. Also, by taking part in this study, you will be helping all of us to learn what helps to reduce CAPVA the most.

5. Do I have to take part in this study?

No, you don't. It is completely up to you whether you would like to take part in this study. If you do not want to take part in the study, you don't have to. Although we would like as many people as possible to take part, your participation in the study is completely voluntary. Even if you do decide to take part, you can still choose to withdraw from the study or from the support that you're receiving, at any point.

6. What will happen if I do not take part?

If you decide that you don't want to take part, then the lead professional working with your family will still work with you as they would normally. You will not be screened for potential suitability for the study and your experience of usual support will not be included in the research.

7. Are there any other restrictions that might prevent me from participating in this study?

The CAPVA programme is designed for families of children and young people aged nine-17 who display verbal, financial, physical and/or emotional means to exert power and control over a parent/carer. When a family is referred to the study, they will usually work with a RISE practitioner across two preliminary sessions to find out if they are suitable to take part in the study. Sometimes, families are not in a good place to take part in the study and may need different support. For example, the RISE practitioner will talk to you about whether there are other violent and abusive behaviours within the home (such as between parents). Also, parents or carers who do not have time or interest in engaging with the CAPVA programme, and therefore this study, will not be able to continue to the next stage.

8. Will you tell me more about the RISE CAPVA programme?

The RISE CAPVA programme seeks to change behaviours of adolescents and young people who are violent or abusive towards their parents and carers. It does this first by seeking to change the ways in which parents and carers respond to the young people's behaviours. The Programme runs for up to 18 sessions and engages parents or carers for a minimum of 12 sessions. It also aims to engage with the young people for six separate sessions. The sessions with parents and carers will teach Non-Violent Resistance (NVR) techniques to help change young people's behaviour in a respectful and calm way, avoiding punishments. RISE practitioners work with parents and carers to help them develop the skills and confidence to use the NVR de-escalation and resistance techniques, refuse demands made by children and young people, and reset boundaries. These skills are developed gradually with practitioner support so that parents or carers will eventually be able to use them without the practitioner. If young people also join the programme, then work with them adopts a flexible skills-based approach using trauma informed care alongside cognitive behavioural training and mindfulness. The practitioner will also work together with a family to build their community support networks. Later sessions focus on reconciliation, ensuring the family is equipped to sustain positive change going forward.

9. How long will my part in the study take?

If you decide to take part in this study, you will be contacted a few times across about 12 months from when you were first referred by a practitioner in your borough. This is because we want to see how you and the young person are getting on and whether the support you will receive makes any difference over time.

10. What should I do if I am interested in taking part?

Before receiving this information sheet, you may have already spoken to a practitioner from your borough. You might also have already spoken to a RISE practitioner to check whether you are eligible to join the study. When we know if someone is eligible to take part in the study, then we send out this sheet again, with a link to click on, if you want to take part. That link will take you to a consent form.

11. What will happen to me if I take part?

If you consent to take part in the study, we'll ask you to complete a survey that is based on questions about your child (or the child in your care), their behaviour, difficulties and relationships in the family. We will also collect some information about your family background. We will ask you to fill out a survey at the start and end of the study (around nine months from now). At both times, we'll ask about the child's violent or abusive behaviour and their difficulties. At the beginning, we will also ask you to tell us about some other difficulties that the young person might have, when they are asked to do things and in how they interact with the world around them. The surveys can be completed online on most devices that have access to the internet. The research team can also help you to fill them in, or you can ask for help from the practitioner working with you. Each survey will normally take about 40 minutes.

An optional interview

If you decide to take part in this study, then you will also be invited to take part in an optional interview around the time you complete your final survey. The interviews will help us understand families' views on the support received and whether that support has helped relationships between parents, carers and young people. Each interview should take no longer than an hour and will be audio-recorded. The recordings will be professionally transcribed, then analysed. Your name will not be used in the transcriptions, and we will remove references to specific people or places.

Child and young person involvement

If your family is randomly allocated to the CAPVA programme, then we may also approach you to let us invite the child or young person themself, to take part in the research directly.

Diagram 1 summarises what will happen to families who take part in the study.

Diagram 1 – what will happen during the study?

Receive information about the CAPVA study	• You will find out about the study from a practitioner. • Then, if your family is eligible to be included in the study, you will be contacted by the practitioner checking the referral information.
Engage in two screening and suitablity sessions	• If you are interested in the study, you will engage in two screening and suitability sessions. • A RISE screening practitioner will explore what CAPVA is like in your home and family.
Be asked to provide consent to take part	• If you are eligible, then you will be asked whether you want to continue to the study. If you decide to take part, then you will give your consent on an online form. • Before you decide whether to take part, you will be informed what support would be provided 'as usual'.
Following consent	• If you provide consent, you will be asked to complete a survey before allocation is made to either business as usual or RISE CAPVA programme. • If you do not consent to join the study, your borough practitioner will be informed and support you as usual.
First survey	• The first survey asks questions about your child or the child in your care, their difficulties, strengths, characteristics and CAPVA behaviours. After survey completion, random allocation will be made.
Randomly allocated to a study group	• You will be randomly allocated by a computerised generator (to either business as usual or RISE CAPVA). • The RISE practitioner will contact you to advise you which group you are in and discuss next steps.
Agreed support begins, either BAU or RISE CAPVA	• The RISE group will begin sessions. • The business as usual group will continue to be supported by their lead practitioner.
Optional interview	• Several months after support begins, you will be invited to take part in an optional interview; • You will receive further information and asked if you agree to be interviewed; • Some young people may also be invited to take part in the research at this point.
Final survey	• About nine months after the screening and suitability sessions, you will be asked to complete the final survey, repeating some of the questions from the first survey to see if anything has changed.

12. What will happen if I no longer want to be part of the study?

If you do agree to join the study, but change your mind, you are free to withdraw from the study at any time without giving a reason. If you have been allocated to the RISE CAPVA programme group, and have already started sessions, then both you and the young person will still be able to take part in it. However, if you have been allocated to the RISE CAPVA group and have not begun the programme itself, then you will not receive that programme. Instead, you will continue to be supported by your local authority.

13. What are the possible disadvantages or risk of taking part?

We do not anticipate that taking part in the study will expose you to additional direct risks. However, we realise that reflecting on your experiences of violence and abuse may bring up troubling emotions. Your RISE or the lead practitioner from your local authority will be your main support during the time that you are participating in the study. The arrangements you have in place with them for support, should not change.

If you experience difficult, unexpected situations during the study, that go beyond the CAPVA you are already experiencing, then please let the study team know. A form will be available to complete online so that you can tell the study trial manager and safeguarding lead about issues you are experiencing. These issues will be recorded, and we will advise you and your practitioner on any necessary response to potential risks of harm raised.

14. What are the possible benefits of taking part?

By taking part in this study, you will contribute to much-needed research on how best to support families experiencing CAPVA. The information from this study will help improve services to other families in the future. By taking part, you will be helping to shape how support services are offered. Whichever group you are allocated to, you can positively impact other families.

15. Will taking part in this study be kept confidential?

We will treat the information shared with us securely and confidentiality will be respected, in accordance with the legal constraints and professional guidelines. The research team has received safeguarding training, and we are aware that there are circumstances in which confidentiality has to be broken. For example, if you tell us something that makes us concerned about your or another individual's welfare or there is a pressing risk of harm, then we will need to follow safeguarding procedures. If that happens, then researchers will also contact the practitioner that supports you and a designated safeguarding officer from your local authority, to agree on appropriate action. If it is a serious incident, then it may also need to be reported to the Youth Endowment Fund.

- You can see more about serious incident reporting here: https://youthendowmentfund.org.uk/wp-content/uploads/2021/08/2103-YEF-Serious-Incident-Policy.pdf

- You can see also more about the ways in which YEF funded research approaches safeguarding here https://youthendowmentfund.org.uk/wp-content/uploads/2024/03/YEF-Safeguarding-Policy.pdf

16. How will you use the data you collect?

To carry out the CAPVA study, we need to collect some personal data from you, including sensitive personal information which is classed as special category data. Personal data allows a person to be identified, such as your child's name and date of birth. Special category data is information which may be considered sensitive, like information relating to your ethnicity.

UH will be using information from you to complete this study and will act as data controllers. This means that UH are responsible for looking after your information and using it properly. RISE will process data coming from referrers and work with you during screening, when they will be data controllers. They will then transfer the information to UH where it will be stored on the secure study database.

Data protection laws require us to have valid reason to use your personal information. This is referred to as the 'lawful basis for processing' data. For the research data collected for the CAPVA study, the lawful basis for processing is as follows:

a) processing your personal data is necessary for the performance of a task carried out in the public interest (Article 6(1)(e) of the UK GDPR); and

b) processing special categories of your personal data (which is personal data about your gender, ethnicity, etc.) is necessary for archiving, research or statistical purposes (Article 9(2)(j) of the UK GDPR)

Individuals have certain rights under data protection laws. There are exemptions from some of these rights where personal data is used for the purposes of research. Your rights to access, change or move your information are limited as your information needs to be managed in specific ways for the research to be reliable and accurate. If you withdraw from the study, information about you that we have already collected will still be kept for the purposes of the study. To safeguard your rights, the minimum personally identifiable information possible will be used. If you have any queries about the data we collect on you, please contact the trial manager using the contact details at the end of this message.

17. How will you keep any information you collect safe?

The confidentiality of people who participate in this study will be maintained. Your answers to the surveys will be stored anonymously and information provided in interviews will be anonymised prior to storage. Your contact details will be kept securely, confidentially and separately from the survey and interview information. You will be allocated a unique study identification number, so your name will not be linked to the research data. All information collected will be used for the

purposes of the study and will be stored in accordance with the Data Protection Act 2018 and UK GDPR. You will not be identifiable in any reports or publications coming from this study. It is intended that all information for this study will be collected and stored electronically. However, in some situations, there may be paper copies of information provided. Any data in a physical format, will be stored in a locked cabinet at the university, this includes any paper consent forms, interview notes or survey responses.

18. What will happen to the results of this study?

We rely on the public task, lawful basis to use your data. We will only use more sensitive information if it is necessary for research purposes or statistical purposes which are in the public interest. We will use the information you give us to evaluate how well the RISE CAPVA programme works, in comparison to other forms of support available. We will write a report about our findings based on all the surveys and interviews completed. The final report will not contain any personal information about the people who took part in the study, and it will not be possible to identify individuals from the report. The report will be published on the UH and YEF websites and we might also use the report for academic articles, and in presentations to academic, policy, local authority, governmental or charity audiences. Any personal information that you give us will be stored securely and kept confidential. If you would like a copy of the published research, please let one of the researchers know and we will be happy to help you access it.

19. Will the data be required for further use?

Personal data collected as part of this study will be held by UH for as long as is necessary to allow for collection and analysis of the data to take place. If you participate in interviews, then your identifiable data will be removed as soon as possible. The audio recordings will be stored on secure servers belonging to UH, that only a limited number of researchers will be able to access. After transcription and anonymisation is finished, the original recordings will be destroyed. After completion of the study, and reporting of the findings, the study database and associated, anonymised data, will be held for 10 years at UH. This is in line with the UH clinical trial support network guidelines. The data held at UH will then be securely disposed of (permanently deleted). To find out more about how UH will use your information, please contact our Data Protection Officer and/or access the privacy policy:

Abi Tomlinson

University of Hertfordshire, College Lane, Hatfield, Hertfordshire, AL10 9AB

✉ dataprotection@herts.ac.uk

The University of Hertfordshire Privacy Policy is available from this link:

https://www.herts.ac.uk/__data/assets/pdf_file/0017/233090/IM08-Data-Protection.pdf

It is important to note that the study database will also be archived by the Office for National Statistics (the ONS). Once we have finished the study, other approved researchers will need to be able to explore whether the RISE CAPVA programme, and other programmes funded by the Youth Endowment Fund (YEF), had an impact over a longer period of time, including whether they reduced young people's involvement in crime and violence. This is why YEF archive data within the ONS. Once we have finished our study, we will share the information we have gathered about each family with the ONS to add to the YEF archive.

Any personally identifying data you shared with us, like your name and address will be removed. Any directly identifying data about your child (e.g. name, date of birth, home address) will be safely passed to the DfE and then replaced with a unique Pupil Matching Reference number (a process called pseudonymisation) from the DfE's National Pupil Database. It will be possible to link child data with public datasets (e.g. within education), however, this will only happen within the ONS secure data storage environment.

Once your data has been transferred to the ONS, UH will hand over control to the YEF for protecting your personal information. Your de-identified data will be held in the YEF archive indefinitely, in the ONS Secure Research Service, along with all the other data collected during the evaluation. The YEF is the data controller of the information in the YEF archive. By maintaining the archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest, and this gives the YEF a lawful basis to use personal information.

The YEF have put in place strong measures to protect the information in the archive. As well as the pseudonymisation process described, the YEF archive is protected by the ONS 'Five Safes' framework. The information can only be accessed by approved researchers in secure settings and there are strict restrictions about how the information can be used. You can find more information about the YEF archive and the Five Safes at https://youthendowmentfund.org.uk/evaluation-data-archive/faqs-the-youth-endowment-fund-data-archive/

20. Who has reviewed this study?

Most university research in the UK is reviewed by an independent group of people, called a Research Ethics Committee. This committee is here to protect your interests. The CAPVA study has received ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee. The UH ethics protocol number is 0233-2025-Aug-HSET.

21. Who can I contact if I have any questions?

If you would like further information or have any questions, please email CAPVAstudy@herts.ac.uk. If, however, you would like to discuss any details personally, please contact Dr Caroline Cresswell, the trial manager, in writing, by phone or by email:

Dr Caroline Cresswell

Department of Psychology, Sport and Geography, University of Hertfordshire, College Lane, Hatfield, AL10 9AB

✆ 01707 286466 ✉ CAPVAstudy@herts.ac.uk or c.cresswell@herts.ac.uk

22. What if there is anything I am not happy about with this study?

If you are unhappy about any aspect of the research study or would like to raise a complaint about your participation in the study, please contact Professor Joanna R Adler (Email: j.r.adler@herts.ac.uk) the principal investigator of this study. If you still feel that your complaint has not been handled to your satisfaction, you can then contact the Chair of the UH Research Ethics Committee, at the following email address: hsetecda@herts.ac.uk or Professor Wendy Wills, Pro Vice-Chancellor (Research and Enterprise), University of Hertfordshire, College Lane, Hatfield, AL10 9AB. w.j.wills@herts.ac.uk

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

Appendix D: CAPVA RCT Participant Information Sheet (summary)

University of Hertfordshire UH

CAPVA STUDY
UNIVERSITY OF HERTFORDSHIRE

RISE TRANSFORMING LIVES

SCAN ME

The CAPVA Study
Participant Information Sheet for Parents & Carers
(summary version)

Randomised Controlled Trial (RCT) of the Child and Adolescent to Parent Violence and Abuse (CAPVA) programme run by RISE Mutual CIC.



What is the study about?

You are being invited to take part in a study about child to parent violence and abuse (CAPVA) because you are a parent or carer of a child (aged 9-17) who is struggling with their feelings and behaviours. This study aims to understand what does and doesn't work, to help your family and other families in the future. It will do so by comparing a support programme provided by RISE Mutual CIC (RISE) with different types of support offered by your local authority. The research is led by the University of Hertfordshire (UH) and funded by the Youth Endowment Fund (YEF).

If I'm interested, will I be able to take part?

When a family is referred to the study, a RISE practitioner will assess whether they are eligible to take part. Sometimes, families are not in a good place to take part in the study and may need different support. Or, parents or carers may not have time or interest for a support programme, and therefore the study. A practitioner will let you know if you are eligible or not.

What if I do not want to take part?

It is completely up to you whether you would like to take part in this study. Even if you do decide to take part, you can still choose to withdraw from the study or from the support that you're receiving, at any point. If you decide that you don't want to take part, then the lead professional working with your family will still work with you as they would normally.

If you are eligible and decide to take part you will be randomly allocated by computer to either of the study groups below. It's like a roll of a dice!

RISE CAPVA group

Families allocated to this group will engage in up to 18 CAPVA programme sessions.

The sessions with parents and carers will teach Non-Violent Resistance (NVR) techniques to help change young people's behaviour in a respectful and calm way, avoiding punishments.



or

Business as usual (BAU) group

In the BAU group, families will receive the support normally available in their area.

Families will at minimum continue to receive the support of a lead professional and a RISE Safety Sheet containing techniques to help support you.

But why will only half receive the programme? By having groups randomly selected to either attend the CAPVA programme or to receive the usual support, we will be able to see whether the CAPVA programme makes a difference to families. It is important to remember that those in BAU will be offered the support that families in your area would normally be getting.

1

What will happen if I decide to take part in the study?

1. Receive information

A practitioner will share information on the study and complete a study referral form with you. You will be contacted if you are able to join the study.

2. Engage in two sessions

If you are interested in joining, you will engage in two screening and suitability sessions. A RISE screening practitioner will explore what CAPVA is like in your home and family.

3. Be asked to give consent

If eligible, and you want to continue, you will be asked to provide your consent to take part in the study. Before deciding, you will be told what usual support will be provided.

4. Following consent

If you do consent to take part, you will be asked to complete the first survey. If you do not consent, your borough practitioner will support you as usual.

5. First survey

The first survey asks questions about your child or the child in your care, their difficulties, strengths, characteristics and CAPVA behaviours. When the survey is finished, group allocation can begin.

6. Random group allocation

A computer will randomly allocate you to the RISE CAPVA or business as usual study group. A RISE practitioner will contact you to let you know.

7. Agreed support begins

The RISE CAPVA group will begin the sessions. The business as usual group will continue to be supported by their lead practitioner.

8. Optional interview

Several months after support begins, you will be invited to take part in an optional interview about your experiences. Some young people may be invited to take part in the research, too.

9. Final survey

The final survey happens about 9 months after the screening and suitability sessions. It will repeat some of the questions from the first survey to see what has changed.

2

What are the possible risks of taking part?

Reflecting on violence and abuse may bring up some troubling emotions.

Your RISE or lead practitioner in your area will be your main support during this study, that will not change.

If you experience difficult situations during the study, a form will be available so you can tell the trial manager or safeguarding lead. Any risk of harm will be reviewed.

What are the possible benefits of taking part?

You will contribute to much-needed research on what works to support families expeirencing CAPVA.

Your the information from this study will help improve and shape the support offered to other families.

Whichever group you are allocated to, you can positively impact other families.

What will happen to my data?

Information will be collected on your family (also called personal data), such as your child's date of birth or your gender/ethnicity.

Under data protection laws, UH will be responsible for looking after your data and using it only for the purpose of carrying out the CAPVA study.

You will be allocated a unique study identification number. So, your name will not be linked to research data (e.g. from the surveys) or any results we publish. Data will be stored securely on the study database.

Once the study is complete, anonymised data will be stored for 10 years, which is needed for reporting and analysis. The data held at UH will then be securely and permanently deleted.

YEF would like to explore the long term impacts of the CAPVA study on young people. This is why we share study data with YEF, who archive the study data on the Office of National Statistics secure database.

Any study data that may identify you will be removed before being shared for archiving. Any identifying data about your child (e.g. name) will be safely passed to the Department for Education as part of archiving and exploring long-term impacts.

For further information about happens to the data collected for the CAPVA study, how UH follow the Data Protection Act 2018 and UK GDPR, and on YEF archiving, can be found on the full version of this document (see below on how to find this).

3

Who has reviewed this study?

Most university research in the UK is reviewed by an independent group of people, called a Research Ethics Committee. This committee is here to protect your interests. The CAPVA study has received ethical approval from the University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee. The UH ethics protocol number is [insert here].



To visit the study webpage and view further information, please scan the code below or visit www.go.herts.ac.uk/RISE-CAPVA-efficacy-study



SCAN ME



If you would like to contact a member of the study team, please email CAPVAstudy@herts.ac.uk



If you have any further questions and would like to speak to the trial manager, Dr Caroline Cresswell, please telephone 01707 286466 or email c.cresswell@herts.ac.uk.

University of Hertfordshire UH

CAPVA STUDY
UNIVERSITY OF HERTFORDSHIRE

RISE TRANSFORMING LIVES

4

Appendix E: Study videos

Please note these videos are only accessible to those that have the links **below** neither are set for public viewing**, indexed for searching,** nor open for comments.

Study video to support recruitment

https://youtu.be/o4j645hlTSc

Study video to support consent

https://www.youtube.com/watch?v=uMGvB0_MVWc

Appendix F: CAPVA RCT Consent Form Parents and Carers

The CAPVA Study Consent Form

(parents and carers)

Full title of study: Randomised Controlled Trial (RCT) of the Child and Adolescent to Parent Violence and Abuse (CAPVA) programme run by RISE Mutual CIC.

Name of Trial Manager: Dr. Caroline Cresswell

Tel: 01707 286466; c.cresswell@herts.ac.uk or CAPVAstudy@herts.ac.uk

Thank you for reading the information about this study and for engaging with the team at RISE for initial screening. If you would like to take part in this study, then please indicate your consent by clicking to agree with the following statements.

1. I confirm that I have read the participant information sheet v1.9 dated 28/08/2025 for the above study and I have had the opportunity to consider the information and to ask questions about the study. ☐

2. I have been told what support I will receive if I do not take part in this study, or if I am allocated to the "business as usual" group in the study. ☐

3. I understand that my participation is voluntary, and I am free to withdraw at any time without giving a reason. To withdraw, I know that I will need to contact the research team, and that this will not affect my legal rights or the support that I receive from my local authority. ☐

4. I understand that the study will involve answering questions about my child or a child in my care. I understand that these questions will ask about their behaviours, difficulties and relationships with myself and with other people. ☐

5. I understand that that some families will be invited to take part in an interview a few months after they join this study. ☐

6. I understand that children and young people whose families are allocated to support from RISE Mutual CIC, may also be approached to participate in an interview or online survey about their experiences. ☐

7. I understand that data collected during the study will be stored securely and will remain confidential. I understand that the data may be looked at by members of the research team, RISE Mutual CIC or statutory services where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

8. I understand that no-one else will have access to information about me, my child, or the child in my care unless a safeguarding issue arises or serious incident takes place. If this happens, then the concern will be passed on to my allocated practitioner within RISE, or it will be passed on to the local authority that referred me to this study, or to another appropriate, safeguarding officer. ☐

9. I understand that the information collected will be anonymised and used in the publication of findings (e.g. in reports), that the information will be archived and shared anonymously with other researchers, and that it may be used to support future research. ☐

10. I agree to take part in the above study. ☐

Appendix G: Non-participation form questions.

Please note this was formatted and accessed via REDCap.

By completing the two questions below you are providing consent for us to use the information for research purposes, which is to help us understand why families choose not to participate.

All responses will be anonymous. We will not share any individual information anywhere and your responses will only be used at a group level.

Please complete the two questions below. We appreciate your time.

1. Please check all the reasons why you chose not to take part in the CAPVA study:

My family circumstances have changed □
I do not have time □
The RISE CAPVA programme does not interest me □
I do not want to take part in research □
Other reason □

If other, please specify: *free text*

2. Is there anything we could have changed to make you more interested in taking part in the study?

Yes □ No □

If yes, please specify: *free text*

Appendix H: FAQs – Before the Study Starts: For Parents and Carers

The RISE CAPVA Study

CAPVA is Child and Adolescent to Parent Violence and Abuse

Frequently Asked Questions-

For Parents and Carers (please note that these were formatted and presented on the webpage. This page hasn't been updated to reflect the early termination of the study, including removal of these FAQs.)

If you have any further questions, please contact the study team by email at CAPVAstudy@herts.ac.uk or via mobile, text or WhatsApp on 07521 433517.

Can I take part in the study?

Q: I have a lot of commitments (such as full-time work, caring for another family member). Can I still be referred?

A: Yes, you can still be referred to the study. If you are placed in the RISE CAPVA group, your RISE practitioner will negotiate times of sessions with you and be as flexible as possible around your family's existing commitments. If you are placed in the Business as Usual (BAU) group, you will receive the usual support available in your area. Your lead professional will be able to talk to you about arranging support for you at a time that fits in with your work.

Q: I know that my child will not engage in the study. Can the rest of the family still take part in the study?

A: Yes, the parents or carers are the main participants in the study.

Q: Our child boards during the school week, can we still take part in the study?

A: Yes, you can still take part in the study. During the referral and screening process your individual family circumstances should be considered by the lead/RISE practitioner. It may be possible for CAPVA support to be offered to you, as a family, when your child is with you. If you have any questions, then please ask your lead practitioner.

Q: My ex-partner and I have joint custody. Can I still take part if my child does not live with me full-time?

A: Yes, you can still take part in the study. During the referral and screening process your individual family circumstances will be considered by the lead/RISE practitioner. It may be possible for CAPVA support to be offered to you, as a family, when your child is with you. If you have any questions, then please ask your lead practitioner.

Q: I have heard about the study from a family member/friend. We have not accessed services; can we still be referred?

A: Unfortunately, you cannot self-refer into this study. Referrals can only be accepted from a lead practitioner. If you require support with CAPVA, please contact your local council for information.

Questions about consent

Q: My ex-partner and I have joint custody. I want to take part in the study, but my ex-partner does not. Do we both have to consent to for one of us to take part?

A: No, you both do not need to consent for one of you to take part. So, you can take part in the study even if your ex-partner doesn't want to consent.

Q: My child has gone into a temporary care placement. Can I take part in the study if the child that was being abusive towards me is currently in care?

A: Yes, if contact with your child is still ongoing, you can still take part in the study. Parents or carers are the main participants in the study.

Q: I am a foster carer and the child in my care is being abusive within my home. Are we still able to take part in the study?

A: Yes, we accept referrals for all types of families that are experiencing CAPVA. The practitioner discussing the study with you and completing a referral form will ask who the main participant for the study will be. The main participant is the key point of contact who gives consent to take part in the study and completes the study questionnaires. They could be a foster carer, parent or other family members. Regardless of family or care status, all families go through the same referral and screening process to find out if they are eligible to join the study.

Moving House?

Q: I want to take part, but I'm moving very soon. Am I still able to take part?

A: Yes, if you are staying within the same local authority, then you should still be able to take part. If you move to another local authority, then it will depend on whether that local authority is taking part in the study.

Why was our referral not accepted?

Q: Our referral was not accepted. How do we find out why and can we appeal?

A: If your referral was not accepted it means that your family did not meet the eligibility criteria. Parent and carers who have a child aged 9-17 years old and are experiencing CAPVA can be referred to the study. Not all families who are referred to the study are accepted. During the screening process your family circumstances will be considered which may mean that the support is not right for your family, or it is not the right time for your family to take part. Your lead practitioner will be able to talk to you about this.

I have some concerns about taking part.....

Q: My child behaves differently in school ('masked'). I don't really want my child's school to be aware of the CAPVA. Does my child's school have to be informed that we are taking part in the study?

A: The study team will not be routinely informing your child's school that you are taking part in the study or indeed, experiencing CAPVA. However, your child's school may have referred you to the study or may be involved in supporting you, which you will be aware of.

Q: Will taking part in the study affect us from accessing further support?

A: Taking part in the study should not affect you from accessing further support that is available in your local authority. Please speak to your lead practitioner who is best placed to advise you as to the support available.

Q: As a family we are on a waiting list for a specific service (e.g. CAMHS); Will taking part in this study affect our position on the list or opportunity to access that service when our time comes?

A: Your participation in the study will not affect your position on a waiting list nor your opportunity to access another service. If you have any queries or concerns about waiting lists or access to services, please speak to your lead practitioner and/or the person who referred you to the service.

Q: We have received *Business as Usual* (BAU) support before, and it has not been helpful to us as a family. What happens if we are randomly allocated to the BAU group and the only support we are offered is support that we have already participated in/been discharged from?

A: Before you are randomly allocated to a group your lead practitioner will let you know what usual support is available to you in your area. The minimum support you can expect, as part of the study, is support from a lead practitioner, a safety sheet showing NVR (non-violent resistance) techniques and a list of helpful organisations. Please also remember that the study is comparing the RISE

Programme with *Business as Usual so* that we can find out what support may have worked well or not so well. The online survey and interview are an opportunity for you to share your experiences of taking part in the study and the impact the support has or hasn't had on you and your family. The information you provide in an interview, about the support that you have received, will help improve services to other families in the future.

Q. I don't understand what is happening to my information (data). Will it be secure? Can you tell me more?

A: Yes, your information will be kept secure in the following ways:

- All your information collected during the study will be stored electronically in a password-protected folder on the secure University data management system (For reference the system is the Microsoft 365 SharePoint).

- Anonymised interview transcripts (if you take part in an optional interview) will be retained on the secure University data management system for up to 5 years after the end of the study. Personal information (such as your name and email address) stored for the purposes of the interview will be deleted at the end of the study (intended date 30/09/2027).

- You and your family will not be identifiable in any reports or publications coming from this study.

- All information will be treated confidentially unless you disclose information relating to any events that have impacted the safety or wellbeing of you, your family, or anyone else, during the study. If this event is a safeguarding issue, then the study team will also contact the practitioner that supports you, or a designated safeguarding officer to agree on appropriate action. If it is a serious incident and safeguarding issue it will need to be reported to the Youth Endowment Fund (YEF) who fund this study.

    - You can see more about serious incident reporting here: https://youthendowmentfund.org.uk/wp-content/uploads/2021/08/2103-YEF-Serious-Incident-Policy.pdf

You can see also more about the ways in which YEF funded research approaches safeguarding here: https://youthendowmentfund.org.uk/wp-content/uploads/2024/03/YEF-Safeguarding-Policy.pdf

The RISE CAPVA Study

CAPVA is Child and Adolescent to Parent Violence and Abuse

-Frequently Asked Questions-

For Parents and Carers

If you have any further questions, please contact the study team by email at CAPVAstudy@herts.ac.uk or via mobile, text or WhatsApp on 07521 433517.

What happens if there's any changes?

Q: My lead practitioner has left; will I still receive my support?

A: Yes, you should be given a new lead professional, and you should still receive support. The support of a lead practitioner is the minimum support offered as part of this study.

Q: I'm half-way through the study and I'm moving to a borough that isn't taking part. Will I lose my lead professional and support?

A: This will depend on individual family circumstances considering the group that you are allocated to, the type of support that you are receiving, the length of time you have left to take part in the study and if your move is temporary or not. Please speak to your lead practitioner who may speak to the study team as necessary.

Q: What happens at the end of the study? Will my support stop? Will I lose the support/involvement of my lead practitioner?

A: It is usual practice, when support is coming to an end, to provide families with advice and signposting to helpful organisations for further support as necessary. Each family's circumstances will differ, and any skills and techniques learnt during the study should help families to continue to move forward in the future.

I have a question about adverse events….

Q: What sort of adverse event do I need to report?

A: You can report any adverse event that has impacted the safety or wellbeing of you, your family, or anyone else. You will have received a link through email where you can report any adverse events you experience or are made aware of. This link takes you to a form on the study database. If you cannot find this link, please contact the study team who will email you one. If preferred, you may also contact the study team directly to report an adverse event.

Q: My practitioner is the lead professional for this study. I know they have reported an adverse event, but I don't agree with their decision. What can I do?

A: We assess each adverse event report separately based on the information provided by families or practitioners. The reports may or may not be considered an adverse event on assessment by the study team. Adverse event reporting is a feature of studies like this as a way to maximise the safety of families taking part. To make sure that no part of the study is causing harm to participants. When an event is reported it is assessed against a list of potential events that might impact families. And if it is deemed to be an Adverse Event as defined by the study, we will then assess whether it is likely that it is caused by the study. You are welcome to contact the study team to provide additional information, or you may submit your own adverse events report.

What do families do during the study?

Q: How do I complete the online survey if I do not have internet or a computer?

A: If you do not have access to the internet, your lead practitioner can help you to complete the online survey, when they are with you, using their mobile device. If you do not have a computer, you can complete the survey using a smart phone. If you would prefer, the link to the online survey can be sent to you via text instead of email. Another option is to complete it over the telephone with a member of the study team. Please contact the study team to receive the link via text or to arrange a time to complete the online survey over the telephone.

Q: I completed the first online survey. Do I have to complete the survey again?

A: Yes please. The research relies on being able to compare the two surveys to see if things have changed for your family over the course of the study. As a 'Thank you' for completing both surveys you will be offered Love2Shop vouchers.

Q: I completed the first survey, and my partner wants to complete the second survey. Does it matter who completes the survey?

A: Ideally, the person who completed the first survey would complete the second survey. People have different views about the same situation, and this is why the study team sends the links to the same person each time and asks who is completing the survey. However, the study team

understands that sometimes parents want to complete the surveys together and sometimes one parent is unable to complete both surveys.

What about the optional interview?

Q: Can I be interviewed in person?

A: Yes. Please let the study team know if you would prefer to be interviewed in person rather than online.

Q: My partner and I both wish to be interviewed. Can we be interviewed together?

A: Yes. Please let the study team know if you would prefer to be interviewed with your partner.

What happens about child participation?

Q: I don't want my child to take part in a survey or interview. I am worried this will create tension between us. What will happen if I don't consent to them taking part?

A: If you do not give your informed consent for your child to take part, they will not be approached to take part.

Q: If I do not give my consent for my child to take part in the survey or interview, can I continue participating in the study?

A: The main participant for the study is you, as the child's main parent or carer, so you can continue in the study, and it will not have an impact on any support you receive.

Q: At what age can my child give their own consent to take part?

If your child is over 16, they can provide consent to participate in research. If a child is under 16, they provide what is called assent, which is their informed agreement to take part. However, as parents/carers are the main participants of this study, and child and young person involvement occurs later, we would ask you to consent for your child to be able to take part before approaching them for assent/consent.

Q: My child is over 16 and I don't want them to take part. Can I say 'no'?

A: Regardless of a child's age, a child or young person will not be approached to take part in this study if a parent/carer participant does not give their informed consent for this.

What happens to family information (data)

Q: What happens if I decide to leave the study, and I don't want my information to be used?

A: Information collected as part of the main CAPVA study (e.g. survey data) will still be used for the purposes of the study. You can request that your interview recording and transcript, are withdrawn from the study within one week of the interview taking place, without providing an explanation to

the study team. If you want to withdraw your recording or transcript or if you have any other questions after you have taken part in the interview, please contact the study team.

What support is available outside the study?

Q: Will there be an opportunity to meet other parents experiencing CAPVA?

A: There may be an opportunity to meet with other parents experiencing CAPVA but that may depend on the support that you are receiving. Please speak to your lead practitioner who may be able to advise if there are any peer/parent support groups available in your local area.

Q: Where can I find out about further resources for me to access in my area?

A: We have identified some resources that may be helpful, these are available on the Safety Sheet, signposting list, and the study webpage. Please speak to your lead practitioner about what resources are available in your local area.

Appendix J: CAPVA Study Acceptability of measures questions

Additional follow-up questions to capture participants' experience of the CAPVA study {these questions were formatted and delivered via REDCap}

Please answer the optional questions below about your experience of taking part in the study.

The information you give will help us find out more about what works for parents or carers taking part in research. There are no right or wrong answers.

If you do not want to answer these questions, please click the next page button to submit your responses.

Using the scale below, please highlight how far you agree or disagree with the following statements.

The information I had helped me understand what I was taking part in (this might include, watching the study video, reading participant information):

😄 I really agree

🙂 I agree a bit

😐 I am not sure/in the middle

😕 I disagree a bit

😠 I really disagree

The time I spent taking part in the research was fair (this might include reading documents, doing questionnaires):

😄 I really agree

🙂 I agree a bit

😐 I am not sure/in the middle

😕 I disagree a bit

😠 I really disagree

The survey questions helped capture what my family were going through (this includes, the ABC-1 and SDQ questionnaires that ask questions on how your child/child in your care has behaved towards you and what they have found difficult):

😄 I really agree

🙂 I agree a bit

😐 I am not sure/in the middle

😕 I disagree a bit

😠 I really disagree

Please use this space to tell us what it was like to take part in the research. It can be positive or not.

Appendix K: Parent & Carer Incidents of Concern form (adverse events)

Confidential

Page 1

Parent/Carer events of concern

This form is for you to record any concerns you experience during your time on the study.

Please let us know about any negative events other than those that are part of your usual experience with CAPVA.

This form will be sent to the trial manager. They will then consult with the study safeguarding lead regarding potential risk. Any necessary steps to keep you or others safe will be taken, and additional support provided as appropriate.

On this form, the word size can be increased using the plus and minus signs on the top right of the screen. You can also have the questions read out to you by enabling the speech function using the speaker symbol on the top right of the screen, then by clicking on speaker symbols next to text.

When did the event happen? Please provide a rough date if you cannot remember exactly.	_____
How did you become aware of this?	_____
Please tell us about any events that have impacted the safety or wellbeing of you, your family, or any one else.	_____
Have any of you experienced something like this before?	◯ Yes ◯ No
How does this compare to previous experiences?	◯ Less severe ◯ About the same ◯ More severe
Please tell us about anything else you think we should know.	_____

Thank you for telling us about your concern.

This form will be sent to the trial manager. They will then consult with the study safeguarding lead regarding potential risk. Any necessary steps to keep yourself or others safe will be taken, and additional support provided as appropriate.

If you would like to tell us about another concern, please scroll to the bottom of the page.

If you need additional support, you can access helpful resources outlined in the following poster. {see next page}

If you would like to save a copy of the signposting list, please click on the link below, and you will be able to download a PDF copy with working hyperlinks.

CAPVA study signposting list.pdf

RISE TRANSFORMING LIVES

SIGNPOSTING LIST

CAPVA STUDY
UNIVERSITY OF HERTFORDSHIRE

Below is some contact information for organisations that may be able to provide further information, guidance and support. It is free to reach out and speak to these organisations.

Family & Relationships

Family Action
Provides emotional and practical support around family pressures. Available Monday-Friday 9am-9pm.
- Telephone: 0808 802 6666
- Text: 07537 404 282
- Email: familyline@family-action.org.uk
- Online Chat: available via website www.family-action.org.uk

Action for Children - Parent Talk
An online support service for parents to access information and support on anything to do with parenting. Available Monday-Friday at different times of the day (more information on website).
- Online chat & WhatsApp: available via website https://parents.actionforchildren.org.uk/

Family Lives
Provides targeted and crisis support to families on, for example, teenagers, divorce, lone parenting, adoption, SEND, and other family issues. Available Monday-Friday 9am-9pm and weekends 10am-3pm.
- Telephone: 0808 800 2222
- Email: askus@familylives.org.uk
- Online chat: available via website https://www.familylives.org.uk/

NHS health advice

NHS 111
Health advice and reassurance, free from landlines and mobiles. If seeking mental health crisis support people can select "option 2".
- Telephone: 111
- Website: www.nhs.uk

Mental health and wellbeing

Hub of Hope
A UK mental health support database. People can find support within their local area by simply entering their address or postcode to the search bar on the website. National charities/services are also listed.
- Website: http://www.hubofhope.co.uk

Mind
Advice, support and information around mental health issues. On the website, you will find 25 mental health and wellbeing apps approved by Mind. Mind do not have a crisis helpline. The helpline is available Monday-Friday 9am-6pm.
- Telephone: 0300 123 3393
- Email: info@mind.org.uk
- Website: www.mind.org.uk

Shout
Support for anyone in crisis and struggling to cope. Free 24/7 text service on all major mobile networks.
- Text: SHOUT 85258
- Website: www.giveusashout.org

Samaritans
Whatever you're going through, a Samaritan will face it with you. You can contact Samaritans for free 24 hours a day, 365 days a year.
- Telephone: 116 123
- Email: jo@samaritans.org
- Online chat: via website www.samaritans.org





Do you or someone else need urgent help?
If you do not feel you can keep yourself or someone else safe, call 999 to speak to the emergency services.

Appendix L: CAPVA Study Lead Professional Adverse Events reporting form

Confidential

Lead Professional AE report

Whilst the family is enrolled in the study, we need to collect information on any adverse events that occur. Please note, adverse events do not have to constitute a safeguarding concern. Adverse events also include any negative event a family experiences while on the study. For example, experiencing distress when completing a questionnaire, or an accident resulting in discomfort or injury.

This form can be used to securely report any adverse events experienced during the study, or any concerns you have about the family.

We understand that you are working with families already experiencing a high level of risk. It is not necessary to report anything that is in line with the family's "general" level of risk.

On this form, the word size can be increased using the plus and minus signs on the top right of the screen. You can also have the questions read out to you by enabling the speech function using the speaker symbol on the top right of the screen, then by clicking on speaker symbols next to text.

For support completing this form, please refer to the User Guide which contains useful information in addition to contact details for Data Managers who can provide technical support. Guide for Lead Professionals completing REDCap surveys v1.1, 06.12.24.pdf

If you have any questions about completing this form or study processes please contact CAPVAstudy@herts.ac.uk or call the Trial Manager, Caroline Cresswell, on 01707 286466.

Adverse Events (incidents of concern)

When did the adverse event happen?

Please provide a rough date if you do not know exactly when it happened.

_____

How did you become aware of this?

_____

Please describe the adverse event and who was involved.

Please provide as much information as possible

_____

Appendix M Email to Lead Professionals - End of Study

This appendix is the version used for intervention group lead professionals, it is identical to the email sent to lead professionals supporting a family in the control group (BAU, with the exception marked)

Email to Lead Professionals re: End of Study Date – Intervention Group

Subject: The CAPVA Study - Important Update for you as Lead Professional

CC site lead(s)

Dear [insert name of lead professional]

Re: Participant name or participant identifier.

We are writing to you as the lead professional who is supporting a family taking part in the CAPVA study. Unfortunately, the funders of this study, the Youth Endowment Fund (YEF) have decided to bring the study to an early closure. The study's delivery phase of intervention will now end on the 27th February 2026 (instead of September 2026).

The decision to end the study early reflects the challenges associated with delivering a complex trial to vulnerable families, across multiple services. It does not reflect concerns with the implementation of the RISE CAPVA intervention itself, nor the local authorities' usual support for families experiencing CAPVA.

The site lead(s), [insert name] for each borough has/have been informed, however as you work closely with a family involved in the study we wanted to write to you personally about that family's ongoing participation.

So, what do I need to know?

- We are aware that you may have a few questions, which we will try to answer below. However, please do get in touch if you would like to speak with us about the information below or have any further questions.

What does this mean for the family I am supporting? INTERVENTION

- If the family you are supporting are still receiving the RISE CAPVA Programme, their RISE practitioner will continue to deliver the Programme as planned. Delivery will continue until the sessions are completed (within the delivery phase), or the family withdraw from the Programme. There will be no more sessions after the delivery end date. RISE practitioners will continue to liaise with you, as lead professional, and provide updates while families are receiving the intervention.

What does this mean for the family I am supporting? BAU

- As the family you are supporting is in the business as usual (BAU) group, the support that they usually receive should continue until the end of the delivery phase (this is in line with what was confirmed on their referral from) or the family withdraw from the support. Further BAU support after the end of the delivery phase will not be part of the study'.

Can I still let you know about anything that concerns me or the family during the study?

- Adverse Event reporting can and should still be reported until the end of study. This may go beyond delivery, up until the Learning Report is published by the evaluation team, expected to be in October 2026.

What about changes in the family's circumstances or the support offered by the local authority?

- Please continue to inform the study team of any change in the participant circumstances by completing the 'Change in Participant Information Form' or emailing the CAPVA Study at capvastudy@herts.ac.uk

Will the family still receive the follow-up questionnaires?

- Yes, the follow-up questionnaires will be sent automatically to the family insert month/at the end of the delivery phase [DELETE AS APPROPRIATE].

  If they mention these, please encourage the family to complete them. The family may ask you to support them in completing the questionnaires, or alternatively, they can get in touch with us.

What happens to data already collected during the study?

- Data already collected will continue to be used by the University of Hertfordshire in line with the existing data protection agreement. This will contribute to the final Learning Report, which will be shared with all partners. The Youth Endowment Fund previously requested child-level data to be archived to assess longer-term outcomes, this will no longer be the case.

If you require any further information or have any concerns about the CAPVA Study ending, please contact the research team at capvastudy@herts.ac.uk, text or WhatsApp 07521 433517 or telephone 01707 284610 if you would prefer to speak to us directly.

We appreciate your involvement in the CAPVA study to date and thank you for your continued support.

Appendix N Crib Sheet for telephone calls to participants

Crib Sheet for telephone calls to participants re: end of study and follow-up questionnaires.

Confirm Identity: Verify that you are speaking to the participant.

Introduce yourself: State your name, role, university and the name of the Study.

Confirm Convenience: Ask if it is a good time to talk, stating approximately how long the call will be.

State the call's purpose: Inform the participant that the CAPVA Study will be ending earlier than expected and the delivery phase will now be ending on the 27th of February 2026. Tell the participant that there are a few things that they might need to know [as follows]:

- [Intervention Group] Your RISE CAPVA practitioner will continue delivering the Programme up until the end of February 2026/until your planned sessions have ended (DELETE AS APPROPRIATE). If you have any questions about your support, your practitioner is the best person to speak with.

OR

- [Control/BAU Group] As part of the business-as-usual group, your usual support should continue as planned. If you have any questions, your lead practitioner is best placed to help.

- [ALL] You will receive an email in [state month] with the final Study follow-up questionnaires. They are the same questionnaires that you completed at the start of the Study. It would be helpful if you completed these questionnaires again. This will capture if things have changed since then. There will be space to add some information about what it was like to take part in the research.

- As a thank you for your time you will receive a Love2Shop voucher for completing the final questionnaires.

- The questionnaire information you provide will be included in a Learning Report on what could have been better about the research.

- Even though the delivery of the support ends in February, the actual Study will end in October, giving the research team time to complete the Report. During this time, you can continue to report any concerns or adverse events as usual.

Questions: Do you have any questions for me?

Closing the call: Inform participant that they will receive an email with all the information that has been discussed and contact details for the research team should they have any questions later.

Confirm participant email address: Verify that the email address on the database is still correct. Update as required.

Thank the participant: Thank the participant for taking part in the CAPVA Study and for taking the call.

Appendix O Follow-up Email to Participants - End of Study

End of Study -Intervention group

The text in this appendix is identical to the text used within the follow-up email to participants (Control Group – BAU), with the exception of the paragraph marked below.

Follow-up email re. End of Study Date – Intervention group (RISE CAPVA Programme)

Subject: Your involvement in the CAPVA Study – Important Message

Dear [insert name of participant]

[DELETE AS APPROPRIATE]

EITHER: Thank you for taking the time to speak with me today. As I mentioned, I am writing to confirm that the delivery phase of the CAPVA study will be ending earlier than planned. The new delivery phase end date is 27th February 2026, rather than the original date in September.

OR: We tried to reach you by phone to share this news directly, and we are sorry we missed you. We are writing to let you know that the delivery phase of the CAPVA study will be ending earlier than planned. The new delivery phase end date is 27th February 2026, rather than the original date in September.

Below is a summary of what this change means for you. If you would like to talk it through, please do not hesitate to get in touch.

What does this mean for you? (INTERVENTION)

- Your support: If you are still receiving the RISE CAPVA Programme, your RISE practitioner will continue delivering the Programme until your planned sessions have ended. If you have any questions about your support, your practitioner is the best person to speak with.
- Your involvement: You are still considered a participant until the end of the study (expected date to be October 2026), or earlier if you decide to withdraw from the study.
- After the study ends: Please speak with your lead practitioner about any ongoing support options.
- Reporting concerns: You can continue to report any concerns or adverse events until the study closes; this is expected to be in October 2026.
- Final questionnaires: We would be very grateful if you could complete the final follow-up questionnaires, which will be sent to you on [insert date if before the end of delivery date/around February or March 2026 [DELETE AS APPROPRIATE]. These will be the same two questionnaires you completed at the beginning, with space to add some information about what it was like to take part in the research.

'What does this mean for you? BAU

- Your support: As part of the business-as-usual group, your usual support should continue as planned. If you have any questions, your lead practitioner is best placed to help'.

- Why they matter: The information you provide will still be useful. Your responses help us to learn from your experience and improve future research. This information is important to us and could really help with supporting families in future research.
- 'Thank you' voucher: You will still receive a Love2Shop voucher for completing the final questionnaires, as a thank you for your time and contribution.
- What happens to the information I give in the questionnaires: All information (data) you share will continue to be handled securely by the University of Hertfordshire. This information will also contribute to a Learning Report on what could have been better about the research. This report will be shared with research partners, including the local authority. A copy of the learning report will also be available on the webpages of the research commissioner, the Youth Endowment Fund, and the University of Hertfordshire.

If you require any further information or have any concerns about the CAPVA Study ending, please contact the research team at capvastudy@herts.ac.uk, text or WhatsApp 07521 433517 or telephone 01707 284610 if you would prefer to speak to us directly.

Thank you for taking part in the CAPVA Study.

Appendix P Email template interview invitation (additional activity)

Four versions of this appendix were developed to accommodate the different site statuses and practitioner roles. Slight modifications were made to acknowledge each recipient's previous contact with the study's evaluation team and to provide a link to a Qualtrics consent form specific to that group. For the non-onboarded sites, additional amendments referred to the study's status and acknowledged that the site had been unable to support the study.

Email template interview invitation

Subject: The CAPVA Study – Invitation to take part in an interview Local Authority Staff – Recruitment Sites

Dear [insert first name],

We contacted you during the autumn of 2025 to let you know that unfortunately the Child and Adolescent to Parent Violence and Abuse (CAPVA) Study will be ending earlier than anticipated. The Youth Endowment Fund (YEF) has decided to bring the study to an early closure.

Why are you contacting me now?

We would like to invite you to take part in a short interview about your involvement in the CAPVA Study. The University of Hertfordshire will be completing a Learning Report to capture insights into the reasons the trial could not be delivered as planned and how a similar trial could be delivered in future. We would appreciate your insights.

What will happen at the interview?

The interview will take place via Microsoft Teams and will last approximately half an hour. If you would prefer to be interviewed in person (face-to-face), please let the research team know and we can arrange this at a place and time that is convenient for you.

We envisage interviewing local authority staff members in pairs, or as a group. However, if you prefer to be interviewed by yourself, please let the research team know and we can arrange this.

How can I find out more?

To help you decide whether to take part, please see the attached participant information sheet where you will find more information on the interview and how it will inform the Learning Report. The materials for the learning report were created by: Caroline Cresswell, Fiona Creevy, Silvana Mengoni and Joanna Adler. Interviews will be led by members of the research team.

If you have any questions, please contact the research team at capvastudy@herts.ac.uk, text or WhatsApp 07521 433517, or telephone 01707 284610 if you would prefer to speak to us directly.

I would like to take part, what do I do?

If you have decided to take part, please complete the consent form via this link: https://herts.eu.qualtrics.com/jfe/form/SV_0vswcUrYrllwgom

The consent form will ask how you would like us to contact you to arrange the interview.

Thank you for considering taking part in an interview. We hope to speak with you soon.

Appendix Q Participant Information Sheet (additional activity)

Four versions of this appendix were developed to accommodate the different sites and professional roles. Slight amendments were made to reflect the differences between recruitment and non-onboarded sites. These key differences - under the heading, 'Why have I been invited to take part in an interview'? - acknowledged that non-onboarded sites were unable to support the CAPVA Study and recognised - under the heading, 'What are the possible disadvantages or risks of taking part'? - that LA staff from non-onboarded sites would not have had the same level of involvement as a site lead at a recruitment site.

Additionally, each version was modified to reflect the role of the professional in supporting the CAPVA Study, acknowledging the relevant employee assistance programmes, potentially interviewing staff from the same organisation in pairs and using a general identifier particular to the interviewee's organisation (e.g. LA Staff 1/RISE staff 1).

Local Authority Staff (Recruitment Sites) - Interview information sheet

Full title of study: Randomised Controlled Trial (RCT) of the Child and Adolescent to Parent Violence and Abuse (CAPVA) Programme run by RISE Mutual CIC.

Introduction

We have invited you to take part in a short interview about your involvement in the Child and Adolescent to Parent Violence and Abuse (CAPVA) Study. Before deciding whether to take part, please read the information below to understand what to expect. You are welcome to discuss it with your colleagues if you wish. If anything is unclear or you would like more details, please contact the research team. Our contact information is on the last page.

Why have I been invited to take part in an interview?

The University of Hertfordshire will be completing a Learning Report commissioned by the Youth Endowment Fund (YEF) following their decision to bring the CAPVA Study to an early close. As you

have played a key role in supporting the CAPVA Study, we would like you to share your insights into the CAPVA Study. By taking part in an interview, you will help us understand why the trial could not be delivered as planned and to explore how a similar trial might be successfully delivered in the future.

Do I have to take part?

No, you do not have to take part. Your participation is completely voluntary. If you choose to take part, you can withdraw at any time before or during the interview, or for up to one week afterwards, without giving a reason.

What are the possible disadvantages or risks of taking part?

We do not expect any direct risks from taking part. However, as the study is concluding earlier than originally planned, we appreciate that this may make the interview feel a little more challenging. Please know that your insights are still valuable to us, and we will do our best to make the process as straightforward and supportive as possible. You will have the chance to debrief with a member of the research team after the interview or you may wish to seek support from a colleague, if needed. For additional support, you may wish to access the local authority's employee assistance programme

What are the possible benefits of taking part?

Your insight into the delivery of the CAPVA study will be of benefit to the commissioned Learning Report. Evidence on interventions for CAPVA is closely aligned with the Government's wider strategy to halve violence against women and girls and improve responses to families in need. This Learning Report has the potential to direct the commissioning of future evaluations in this area.

What am I being asked to do?

If you choose to take part, you will be asked to complete a consent form. The research team will then contact you to arrange a convenient time for the interview. The interview will take place via Microsoft Teams (or in person if your preference is for a face-to-face interview) and will be recorded. The researcher will take notes if you do not wish for your voice to be recorded. It should last approximately half an hour. During the interview, you will be asked to share your experiences of engaging in the CAPVA Study.

We envisage interviewing local authority staff in pairs, or as a group. However, if you prefer to be interviewed by yourself, please let the research team know and we can arrange this.

What should I do if I am interested in taking part?

If you have decided to take part, please access the consent form using the Qualtrics link provided in the email invitation you received for the interview. A member of the research team will contact you to arrange the interview at a time that is convenient for you and your colleague(s), where appropriate.

If you have any questions, please contact the research team at capvastudy@herts.ac.uk, text or WhatsApp 07521 433517 or telephone 01707 284610 if you would prefer to speak to us directly.

Will the information I provide during the interview be kept confidential?

Yes, everything shared in the interview will be treated as confidential by the research team.

However, if you share something that raises a concern about safety or the wellbeing of you or anyone else, we may need to share that information. In such cases, the research team will contact the relevant designated safeguarding officer to agree on next steps.

Depending on the nature of the concern, we may need to report it to the YEF. You can read more about the YEF's policies here:

- YEF Serious Incident Policy
- YEF Safeguarding Policy

Furthermore, if you are interviewed with your colleague(s), we will ask all interview participants to respect each other's privacy and not share what was discussed.

What will happen to the information I provide?

Interviews will be recorded on Microsoft Teams or a portable digital voice recorder (if the interview is conducted in person). Teams recordings will be converted to audio-only files. All files will be stored securely using two-factor authentication on the University's Microsoft OneDrive data management account. Audio files will be transferred securely to a professional transcriber. Any names or identifying details will be removed from the transcripts. Once transcription is complete and checked, both the video (if recorded on Microsoft Teams) and audio recordings will be deleted.

If you do not want the interview recorded, the researcher will take handwritten notes instead. Any names or identifying details will not be written up and the notes will be stored in a locked cabinet at the University.

All data will be used for the purposes of this study. Transcripts will be analysed, and anonymised quotes, about delivering the study, may be included in the Learning Report. The Learning Report will be published on the YEF and University of Hertfordshire websites, shared with each local authority, and may help direct the commissioning of future research and evaluation in this area. If you would like a copy of the Learning Report, please let the research team know.

Will my identity be disclosed?

No, you will not be identifiable in the Learning Report or any reports or publications from this study. If we include a quote from you, it will be labelled with a general identifier (e.g. LA staff 1), and any names or specific places will be removed. Your contact details will be stored securely and separately from interview data. Only authorised members of the research team will access them to contact you if needed.

Can I withdraw data I provide?

Yes, you can request to withdraw your interview data, without giving a reason, by contacting the research team (contact details are on the last page). You can request withdrawal within one week of the interview. If you do, you will not be quoted in any publications.

However, full removal of your individual contributions may not be possible if you were interviewed with your colleague(s) as this data reflects shared discussion. For more information on this, see the UK Statistics Authority's guidance on limitations to consent in group settings, which can be found in the section called 'Ethical Consent'.

How will the interview data be stored?

All transcripts from interviews will be stored securely using two-factor authentication on the University's Microsoft OneDrive account. Only research team members involved in analysis and reporting will have access. If any paper documents are created (e.g. consent forms or handwritten notes during the interviews), they will be stored in a locked cabinet at the University.

The data will be handled and stored in accordance with the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR). If you have questions about your data, please contact the research team at capvastudy@herts.ac.uk.

To learn more about how the University of Hertfordshire uses your data, you can contact the University's Data Protection Officer below or view the University privacy policy:

Abi Tomlinson

University of Hertfordshire, College Lane, Hatfield, Hertfordshire, AL10 9AB

✉ dataprotection@herts.ac.uk

The University of Hertfordshire Privacy Policy is available from this link:

https://www.herts.ac.uk/__data/assets/pdf_file/0017/233090/IM08-Data-Protection.pdf

How long will the data be stored for?

Once transcripts are anonymised, all original interview recordings will be deleted. Anonymised transcripts will be securely stored using two-factor authentication on the University's Microsoft OneDrive account for up to 5 years after the study ends. Personal information that was stored for the purpose of the study (e.g. your name and email address) will be deleted at the end of the study.

Which body has reviewed this study?

The CAPVA Study has received ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH ethics protocol number is 0233-SFa-HSET-2025.

Who can I contact for further information?

Dr Caroline Cresswell (Trial Manager).

Professor Joanna Adler (Principal Investigator).

Department of Psychology, Sport and Geography,

School of Health, Medicine and Life Sciences,

University of Hertfordshire, College Lane, Hatfield, AL10 9AB

01707 284610 capvastudy@herts.ac.uk

What if I have any concerns about the conduct of this study?

If you have any concerns or wish to make a complaint about your participation, please contact the study's Principal Investigator, Professor Joanna R. Adler, at j.r.adler@herts.ac.uk.

If your concern is not resolved to your satisfaction, you may contact:

- The Chair of the UH Research Ethics Committee: ethicsadmin@herts.ac.uk.
- Or, Professor Wendy Wills, Pro Vice-Chancellor (Research and Enterprise): w.j.wills@herts.ac.uk.
  University of Hertfordshire, College Lane, Hatfield, AL10 9AB

Thank you for reading this information and considering taking part.

Appendix R The CAPVA Study Interview Consent Form

The CAPVA Study Interview Consent Form – LA Staff Recruitment Sites.

As above, four versions of the material included in this appendix were developed to accommodate the different site and professional statuses. The text included here was delivered via Qualtrics.

The CAPVA Study Interview Consent Form was sent to all LA and RISE staff who expressed an interest in the interview process. Specific role modifications were applied to each consent form where reference was made to *The CAPVA Study Participant Information Sheet* specific to that role.

The CAPVA Study Interview Consent Form

Local Authority Staff - Recruitment Sites

Trial Manager: Dr Caroline Cresswell

Principal Investigator: Professor Joanna Adler

✉ capvastudy@herts.ac.uk 01707 284610 07521 433517

Thank you for reading the participant information sheet [document added to consent form on Qualtrics for further reference]

If you would like to take part in an interview, please tick the boxes to show that you agree with the statements.

I confirm that I have read *The CAPVA Study Participant Information Sheet Local Authority Staff (Recruitment Sites) - Interviews v1.0 dated 01/12/2025* and have had the opportunity to consider the information and ask questions.	
I understand that participation is voluntary, and I can withdraw at any time without explanation.	
I understand that the interview will be held on Microsoft Teams, or in person if my preference is for a face-to-face interview and recorded. If I do not want the interview recorded, the researcher will take notes instead. I understand that video and audio recordings, and personal information used for the purpose of the study (e.g. name or email), will be destroyed after transcription and anonymisation.	
I understand that I may request withdrawal of data I provide, for up to one week after the interview. If the information was shared during a joint interview with another staff member, it may not be possible to remove all of it.	
I understand that all data from the interview will be securely stored and accessed only by the research team. Anonymised transcripts or notes will be kept securely for up to 5 years after the study ends.	
I understand that the information I share is confidential and will not be disclosed unless a concern is raised about the safety or the wellbeing of myself or anyone else, in which case the research team will contact the relevant safeguarding officer.	
I understand that anonymised data may be used in published findings (e.g. the Learning Report) and may be shared with other researchers to support further research.	

Please print name if you consent to take part in an interview:

[signature text box]

If you do not consent to take part, please close the browser. Thank you for your time.

To help arrange your interview, please answer the questions below:

How would you like the research team to contact you to arrange the interview?

Telephone

[branch logic to ask for number]

Email

[branch logic to ask for email]

Either

[branch logic to ask for number and email]

Please state below which days and times are best to contact you:

[free text box]

[Submit button]

Exit page:

Thank you for consenting to take part in an interview. A member of the research team will be in contact with you shortly.

If you have any questions in the meantime, please contact the research team at capvastudy@herts.ac.uk, text or WhatsApp 07521 433517, or telephone 01707 284610 if you would prefer to speak to us directly.

Appendix S Interview Schedule for LA Staff (Recruitment Sites)

The RISE CAPVA Study

Interview Schedule

Local Authority Staff – Recruitment Sites

Introduction

- Thank you for consenting to take part in this interview. Before we start, I'll just give a short overview of the participant information sheet.
- The interview will focus on your involvement and experience of the CAPVA Study. I will ask you questions about the CAPVA Study and not the RISE CAPVA Programme itself.
- The interviews will be used to produce a learning report, commissioned by the Youth Endowment Fund (the funders of the original study). The learning report will help inform the development of potential research or evaluation in this area.
- The research team is based at the University of Hertfordshire and is independent of both the Youth Endowment Fund and RISE Mutual CIC.
- The interview should last around half an hour. You can skip any question, take a break or stop the interview at any time. You can continue later or withdraw from the interview entirely if you wish.
- *Note for researcher: ensure you check-in midway to see how the participant is feeling and assess/ask whether they would benefit from a break.*
- Everything you share will be treated confidentiality. The only exception is if you disclose something that raises concerns about the safety of yourself or others. We will then notify the designated safeguarding lead in your borough, where it is deemed appropriate.
- [Where participants have agreed to a joint interview]. Thank you both/all for agreeing to be interviewed together. We ask that you each contribute as freely as possible, and we will do

our best to ensure that each voice is heard. As you will hear what your colleague/s say, then we ask that you respect each other's views, experiences and confidentiality.

- The learning report, further publications, or other ways we present findings, will be anonymised. Therefore, we will not include any names or any information that will identify you professionally or the families involved in the study.
- Is there anything you would like to ask me before we start?
- I would like to record this interview. Are you happy for me to start the recording?

[If yes to recording], I am now going to start the recording.

[If no to recording], I will write notes on what you say.

Note for researcher: If recording via MS Teams, ensure you make participants are aware that the video recording will be converted into an audio file. Tell them it is completely fine to turn off their camera if they wish to.

Part 1: Involvement in the CAPVA Study

I would like to start with a few questions about your role in the CAPVA Study.

1. Please tell me a little about your role in the local authority in relation to the CAPVA Study.
    - ***a.*** *Did you have to adapt your role in any way to fit in within the study's requirements?*
    - ***b.*** *If yes, do you feel adapting your existing role had any impact on your work?*

2. Why do you think your borough decided to take part as a site for the CAPVA Study?
    - ***a.*** *What do you believe were the expectations of the local authority, your team, and/or other stakeholders about what the study would achieve?*

Part 2: Your experience as site lead

I will now ask you some questions on your experience of acting as a site lead for the CAPVA Study.

1. Please tell me a bit about the experience of leading your local authority's participation in the CAPVA Study [N.B. ascertain if it was well-received or not].
    - ***a.*** *Were there any concerns expressed by senior leads? If so, please explain the nature of these concerns.*
    - ***b.*** *Were there any concerns expressed by practitioners? If so, please explain the nature of these concerns.*
    - ***c.*** *Were you able to address any of these concerns? If yes, what made the difference?*

2. I'm going to ask you to think about different stages of the study. Please tell me what you think worked well and what was more challenging within each of those stages. *[N.B. Ask them to state if they had no part in a stage(s)].*
    a. Study promotion with teams
    b. Referring to the study [N.B. probe on referral pathways, identification of lead professional and BAU]
    c. Gaining consent from families for study referral
    d. Liaising with RISE
    e. Liaising with the evaluators.
3. Where difficulties were identified, were you able to address them?
    a. *[If yes] How were these addressed?*
    b. *[If no] What would you have liked to have done to address them?*
4. What do you think could be done differently to avoid similar issues in future studies?

Part 3: Your views on the CAPVA Study

I would now like to move on to questions about your views on the CAPVA Study and gather your recommendations for any future evaluations in this area of practice.

1. Did the CAPVA Study bring any opportunities or benefits to your service?
    a. *What factors helped make this possible?*

2. What advice would you give to people working in another service, thinking about taking part in a study like this?
    a. *What should they know or prepare for in advance?*
    b. *Is there anything you wish you had known before joining the CAPVA Study?*
    c. *Do you have any recommendations for working with local authorities on a trial or other evaluation?*
3. Do you think your local authority would consider taking part in an evaluation again, in the future?
    a. *[if yes] What conditions or factors would make this possible?*
    b. *[If no] What changes might encourage participation?*

Part 4: Closing questions

Now for some questions to capture your final reflections.

1. What have been your main highlights during the CAPVA Study?
2. Is there anything else you would like to share about your experience of the CAPVA Study?
3. Do you have any questions to ask me?

Thank you so much for taking part in this interview.

Note for researcher: State you will now turn off the recording, reaffirm that you are available for debrief and state next steps.

Appendix T Interview Schedule for LA Staff (Non-Onboarded Sites)

Introduction

- Thank you for consenting to take part in this interview. Before we start, I'll just give a short overview of the participant information sheet.
- The interview aims to understand why [named LA] felt unable to sign up as a RISE CAPVA Study site. Therefore, the interview will focus on the reasons why the local authority felt unable to support the CAPVA Study, rather than the RISE CAPVA Programme itself - an intervention designed to support families experiencing child and adolescent to parent violence and abuse.
- The interviews will be used to produce a learning report, commissioned by the Youth Endowment Fund (the funders of the original study). The learning report will help inform the development of potential research or evaluation in this area.
- The research team is based at the University of Hertfordshire and is independent of the Youth Endowment Fund and services involved in this study, including RISE Mutual CIC (whose CAPVA/NVR (non-violent resistance) Programme, the University were commissioned to evaluate).
- The interview should last around half an hour. You can skip any question, take a break or stop the interview at any time. You can continue later or withdraw from the interview entirely if you wish.
- *Note for researcher: ensure you check-in midway to see how the participant is feeling and assess/ask whether they would benefit from a break.*
- Everything you share will be treated confidentiality. The only exception is if you disclose something that raises concerns about the safety of yourself or others. We will then notify the designated safeguarding lead in your borough, where it is deemed appropriate.

- [Where participants have agreed to a joint interview]. Thank you both/all for agreeing to be interviewed together. We ask that you each contribute as freely as possible, and we will do our best to ensure that each voice is heard. As you will hear what your colleague/s say, then we ask that you respect each other's views, experiences and confidentiality.
- The learning report, further publications, or other ways we present findings, will be anonymised. Therefore, we will not include any names or any information that will identify you professionally.
- Is there anything you would like to ask me before we start?
- I would like to record this interview. Are you happy for me to start the recording?

[If yes to recording], I am now going to start the recording.

[If no to recording], I will write notes on what you say.

Note for researcher: If recording via MS Teams, ensure you make participants aware that the video recording will be converted into an audio file. Tell them it is completely fine to turn off their camera if they wish to.

Part 1: Your impressions of the CAPVA Study

I would like to start by asking you a few questions about your initial impressions of the CAPVA Study.

1. When did you first hear about the CAPVA Study?
    - ***a.*** *Did you see the potential for evaluating responses to CAPVA?*
    - ***b.*** *Did you have any concerns about the CAPVA Study?*
    - ***c.*** *Can you recall your thoughts on its potential for your service?*

2. If you communicated with your local authority senior leadership and/or your teams about the study, how did they respond? [N.B. ascertain if it was well-received or not]
    - ***a.*** *Were there any concerns expressed by senior leads? If so, please explain the nature of these concerns.*
    - ***b.*** *Were there any concerns expressed by practitioners? If so, please explain the nature of these concerns.*

Part 2: Reasons why the local authority did not support the CAPVA Study

I would now like to ask questions to understand why the service did not get involved and gather your recommendations for any future evaluations in this area of practice.

1. As you know, this interview is about understanding why [named LA] was not involved in the CAPVA study. Could you please tell me a bit more about the reasons [named LA] did not become a referrer for the CAPVA Study (i.e. refer into the randomised controlled trial)?

2. What challenges or barriers do you think contributed to [named LA] not being able to act as a referrer for the CAPVA Study?

3. If another research project on CAPVA were commissioned in the future, what do you think would need to change to secure (or at least to facilitate) the local authority's involvement?
    a. *[N.B. probe on if any action from the following may have made a difference: research commissioners, the evaluators, the LA/other services, the delivery team].*

Part 3: Closing questions

Finally, I would like to ask you some closing questions.

1. Is there anything else you would like to share?

2. Do you have any questions to ask me?

Thank you so much for taking part in this interview.

Note for researcher: State you will now off the recording, reaffirm that you are available for debrief and state next steps.

Appendix U Interview Schedule for RISE Staff (Management)

Introduction

- Thank you for consenting to take part in this interview. Before we start, I'll just give a short overview of the participant information sheet.
- The interview will focus on your involvement and experience of the CAPVA Study. I will ask you questions about the CAPVA Study, and not the RISE CAPVA Programme itself.
- The interviews will be used to produce a learning report, commissioned by the Youth Endowment Fund (the funders of the original study). The learning report will help inform the development of potential research or evaluation in this area.
- The research team is based at the University of Hertfordshire and is independent of both the Youth Endowment Fund and RISE Mutual CIC.
- The interview should last around half an hour. You can skip any question, take a break or stop the interview at any time. You can continue later or withdraw from the interview entirely if you wish.
- *Note for researcher: ensure you check-in midway to see how the participant is feeling and assess/ask whether they would benefit from a break.*
- Everything you share will be treated confidentiality. The only exception is if you disclose something that raises concerns about the safety of yourself or others. We will then notify the relevant designated safeguarding lead, where it is deemed appropriate.
- [Where participants have agreed to a joint interview]. Thank you both/all for agreeing to be interviewed together. We ask that you each contribute as freely as possible, and we will do our best to ensure that each voice is heard. As you will hear what your colleague/s say, then we ask that you respect each other's views, experiences and confidentiality.
- The learning report, further publications, or other ways we present findings, will be anonymised. Therefore, we will not include any names or any information that will identify you professionally or the families involved in the study.

- Is there anything you would like to ask me before we start?
- I would like to record this interview. Are you happy for me to start the recording?

[If yes to recording], I am now going to start the recording.

[If no to recording], I will write notes on what you say.

- *Note for researcher: If recording via MS Teams, ensure you make participants aware that the video recording will be converted into an audio file. Tell them it is completely fine to turn off their camera if they wish to.*

Part 1: Involvement in the CAPVA Study

I would like to start with a few questions about your role in the CAPVA Study and your expectations of the evaluation.

1. Please tell me a little about your role in the CAPVA Study.

2. Why was it important to evaluate the RISE CAPVA Programme?
    a. *What did you hope the evaluation would achieve?*

Part 2: Experience of the CAPVA Study

I will now ask you some questions about your experience during the CAPVA Study.

1. At the beginning of the study, how was the research received among the staff?
    a. *Were there any concerns expressed?*
    b. *If yes, were there any changes made at this stage?*

2. When liaising with local authorities to help secure their participation in the evaluation of the RISE CAPVA Programme, what was their reaction to the study?
    a. *Were any local authorities enthusiastic about taking part in an evaluation of the RISE CAPVA Programme? If so, did they express why?*
    b. *Did any local authorities express any reservations or concerns about taking part? If so, did they express why?*

3. Were any local authorities particularly reticent about an evaluation of the RISE CAPVA Programme?
    a. *If so, did they express why?*

   - ***b.*** *N.B. Probe on perceived basis of reticence – the RISE CAPVA Programme itself? The term CAPVA? The study? Service context? Risk aversity?*
   - ***c.*** *Were you able to 'win over' any sites that expressed initial reticence? If yes, what made the difference?*
4. I'm going to ask you to think about different stages of the study. Please tell me what you think worked well and what was more challenging within each of those stages.
   - **a.** Study promotion
   - **b.** Referrals
   - **c.** Family recruitment (including triage and screening stages)
   - **d.** Programme delivery as part of the study
   - **e.** Ongoing communication with LAs

5. Where difficulties were identified, were you able to address them?
   - ***a.*** *[If yes] How were these addressed?*
   - ***b.*** *[If no] What would you have liked to have done to address them?*

Part 3: Any future evaluation

I would now like to hear any recommendations you may have for a future evaluation in this area of practice.

1. What advice would you give to anyone evaluating the RISE CAPVA Programme or something similar, in the future?
   - ***a.*** *What should they know or prepare for beforehand?*
   - ***b.*** *Is there anything you wish you had known before being involved in the CAPVA study?*
   - ***c.*** *Do you have any recommendations for working with local authorities on a trial or other evaluation?*

2. What do you think could be done differently to avoid similar issues in any future evaluation?

Part 4: Final reflections

Now for some questions to capture your final reflections.

1. What have been your main highlights during the CAPVA Study?
2. Is there anything else you would like to share about your experience during the CAPVA Study?
3. Do you have any questions to ask me?

Thank you so much for taking part in this interview.

Note for researcher: State you will now off the recording, reaffirm that you are available for debrief and state next steps.

Appendix V Interview Schedule for RISE Staff (CAPVA Practitioners)

Introduction

- Thank you for consenting to take part in this interview. Before we start, I'll just give a short overview of the participant information sheet.
- The interview will focus on your involvement and experience of the CAPVA Study. I will ask you questions about the CAPVA Study, and not the RISE CAPVA Programme itself.
- The interviews will be used to produce a learning report, commissioned by the Youth Endowment Fund (the funders of the original study). The learning report will help inform the development of potential research or evaluation in this area.
- The research team is based at the University of Hertfordshire and is independent of both the Youth Endowment Fund and RISE Mutual CIC.
- The interview should last around half an hour. You can skip any question, take a break or stop the interview at any time. You can continue later or withdraw from the interview entirely if you wish.
- *Note for researcher: ensure you check-in midway to see how the participant is feeling and assess/ask whether they would benefit from a break.*
- Everything you share will be treated confidentiality. The only exception is if you disclose something that raises concerns about the safety of yourself or others. We will then notify the relevant designated safeguarding lead, where it is deemed appropriate.
- [Where participants have agreed to a joint interview]. Thank you both/all for agreeing to be interviewed together. We ask that you each contribute as freely as possible, and we will do our best to ensure that each voice is heard. As you will hear what your colleague/s say, then we ask that you respect each other's views, experiences and confidentiality.

- The learning report, further publications, or other ways we present findings, will be anonymised. Therefore, we will not include any names or any information that will identify you professionally or the families involved in the study.

- Is there anything you would like to ask me before we start?
- I would like to record this interview. Are you happy for me to start the recording?

[If yes to recording] I am now going to start the recording.

[If no to recording], I'll write notes on what you say.

Note for researcher: if recording via MS Teams, ensure you make participants aware that the video recording will be converted into an audio file. Tell them it is completely fine to turn off their camera if they wish to.

Part 1: Involvement in the CAPVA Study

I would like to start with a few questions about your role in the CAPVA Study.

1. Please tell me a little about your role in the CAPVA study.
    - ***a.*** *Did you have to adapt your role in any way to fit in within the study's requirements?*
    - **b.** *If yes, do you feel adapting your existing role had any impact on your work?*

2. When you first heard about the study, can you remember what you thought of it?
    - **a.** *[N.B. Ask where appropriate] What did you hope the evaluation would achieve?*
    - ***b.*** *Did you have any concerns? If yes, did you feel able to voice them?*

Part 2: Your experiences during the CAPVA Study

I will now ask you some questions about your experience during the CAPVA Study.

1. Please think about different stages of the study. Please tell me what you think worked well and what was more challenging within each of those stages.
   [N.B. Ask them to state if they had no part in a stage(s)].
    - **a.** Study promotion

   b. Referrals
   c. Family recruitment (including triage and screening stages)
   d. Programme delivery as part of the Study
   e. Communication with local authorities for the study

2. Where difficulties were identified, were you able to address them?
   a. *[If yes] How were these addressed?*
   b. *[If no] What would you have liked to have done to address them?*

3. What do you think could be done differently to try to avoid similar issues in future studies?

Part 3: Final reflections on the CAPVA Study

Now for some questions to capture your final reflections.

1. What have been your main highlights during the CAPVA Study?

2. What advice might you give to another practitioner involved in similar research?
   a. *Is there anything you wish you had known before becoming involved?*

3. Is there anything else you would like to share about your experience during the CAPVA Study?

4. Do you have any questions to ask me?

Thank you so much for taking part in this interview

Note for researcher: State you will now off the recording, reaffirm that you are available for debrief and state next steps.

Appendix W Standards for Reporting Qualitative Research (SRQR)

http://www.equator-network.org/reporting-guidelines/srqr/

Title and abstract	**Section**
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	Cover page
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	Executive summary
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	Research methods
Purpose or research question - Purpose of the study and specific objectives or questions	Additional activity research questions
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	Research methods/qualitative analysis
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	Ethics, reflexivity and trial registration
Context - Setting/site and salient contextual factors; rationale**	Intervention
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	Additional activity participants
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	Ethics, reflexivity and trial registration
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	Additional activity design

Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	Appendices
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	Then report participants
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	Data collection-additional activity
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	Qualitative analysis
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	Qualitative analysis
Results/findings	
Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	Interview findings
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	Interview findings
Discussion	
Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	IPE interpretation
Limitations - Trustworthiness and limitations of findings	IPE interpretation
Other	
Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	See reflexivity
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	About the Youth Endowment Fund

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388