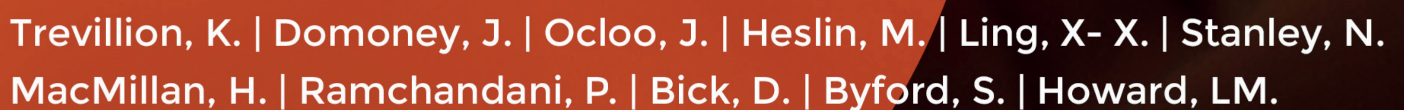
for baby's sake
break the cycle

KING'S College LONDON

Final Evaluation Report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Glossary

Accident and Emergency
Accident and Emergency services are hospital-based rooms or departments that provide care to people who have severe injuries or sudden illnesses and require emergency treatment.

Adverse Childhood Experiences (ACEs)
Adverse childhood experiences (ACEs) are defined as traumatic or stressful experiences that occur in childhood, including physical, sexual, emotional abuse, neglect, exposure to domestic violence and abuse, parental separation, growing up in a household where there are adults with mental health or drug or alcohol problems or who have spent time in prison.

Domestic Violence and Abuse (DVA)
Domestic violence and abuse can be defined as any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass, but is not limited to:

- psychological abuse
- physical abuse
- sexual abuse
- financial abuse
- emotional abuse

For Baby's Sake **three-way [therapeutic practitioner] model**
The three-way model describes the delivery model of having different practitioners working separately and therapeutically with the father and mother to end the domestic abuse; overcome the impact of the abuse; and nurture the development of the baby and any other children in the family. The practitioners in the team work closely together to manage the risks within each family member's journey and to act swiftly to address any safeguarding concerns that may emerge.

For Baby's Sake **prototype phase**
The *For Baby's Sake* prototype phase describes the initial operation of the programme from 2015 to the end of 2019 in the two prototype sites: Hertfordshire and London Three Boroughs.

For Baby's Sake **whole-family approach**
The whole-family approach developed by *For Baby's Sake* aims to support the entire immediate family unit in addressing the cycles of domestic violence and abuse (including the impact of parents' own childhood experiences of adversity) and seeks to improve parents' mental health, babies' development (especially emotional and social) and parent-child attachment outcomes.

Health Visitor
A health visitor is a nurse whose job it is to visit people in their homes and offer advice on matters such as how to look after very young babies.

Improving Access to Psychological Therapies (IAPT)
IAPT is an England and Wales wide programme, which began in 2008, with the direct objective to improve access for people with anxiety and depression to evidenced-based psychological therapies, such as Cognitive Behavioural Therapy.

Independent Domestic Violence Advisor (IDVA)
The main purpose of Independent Domestic Violence Advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk. They also discuss the range of suitable options leading to the creation of a workable safety plan.

Independent Sexual Violence Advisor (ISVA) Independent Sexual Violence Advisors (ISVAs) are specially trained and can support and advise female and male survivors of rape and sexual abuse, regardless of when it happened. The role of an ISVA is to provide support, advocacy and follow-up including support throughout the criminal justice process, should people choose that route.

Local Safeguarding Children Board/Partnership (LSCB/LSCP)
The Local Safeguarding Children Boards (recently reshaped to become Local Safeguarding Children Partnerships) seek to enhance the safety and wellbeing of children by supporting organisations working with children to meet their statutory responsibilities for safeguarding and to promote the welfare of children. LSCBs/LSCPs coordinate the work to safeguarding children and make sure this work is effective in improving outcomes for children.

Multi-Agency Safeguarding Hub (MASH)
The MASH brings together a team of multi-disciplinary professionals from relevant local public sector agencies into the same room to deal with all safeguarding concerns, where someone is concerned about the safety or well-being of a child. Information from relevant agencies is collated to assess risk and decide what action to take. As a result, the agencies will be able to act quickly, in a coordinated and consistent way, ensuring that vulnerable children and families are kept safe from harm.

Multi-Agency Risk Assessment Conference (MARAC)
MARACs consist of statutory and voluntary services collaborating to plan individually tailored support to protect victims at high risk of harm.

Perinatal period
There is no universally agreed definition of when the perinatal period commences and ends. For the purposes of this project, the intention is to capture early interventions in the life of the child which have the potential to be preventative. There is growing consensus, based on a wealth of evidence from longitudinal studies about adverse outcomes for children, that the period from conception to age two is a particularly important stage at which to target preventative intervention efforts. Therefore, this project defines the 'perinatal period' as occurring from conception up to 24 months postnatally.

Psychosocial interventions

Psychosocial interventions refer to therapeutic techniques that are non-pharmacological (i.e. they do not involve medication) and which seek to address the psychological or social aspects of an individual/group of individuals.

Public Law Outline process

These are meetings that are called if the Local Authority and Social Workers are concerned about the care that a child is receiving. The Public Law Outline process involves making an application to the Court to see if the Court will make orders to protect the child.

Randomised controlled trial (RCT)

A randomised controlled trial (RCT) study in which similar people are randomly assigned to 2 (or more) groups to test a specific treatment or intervention. One group (the experimental group) receives the intervention being tested, the other (the comparison or control group) has an alternative intervention, an intervention (placebo) or no intervention at all. The groups are followed up to see how effective the experimental intervention was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically.

Violence Against Women and Girls (VAWG) services

These are services that work to address acts of violence committed against women or girls that have resulted, or are likely to result in, physical, sexual or mental harm or suffering. Acts of violence can include threats of violence, coercion or arbitrary deprivation of liberty in the public or private sphere.

Abbreviations

A&E – Accident and Emergency service

ACEs – Adverse Childhood Experiences

AD-SUS - Adult Service Use Schedule

AUDIT - The Alcohol Use Disorders Identification Test

CAN-M – Camberwell Assessment of Need Mother's Version

CAS – Composite Abuse Scale

CAMHS – Child and Adolescent Mental Health Service

CEACs - cost-effectiveness acceptability curves

CIs - confidence intervals

DVA - Domestic Violence and Abuse

DUDIT - The Drug Use Disorders Identification Test

EPDS - Edinburgh Postnatal Depression Scale

EQ-5D-5L - The five-level version of the EuroQol measure of health-related quality of life

GAD-7 - Generalised Anxiety Disorder Assessment

GIG – Give it a Go exercises

IAPT – Improving Access to Psychological Therapies

IDVA – Independent Domestic Violence Advisor

ICERs - incremental cost-effectiveness ratios

LA – Local Authority

LSCB - Local Safeguarding Children Board

LSCP – Local Safeguarding Children Partnership

MARAC – Multi-Agency Risk Assessment Conference

NBO – Newborn Behavioural Observation

NHS – National Health Service

PDS – Posttraumatic Diagnostic Scale

QALYs – Quality-Adjusted Life Years

RCT – Randomised controlled trial

SAPAS – The Standardised Assessment of Personality – Abbreviated Scale

VAWG – Violence Against Women and Girls

VIG – Video Interaction Guidance

WEMWBS – Warwick-Edinburgh Mental Wellbeing Scale

Background to the research evaluation

The extent and nature of domestic violence and abuse

Domestic Violence and Abuse (DVA) can be defined as the use of threatening behaviour, violence or abuse committed by a relative, partner or ex-partner against someone aged 16 years and above. Latest figures published in a nationally representative survey of people aged 16-59 years in England and Wales show that women are twice as likely as men to have experienced DVA in the past year; an estimated 1.3 million women and 695,000 men reported DVA in the last year (Office for National Statistics, 2018a). Recurring acts of DVA, coercive controlling abuse, sexual abuse and more severe forms of DVA are also much more likely to be reported by women than men (Ansara and Hindin, 2010, Myhill, 2015, Office for National Statistics, 2018a). Women are also twice as likely to report DVA from a partner/ex-partner than men (Office for National Statistics, 2018a).

Police-recorded DVA offences increased by 23% from 2017 to 2018, and the percentage of convictions for DVA offences is at its highest since 2010, with 76% of prosecutions ending in convictions in England and Wales (Office for National Statistics, 2018a). Alongside criminal justice contacts, people who experience DVA frequently present at Accident and Emergency (A&E) services, primary care and mental health services. DVA is also present in other health service contacts, such as antenatal services, with prevalence estimates for DVA in pregnancy ranging from 3% to 30% (Van Parys *et al.*, 2014). Perhaps not surprisingly then, we see that DVA accounts for more than 3% of the NHS budget (Walby, 2004).

Traumatic events in childhood and its relationship to domestic violence and abuse

Adverse childhood experiences (ACEs) are defined as traumatic or stressful experiences that occur in childhood, including physical, sexual, emotional abuse, neglect and exposure to DVA (Hughes *et al.*, 2017). Evidence indicates that children who are exposed to four or more ACEs in childhood are at increased risk of experiencing physical and mental health problems throughout the lifetime (Dube *et al.*, 2003, Edwards *et al.*, 2003, Nusslock and Miller, 2016, Reuben *et al.*, 2016). A recent systematic review also demonstrated a strong link between four or more ACE experiences and victimisation and perpetration of interpersonal abuse, including DVA, in adulthood (Hughes *et al.*, 2017). Other work supports these findings, with evidence to suggest that exposure to DVA in childhood is associated with DVA victimisation and perpetration in adolescent relationships and during adulthood (Fergusson and Horwood, 1998, Roberts *et al.*, 2010, Russell *et al.*, 2010). Among those who perpetrate DVA, experience of childhood abuse is common, and this is a risk factor for both mental health problems and DVA perpetration (Machisa *et al.*, 2016). ACEs are found to be associated with perceived parental stress and parent-child conflicts, with this association largely explained through the presence of maternal mental health problems (Guss *et al.*, 2018, Sun *et al.*, 2017).

Domestic violence and abuse and mental health

Strong associations are found between DVA victimisation/perpetration and a range of mental health problems, including depression, anxiety, substance use, post-traumatic stress disorder and eating disorders (Bundock *et al.*, 2013, Devries *et al.*, 2014, Oram *et al.*, 2014, Trevillion *et al.*, 2012). Mental health problems may arise as a direct result of experiencing DVA. In addition, people with mental health problems are more likely to experience DVA than those without mental health problems (Khalifeh *et al.*, 2015, Trevillion *et al.*, 2012). A bi-directional relationship is, therefore, observed whereby DVA may lead to the development of mental health problems and those with mental health problems are more vulnerable to experiencing DVA (Chandan *et al.*, 2019).

Impacts of domestic violence and abuse on parents and children

Pregnancy can be a time of vulnerability for DVA due to changes in the physical, emotional, social and economic demands on mothers and fathers. DVA in pregnancy is associated with poor obstetric outcomes including low-birth weight and pre-term birth (Hill et al., 2016). DVA is also a strong risk factor for antenatal and postnatal depression (Howard et al., 2013). DVA is found to extend to the postnatal period and early childhood period (Howard et al., 2013). Indeed, it is estimated that around 1 in 5 children in the UK experience DVA during their childhood (Radford *et al.*, 2011) and children living in a household with DVA are 30-60% more likely to experience child abuse (Hester *et al.*, 2007, Humphreys and Thiara, 2002).

DVA can have profound consequences on the physical and psychological well-being of children throughout childhood and adolescence (Cawson, 2002, Davies, 2008, Holt *et al.*, 2008, Kitzmann *et al.*, 2003, Stanley, 2011, Wolfe *et al.*, 2003). Several studies have shown significant associations, independent of other risk factors, between children's exposure to parental DVA and adjustment problems such as poor peer relationships, low academic attainment and engagement in risky health behaviours (Kitzmann *et al.*, 2003, Wolfe *et al.*, 2003). In addition, exposure to DVA in the first 1001 days of life (i.e. from conception to the age of two) is associated with adverse outcomes including poor mental/physical health, lower academic achievement, and impaired social development (Burke *et al.*, 2008, Evans *et al.*, 2008, Huth-Bocks *et al.*, 2002, Shay-Zapien and Bullock, 2010). A mother's emotional state can have a direct influence on fetal development, by altering the environment in the womb (Glover and Capron, 2017). Ongoing stressors, such as DVA, can disrupt neurodevelopment which impacts the cognitive functioning and emotional regulation of children; this can in turn shape behavioural and emotional outcomes (NSCDC., 2007). Sensitive, attuned caregiving by parents provides an important foundation for the development of secure and healthy attachments, particularly in the first 1001 days of life; these attachment styles shape the relationships that children form across their lifetime. Unfortunately, DVA can affect a parent's ability to provide consistent, sensitive caregiving; this is particularly relevant among parents who did not receive this level of caregiving themselves (Barlow and Underdown, 2017).

Interventions to address domestic violence and abuse experienced by families

Pregnancy and childbirth are major milestones in the lives of many mothers and fathers. The transition to parenthood brings rewards as well as challenges for both parents (Gottman and Notarius, 2000), including an increase in relationship distress among couples (Morse *et al.*, 2000). The perinatal period (defined here as the period from conception until 24 months after birth) can be a significant motivator for change. Indeed, this period presents an opportune time to intervene to prevent DVA and to promote healthy relationships between parents and children. Presently, however, interventions have generally focused on supporting the needs of victims/survivors alone and few also seek to target DVA, and its associated consequences, in conjunction with perpetrators and children. Even fewer interventions adopt a whole-family approach that seeks to address the mental health problems experienced by parents and protect and support the mental health of the baby and other children in the family. Indeed, we conducted a systematic review as part of this evaluation to identify perinatal psychosocial interventions (i.e. interventions that emphasise psychological or social factors rather than biological factors) among parents who report interpersonal abuse victimisation (i.e. people with experience of child maltreatment and/or DVA), and our results support these summaries.

Systematic review of psychosocial interventions

Our systematic review examined experimental studies, including randomised controlled trials (RCTs) and non-randomised controlled trials, cluster-randomised trials, parallel group studies and quasi-experimental studies (including pre-post designs, cohort studies and time series studies). Eligible studies needed to have conducted psychosocial interventions with women who were pregnant or in the first two years post childbirth, and/or their partners/children (if the intervention included them); at least half of the women in each intervention needed to have experience of interpersonal abuse victimisation (i.e. childhood maltreatment and/or DVA victimisation). Included studies must have measured physical and/or mental health or social care outcomes for the parent and/or child.

We identified 12 interventions, seven conducted in the USA, one in Australia, one in New Zealand, one in Hong Kong, one in Peru and one in the Netherlands; no studies were conducted in the UK. A total of seven of the 12 interventions were targeted at mothers only (Cripe *et al.*, 2010, McFarlane *et al.*, 2000, Parker *et al.*, 1999, Sharps *et al.*, 2016, Taft *et al.*, 2011, Tiwari *et al.*, 2005, Zlotnick *et al.*, 2011), and three were targeted towards mothers and their children only (Ammerman *et al.*, 2016, Lavi *et al.*, 2015, Mejdoubi *et al.*, 2015). Only two of the 12 interventions were also targeted at fathers and delivered a co-parenting intervention (Bugental *et al.*, 2002, Fergusson *et al.*, 2005) (N.B. one of the interventions was only able to present data on mothers due to a lack of engagement from fathers (Bugental *et al.*, 2002)). Five of the 12 interventions described home visitation intervention programmes for at-risk/abused families. Six of the 12 studies described non-home-visitation-based interventions of therapeutic models, including empowerment models (n=3), psychotherapeutic models (n=2) and counselling models (n=1); one study described a mentoring intervention. Further details about these studies can be found in Appendix 2 (see also PRISMA diagram in Appendix 3 for details on the review search outcomes) and are summarised in the next two sections.

Randomised controlled trials

Home Visitation based interventions

Ammerman et al (2016) conducted a randomised controlled trial (RCT) in the USA which examined the influence of child maltreatment history on responses to an adapted cognitive behavioural therapy model integrated within a home visitation programme - In-Home Cognitive Behavioural Therapy (IH-CBT). IH-CBT consisted of fifteen 60-minute weekly sessions, which delivered principles and techniques of Cognitive Behavioural Therapy with strategies that sought to: (1) promote engagement, (2) make content relevant to the needs of mothers (e.g. addressing primary concerns of young, low income new mothers who were socially isolated), (3) facilitate delivery in the home, and (4) engender collaborative relationships between the therapist and home visitor. A total of 93 mothers who reported childhood maltreatment and who had major depressive disorder participated in the trial. Women were randomised to receive either IH-CBT plus home visiting (n=47) or standard home visiting only (n=45). The authors found that many mothers participating in the home visitation programme reported moderate to severe levels of childhood maltreatment (Ammerman et al., 2016). Maltreatment history among mothers was found to be associated with depression, impaired social functioning and lower nurturing and stimulating parenting behaviours, regardless of what treatment condition women were allocated to. The authors concluded that mothers with childhood maltreatment histories may require more sessions of treatment to target trauma-related clinical features (Ammerman *et al.*, 2016).

Sharps et al (2016) conducted an RCT in the USA that compared a Domestic Violence Enhanced Home Visitation Programme (DOVE), embedded within a routine home visitation programme, against a standard home visitation programme model. The DOVE intervention comprised a structured brochure-based empowerment model, with six sessions between 15-25 minutes in length, that provided information on the cycle of violence, safety planning, and local partner violence support services. A total of n=239 pregnant women who experienced partner violence from a current or former partner were randomised to the DOVE intervention (n=124) or the standard home visitation programme (n=115). Women in both groups reported reductions in partner violence in the postnatal period, although women receiving the DOVE intervention reported significantly greater reductions (Sharps *et al.*, 2016).

Bugental et al (2002) conducted a USA RCT examining the increased benefit of adding a cognitive retraining component within a home visitation programme designed to prevent child maltreatment. The cognitive retraining component was delivered as a two-part procedure, involving strategies to support shifts in mother's primary appraisal processes (i.e. causal appraisal of reasons for caregiving difficulty) and secondary appraisal processes (i.e. problem-focused coping). A total of 96 mothers, half of whom reported childhood abuse, were randomly assigned to receive either: (1) home visitation including a cognitive retraining component and an information resource about local support services (n=35), (2) a home visitation programme and an information resource about local support services (n=34), (3) an information resource about local support services (n=27). At post-treatment assessments, mothers receiving the home visitation plus cognitive retraining component reported significantly lower levels of harsh parenting than the other two conditions; incidents of physical abuse towards children were also considerably lower among mothers receiving the home visitation plus cognitive retraining component (Bugental *et al.*, 2002).

A New Zealand RCT conducted by Fergusson et al (2005) compared the effectiveness of an Early Start home visitation programme to no intervention, over a 36-month period among

427 at-risk families. Half of all participating families reported experiences of child maltreatment; current partner violence was also frequently reported. The Early Start home visitation programme was based on social learning models and comprised: (1) assessment of family needs, issues, strengths/challenges and resources; (2) problem-solving of family challenges; (3) mentoring, advice and support to mobilise the strengths and resources of families and to support families during the pre-school childhood years. Post-intervention, families receiving Early Start (n=206) reported significantly higher levels of positive and non-punitive parenting and significantly lower levels of perpetration of severe physical assault against their children, compared to families not receiving the intervention (n=221); children of families receiving Early Start also had better behavioural adjustment (Fergusson *et al.*, 2005).

Mejdoubi et al (2015) assessed the effectiveness of a Nurse-Family Partnership home visitation programme adapted for implementation to young disadvantaged families in the Netherlands (the VoorZoog intervention). Four-hundred and sixty pregnant women were randomly assigned to either the VoorZorg intervention (n=237) or usual care (n=223); over half of the sample reported partner violence victimisation. The VoorZorg intervention comprised ten visits during pregnancy, 20 in the first-year post childbirth and 20 in the second-year post childbirth. During each visit, topics in six domains (i.e. personal health, environmental health, life-course development, maternal role, family and friends, statutory services) were delivered using well-structured manuals. The authors found that women receiving the intervention had significantly lower Child Protection Service contacts for their children than women receiving usual care. Children's internalising behaviours were also lower among mothers receiving the intervention than women receiving usual care; no statistically significant differences were found between the groups in relation to a positive home environment (Mejdoubi *et al.*, 2015).

Following our review, we identified a subsequent evaluation of a nurse home visitation programme conducted by a group of Canadian academics (this paper is not included in the table of Appendix 2 as it did not form part of our review). This evaluation augmented a partner violence intervention within several USA nurse home visitation programmes (Jack *et al.*, 2019). The nurse home visitation programme involved nurses delivering up to 64 regular visits with women from early pregnancy to the child's second year birthday. In each visit, work was done around personal and environmental health, life-course development, maternal role, family and friends and statutory services. The study's augmented partner violence model comprised: (1) detailed partner violence education for home visitation nurses; (2) universal assessment of safety or case-finding approaches to identify partner violence; (3) empathic nurses' responses to disclosures of partner violence; (4) risk assessment; (5) nurse assessment of mental health and substance use needs, alongside assessment of women's readiness to address partner violence; (6) education for women around safety, impacts of partner violence on health, self-efficacy and system navigation when seeking support. The nurses delivering this augmented programme were also given guidelines for reflective supervision, a checklist to assist implementation of the model at their site and a clinical pathway to guide decision making. The authors evaluated the success of this model using a cluster RCT design, whereby programme sites rather than individual participants were randomly allocated to receive the intervention. The authors found that the additional partner violence components embedded within the nurse home visitation programme did not significantly improve women's quality of life or mental health outcomes, over and above what the standard programme achieved. In summarising the findings, the authors note that fidelity to the augmented intervention was

low among nurses and less than half of women who disclosed partner violence received one or more of the tailored intervention components (Jack *et al.*, 2019).

Non-Home visitation-based interventions

Our systematic review also identified five RCTs which described therapeutic interventions based on empowerment models, psychotherapeutic models, counselling models and a mentoring intervention (as described below).

Zlotnick et al (2011) conducted a USA RCT of an Interpersonal Psychotherapy intervention compared to standard care among 54 pregnant women who had experienced abuse from their partners in the previous year. The Interpersonal Psychotherapy intervention consisted of four 60-minute sessions, delivered over one month, that sought to: (1) decrease isolation and enhance participants' social networks, (2) improve their interpersonal relationships and change their expectations of them, and (3) master their role transition to parenthood. Moderate effects were found for the intervention in reducing women's depressive and post-traumatic stress symptoms during pregnancy. However, at three months post childbirth, no significant differences were observed between the two groups in relation to women's major depressive episodes, post-traumatic stress symptoms or partner violence victimisation (Zlotnick *et al.*, 2011).

McFarlane et al (2000) conducted a USA RCT to examine the effectiveness of three types of DVA interventions among 329 pregnant Hispanic women reporting partner violence in a current relationship. The three interventions comprised: (1) a brief intervention of a wallet-sized resource card on partner violence, including phone numbers of local support services and information about personal safety planning; (2) a counselling intervention, consisting of unlimited counselling sessions focused on support and education around partner violence; (3) an outreach intervention comprising unlimited counselling sessions plus the services of a "mentor mother" who offered support, education and referral for partner violence. The interventions were delivered throughout pregnancy. The authors found that severity of partner abuse significantly reduced among women, regardless of which of the three types of interventions they received (McFarlane *et al.*, 2000).

An Australian cluster RCT conducted by Taft et al (2011) compared the effectiveness of a mentoring programme (titled MOSAIC) against usual care among 174 at-risk pregnant women engaged with primary care services; over 70% of women reported partner abuse. The MOSAIC intervention comprised three to twelve months of weekly/fortnightly mentoring, delivered by trained non-professionals who provided befriending, domestic violence advocacy, support for depression, parenting, safety and self-care and information on legal and parenting services. Women receiving the intervention (n=113) reported less partner violence at the twelve-month post-treatment than women in the comparison condition (n=61); all other outcomes did not show a trend in favour of the intervention (Taft *et al.*, 2011).

Tiwari et al (2005) conducted an RCT in Hong Kong to test the effectiveness of an empowerment intervention (based on the Parker et al 1992 model (see below)) against a wallet-sized resource card on partner violence. A total of 110 pregnant women who had been physically, emotionally and/or sexually assaulted by their partners in the previous year were randomised to the empowerment intervention (n=55) or the resource card condition (n=55). The empowerment intervention consisted of a single 30-minute session which included advice in relation to safety planning, choice-making and problem-solving. At six-weeks post

childbirth, women receiving the intervention reported significantly less psychological abuse and minor physical violence than women receiving the comparison condition; experiences of sexual abuse and severe physical abuse were not significantly different between the groups. Women receiving the intervention also reported significantly lower postnatal depressive symptoms and higher physical functioning than women in the comparison condition (Tiwari *et al.*, 2005).

A pilot RCT conducted in Peru by Cripe et al (2010) examined the effectiveness of an empowerment care model versus standard care among 220 pregnant women who reported partner violence within the past twelve months. The empowerment intervention comprised supportive counselling, education and advice (including safety planning) delivered over a single session lasting 30 minutes. Women receiving the empowerment care model reported more safety behaviours post-intervention than women receiving standard care (Cripe *et al.*, 2010).

Non-randomised controlled interventions targeted at mothers only/mothers and children

Finally, our systematic review identified two non-RCT designs which described therapeutic interventions based on empowerment/counselling models and psychotherapeutic models (as described below).

Lavi et al (2015) conducted a pre- and post-treatment assessment of a perinatal child-parent psychotherapy programme in the USA, delivered to 64 pregnant women who disclosed partner violence victimisation in their current relationship. The perinatal child-parent psychotherapy intervention comprised 27 weekly one-hour sessions, providing psychoeducation on infant development and the impact of DVA on a child, mindfulness strategies, reflective developmental guidance and insight-orientated interpretation. The perinatal adaptation of the programme sought to promote self-care, attunement and responsiveness to the infant's signals, and addressed negative maternal attributions of the infant and potential maladaptive caregiving through exploration of attributions/behaviours in relation to the mother's own experience of current/past abuse victimisation. The authors sought to assess the impact of the treatment on women's depressive and post-traumatic stress symptoms as well as their child-rearing attitudes. Women completing treatment reported significantly lower depressive symptoms and higher positive child-rearing attitudes (Lavi *et al.*, 2015).

Parker et al (1992) conducted a non-randomised controlled study of 199 USA pregnant women who had been physically/sexually assaulted by their partners in the year prior to or during their pregnancy. The study compared an empowerment intervention, with or without three additional counselling and information sessions, against a wallet-sized resource card on partner violence. The empowerment intervention was delivered three times, for around 30 minutes, during pregnancy and consisted of developing a safety plan and providing information on the cycle of DVA and information on legal protections and details on community support services. Women receiving the intervention (n=132) reported less partner violence in the six- and twelve-months post childbirth than women in the comparison condition (n=67); the findings were not statistically significant (Parker *et al.*, 1999).

Additional evidence on interventions

In addition to our systematic review, several community-based interventions have shown promise in reducing the frequency and severity of DVA and mental health problems among female victims/survivors (Warshaw *et al.*, 2013). However, these interventions have not been thoroughly evaluated in light of impacts on children's health or the specific needs and demands of pregnant women. In addition, a 2014 Cochrane review found insufficient evidence for the effectiveness of DVA-focused interventions on pregnancy outcomes; the authors concluded that more high-quality intervention studies were needed, which were adequately powered to examine the ability of interventions to prevent or reduce DVA during pregnancy and to improve maternal and neonatal mortality and morbidity outcomes (Jahanfar *et al.*, 2014).

There have been some interventions piloted in the UK that aim to address perpetrators' parenting (McConnell *et al.*, 2017). In addition, some DVA perpetrator programmes also deliver support services to participants' partners and children (Alderson *et al.*, 2013). Most interventions that include fathers, however, concentrate on those families with school-aged children and so earlier intervention in the first 1001 days of life is severely lacking. As our review highlighted, there are only a few interventions that focus on working with families during the perinatal period (Jack *et al.*, 2012, Jahanfar *et al.*, 2014), and these predominantly work with mothers and children alone. Similarly, as exampled by our review, existing interventions largely fail to address the trauma that parents may have experienced in their own childhood.

It is increasingly acknowledged that separation or a termination of contact between an abusive parent and their children is not always the safest or the preferred solutions for families living with DVA (Stanley, 2011). A few examples of whole-family interventions are, therefore, emerging that aim to work with all family members, whether they live together or not. These approaches reflect the shift towards increasing perpetrators' accountability regarding the impacts of children's exposure to DVA, as well as the fact that research suggests fatherhood may be a significant motivator for behaviour change (Meyer, 2018, Stanley *et al.*, 2012). There are a growing range of whole-family models and interventions being developed and tested in Europe, Australia and the USA. These interventions vary considerably with respect to their length and the setting in which they are delivered (Stanley and Humphreys, 2017), and, to date, they have not provided an holistic package of support which includes whole-family work, early therapeutic intervention, infant development and parental mental health.

For Baby's Sake seeks to address the limitations of existing interventions by developing a whole-family approach that addresses the cycles of DVA (including the impact of parents' own childhood experiences of abuse) and improve mental health and parent-child attachment. Delivered through pregnancy until the child's second year, trained practitioners work separately with expectant mothers and fathers with the goals of breaking cycles of DVA and ensuring the best outcomes for children. *For Baby's Sake* aims to engage each family member through a single, synchronised programme that coordinates each person's involvement, enabling a full picture of the risks and potential impacts for all involved.

Summary of Key Findings

- Every year, millions of women in the UK experience DVA. In addition, around 1 in 5 children grow up in a household with DVA
- DVA is strongly associated with a range of adverse physical and mental health impacts
- Many women report experiencing DVA in the pregnancy period and this can result in adverse physical and mental health outcomes for women and their children
- Adults who have experienced ACEs are at increased risk of DVA victimisation and perpetration
- To date, most interventions that seek to address the harms associated with DVA among families focus on supporting the needs of survivors alone
- Most existing interventions are delivered over a short time-period, adopt a range of different therapeutic models (e.g. cognitive-behavioural therapy, psychotherapy, counselling) and do not thoroughly evaluate impacts on children's health
- Few interventions adopt a whole-family approach to addressing DVA, which aims to improve the mental health and well-being of the entire family unit as well as promoting positive parenting practices
- A review of the literature highlights that *For Baby's Sake* is the first programme to seek to address existing limitations of whole-family interventions, as it works with both parents from pregnancy and combines evidence-based treatments for DVA, trauma and adult mental health alongside parenting interventions focused on infant mental health and parent-infant attachment.

Outline of *For Baby's Sake*

Description of the programme

For Baby's Sake is a structured and modular programme for expectant mothers and fathers who wish to co-parent. The programme is delivered flexibly to meet the individual needs of mothers, fathers and infants, for up to two-and-a-half years. The programme has been created for parents who have a commitment to co-parenting, irrespective of whether or not they are a couple and they may choose to stay together or separate at any time on the programme. *For Baby's Sake* uses a strengths-based model which addresses complex issues that mothers and fathers have previously experienced and are currently experiencing. The programme works separately but in a coordinated way with both the mother and father, and risks for each family member are managed swiftly to ensure that any safeguarding concerns that may emerge are adequately addressed.

Staff who deliver the programme are called practitioners, and these members of staff come from a variety of different professional backgrounds (e.g. police, probation, the domestic violence sector, early years' services). *For Baby's Sake* practitioners undertake a significant amount of training before starting their work with families (see Appendix 6 for details on the initial training schedule) about how to deliver the modular programme as well as training around issues including safeguarding, mental illness, parent-infant relationships and therapeutic skills (see Appendix 7 for details of the training provided during the prototype phase).

Programme sessions are delivered face-to-face (either at the programme offices, Local Authority/community organisations or parent's home, if safe to do so) and the average duration of each session is around 1 hour and 10 minutes. Sessions are designed to assist parents to address past behaviours and experiences, including ACEs, and to overcome current DVA and promote attuned, sensitive parenting. The therapeutic models in the programme seek to promote parents' emotional self-regulation, empower them to reduce stress, improve their life skills and maintain healthy adult relationships. Both parents are also supported with their parenting behaviours, to give their babies and children the consistent and sensitive care that leads to secure attachments. The programme adopts a trauma-informed approach to breaking behaviour patterns, and integrates a range of therapeutic techniques to support behaviour change and recovery from trauma, including Cognitive Behavioural Therapy (Beck, 2011), Transactional Analysis (Berne, 2016), Gestalt techniques (Kellogg, 2014), Mindfulness (Whitaker *et al.*, 2014) and systemic practice in Motivational Interviewing (Rollnick and Miller, 1995). Focusing on parents' ACEs, the Inner Child Work (Bradshaw, 1992) enables parents to come to terms with these experiences and to process their childhood trauma within a recovery framework, by exploring how their behaviours, thoughts and feelings may be being replayed from or triggered by their past and also by drawing on resilience factors from their childhoods. Through recognition and connection with the child within themselves, parents are supported to build resilience for themselves and the capacity to be a 'good enough' parent. Therapeutic work around parenting adopts an attachment-based approach, for both mothers and fathers, using the Brazelton Newborn Behavioural Observation (Nugent, 2015) and Video Interaction Guidance (Kennedy *et al.*, 2011) methods. These methods aim to sensitise parents to their baby's communications and to build parents' competencies and foster positive parent-infant interactions.

The programme's content and approach to working with parents aims to reassure mothers and fathers that they will not be judged for their behaviour or what they have experienced but, instead, will be empowered to take responsibility for their own lives and for their baby's emotional, social and physical development.

Referral to and uptake of *For Baby's Sake*

Eligible parents can either self-refer to *For Baby's Sake* or can be introduced by statutory agencies including midwifery and health visiting services, social care services, GP services, police or probation or local voluntary and community sector services. While *For Baby's Sake* is offered to parents who both agree to participate, mothers and fathers attend their own separate sessions, delivered by different practitioners.
Similarly, the initial contact is handled separately, with different *For Baby's Sake* practitioners contacting the mother and father and asking them to commit to a Welcome Session and four initial assessment sessions (titled "Getting Started with *For Baby's Sake"*). Each of these sessions are tailored individually to mothers and fathers, who are seen at the same time (if possible) but separately. These initial sessions allow both parents and practitioners to decide if the programme is right for the family. These sessions are partly an opportunity to assess eligibility (see details on eligibility criteria below) and appropriateness, but they also include wide-ranging information gathering and activities designed to facilitate a secure foundation for the delivery of *For Baby's Sake* through assessment of risk, vulnerability and resilience factors, physical and emotional safety planning and referral to DVA agencies (if applicable). These sessions also include an introduction to the therapeutic process, particularly though empathic listening and motivational interviewing by practitioners. Some themes that run throughout the programme are introduced and some related therapeutic activities are also undertaken (e.g. mindfulness; initial psychoeducation around guilt and shame and healthy expression of feelings; enhanced safety planning; psychoeducation around stages of change and about stress and the impact on the foetus; self-soothing approaches; progressive muscle relaxation). Practitioners who work with the fathers conduct an extensive assessment into his use of DVA; enquiry around DVA is informed by an understanding that guilt, shame and rage are inextricably linked. After the Welcome Session and the four Getting Started with *For Baby's Sake* sessions, a further session will take place to invite eligible families onto the full programme or to support families not proceeding to receive more appropriate support.

Antenatal sessions

Following sign-up to the programme (titled "Moving Forward"), the therapeutic core of *For Baby's Sake* begins with a focus on safety and reducing stress. While the mother engages in individual sessions of the Opening Doors module, the man attends individual sessions in the Basic Tools module. The Opening Doors module includes psychoeducation, trauma-focused and cognitive behavioural therapy exercises for anxiety and depression. The Basic Tools module utilises a cognitive behavioural therapy framework to address negative thinking and patterns of denial and blame. Mothers might have up to eight Opening Doors sessions prior to childbirth, which focus on promoting the safety of the mother and the unborn child, preventing further traumatisation, meeting individual needs and building the mother's understanding of DVA. Fathers attend ten Basic Tools sessions focusing on anger, masculinity and impacts of DVA on the co-parent and baby. Fathers cover material under the heading of "Owning It", focusing on denial, responsibility, sexual respect and love. Both parents

separately participate in an antenatal parenting module, titled "Where's the Baby?", delivered by an Infant Development and Family Practitioner. This attachment-focused module helps parents to understand what their baby needs in the womb and how their baby's brain develops antenatally and until the age of two. It supports them to bond with their baby whilst in the womb and to understand what babies need to ensure a secure attachment; parents also learn how to read their baby's cues from birth. If parents already have other children, the Infant Development and Family Practitioner will help them with these relationships, so parents can support the development of all their children.

Postnatal sessions

Following the baby's birth, the Infant Development and Family Practitioners undertake the Newborn Behavioural Observations (NBO) separately with mothers and fathers. NBO is a relationship-building tool, used with parents and their baby from birth to 3 months old, to help them understand and respond to their newborn's unique communication. The next parenting intervention for both parents is Video Interaction Guidance (VIG), which again supports communication and sensitive attuned parenting. The Infant Development and Family Practitioners have received accredited training to deliver VIG (and more recently other practitioners have also started VIG training). The parents are guided to analyse and reflect on video clips of their interactions with their baby in order to enhance communication within their relationship. The practitioners are guided by the values and beliefs around respect and empowerment and that the power and responsibility for change resides within each parent and their situation.

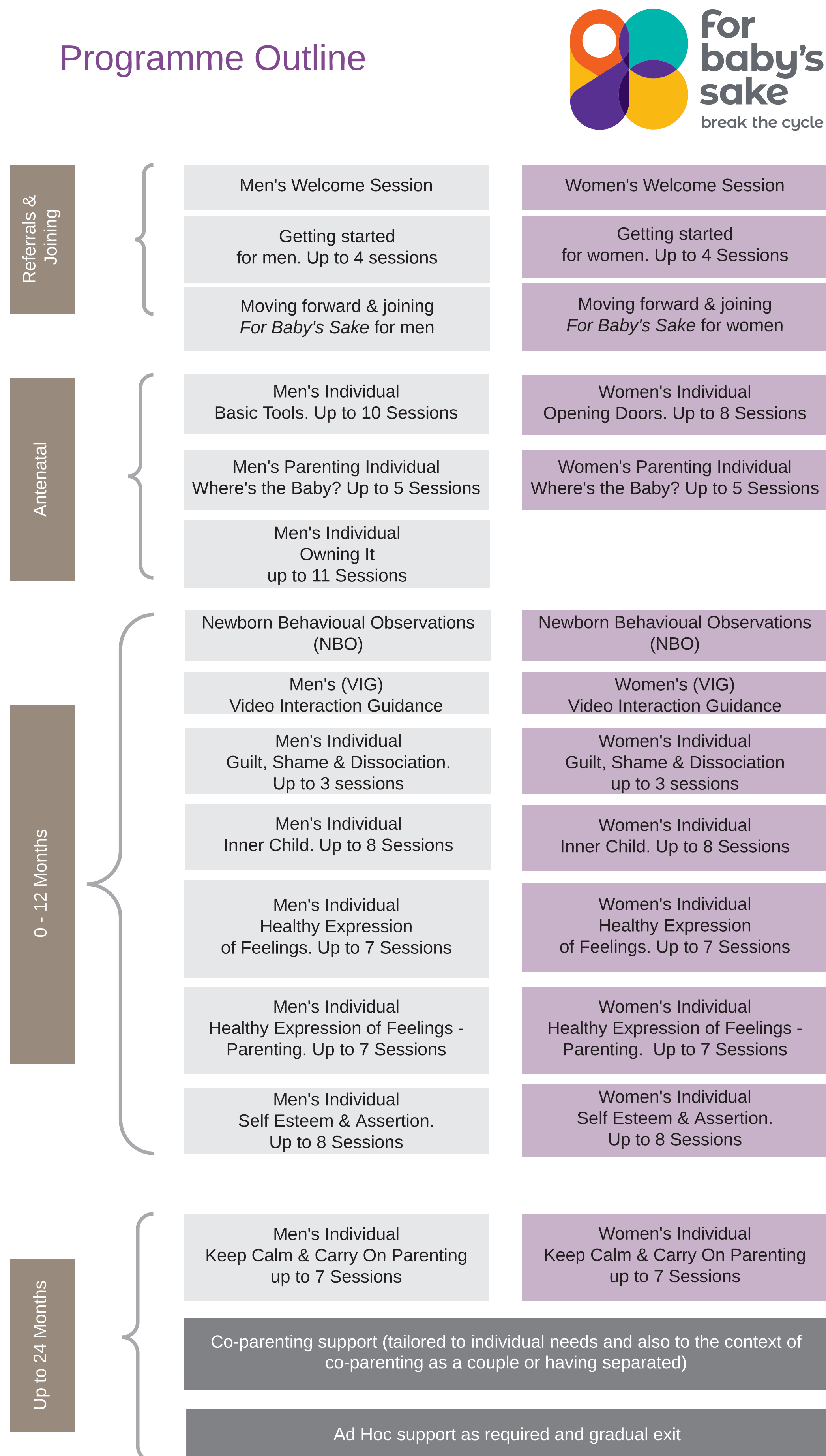
The trauma-informed therapeutic work with mothers and fathers also deepens postnatally. They separately undertake the Healthy Expression of Feelings module, with their Women's or Men's Practitioner respectively, which is in two parts. The first part explores healthy expression of emotions, guilt, shame and dissociation and strengthens the foundations for emotional self-regulation. The second part provides support to distinguish between a range of emotions they may be feeling as adults (including happiness, sadness, frustration) and to express them in a healthy way. The second part is complemented by a Healthy Expressions of Feeling – Parenting module which, again delivered separately, supports mothers and fathers to be attuned and to respond sensitively to their baby's different emotions. Parents will also engage in eight one-to-one Inner Child sessions (which utilise Gestalt therapy techniques and transactional analysis principles) and examine their own childhoods and whether they wish to incorporate or differentiate from their parents; these sessions also focus on parents' own needs and self-nurture, including supporting parents to process feelings related to ACEs and to draw on sources of resilience from their childhoods. This is followed by a module of up to eight sessions on Self-Esteem and Assertion, covering self-esteem and assertion, behavioural skills development and goal setting, with their Men's or Women's Practitioner.

In the baby's second year, extra support is available to both parents to aid sustained recovery from mental health problems, such as post-traumatic stress and/or anxiety. Mothers and fathers also complete the seven sessions of Keep Calm and Carry On Parenting module (delivered separately for mothers and fathers), which assists parents in managing their toddler's behaviour and in setting routines. Parents who already have a toddler when they join *For Baby's Sake* will be offered this module earlier on, to help them in their parenting of their toddler. Towards the end of the programme, *For Baby's Sake* practitioners will offer

support to parents on having a safe and healthy co-parenting relationship. The content is tailored to reflect individual needs and also depends generally on whether the parents will be co-parenting together as a couple or co-parenting apart, having separated.

At the end of each completed module in the programme (including the antenatal modules), each parent undertakes a “Moving Forward” review with their practitioner to reflect on the learnings, to mark the end of that module and to plan towards the next module. An “End of Programme Review” is undertaken when a parent completes or leaves the programme. Ad-hoc support is also provided to mothers and fathers, as required and practitioners begin work with families around finishing the programme in advance of the final session. See Figure 1 below for a graphical representation of the programme outline.

Figure 1: Graphical representation of For Baby's Sake programme



THE STEFANOU FOUNDATION
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Criteria for families engaged with *For Baby's Sake*

Parents undertaking *For Baby's Sake* need to meet the following criteria:

- Both parents need to be committed to taking part in *For Baby's Sake* and to start during pregnancy
- Parents may join whether or not they are together as a couple (at the outset or subsequently). They may wish to stay together, or to separate, or be undecided about the future of their relationship as a couple but they must both want to co-parent their unborn baby
- The mother and father must be aged 17 or over by the time their baby is born
- The mother must be primarily experiencing DVA from the father of the unborn child (though there can be bi-directional DVA) and the risks of DVA are anticipated to recur, endure and/or escalate
- Parents must reside within the areas where *For Baby's Sake* operates. For the prototype phase the two sites were Hertfordshire (covering Stevenage, North Hertfordshire and Welwyn Hatfield) and London Three Boroughs (comprising Westminster City Council, Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham)

Parents will not be eligible to take part in *For Baby's Sake* if:

- The nature of the mental health needs, substance misuse problems or other needs/issues faced by one or both parents mean they are not capable of engaging fully in the programme
- It is already certain that the unborn child will be permanently removed from the parents' care after delivery, under care proceedings

When one parent disengages the other parent is offered a planned early ending after a period. The planned ending offers an appropriate combination of support, including completion of the current phase of work and careful closure and signposting to alternative support. Similarly, both parents are offered an appropriate planned early ending where the woman has a termination or miscarriage, during or after the Welcome, Getting Started and Sign-Up stages.

The Foundation's Developmental Activities for the Programme

As part of this evaluation, the King's College London evaluation team (see Appendix 4 for team details) undertook detailed qualitative interviews with *For Baby's Sake* Senior Leadership Team staff between April and June 2019. During these interviews, discussions focused on the development of *For Baby's Sake.* In this section, extracts from these interviews will be interspersed within a wider outline of the development of the programme.

The Stefanou Foundation was established philanthropically by Stelio Stefanou in 2008, with funds generated from the sale of his business in 2007, with the aim of protecting those who do not have a voice in our society, including babies and older people. Initial development of this remit focused on the ways in which to best protect babies in our society. The Chairman wanted the Foundation to have a strong commitment *"to protect babies, who were in danger and couldn't speak for themselves".* The Foundation spent over five years developing *For Baby's Sake,* and some of the key steps involved in this development are outlined below.

Researching the area

A starting point for the Foundation in developing this programme was to research the area. This began with a review of some high-profile child death reviews. The Foundation found that a common thread among these cases was the presence of DVA in the family and the impact of this abuse on all family members. As a result, they decided to focus on addressing DVA within families to ensure improved outcomes for children.

One of the first steps the Foundation took in preparing for the development of *For Baby's Sake* was to examine the evidence base and to identify the causes and impacts of DVA. The Foundation's Director researched the academic literature, initiated conversations with key academics and practitioners in the field and attended relevant national and international academic and practice-based conferences. A key repeating theme from all sources was *"the importance of protecting babies"* in relation to DVA. There was a developing evidence base which highlighted the impact of sustained high levels of stress during pregnancy on the development of infants in utero (Glover and Capron, 2017), and the impact of DVA on babies' brain development in the first two years of life (Burke *et al.*, 2008, Flach *et al.*, 2011).

Other key themes that came out of these sources were *"the impact of childhood trauma"* in the lives of people experiencing and using DVA in their intimate relationships as adults, as well as issues of *"complex developmental trauma"*. Complex developmental trauma describes the relationship between children's exposure to multiple traumatic events and its adverse impacts on their health and wellbeing over the lifetime. Early exposure to repeated traumatic events most often occurs in children's caregiving systems and commonly includes physical, sexual, emotional abuse, maltreatment and neglect as well as exposure to parental DVA (Van der Kolk, 2017). Evidence indicates that children exposed to abuse in childhood are vulnerable to experiencing or using violence in their adult relationships (Hughes *et al.*, 2017). An additional important evidence-based theme related to the health impacts of abuse, was the impact of DVA on mental health problems (Howard *et al.*, 2013, Trevillion *et al.*, 2012).

Based on this work, the Foundation started to look at the ways in which these interconnecting issues were being addressed in practice at that time. They identified that services that were

providing support for these key themes were not integrated and that they *"were quite siloed"* in their working partnerships. Through discussions with services, the Foundation realised that "*the different disciplines and the different professions were all constrained by different things"*. For example, when talking to health visitors they heard responses such as "*the most important thing to do, is to get into the home. You have to see what's going on and try to help parents in their own home*". This contrasted with the experiences of some DVA services who explained that their Independent Domestic Violence Advisors would "*never go into the home",* in order to protect the safety of the person that they were supporting to overcome the abuse. The Foundation started to consider how it could draw on the important good practice from the different fields, whilst reconciling the different approaches. One example was determining how to work with mothers in their homes whilst ensuring a safe space for discussion about DVA which maintained the highest standards of safety and risk management. Their discussions with various relevant organisations left them with the picture that existing services were delivering "*different components of the work*" and that, while they were doing valuable work in challenging circumstances and making a difference, "*they were always constrained because of a lack of a solution to other parts of the picture*".

Developing a new approach to working

In starting work to develop a new whole-family approach to DVA, the Foundation identified the need to develop an inter-generational programme in relation to babies' and children's exposure to DVA, which would be the earliest possible intervention for the baby and an earlier than usual intervention for the parents and other children in the family. This thinking was informed by the Foundation's review of the evidence base and from an understanding that the transition to parenthood is a key time to intervene, due to a motivation for change among expectant mothers and fathers:

'more intensity is definitely needed for where there's a baby, because you can make the biggest change…People are open to the change, but also we know how a baby is influenced in the womb now, and we have to use that' (Senior Leadership Team member)

Given what the Foundation had learned about the association between DVA experienced in childhood and abuse within intimate relationships as an adult, along with the potential for previous adverse experiences to negatively impacting on parenting, they felt the programme would require intensive input over a longer period. Indeed, it was felt that "*that approach and that model, and that level of intensity is needed for the families"*. The theory of change behind the programme was around:

'the mutually reinforcing benefits of having all the components in the programme, bringing an end to domestic abuse, overcoming the impact of the trauma of the domestic abuse, processing the trauma from their [the parents'] own childhoods, being supported to form secure attachments with their baby and support the emotional and social development of the baby, and to be doing that over the period from conception to aged two. Our theory of change…sounds like an extraordinarily ambitious group of aims, but we stand a better chance of achieving any one of them if we go for the lot' (Senior Leadership Team member)

The programme that was being developed sought to promote recovery from abuse for all members of the family. This model was visualised using a "*three-way model*" (i.e. different

practitioners working separately and therapeutically with the father and mother to end the DVA; overcome the impact of the abuse; and nurture the development of the baby and any other children in the family. The staff resourcing of this three-way model was anticipated to require a practitioner for fathers, a practitioner for mothers, and a practitioner for the baby and any other children in the family; this was the default staffing arrangement for implementing the three-way model during the prototype phase:

'the design of the programme, that paid close attention to every family member's needs. The woman's practitioner working with the woman and the man's practitioner working with the dad. The infant development and family practitioner keeping the baby in mind and working on the parenting' (Senior Leadership Team member)

The Foundation felt this three-way model, requiring strong and regular "*communication between our practitioners*", would achieve timely and quality "*insights into the risks for the families*" which would allow them to "*manage the risks differently*" from other services that work in isolation with different members of a family. The Foundation took the position that they would "*stand a better chance of helping any member of the family, if we help every member of the family…we see the support for the baby as being mutually reinforcing, for support for the mother and the support for the father"*

Pre-defined principles for the programme

The Foundation consulted with their Board during the design of the programme and together they agreed that a key principle of the programme should be on trying to "*break the cycle*" of abuse, whereby experiences of DVA continue to affect future generations of families.

As the development work continued, other key principles arose, including a need to ensure the programme adopted a "*holistic approach*" and an approach that sought to "*make it easier for people in those situations to come forward and seek help, particularly mums".* The latter point was highlighted given the barriers to disclosure of DVA faced by pregnant women who may fear children's social care taking their baby away or requiring them to separate from their co-parent.

Design of the manualised programme

The Foundation identified the need to "*commission co-designers, to help us create the programme*". They identified clinicians and experts that were doing "*leading edge work*" in the areas of supporting women to overcome DVA, supporting men who use DVA to stop the abuse, and in supporting early years parenting. The Foundation identified Dr Roxane Agnew-Davies (Clinical Psychologist and expert in addressing DVA and its impact on women's mental health), Mark Coulter (Domestic Violence Prevention Manager at Hull City Council till 2014, then consultant at Mencentric Limited, and expert in supporting men to bring an end to perpetration of DVA) and Dr Christine Puckering (Clinical Psychologist and expert in sensitive, attachment-based parenting).

The Foundation facilitated a learning exchange between the co-designers, with time committed to understand each of the co-designer's expertise, approaches and influences. The Foundation realised that they had a rare opportunity to use their philanthropic resources to

provide "*the space and the scope to do things really well and to give people time".* This was because they did not experience the same constraints as existing services, whereby financial and management resources were already concentrated on supporting important existing services. Early discussions between the co-designers identified common therapeutic themes at the core of their different areas of work; techniques were also shared and adapted for inclusion in the programme.

The Foundation brought these three experts together to develop a new programme that was not simply an amalgamation of their individual existing programmes but one which understood *"each other's worlds and to carry on working with us to create a completely new programme"*. The brief was for the programme to integrate support for each family member (mother, father, baby and any other children in the family) and to prioritise mental health, parent-child attachments and the early emotional, social and cognitive development of the baby.

The development of the manualised programme was informed by a range of evidence-based theories and models. These include the ecological framework of interpersonal abuse (Heise, 1998) which identifies that some people/groups are at higher risk of abuse and this is the result of a complex interplay between four key levels: (1) the individual level (e.g. an individual's experience of childhood maltreatment, mental health/substance use problems, history of violent behaviour); (2) the personal relationship (e.g. an individual's experience of poor parenting practices, violent parental conflict, friends/peers that engage in violence); (3) the community level (e.g. communities that experience poverty, high crime levels, high unemployment and residential mobility), and (4) the societal level (e.g. societies that permit gender, social and economic inequalities and cultural norms that support violence). Other models which the programme incorporated were an understanding of the help-seeking behaviours of abusive men (Stanley *et al.*, 2012); how infant mental health is shaped by parental sensitivity and can be enhanced through the use of video-feedback interaction work, and the strength of attachment-based parenting support (Bakermans-Kranenburg *et al.*, 2003). Common therapeutic themes that ran across the different areas of the co-designers' work included the healthy expression of emotions (e.g. anger, grief, shame and fear) and trauma recovery frameworks. All these models became central elements within the trauma-informed and attachment-focused therapeutic model and were synthesised to create a coherent programme (for further details on the therapeutic model see Domoney *et al.*, 2019).

Selection of sites for implementation of the programme

The Foundation's Chairman, other Board members and senior leadership had previously worked in the public services and infrastructure sectors and had extensive experience of partnership working with local government. This experience led to them being clear that the programme should be embedded within public services and within the established safeguarding regimes of the sites they selected. They selected two sites: Hertfordshire and the London borough of Westminster, and they started conversations with Hertfordshire County Council and Westminster City Council. In June 2011, Westminster City Council (WCC) had entered a formal partnership arrangement with the Royal Borough of Kensington and Chelsea (RBKC) and the London Borough of Hammersmith and Fulham (LBHF) to create the 'Tri-Borough'. Having launched *For Baby's Sake* in Westminster in March 2015, the Foundation subsequently extended their work across the rest of the Tri-Borough area in

January 2017. Informing the Foundation's decision to select the two initial prototype sites of Westminster and Hertfordshire was the need to ensure the sites had different population characteristics, different levels of urbanicity, as well as different public sector structures. In addition, the local government, health and policing structures in the two sites were different. This meant the Foundation faced distinct practical implications within each site, in relation to building referral pathways and establishing multi-agency partnerships. The Foundation's leadership already had established links with Hertfordshire and Westminster, as they had previously worked in these areas and had some knowledge of the strategic context. These previous relationships and background knowledge facilitated early conversations with both authorities about them potentially hosting a new intervention. The Foundation's central office was located in Hertfordshire and its leadership became involved in wider strategic public-voluntary sector initiatives there, while the operational Director of *For Baby's Sake* had worked for the NHS in Hertfordshire for over 15 years and her multi-agency relationships contributed considerably to a smooth embedding of the programme in the county. A description of the two sites is presented in the Box 1 below.

The Foundation launched the programme in the two sites on 13 April 2015. The first referral for the Hertfordshire site came on 1st May 2015 and the first referral for the London Three Boroughs site on 14th May 2015.

Box 1: Description of the study sites

The county of Hertfordshire has a population of approximately 1.18 million people, of which 81% are white British, 62% are of working age and 32% have a level 4 qualification (i.e. university degree, higher education or professional qualification). In 2017 there were a total of 14,301 live births (Office for National Statistics, 2018b). Communities in this area are relatively stable, with successive generations often living close to each other.

The London Three Boroughs site has a population of approximately 560,538 people, of which less than 50% are white British, around 70% are of working age and around 50% have a level 4 qualification. In 2017 there were a total of 6,572 live births (Office for National Statistics, 2018b). Communities in this area are highly diverse and transient.

The Foundation ensured the programme was co-located with each of the two sites. In the London Three Boroughs site (i.e. Westminster, Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham), the *For Baby's Sake* team was situated within a local children's centre and in the Hertfordshire site the *For Baby's Sake* team was located within a 'Thriving Families' team office (the Hertfordshire 'Troubled Families' service - UK programme of targeted intervention for families with multiple problems). The Foundation also ensured that the programme used the sites' local case management systems so that appropriate information sharing across the co-located teams and other relevant organisations would be achieved. However, the *For Baby's Sake* teams were independent of the Local Authorities, and separately managed.

Pre-implementation work

Establishment of steering and operational groups

The Foundation established a Steering Group in 2012 to inform the design of the programme, and to be a sounding board in which to test support for the core principles underpinning the programme. The Steering Group members included strategic multi-agency partners in the two sites (i.e. Hertfordshire and Westminster in London) and national stakeholders. As the Foundation approached implementation of *For Baby's Sake* in the two prototype sites, separate partnership Operational Groups were formed in each location. The reason for doing this was to build trust among stakeholder/future partners in each of the respective locations. The Foundation also identified that they would need the programme to be embedded within the local systems and structures of each site, as the "*higher the risk level you were working at and the more you want to achieve outcomes, the more embedded and integrated you would [need to] be*". The Steering Group and Operational Groups were seen as a means to facilitate this integration within the sites. The Foundation took the stance that "*people trust if they feel safe in the knowledge about how something is being delivered*". It was perceived that creation of a Steering Group with membership at a strategic level nationally and across both sites and Operational Groups with a wide membership from local partners would help ensure the programme would be "*completely embedded in the public sectors*" because the groups' members could facilitate this process, and the groups' existence would act to reassure other partners in the area, through its support and acceptance of the programme.

The Foundation brought together health, local government, police, probation and social care experts in the respective locations in different ways throughout the process. Reflecting on this process, one of the staff of the Senior Leadership team noted:

'We expected them all to know each other and for us to be the only ones who didn't, but no, actually, we were introducing people to each other all over the place. So those were some of the starting points'

The Steering Group and Operational Groups informed aspects of the programme's design and narrative, to ensure it would align with the different organisational cultures and disciplines in their locations. The Groups highlighted key areas that the programme would need to sensitively manage in relation to prioritising safety while also creating the conditions for change (e.g. in establishing non-judgmental and strengths-based therapeutic relationships whilst remaining non-collusive and realistic as to the gains that could be achieved). The Steering Group and Operational Groups had the effect of giving "*the professionals a chance to voice their expectations and their hopes and fears for this programme*" and it allowed the Foundation to learn from the Groups which was a "*really important experience*".

Identifying strategies in which to facilitate engagement by families

The Foundation also spent time thinking about some key issues that might affect the ability of families to engage with the programme. These included: (1) how to approach families safely, so that they were not put at further risk of DVA due to their participation in the programme; (2) working out the "*logistics for transport for families*" such as whether families needed access to public transport; (3) the "*flexibility of when appointments are*" made, and (4) for mothers, consideration of "*not over-burdening the mother with visits and work in the early postnatal period*"

Building on these questions, the Foundation obtained the views of people with lived experiences, to help them shape the programme. They spoke to first-time teenage parents participating in a Family Nurse Partnership programme (Robling *et al.*, 2016); many of the parents undertaking this programme had experience of DVA. They also arranged a meeting with men who had participated in the Strength to Change programme, which addressed the behaviours of abusive men (Stanley *et al.*, 2012).

Social marketing exercise

Another key consideration for the Foundation was the marketing materials that they would produce to advertise the programme. One of the staff of the Senior Leadership Team expressed that it was challenging to promote a DVA service:

'While, at the same time, speaking to our service users, who we knew did not use the language of domestic abuse to explain what was going on in their lives'

The Foundation were conscious of the need to "*get the language right*" and so for this reason they engaged an organisation, the National Social Marketing Centre, to undertake a social marketing exercise for them. Through the social marketing exercise the Foundation sought to:

'Learn more about the families. We were conscious that we were the first programme working in this way with the whole family'

The marketing exercise consisted of 17 focus group interviews with people who had experienced DVA and experts working in the field. The interviews sought to explore the potential motives of families to engage with such a programme, as well as interviewees' views on how people can overcome DVA and be a good parent, as well as their views on a co-parenting approach. A key outcome of this exercise was the point that:

'Mothers in that context might be identifying the need for supporting the father in the relationship with the child, but they may struggle a bit with identifying their own needs, even though they're sensing that it's having an impact'

The marketing exercise also highlighted to the Foundation that, in terms of the expectant parents' positioning in relation to the stages of change observed in DVA relationships (Prochaska *et al.*, 1994):

'Reaching the families was going to be challenging, because we were an earlier intervention and we were trying to attract pre-contemplated [sic] parents. Moving into contemplated [sic] maybe, on a good day being ready, but we were not a later intervention'

The Foundation reflected that the marketing materials that they generated would need to:

'Convey the balance, the mixture of hopes and fears. Sometimes the challenge is about, is this programme going to feel like a parenting programme? Is it going to feel like a domestic abuse programme? One of the things that we've tried to do above all in here, is to convey that we're not going to be judgemental'

For example, developing materials that sought to talk to mothers and to tap into the concerns that mums might have, using language such as:

‘Do you want to break free from your past?” Or “perhaps you’re in a relationship that scares you?” Again, painting a picture of hope, about what this programme could give and just naming it’

Alongside developing different targeted materials for fathers, such as adverts which used language such as:

‘Does your behaviour harm your children or your unborn baby?...Are you ashamed of your behaviour?’

The marketing exercise confirmed to the Foundation that they needed to be ready to handle the “*communications challenge*”.

Summary of Key Findings

The findings of this chapter highlight key developmental work that was undertaken by the Foundation as part of creating *For Baby’s Sake*:

- The Foundation undertook a range of activities, engaged in thoughtful reflection and adopted a detailed and long-term approach to ensuring the solid development of the programme, which was steeped in a strong evidence base
- The Foundation pulled together a range of different research and practice perspectives to create a novel programme that aimed to address whole-family approaches to addressing DVA, through the provision of individual support to mothers that are experiencing DVA, fathers that are using DVA and parenting support for both parents to ensure their baby and children have a healthy start in life, particularly in terms of their baby’s social and emotional development
- The Foundation identified three co-designers who each brought trauma-informed expertise in one dimension (i.e. to end DVA; to overcome the impact of DVA; and to nurture the development of the baby and any other children in the family). The Foundation appointed them to collaborate with each other and with the Foundation to co-design a holistic, trauma-informed and attachment-based intervention
- Co-located working practices and integrated case management systems were established with the aim of promoting the embedding of the programme within the two selected sites
- The establishment of the Steering Group and two prototype site-specific Operational Groups, comprised of key stakeholders, helped inform the priorities for each area and to support the programme’s implementation
- The social marketing exercise helped inform the key messages and language that the Foundation needed to use in promoting the programme to families and stakeholders

Developments of the programme since the launch of the prototype phase

This chapter was written by the Stefanou Foundation to highlight how *For Baby's Sake* has developed since the launch of the prototype phase of the programme.

The information in this chapter covers the following elements:

- Development of the manualised programme and key elements of the therapeutic approach
- New branding
- Development of case management, data collection and risk management
- Development of training, staffing and team structures
- Sharing the learning and contributing to policy and practice
- Beginning to scale up and roll out *For Baby's Sake*
- Summary of key findings from the developments

Development of the manualised programme and key elements of the therapeutic approach
1. The drivers of the developments were to strengthen engagement with service users, enhance the therapeutic approach alongside risk management and support practitioners to work in a trauma-informed and attachment-focused way.
2. The importance of delivering the manual flexibly was apparent almost immediately and guidance was issued to practitioners to this effect, reinforced by training and coaching from the co-designers. When it became clear that the Orientation and Initial Assessment phase of the programme was taking longer than intended to complete, especially for the fathers, a review of this phase took place, in consultation with the co-designers and learning from the experience of practitioners about what was working well and which elements were sometimes sources of disengagement. The review led to streamlining and further encouragement to practitioners to deliver the material flexibly, underpinned by more clarity about the essential elements of this phase. The terminology of this phase also changed to be more motivational, with Orientation becoming Welcome and Initial Assessment becoming Getting Started.
3. Again, in consultation with the co-designers, a review of the flow of the therapeutic work led to the bringing forward of the material on Healthy Expression of Feelings. It was felt that equipping service users with greater ability to recognise their emotions and a broader vocabulary to discuss them would enable them to access the Inner Child module, which constituted the therapeutic core of the programme.
4. The Healthy Expression of Feelings module begins by looking at guilt, shame and dissociation. The teams' experience of working with this material drew out the central importance of supporting parents to understand and process their shame about past experiences. This learning resulted in the *For Baby's Sake* Director leading the development of a "Shame Lens" tool (see image below) as a new way to explain the rationale for the combination of therapeutic approaches within the programme which supported parents to process their trauma and break cycles of traumatic childhood adversity.

Shame Lens Image

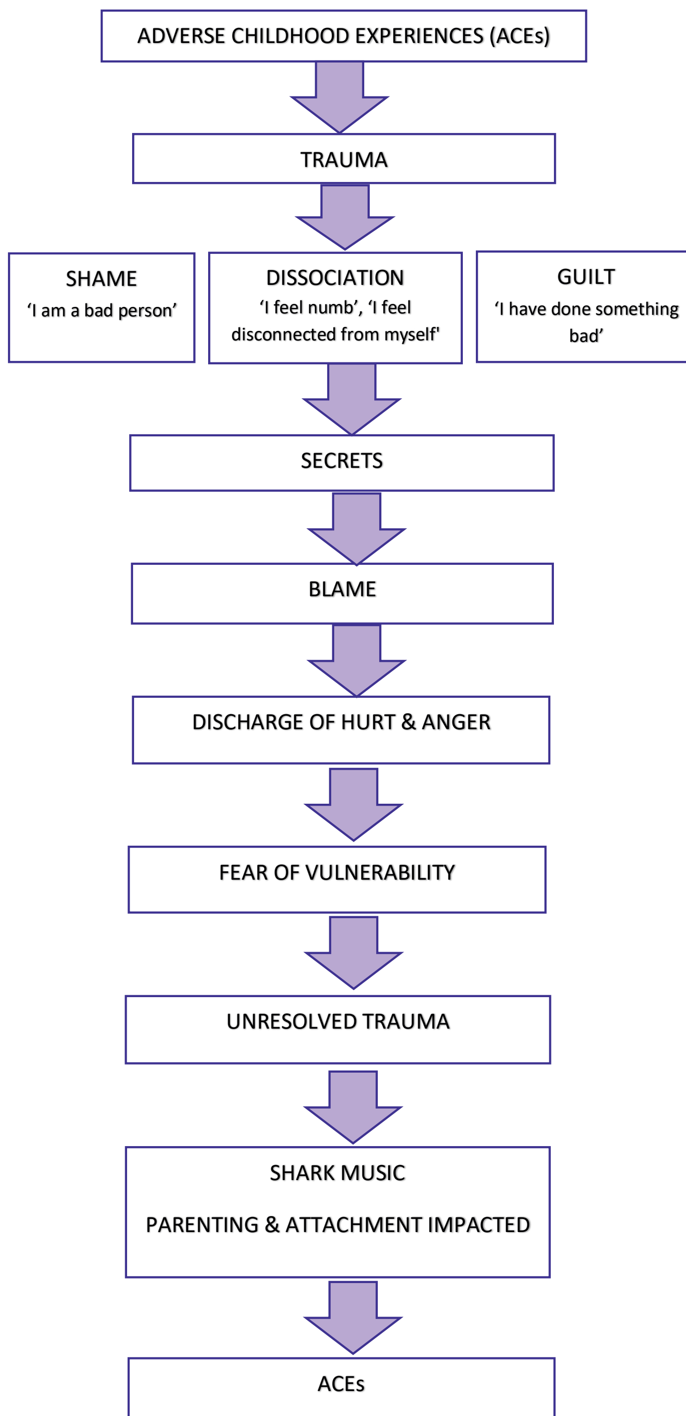
Shame Lens Presentation of *For Baby Sake*

What is needed?

- Hope
- Compassion
- Empathy
- Courage
- Ability to tell the story
- Positive self-talk
- Understanding triggers
- Resilience
- Connections

How is it delivered in *For Baby's Sake*?

- Underpinned by Attachment Theory
- Trauma-focussed
- Through a 'shame lens'
- Motivational Interviewing
- Transactional analysis
- Gestalt theory
- C.B.T techniques
- Mindfulness
- Containment
- Circle of security
- Psychodynamic
- Therapeutic relationship
- Video Interaction Guidance (VIG)



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Development of the manualised programme and key elements of the therapeutic approach
5. Another significant addition to the manual was guidance to practitioners on post-incident response procedures, which were developed collaboratively, drawing on the insights of practitioners working with different family members and involving the Foundation's Independent Safeguarding Advisor. These guidelines use the three-way therapeutic practitioner model to assess and manage risks and address the physical and emotional safety of each family member. The guidance emphasises that safety of the mother and children is the priority. It combines rigorous safety planning and multi-agency working with guidance on working with the father in a non-collusive and trauma-informed way to enable him to understand the incident and especially to locate the origins of the feelings that led to his aggression and violence. The guidance recognises that working with the man's shame, guilt and remorse will contribute to everyone's safety.
6. Over the course of the prototype phase, various accredited tools have been introduced to the manual for practitioners to use with service users, for example to gauge attachment (Maternal/Paternal Attachment Questionnaires), depression and anxiety (PHQ-9 and GAD7) and resilience (Resilience Questionnaire).
New Branding
7. The programme had been launched in 2015 with the working title of 'Healthy Relationships: Healthy Baby'. In 2017, the Foundation commissioned consultancy support, including consultation with stakeholders and service users to gauge what was important to them about the programme, which led to a new permanent name for the programme, *For Baby's Sake,* along with associated branding.
Development of case management, data collection and risk management
8. *For Baby's Sake* uses a holistic and structured professional judgment approach for risk assessment and management, bringing together insights about individual and whole family risk factors, vulnerabilities and resilience factors, supported by the three-way therapeutic practitioner model. Towards the end of the prototype phase, the Foundation introduced the SARA-V3 (Spousal Assault Risk Assessment) tool to provide an appropriate framework and organised training for all teams by one of the Canadian creators of SARA, Randall Kropp. SARA-V3 is an internationally recognised framework for identifying which risk factors are present and relevant in a particular case and conducting case formulation, including considering potential future risk scenarios, and creating tailored risk management plans. The approach involves looking at victim-related factors as well as the factors related to the perpetrator or offender. This rounded approach was felt to fit well with the *For Baby's Sake* approach and, especially in readiness for roll-out, would provide a robust and consistent framework, thereby helping to maintain fidelity. In the UK, SARA-V3 is currently used mostly in probation services and *For Baby's Sake* could potentially generate useful learning about using it in community settings, given the insights into case formulation from working with all family members under the *For Baby's Sake* three-way therapeutic practitioner model.
9. Throughout the prototype phase, the local *For Baby's Sake* teams collected data about the characteristics of service users, their journeys and outcomes through the programme and other process data. This information has been used in local case management, the Foundation's own oversight of the management and development of the programme and in briefings for stakeholders. The dataset has developed over the prototype phase, for example, adding in data fields on the ACEs and resilience factors of the parents and strengthening the dataset on their complex needs.

10.	Towards the end of the prototype phase, Kim Technologies provided the Foundation with *pro bono* support to create a data storage and analysis facility using the Kim platform. Again, this is intended not only to support the existing sites but also to underpin the scaling up of *For Baby's Sake*.
Development of training, staffing and team structures	
11.	As part of its commitment to maintaining the highest standards of safeguarding, in 2015, the Stefanou Foundation's Board of Trustees appointed an Independent Safeguarding Advisor, whose had a career in the police, involving extensive senior level leadership of policing and multi-agency work on domestic abuse and children's safeguarding, before setting up as an independent consultant. His role as Safeguarding Advisor to the Stefanou Foundation has included advising the Foundation's Board and Senior Leadership Team and also supporting the teams.
12.	**As pointed out later in this report (see chapter "*For Baby's Sake Practitioner Qualitative Interviews*" summarising the *For Baby's Sake* team members' job descriptions), some roles have developed during the prototype phase. Notably, one of the Team Managers, who is a qualified therapist, now also holds the position of Therapeutic Lead. This development has supported the transition towards providing more of the practitioner training and coaching in-house.**
13.	Comments elsewhere in this report, along with the training records listed in Appendices 6 and 7, highlight the training and coaching of practitioners throughout the prototype phase. Some of the initial training by the programme co-designers was video recorded and is still used within training of new practitioners in existing and new sites. Training from a range of other experts was introduced in response to requests from practitioners for background briefing on concepts that are fundamental to *For Baby's Sake*, such as trauma-informed and attachment-focused working. Skills training has included methods such as motivational interviewing.
14.	Towards the end of the prototype phase, the Foundation's Senior Leadership Team and Team Managers began discussions about the most effective staffing arrangement for implementing the three-way therapeutic practitioner model. This model is defined as "different practitioners working separately and therapeutically with the father and mother to end the domestic abuse; overcome the impact of the abuse; and nurture the development of the baby and any other children in the family. The practitioners in the team work closely together to manage the risks within each family member's journey and to act swiftly to address any safeguarding concerns that may emerge."
15.	For most of the prototype phase, this has been implemented through the Women's Practitioner supporting the mother, the Men's Practitioner supporting the father and the Infant Development and Family Practitioner supporting both parents separately with the parenting. As caseloads grew, the pressure on the Infant Development and Family Practitioner role also grew and, as data elsewhere in this report shows, the fathers especially were not receiving the intended level of parenting intervention. (The pressure on the Infant Development and Family Practitioners' time has been greater than originally anticipated because the work was originally envisaged to be delivered partly through group work.)
16.	As a way of managing during maternity absence, the London team tried out a model whereby a single practitioner working with the mother combined the adult-focused and parenting-related support to her, while a single practitioner working with the father similarly combined the adult-focused and parenting-related support to him. This approach was reported to have advantages in terms of providing more opportunities to provide parenting-related support. An additional reported benefit was the opportunity to make use of the synergies between the adult-focused and parenting-related work within a trauma recovery framework. For example, when a parent

	was considering the future they wanted for their baby, and naturally compared this with their own childhood experience, the single practitioner would be able to follow this lead without being concerned about straying into the territory of another team member's work.
17.	For these reasons, the Foundation's Board agreed on a new default staffing arrangement for use beyond the prototype phase, where each family will be supported by two practitioners, one working with the mother and the other working with the father. Each of these practitioners will deliver both the adult-focused and parenting-related aspects of the programme. Both practitioners will be required to maintain a focus on the development of the baby and any other children in the family and also to work closely together to manage risk, in order to maintain the essential elements of the three-way therapeutic practitioner model.
18.	The Stefanou Foundation's Board approved this development, based on the rationale and also the implementation plan, which includes risk mitigation and close monitoring of the impact, including on the level of parenting support for both parents, the skills base within the teams and the maintenance of the three-way therapeutic practitioner model. As a first step towards implementing the new arrangements, all Men's and Women's Practitioners are now being trained and supervised to deliver Video Interaction Guidance, as the central therapeutic parenting intervention within the programme.
Sharing the learning and contributing to policy and practice	
19.	Throughout the prototype phase, the Foundation's Senior Leadership Team have participated at national and international levels to share the learning from the creation of *For Baby's Sake* and worked with other experts towards developing policy and practice in fields such as domestic abuse, infant mental health and trauma-informed working. We outline below the international interest in *For Baby's Sake.*
20.	Having presented a symposium at the World Association of Infant Mental Health (WAIMH) Congress in Edinburgh in 2014, while the programme was still in design phase, the Foundation returned to WAIMH in Rome in 2018, this time to deliver a poster workshop in partnership with King's College London. The Foundation explained the creation and implementation of *For Baby's Sake*, while the evaluation team explained the evaluation, including early findings, and also some information specifically on the perspectives of fathers. The Foundation's *For Baby's Sake* Director was invited by the Australian Association of Infant Mental Health to present a keynote speech and run two workshops at their conference in June 2019.
21.	Following the European Conference on Domestic Violence in Porto in 2017, the evaluation team led by King's College London, in association with the Foundation, were accepted to write a joint paper for the Journal of Family Violence, which was published in January 2019 (Domoney *et al.*, 2019). Following up this paper, the Foundation and the evaluation team, led by King's College London, delivered a symposium to the European Domestic Violence Conference in Oslo in September 2019.
22.	At national level, the Foundation has played a leading role in association with the University of Bristol, the University of Cambridge and the Violence, Abuse and Mental Health Network to convene a wide range of national experts with the aim of creating a core outcome set for domestic abuse services.
23.	The Foundation has also contributed to the development of tools and techniques for practitioners. One example is supporting the development of a new 'Parent and Baby Star', for parents who may need extra support in the perinatal period. The star tool can help parents to identify where they are doing well, where they would like support and the progress they have made over time. This accredited tool was developed by Triangle Social Enterprise in collaboration with the Stefanou Foundation, East and North Hertfordshire Clinical

	Commissioning Group, Herts Valleys Clinical Commissioning Group and Hertfordshire County Council.
24.	The Foundation has also created a new 'Parental Relationships Spectrum' tool to support professionals working with parents to assess whether the relationship is conflictual or abusive, including whether there is coercive controlling behaviour. There is growing interest in this tool, including from national government.
25.	More broadly, the Foundation has continued to keep abreast of developments in policy and practice and to learn from others' expertise, including through participation in a range of networks, including various All Party Parliamentary Groups, membership of the Institute of Health Visiting, the Early Years Funding Group and the Social Impact Investors Group run by the Association of Charitable Foundations.
Beginning to scale up and roll out *For Baby's Sake*	
26.	The Foundation has begun to expand the operation of *For Baby's Sake*. A new Cambridgeshire project opened in August 2019, serving families living in Cambridge City, South and East Cambridgeshire. This project has been established through a collaborative arrangement with Cambridgeshire County Council, where the service is being funded by the County Council and philanthropic funding on a 50/50 matched funding basis. In an evolution of the model, the staff are employed by Cambridgeshire County Council and a collaborative agreement between the County Council and the Foundation sets out partnership arrangements, including in respect of handling the recruitment, training and supervision of staff and oversight of the operation to ensure fidelity to the model and to share the learning about delivery, outcomes and impact.
27.	A fourth site has been launched in Blackpool, through a partnership arrangement with Blackpool Council and the Blackpool Better Start Partnership. Blackpool is one of the Better Start areas that secured long-term funding from the National Lottery Community Fund to support the early development of babies and young children from conception to age three and improve life chances for these babies and their families. The operational costs of *For Baby's Sake* are being met through this funding and the staff are employed by Blackpool Council, through a collaborative agreement along similar lines to the agreement with Cambridgeshire. The Blackpool Better Start Partnership takes a trauma-informed and attachment-focused approach and invited *For Baby's Sake* to be the intervention for families wishing to break the cycle of domestic abuse.
Summary of Key Findings from the Developments	
a.	The Foundation continued to undertake a range of activities and engage in thoughtful reflection to take forward the development of the programme, drawing on experience of implementing *For Baby's Sake* in practice and on the evolving scientific evidence related to the various strands of the programme.
b.	The Foundation has strengthened its internal capacity to manage the delivery and development of the programme, including by appointing an Independent Safeguarding Advisor and a Therapeutic Lead.
c.	In-house data collection and analysis of has developed over the course of the prototype phase, with practitioners collecting detailed data on service users' characteristics (including their history of traumatic adverse childhood experiences and resilience factors), along with process and outcome data. The *pro bono* support from Kim Technologies to create a new *For Baby's Sake* data storage and analysis platform is a significant development and it will be important to harness the potential of this facility to support the roll-out of *For Baby's Sake*, especially to assess and maintain fidelity to the model.

d.	The Foundation's creation of the Shame Lens diagram reflects the learning about the centrality within the programme's trauma recovery framework of supporting service users to process their shame, particularly about their adverse childhood experiences. It also aims to support practitioners by summarising the rationale for the various therapeutic techniques within the programme. The post-incident response procedures developed by the Foundation address physical and emotional safety, prioritising the safety of the mother and children while recognising that their safety can be enhanced by non-collusive trauma-informed work with the father on his feelings of shame.
e.	The Foundation's basis for deciding to adapt the staffing arrangements for implementing the three-way therapeutic practitioner model resonates with findings later in this report, including about the need to increase the availability of parenting support for fathers. The changes (one practitioner supporting the mother, another practitioner supporting the father, each practitioner integrating adult-focused and parenting support into their delivery) will need careful implementation, in line with the Foundation's implementation plan, in order to mitigate the risks and secure the intended benefits.
f.	The Foundation has continued to learn from others and to share their learning, including through presentations at international conferences, playing a leading role in the initiation of a major domestic abuse sector project to create a core outcome set for domestic abuse and by developing and co-designing some practitioner tools for wider use by professionals, including the Parental Relationships Spectrum.
g.	Progress has begun to scale up *For Baby's Sake*: a new project opened in Cambridgeshire in August 2019 through a collaborative agreement with Cambridgeshire County Council and an innovative shared public sector/philanthropic funding model. A fourth project has been mobilised in Blackpool through a collaborative agreement with Blackpool Council on behalf of the Blackpool Better Start Partnership.

Research Evaluation Methodology

The Stefanou Foundation commissioned King's College London and its academic partners (McMaster University in Canada, University of Central Lancashire, University of Cambridge, Warwick University) to undertake an independent evaluation of *For Baby's Sake*. Our research evaluation team comprises UK and international consultant perinatal and child and adolescent psychiatrists and a paediatrician, professors of midwifery, social work and health economics (see Appendix 4 for a list of the research evaluation team).

Study aims

Our evaluation aimed to assess the following components of *For Baby's Sake* over a four-year period, from March 2015 to April 2019, extended by six months to September 2019:

- whether the programme operates as anticipated
- whether the programme delivers (or gives an early indication of delivering) a range of positive short-term outcomes which may also signal the likelihood of medium- and longer-term outcomes for families
- evidence that the benefits delivered would outweigh the costs of the programme in the short, to medium term and to explore initial indications of cost-effectiveness
- whether the intelligence gathered, and benefits observed enable further development/piloting of the programme and support the case for funding

The process, outcome, and economic components of the evaluation are similar to those that we have used to inform the evaluation of other complex DVA interventions with vulnerable groups (Jack *et al.*, 2012, Trevillion *et al.*, 2014). We have found that the collection of process data is of key importance in the evaluation of complex interventions, and our recent findings suggest that evaluation designs which utilise routine outcome data may be more appropriate for complex DVA interventions with vulnerable groups (Jack *et al.*, 2019, Trevillion *et al.*, 2012).

Evaluation methodologies

To assess whether the programme operates as anticipated

A range of process-related data and quantitative and qualitative data were collected from families, *For Baby's Sake* practitioners and key stakeholders. These sources of data sought to chart the nature of families attracted to and retained on the programme; to chart *For Baby's Sake* practitioner capacity and skills to deliver the programme; the balance and content of therapeutic interventions; family, stakeholder and *For Baby's Sake* practitioner experiences and views on *For Baby's Sake*. Details on these methodologies are described below.

The nature of families attracted to and retained on the programme

Alongside the Foundation's own monitoring and case management systems, we established reporting systems for *For Baby's Sake* practitioners to routinely record details on:

- the number of families approached for participation, and how they were identified

- the number of families that agreed to take part, and their motivations for agreeing
- the number of families that declined to participate/dropped-out, and the reasons for refusal or withdrawal
- details on the needs, circumstances and relationships of families approached to take part, including age, ethnicity, education, marital and socio-economic status, living situation, and nature and extent of domestic abuse

We worked closely with the two sites to establish a spreadsheet that records key process data on the progress of the programme. From the data collected in the site spreadsheets we were able to monitor staff caseloads and the number of contacts with families, including number of sessions offered and delivered and the length of sessions (see Chapter "*Programme referrals, uptake and engagement of families*" for full details).

We used standardised reporting guidelines (i.e. the CONSORT flow diagram (Moher *et al.*, 2001)) to chart how many individuals and families were approached to take part in the programme, how many were excluded and the reasons for exclusion, how many agreed to take part and how many dropped-out. This information will be an important reference point in the estimation of participation and drop-out rates for any future developments of the programme. We also identified routes into the programme (see Chapter "*Programme referrals, uptake and engagement of families*" for full details) and explored the role of the social marketing campaign in promoting self-referral to the service (see Chapter "*Social Marketing activities*" for full details).

We had planned to undertake basic descriptive analyses to summarise key characteristics of families attracted to and retained on the programme, compared to those who refused/withdrew. Unfortunately, this was not possible as there were insufficient data on those who did not engage with the programme to make such comparisons.

For Baby's Sake practitioner capacity and skills to deliver the programme

We developed systems to monitor *For Baby's Sake* practitioner capacity by asking the two teams to routinely record details on:

- training received (e.g. type, content and duration), to assess ongoing skills development
- work that was planned and delivered, including agreed plans, key objectives with associated actions, timescales and status updates
- reflective logs, including details on challenges, risks and successes
- staff caseloads and number of contacts with families, including attempted and actual contacts
- number of sessions offered and delivered
- clinical supervision details, including amount and duration

We summarised details on the training, educational and supervisory components of the programme to inform the minimum requirements and operationalisation of these components for the successful completion of any future roll-outs. We conducted descriptive analyses (using the statistical packages SPSS and STATA) to summarise practitioner caseloads,

contacts and work conducted with individuals/families to inform levels of engagement and calculations of the cost of the programme (see Chapter "*Economic Analyses*" for more details). We also conducted a content-analysis of information collected on work that was planned and delivered (by analysing team minutes at both sites) to inform future training, capacity and skills building activities for any future roll-outs (see Chapter "*For Baby's Sake Practitioner Experiences of Delivering the Programme*" for more details).

The balance and content of the therapeutic interventions

We developed a measure of fidelity in collaboration with the Foundation to chart the balance and content of therapeutic sessions. These measures were used to assess the extent to which core components of the manualised programme were delivered as intended. During the development of the measures, we met with *For Baby's Sake* practitioners to discuss the purpose and application of assessing treatment fidelity, and to review the best options for measuring this. We explained to the practitioners that implementation with fidelity means using the programme modules consistently and accurately, as they were intended to be used. We spoke of how it is important for the research evaluation to assess whether the modules are used consistently and accurately, with the same intent and validation during their development.

We used the manual to develop fidelity checklists which could be compared against audio-recorded programme sessions. Each session within the manual includes a list of core components to be covered. This may include worksheets to be used, concepts to be explained, and techniques to be practiced. Each session also includes more general therapeutic elements such as checking in, providing between session tasks (called "Give it a Go" (GIGs)), and reviewing the session. These components were used to create a checklist for each session. These checklists were reviewed by *For Baby's Sake* staff to ensure they reflected key session content and any suggested changes were made.

To measure the extent to which sessions adhered to the manual content, practitioners were asked to audio-record sessions with mothers and fathers (with consent). We developed a script for practitioners to use to describe the process to families and this script was incorporated within their formal consent forms; the script sought families' permission for the evaluation team to access their pre-recorded sessions. Audio files from the sessions were labelled with a module name, session number, and person identification code. During our evaluation interviews with families, we gained consent to listen to these recorded sessions.

A sample of audio-recordings of sessions from participants in the evaluation were obtained from each site. The sample was stratified to ensure that it included sessions from a range of modules, a range of mothers and fathers and, where possible, a range of practitioners. Raters then listened to the sample of the recorded sessions to check adherence to the pre-established components in the checklists. Each component on the checklist was scored as present, not present or not applicable. This provided an overall percentage score of the extent to which the session included the intended content.

In addition, each session was rated for general adherence to the programme's content on a scale of 1 to 3. This score was intended to reflect adaptations to programme delivery, which included the decision to deliver the manual content flexibly, according to the needs of mothers and fathers. Therefore, it was understood that the content recorded for a labelled session (e.g. Basic Tools 2) might not adhere closely to the specific checklist associated with

that label but might instead include manualised content from other sessions. This score also captured whether the session kept to time (as defined within the manual) and the amount of diversion to other topics which were outside of the programme aims.

A score of 1, 2 or 3 was given in line with the following categories:

1. The practitioner may deviate from the manual, introduce unrelated content, or struggle to re-engage the parent in the programme content. Large parts of the session are not related to manualised content

2. The practitioner maintains a good focus on the programme throughout most of the session. Key messages are delivered which illustrate the overall aims of the programme (e.g. focus on safety planning, learning to express emotions etc.) but there is some deviation and/or unrelated content

3. The practitioner can maintain focus on the programme or is adept at returning to the programme when the parent deviates. Key content is delivered, and the practitioner draws the parent's attention to the messages and concepts which are in line with the manual

In addition to measuring the extent to which sessions delivered adhered to the manual content, the evaluation aimed to summarise the overall delivery of the programme content. To do this, practitioners were asked to keep session-by-session records of all contacts with service users, which detailed the frequency, duration and mode of delivery of sessions. These records were anonymised by the programme officers at the sites and shared with the evaluation team in order for the team to analyse data from the wider sample of families who engaged with the programme. This provided an indication of the length and frequency of input. The records were used to calculate the following: the number of sessions delivered to mothers and fathers across different modules between April 2015 and March 2019; the number of cancellations of sessions as a proportion of sessions offered; the average length of sessions; the average time (months) mothers and fathers spent on the programme (see chapter "*Programme referrals, uptake and engagement of families*" for the results of this work).

For Baby's Sake practitioner, family and stakeholder experiences and views on the programme

We conducted individual interviews with *For Baby's Sake* practitioners at the beginning, middle and end of the evaluation period (see year 1 and year 2 evaluation reports for results from the beginning and middle interviews). Interviews explored practitioners' expectations, experiences and reflections of their work and the programme, including challenges and successes (see Chapter "*For Baby's Sake Practitioner Qualitative Interviews*" for the results). We also conducted individual interviews with mothers and fathers engaged in the programme, to explore their motivations for taking part, their expectations/experiences of *For Baby's Sake*, which therapeutic components were found to be most/least beneficial and any barriers and facilitators to completion of *For Baby's Sake* (see Chapter "*Qualitative Interviews with Families engaged with For Baby's Sake"* for the results). Finally, we undertook focus group interviews with key stakeholders in each of the two sites. The focus group interviews explored stakeholders' experiences, perceptions and expectations of the programme (see Chapter *"Qualitative Interviews with Stakeholders"* for the results).

All interviews were audio-recorded, with the consent of participants, and transcribed verbatim. Interviews were analysed using thematic analysis; it was not assumed that themes would ‘emerge’ from the data but that interpretive work would be required to identify themes. Analysis began with identification of patterns in the data before an initial coding frame was developed. The appropriateness of the coding frame was checked through progressive iterations and reapplied to earlier transcripts as it developed. A total of 20% of the coding of each set of interviews (i.e. families, stakeholders and practitioners) was cross-checked to ensure reliability and over 80% agreement was attained among raters. Nvivo 12 on MS Windows (NVivo, 2012) was used for indexing material and for retrieval of text chunks pertaining to the same or similar codes. Data that did not seem to fit into the coding frame were actively sought. Codes with similar information were merged and pruning of irrelevant codes was undertaken. Initial themes were developed and then interrogated to achieve a final level of abstraction in the form of interpretive themes. A framework-analysis based approach was then used to qualitatively explore practitioner, family and stakeholder expectations, experiences and views about the programme over time.

Additional data sources

Although not part of our original evaluation plan, we interviewed the three *For Baby’s Sake* Senior Leadership Team staff members. We conducted individual interviews with each member of the Senior Leadership Team between April and June 2019. These interview discussions focused on the development of *For Baby’s Sake* (see Chapter “*The Foundation’s developmental activities for the programme*” for the results). All interviews were audio-recorded, with the consent of participants, and transcribed verbatim. Interviews were analysed using thematic analysis; it was not assumed that themes would ‘emerge’ from the data but that interpretive work would be required to identify themes. Analysis began with identification of patterns in the data before an initial coding frame was developed. The appropriateness of the coding frame was checked through progressive iterations and reapplied to earlier transcripts as it developed. NVivo 12 on MS Windows (NVivo, 2012) was used for indexing material and for retrieval of text chunks pertaining to the same or similar codes. Data that did not seem to fit into the coding frame were actively sought. Codes with similar information were merged and pruning of irrelevant codes was undertaken. Initial themes were developed and then interrogated to achieve a final level of abstraction in the form of interpretive themes.

To examine whether the programme delivers [or gives an early indication of delivering] a range of positive short-term outcomes for families

We established a cohort of families engaged with *For Baby’s Sake*, who agreed to take part in our evaluation, and we followed them up over time to measure their outcomes.

Mothers and fathers engaged with *For Baby’s Sake* were eligible to participate in the evaluation if:

- Either the mother and/or father wished to participate in the study
- The mother and/or father had a sufficient level of English to complete the study questionnaires

Mothers and fathers were excluded from the evaluation study if:

- They were considered by the researcher(s) to be too unwell or distressed to participate in the study
- They were unable to give informed consent to the study

Identification of study population

For Baby's Sake practitioners across both sites were asked to identify families approached for participation in *For Baby's Sake* and ask them if they would be interested in hearing about the research evaluation. Researchers attended staff team meetings to describe the study evaluation and gain feedback from practitioners. Families were informed of the study evaluation by practitioners at the Welcome and Getting Started sessions.

Ethics Approval

NHS Research Ethics Committee approval was granted for this evaluation on 25th January 2016 by the London-Camberwell St Giles Research Ethics Committee (Reference number: 15/LO/2006).

Recruitment

Parents who met the cohort criteria for the evaluation study were recruited to the study by the researchers via an introduction by the *For Baby's Sake* practitioners at both sites. Eligible participants were approached for participation in the study by *For Baby's Sake* practitioners, who judged the potential risks of participation for participants and, if deemed safe, described: the study aims and procedures; the nature of informed consent, and any queries/concerns participants had regarding their participation in the study. Participants who were interested in the study were asked to provide their contact details (i.e. address, telephone number) so that researchers could contact them to arrange an interview. Participants were asked to nominate a secure point of contact (e.g. letter, mobile phone call) and time when researchers could contact them to discuss the project. The study Participant Information Sheet informed potential participants about all parts of the study (including the follow-up interviews); this information was provided to potential participants at least 24 hours before an interview took place. Prior to the start of the baseline interview, the researcher obtained written informed consent for participation in all parts of the study. Participants were asked to consent to the videotaping of parent-child interactions and audio-recordings of their experiences and opinions of taking part in the programme.

Participants who agreed to be approached about the evaluation study - but decided not to sign-up to *For Baby's Sake* - were still asked by the researchers to take part in the evaluation. For those who agreed to take part in the evaluation but not the *For Baby's Sake* programme, we sought to examine their health and wellbeing over time and to explore their reasons for not proceeding (N.B. all the participants in our evaluation took part in the *For Baby's Sake* programme so this analysis was not applicable). For those who did not take part in the evaluation, we e-mailed them a link to a brief online anonymous survey (approximately 3 minutes in length) to explore their reasons for non-participation; participants were offered a small gift token to complete the survey (£5 coffee voucher to use in a big high-street chain store). Unfortunately, despite multiple attempts to survey people who did not engage with *For Baby's Sake* or did not take part in our evaluation, no such participants took part.

We interviewed participants at three separate time-points: (1) the baseline interview, as close to sign-up as possible (this could be in the antenatal or postnatal period, depending on the length of the *For Baby's Sake* assessment and sign-up process; questionnaires were adjusted as appropriate); (2) one-year post sign-up to the programme, and (3) two-years post sign-up to the programme. The scheduled interview content is outlined below. In order not to overburden participants, we provided the option for the interview to be completed over two separate sessions. In addition, our approving ethics committee requested that we break down the components of the interview in to "essential" and "desirable" questions, to ensure people were not overburdened. All service users participating in the evaluation were given a £20 gift token per interview, to thank them for their time.

Informed consent and capacity

The General Medical Council (GMC) guidance on obtaining consent from adults for research purposes was followed (General Medical Council, 2010). Evaluation team members had up-to-date Good Clinical training (which included training on obtaining informed consent for research) and undertook Level 1 training for Safeguarding Adults and Safeguarding Children.

During recruitment, potential participants were offered clear information both verbally and in writing (i.e. Participant Information Sheet), about the purpose, subject and nature of the study and what would be required of them if they consented to participate. In addition to giving potential participants a minimum of 24 hours to consider their participation in the study before consent was sought, it was emphasised that participation was voluntary. During the formal consent process, each participant was informed that their responses were anonymous and confidential (e.g. no names would be used on questionnaires, and questionnaires would not be seen by anyone outside of the study). Participants were advised that they did not have to answer any questions, if they did not wish to, that they could take a break or terminate the interview at any time, and that declining to participate would not in any way affect the services they were receiving.

Detailed information regarding the conduct of the research interviews was included in a Standard Operating Procedure (SOP) for the study (see an extract from the SOP in Appendix 5). Research interviews were conducted by trained researchers in a private room within a community setting or, if deemed safe, the participants' homes; joint researcher visits were conducted in home settings, where suitable. Researchers were supervised by Professor Louise M Howard, a consultant psychiatrist.

The information provided by the participants was confidential and anonymised. In some situations, however, it may have been necessary to disclose personal information without a participant's consent, if it was in the public interest (i.e. where a failure to do so may expose the participant or others at risk of death or serious harm). The limits of confidentiality were explained on the Participant Information Sheet and discussed with all participants as part of the informed consent process. The General Medical Council guidance on confidentiality was followed (i.e. disclosure of personal information without consent may be justified in the public interest where failure to do so may expose the person or others to risk of death or serious harm). If any cases arose where the participant or others were exposed to a risk so serious that it outweighed the participant's privacy interest, consent to disclose would be sought. If consent could not be obtained, the information would be disclosed to an appropriate person or authority. The researchers would contact their line manager (Professor Louise M Howard,

a consultant psychiatrist) to discuss any situations when confidentiality may have needed to be broken.

Data collection

Wherever available, we used existing instruments that had previously been validated with families who have experienced and perpetrated DVA. For full details of measures used, please see Appendix 1.

Interview one: as close to sign-up as possible

Essential items

Study specific instruments:

- Socio-demographic characteristics, including gender, age, ethnicity, socio-economic, employment, education status and smoking questions
- Abuse experiences questionnaire, adapted from validated instruments, this questionnaire identified the types of domestic violence experienced, the perpetrators and impact of domestic abuse

Standardised instruments for assessment of parents' outcomes (measures are for mothers and fathers unless specified otherwise):

- Prenatal Attachment inventory (if antenatal, asked of mothers only)
- The Composite Abuse Scale (CAS)
- Edinburgh Postnatal Depression Scale (EPDS)
- Posttraumatic Diagnostic Scale (PDS)
- The Standardised Assessment of Personality – Abbreviated Scale (SAPAS)
- Camberwell Assessment of Need – Mother's Version
- Social Provisions Scale
- The five-level version of the EuroQol measure of health-related quality of life (EQ-5D-5L)
- Adult Service Use Schedule (AD-SUS)
- Generalised Anxiety Disorder Assessment (GAD-7)
- The Alcohol Use Disorders Identification Test (AUDIT) [if participants responded positively to the screening questions for alcohol use issues]
- The Drug Use Disorders Identification Test (DUDIT) [if participants responded positively to the screening questions for drug use issues]

Desirable measures (these items were collected if time permitted within the scheduled interview appointment and if participants felt able to/wanted to complete them):

- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- Improving Access to Psychological Therapies (IAPT) Work and Social Adjustment Scale

- Experiences in Close Relationship-Revised Questionnaire
- **The following baby outcomes were also collected from the *For Baby's Sake* teams:**
    - Foetal growth
    - Birth weight
    - Preterm birth information (if applicable)
    - APGAR score – a summary of the physical condition of the new-born infant immediately after birth which includes colour, heart rate, reflexes, muscle tone and respiration at 1 min and 5 min after birth.

Interview two: one-year post-sign up to the programme

Standardised instruments for assessment of parents' outcomes (measures are for mothers and fathers unless specified otherwise stated):

Essential items:

- The Composite Abuse Scale (CAS)
- Abuse experiences questionnaire [adapted from validated instruments]
- Edinburgh Postnatal Depression Scale (EPDS)
- Posttraumatic Diagnostic Scale (PDS)
- Smoking questions
- The Standardised Assessment of Personality – Abbreviated Scale (SAPAS)
- Camberwell Assessment of Need – Mother's Version
- Social Provisions Scale
- The five-level version of the EuroQol measure of health-related quality of life (EQ-5D-5L)
- Adult Service Use Schedule (AD-SUS)
- Generalised Anxiety Disorder Assessment (GAD-7)
- The Alcohol Use Disorders Identification Test (AUDIT) [if participants responded positively to the screening questions for alcohol use issues]
- The Drug Use Disorders Identification Test (DUDIT) [if participants responded positively to the screening questions for drug use issues]

Standardised instruments for assessment of child outcomes:

- Video-taped play interactions
- Parenting Stress Index (Short Form)
- Ages and Stages Questionnaire

Desirable items (these items were collected if time permitted within the scheduled interview appointment and if participants felt able to/wanted to complete them):

- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

- IAPT Work and Social Adjustment Scale
- Experiences in Close Relationship-Revised Questionnaire
- Infant Behaviour Questionnaire-Revised
- Child-Behaviour Checklist [if child is over 18 months]

Interview three: two-year post-sign up to the programme

Standardised instruments for assessment of parents' outcomes (measures are for mothers and fathers unless specified otherwise):

Essential items:

- The Composite Abuse Scale (CAS)
- Abuse experiences questionnaire [adapted from validated instruments]
- Edinburgh Postnatal Depression Scale (EPDS)
- Posttraumatic Diagnostic Scale (PDS)
- Smoking questions
- The Standardised Assessment of Personality – Abbreviated Scale (SAPAS)
- Camberwell Assessment of Need – Mother's Version
- Social Provisions Scale
- The five-level version of the EuroQol measure of health-related quality of life (EQ-5D-5L)
- Adult Service Use Schedule (AD-SUS)
- Generalised Anxiety Disorder Assessment (GAD-7)
- The Alcohol Use Disorders Identification Test (AUDIT) [if participants responded positively to the screening questions for alcohol use issues]
- The Drug Use Disorders Identification Test (DUDIT) [if participants responded positively to the screening questions for drug use issues]

Standardised instruments for assessment of child outcomes:

- Video-taped play interactions
- Bayley Scales of Infant Development
- Parenting Stress Index (Short Form)
- Child-Behaviour Checklist

Desirable items (these items were collected if time permitted within the scheduled interview appointment and if participants felt able to/wanted to complete them):

- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
- IAPT Work and Social Adjustment Scale
- Experiences in Close Relationship-Revised Questionnaire

- Infant Behaviour Questionnaire-Revised

Children's services / safeguarding data

Data on the safeguarding category or categories of the infant and family were also collected from *For Baby's Sake* teams.

Data collection and storage

Study data, including audio and video recordings, were stored within the Health Service and Population Research Department and will be retained for up to 12 months after the study has ended. During this time, only the study team will have access to the data, and it will be stored within locked filing cabinets or on the King's College London secured computer network. Data will then be archived within the King's College London library for a further two years. Should it be necessary to access any of the data that has been archived, the study team will be required to obtain formal written agreement from the King's College London library to access the materials. Data will then be destroyed securely by the King's College London library (i.e. three years after the study has completed) in line with the Data Protection Act 2018.

Analyses

Descriptive analyses included changes in parent and child attachment and interactions, infant and sibling development, parental stress and sensitivity, parental experiences of abuse, health and quality of life. Descriptive analyses were also conducted to present obstetric data on stress in utero and the perinatal period, and on the safeguarding statuses of families. Observations of parent-infant interactions were coded by a trained, independent rater (who was not part of the study team and who did not have any knowledge about the families).

Economic evaluation of *For Baby's Sake*

Aim and objectives

The overall aim of the economic analysis of *For Baby's Sake* was to examine evidence that the benefits delivered would outweigh the costs of the programme in the short- to medium-term and to explore initial indications of cost-effectiveness. For the purpose of the economic evaluation, the short-term was defined as covering the two years between baseline (when participants have their first interview to collect research data), and the final follow-up interview two years later. The medium-term was defined as five years post baseline.

Specific objectives were as follows:

- To undertake a detailed costing of the programme
- To record the use of all health, social care and criminal justice sector services at entry to the study and at the follow-up points 1- and 2-years post baseline
- To undertake a short-term cost-offset analysis to explore whether the programme costs are 'offset' by savings elsewhere (e.g. reductions in the use of other services, criminal justice sector involvement etc.)
- To develop an economic decision model to explore the short- to medium-term cost-effectiveness of *For Baby's Sake* in comparison to a hypothetical control group

Perspective

The intended primary perspective of the economic evaluation was a broad perspective including all NHS and Personal Social Services used by the mother and baby, key NHS and Personal Social Services used by the father (those the programme was hypothesised to impact upon), plus productivity losses for both mothers and fathers and criminal justice sector resources relating to domestic abuse. Additionally, we included the use of fostering/kinship care by other children in the immediate family.

Economic outcomes

The primary economic outcome was quality adjusted life years (QALYs) for mothers, calculated using the EQ-5D-5L measure of health-related quality of life (Herdman *et al.*, 2011), described in the *Measurement details* section above. The EQ-5D-5L was self-reported by both mothers and fathers at baseline, one-year post-baseline and two-years post-baseline. QALYs measured by the EQ-5D are the measure of outcome recommended by NICE for economic evaluations (National Institute for for Health and Care Excellence, 2008).

Resource use

Data on direct contacts with *For Baby's Sake* practitioners were recorded by *For Baby's Sake* practitioners in dedicated excel spreadsheets. This included the type, number and duration of contacts for each participant.

All other resource use was measured using adapted versions of the Adult Service Use Schedule (AD-SUS), an instrument used to collate service use and related resource use data which has been successfully used in a range of similar populations (Byford *et al.*, 2013, Howard *et al.*, 2011, Trevillion *et al.*, 2014). The AD-SUS was adapted for the study using data from previous studies carried out by the team in similar populations (Trevillion *et al.*, 2014), review of other relevant literature and discussion with the *For Baby's Sake* team. The AD-SUS is self-reported and administered in interview with research assessors at baseline (covering the previous 6 months) and then at one year and two years post-baseline (covering the period since last interview).

Two versions of the AD-SUS were developed, one completed by mothers (covering resource use by the mother, the baby and other children in the immediate family), and one completed by fathers (covering resource use by the father). The AD-SUS completed by mothers covered use of all hospital and community-based health and social care services by the mother and her baby (accommodation, fostering/kinship care, inpatient, outpatient, day case, A&E, community-based services etc.), fostering/kinship care for siblings, plus employment status and time off work, if relevant. The AD-SUS completed by fathers was a brief version used to measure individual-level use of key services the programme was expected to impact upon, including hospital and community-based health and social care services (inpatient, day case, outpatient and community-based services) related to mental health and substance use, plus employment status and time off work, if relevant.

Instances of domestic abuse over the two-year post-baseline follow-up period were captured using the Composite Abuse Scale (CAS). At the one and two year post-baseline follow-up interviews, a cut-off point of three was applied with scores higher than two indicating domestic abuse (Hegarty, 2007). However, at baseline, it was assumed that all mothers were

experiencing domestic abuse as this was a prerequisite for entry into the programme. This was tested in sensitivity analysis using the CAS cut-off of three.

Costs

All costs were reported in pounds sterling at 2017-2018 prices. Discounting was applied to costs and outcomes falling in the second year of follow-up post-baseline at a rate of 3.5% as recommended by the National Institute of Health and Care Excellence (National Institute for Health and Care Excellence, 2015) and Her Majesty's Treasury (Treasury, 2014).

For Baby's Sake

We undertook a detailed, micro-costing of *For Baby's Sake* which takes a 'bottom-up' approach involving the identification and costing of each individual component that makes up the programme as a whole. There are three key components to *For Baby's Sake*:

- Training - The total cost of training all *For Baby's Sake* practitioners was provided by the Stefanou Foundation and divided by five full-time practitioners per team, assuming practitioners would, on average, deliver the service for three years to take turnover of staff into consideration
- Materials - The total cost of the *For Baby's Sake* training manuals was estimated by the Stefanou Foundation and divided by the total number of *For Baby's Sake* practitioners who were trained per team and the average period of time a practitioner would deliver the service
- Implementation – A unit cost per hour for *For Baby's Sake* practitioners' time was calculated based on information on profession, pay grade and working time, plus employer on-costs (national insurance and superannuation) and relevant overheads (managerial, administrative, capital etc.), in line with the approach taken to calculate national unit costs of health and social care professionals (Curtis and Burns, 2018). These on-costs and overheads are those of relevance to professionals employed by statutory services and thus may not match those in the non-statutory sector (as is the case for the Stefanou Foundation in the two *For Baby's Sake* prototype sites). However, this provides unit costs of greater relevance to a national roll-out of *For Baby's Sake*, should the service prove effective and cost-effective. Indirect time (time spent doing work on *For Baby's Sake* that does not involve direct contact with individual participants) was estimated using a practitioner-completed questionnaire on the time spent in various *For Baby's Sake* activities in a typical week. This was used to calculate the ratio of direct to indirect contact time for practitioners, which was then applied to the estimated practitioner cost per hour to provide a unit cost per hour of direct service user contact

Health and social services

Nationally applicable, published unit costs were applied to all other health and social care resource use data. Unit costs for hospital and community health and social services were obtained from the NHS Reference Costs (Department of Health, 2018) and the Unit Costs of Health and Social Care annual compendium (Curtis and Burns, 2015).

Domestic violence and abuse

Unit costs applied to criminal justice events were taken from the Home Office Economic and Social Costs of Domestic Abuse (Oliver *et al.*, 2019), and inflated up to 2017/18 prices where necessary using the Hospital and Community Health Services Pay and Prices Index or Retail price index, as appropriate (Curtis and Burns, 2018).

The Home Office unit costs of DVA include the costs in anticipation of crime (defensive expenditure and insurance administrations costs), the costs as a consequence of crime (cost of stolen/damaged property, physical and emotional harms to the victims, lost output, health service costs and victim service costs) and the costs in response to crime (police costs and other criminal justice sector costs). As the individual-level cost of health service use were estimated using data collected from the *For Baby's Sake* cohort, we excluded this element of the unit cost of domestic abuse and recalculated weighted unit cost.

The Home Office costs of domestic abuse (Oliver *et al.*, 2019) include costs associated with lost productivity (time off work due to domestic abuse). This data is based on a much larger sample size and is thus a more robust estimate than the data collected in the *For Baby's Sake* study. To avoid double counting, productivity losses were not calculated using data collected in the AD-SUS on time off work.

We applied the annual unit cost for an episode of domestic abuse (Oliver *et al.*, 2019) to those participants reporting domestic abuse indicated by a CAS cut-off of three as recommended (Hegarty, 2007) at the one-and two-year post-baseline follow-up interviews.

Missing data

Missing individual items were estimated as follows:

- Foster care: Missing number of foster care days was assumed to be 1 if the use was clearly indicated, otherwise zero
- Outpatient services: Missing number of outpatient contacts was assumed to be 1 if the use was clearly indicated, otherwise zero
- Inpatient services: Missing number of nights was assumed to be 1 if the use was clearly indicated, otherwise zero
- A&E: Missing number of A&E contacts was assumed to be 1. If associated admission or transport by ambulance was missing, this was assumed to be zero
- Community services: Missing number of contacts with community services was assumed to be 1 if use was clearly indicated, otherwise zero
- In terms of missing EQ-5D-5L data, any single missing items was imputed by the median of all observed values in that dimension for the relevant group (mothers or fathers).
- All other missing items were estimated as the mean for the whole sample at that time point

Completely missing AD-SUS, CAS or EQ-5D-5L questionnaires were deemed to be a loss to follow-up at that time point and were excluded from the main economic analyses. However, we also carried out an 'intention to treat' analysis, imputing missing data using mean imputation from those *For Baby's Sake* participants with available data. Simple and multiple imputation were not possible due to the small sample sizes.

Analyses

Data were analysed using the latest version of STATA available at the time of analysis (Stata, 2011).

Description of resource use

Service use and other resource use data are reported as the percentage of participants using the service or resource.

Description of costs

Cost components and total costs at each time point are reported descriptively as mean and standard deviations for mothers and their baby and for fathers.

Description of outcomes

EQ-5D-5L scores (known as utilities) and QALYs at each time point are reported descriptively as mean and standard deviations for mothers and for fathers.

Cost-offset analysis

A cost-offset analysis (also known as a cost-savings analysis) was conducted which assessed whether the cost of providing *For Baby's Sake* was offset by savings over the two-year post baseline (study start) follow-up period for the *For Baby's Sake* cohort in comparison to a group who did not receive *For Baby's Sake*. For example, lower use of other health or social care services or a lower number of incidents of domestic abuse.

Since the *For Baby's Sake* study did not include a control (comparison) group, a hypothetical comparison was created which assumed that families who did not receive *For Baby's Sake* would be similar to the participant families prior to receipt of the intervention. In other words, a before and after study was conducted which involved comparing the total cost of service use and domestic abuse in the period before the programme was received (the hypothetical comparison group) with the total cost of service use and domestic abuse, plus the cost of *For Baby's Sake*, in the period after baseline to the programme (the programme group). Since participants only reported service use for the six-months prior to baseline, these costs were extrapolated to cover the same time period as the actual length of follow-up for each individual *For Baby's Sake* family. In other words, if a family were followed up 2 years after baseline (study start), then six-month costs prior to entering *For Baby's Sake* for that particular family were multiplied up to two years; if a participant family were followed up 23 months after baseline, then six-month costs prior to entering the programme for that particular family were multiplied up to 23 months. To take into consideration the birth and child-related costs, which were recorded for the programme group but not for the hypothetical comparison group (since the baby had not been born in the pre-baseline period), costs associated with the birth and the baby for each family in the two years post baseline were added to the pre-baseline costs for that family.

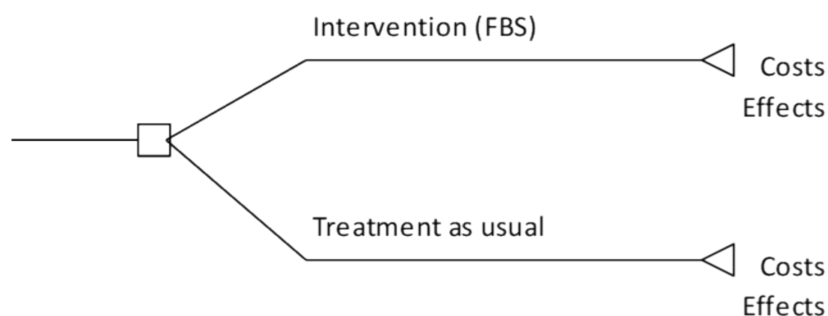
Cost-offset analyses focused on the service and domestic abuse costs for the mother and her baby (base case). A secondary analysis focusing on the costs per family (mother, baby and father) was planned, however this analysis could not be conducted due to very small sample sizes which are described in the results section.

Differences in costs before and after baseline (i.e. programme group versus hypothetical comparison group) were tested using standard parametric tests (ordinary least squares regression) but with mean differences and 95% confidence intervals obtained by non-parametric bootstrap regressions (ordinary least squares, 1000 repetitions). This is the recommended approach for the analysis of cost data which is commonly found to be highly skewed (non-normally distributed) (Thompson and Barber, 2000).

Short-term (2-year) cost-effectiveness analysis

To assess whether *For Baby's Sake* is cost-effective, and given the lack of a comparison group, we developed a decision analytic model that compared the costs and effects for the evaluation study participants to a hypothetical comparison group who do not receive the *For Baby's Sake* service. Decision models map the care pathways of alternative strategies in terms of both costs and outcomes (Petrou and Gray, 2011). A decision tree, shown in Figure 2, was developed to capture the alternative pathways of receiving the *For Baby's Sake* service or not receiving the *For Baby's Sake* service, and used to perform a 'within-trial' economic evaluation where costs and effects of the cohort were limited to the duration of the follow-up of the *For Baby's Sake* evaluation (2-years post baseline).

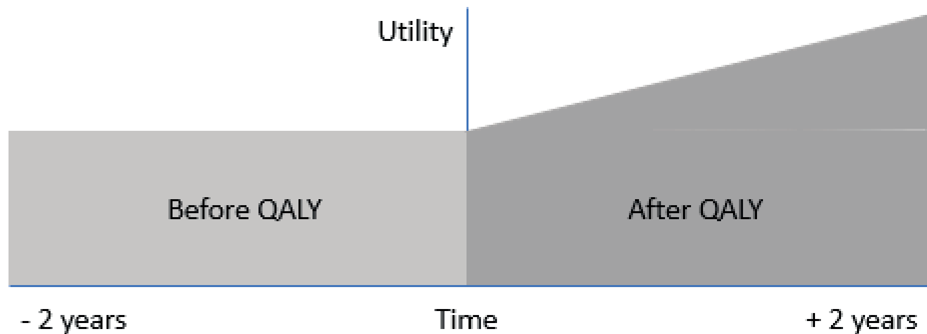
Figure 2: Short-term (2-year) cost-effectiveness decision analytic model



In line with the cost-offset analysis, we assumed that those not receiving the *For Baby's Sake* intervention (the hypothetical comparison group) would be similar to the participating families prior to baseline. Costs for this hypothetical comparison group were estimated in the same way as described for the cost-offset analysis. For effectiveness, QALYs were assumed to be linear and equal to baseline values for the full two-year period prior to entry into the *For Baby's Sake* evaluation. QALYs were calculated using data from the EQ-5D-5L which firstly involves applying appropriate quality weights (known as utilities) to EQ-5D-5L scores. Nationally appropriate, published quality weights are available for the full range of possible EQ-5D-5L scores (Devlin *et al.*, 2017). QALYs are then calculated as the total area-under-the-curve (Manca *et al.*, 2005), where the y-axis is utilities (generated from the EQ-5D-5L) and the x-axis is time (two-years) and assuming EQ-5D-5L scores, and thus utilities, across the two-

year period remain equal to the EQ-5D-5L scores reported at baseline prior to receipt of the *For Baby's Sake*), as illustrated in Figure 3.

Figure 3: Illustration of estimation of QALYs



Cost-effectiveness analysis followed standard UK approaches (Drummond *et al.*, 2015) and was explored initially by calculating incremental cost-effectiveness ratios (ICERs) for the *For Baby's Sake* cohort in comparison to the hypothetical comparison group. An ICER is calculated by dividing the difference in costs between the intervention and comparison group by the difference in effects between the intervention and comparison group (York Health Economics Consortium, 2016). Cost-effectiveness was also explored using the net benefit approach, which avoids the interpretation and statistical problems related to the incremental cost effectiveness ratio (Briggs, 1999). Monte Carlo simulation (a mathematical technique that generates random values from observed data for modelling uncertainty of single point estimates) was used in a probabilistic sensitivity analysis to draw random samples from the distribution of parameters with uncertainty in 5,000 simulations to explore the impact of that uncertainty on the results of the cost-effectiveness analysis.

The results are reported visually in cost-effectiveness planes which show the costs on the y-axis plotted against the effects on the x-axis for each of the 5,000 simulations. Data points in the north-east quadrant indicate simulations where the intervention is more costly and more effective than the comparison. Data points in the north-west quadrant indicate simulations where the intervention is more costly and less effective than the comparison. Data points in the south-east quadrant indicate simulations where the intervention is less costly and more effective than the comparison. Data points in the south-west quadrant indicate simulations where the intervention is less costly and less effective than the comparison. Uncertainty was explored using cost-effectiveness acceptability curves (CEACs). CEACs show the probability that an intervention is cost-effective compared to a comparison group for a range of maximum monetary values that a decision-maker will be willing to pay (Fenwick and Byford, 2005). For example, NICE use a willingness to pay threshold of £20,000-£30,000 per QALY (National Institute for for Health and Care Excellence, 2008). The higher the probability that an intervention is cost-effective compared to the comparison group, the more likely it is that the intervention is cost-effective (good value for money) compared to the comparison group. Analyses were performed in Microsoft Excel.

Medium-term (5-year) cost-effectiveness analysis

A Markov model was developed based on the pathways followed by women experiencing domestic abuse to compare the costs and effects of the *For Baby's Sake* cohort and a hypothetical comparison group over the medium term (5 years after the baseline). The model contains three health states: domestic abuse, no domestic abuse and death (see Figure 4). The aim was to simulate a cohort of 1,000 women aged 16 years old and above who have experienced domestic abuse passing through the model for five one-year cycles. All individuals are assumed to start in the domestic abuse state and can remain in the domestic abuse state or move (transition) to either no domestic abuse or death after one year (the first cycle). After the first cycle, individuals in the no domestic abuse state can remain in the no domestic abuse state or transition to domestic abuse or death and individuals in the domestic abuse state can remain in the domestic abuse state or transition to no domestic abuse or death.

Figure 4: Medium term (5 year) cost effectiveness decision analytic model

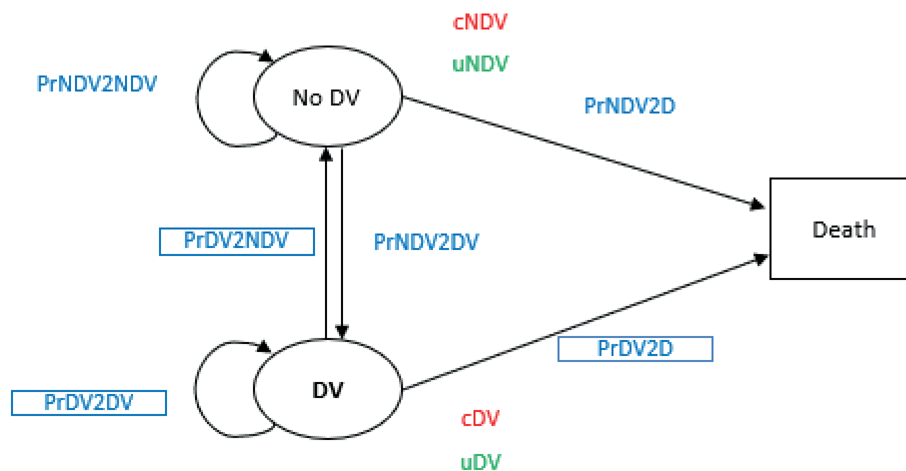


Figure 4 Key - DA=domestic abuse; NDA=no domestic abuse; PrNDA2NDA=probability of remaining in no DA state; PRDA2DA=probability of remaining in DA state; PrDA2NDA=probability of moving from DA to no DA; PrNDA2DA=probability of moving from no DA to DA; cNDA=costs in the no DA state; cDA=costs in the DA state; qNDA=QALYs in the no DA state; qDA=QALYs in the DA state

Transition probabilities in a Markov model are needed to capture the movement of individuals between the health states during each cycle (reflected by the arrows in the Figure 4). Probabilities of those in the *For Baby's Sake* group were calculated from the *For Baby's Sake* cohort data whilst those for the comparison group are not directly available and thus must be identified through review of the literature on the mortality rate and the probability of experiencing domestic abuse for women who have experienced domestic abuse before.

Cost and outcome data were taken from the *For Baby's Sake* study follow-up data for the *For Baby's Sake* group and from the *For Baby's Sake* study baseline data for the hypothetical

comparison group, in line with the approach taken for the cost-offset and short-term cost-effectiveness analyses. The model applies a discount rate of 3.5% to both costs and outcomes falling in years 2 to 5, in line with the approach recommended by NICE for economic evaluation (National Institute for for Health and Care Excellence, 2013).

Sensitivity analyses

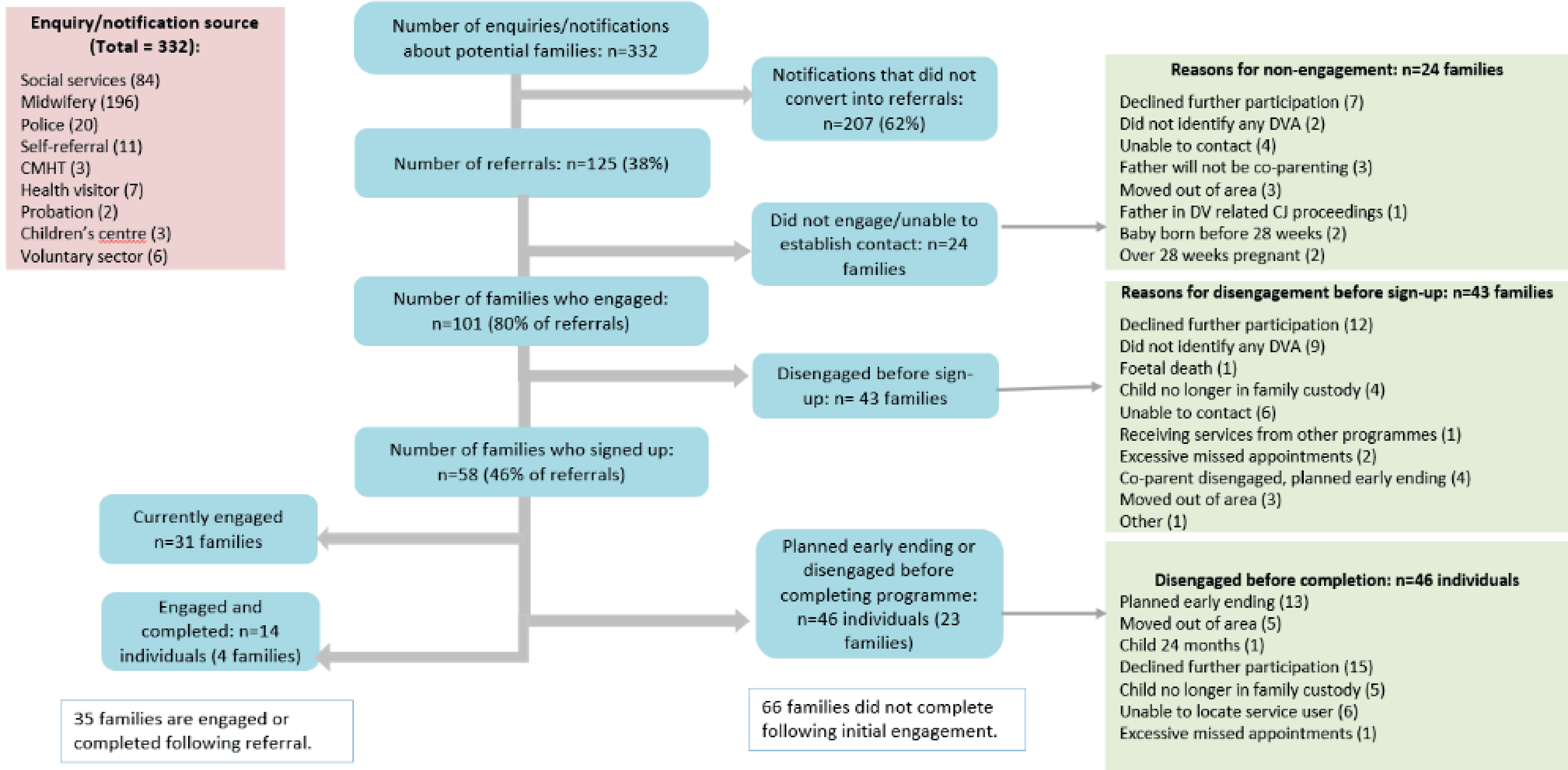
The primary analyses were based on complete cases (excluding those with missing AD-SUS, EQ-5D-5L or CAS questionnaires at one or more time points). To explore the potential impact of excluding non-responders, we examined the sociodemographic and clinical characteristics of the full sample compared with those included in the analysis. We also carried out an intention to treat analysis, imputing missing data using mean imputation from those *For Baby's Sake* participants with available data. Simple and multiple imputation were not possible due to the small sample sizes.

The primary analysis was conducted assuming all mothers were abused at baseline as this was an inclusion criterion for acceptance into *For Baby's Sake*. However, not all mothers reported abuse at baseline which may be a genuine lack of abuse at study entry, or a perception of a lack of abuse, due to them not yet identifying their partner's behaviour as abusive, or could be a deliberate attempt to hide or minimise the abuse due to fear or shame (Trevillion et al, 2014). Since we do not know the reasons, we conducted a sensitivity analysis using a CAS cut-off of three, which is recommended (Hegarty, 2007) to indicate the experience of abuse or not and reduce the risk of false positives (i.e. the risk of overstating the prevalence of abuse). We recognise that conducting a sensitivity analysis using a cut-off of three at baseline introduces the inverse risk of false negatives (i.e. the risk of understating the prevalence of abuse) at that stage, however we can hypothesise that the 'true' level of abuse falls somewhere between the two analyses.

Programme Referrals, Uptake and Engagement of Families

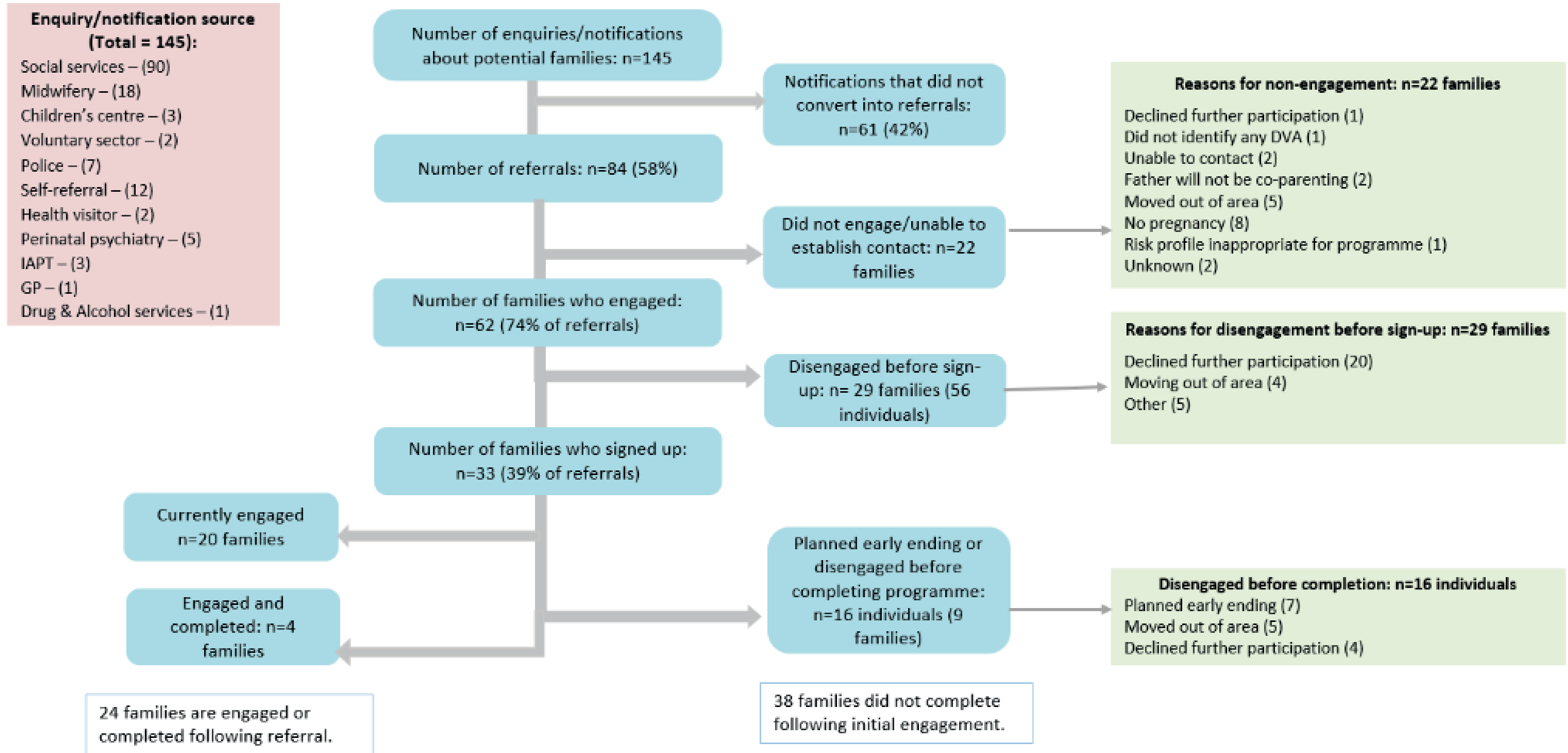
Figures 5 and 6 on the following two pages present details on the flow-through of families referred to *For Baby's Sake* at both sites between April 2015 and March 2019, as well as summarising the key reasons for disengagement.

Figure 5: Referrals in the Hertfordshire site from April 2015 to March 2019



Developed in collaboration with the Stefanou Foundation

Figure 6: Referrals in the London Three Boroughs site from April 2015 to March 2019



Developed in collaboration with the Stefanou Foundation

Notification and referral sources

The above two flow-diagrams show the number of notifications that the sites received (where professionals have consulted or notified the programme about a potential family they have identified) and the number of these notifications that converted into referrals (where a family is referred to *For Baby's Sake* with the family's consent to be contacted by the *For Baby's Sake* team). Across both sites, reasons for notifications not converting into referrals included, for example, no current pregnancy, no identified DVA, or that the families had moved out of the area.

The diagrams highlight that the two sites received notifications and referrals from a wide range of different sources, including social care, midwifery, police and mental health. In Hertfordshire (where all *For Baby's Sake* families live within the catchment area of single NHS Trust's maternity unit) most referrals came from monthly Maternity Sharing meetings, with social services being the second highest referring agency. In London Three Boroughs, the majority of referrals came from children's social care, with maternity services being the second highest referring agency.

Both sites also received notifications and referrals from police, mental health teams and the voluntary sector, suggesting that sites were successful in promoting the programme to these services. The programme also had some success in getting the message across to families, as a total of 23 informal notifications or self-referrals to the programme were made. However, most of these were from families that did not meet the programme inclusion criteria.

Engagement of families

In London Three Boroughs, 58% of notifications converted into referrals, and 74% of these families went on to engage with *For Baby's Sake*. There were varied reasons for non-engagement, including moving out of area, teams being unable to establish contact, and families not meeting the cohort criteria. *For Baby's Sake* is structured so that families undertake the Getting Started module before deciding whether to sign up for the full programme. Of the 62 families who had engaged initially, 33 signed up (39% of those referred). Reasons for not signing up were mainly recorded as 'Declined further participation'. Of the 33 families who signed up, 24 (28% of those referred) had either completed the programme or were still participating at the time of analysis.

In Hertfordshire, 38% of notifications converted into referrals, and 80% of these families went on to engage with *For Baby's Sake.* There were varied reasons for non-engagement, including the family declining further participation, teams being unable to establish contact, and families not meeting the cohort criteria. Of the 101 families who engaged initially, 58 went on to sign up for the programme. This represents 46% of those referred. Reasons for not signing up included, for example, declining further participation, the child no longer being in custody of the family, and teams being unable to contact the family. Of the 58 families who signed up, 35 (28% of those referred) were either still in receipt of the programme or had completed it at the time of analysis.

Across both sites, of the 91 families who chose to sign up, 57 families either completed the programme or were still participating, representing a 36% attrition rate after sign-up. Reasons for attrition following sign-up in both sites included planned early endings (where one partner had disengaged), moving out of area, and declining further participation.

Uptake and delivery of the programme

London Three Boroughs

Anonymised records from all families engaged in the programme were used to calculate overall delivery of the programme. From April 2015 up to the end of March 2019, 88 individuals in the London Three Boroughs site had attended a Welcome Session: 38 of these were fathers (43%). A total of 270 Getting Started sessions (also called Initial Assessment, consisting of several sessions, sometimes up to 11) had been delivered to 73 individuals (37 fathers; 50%). 43 sign-up sessions were delivered (21 fathers; 49%).

From February 2016 up to the end of March 2019, 1077 post sign-up sessions were delivered. Of these, 586 (54%) were sessions delivered to women, 434 (40%) were sessions delivered to men, and 50 (5%) were delivered to a child in the family, i.e. a sibling of the baby; for seven sessions it was not clear who the session was delivered to. Table 1 shows the number of sessions delivered to mothers and fathers across the different modules of the programme. 'Other adult sessions' refers to sessions which were not categorised under a specific module, but instead were delivered flexibly to meet service user needs as they arose.

Table 1: Number of post sign-up sessions delivered between April 2015 and March 2019 in London Three Boroughs

Module	Mothers (n)	Fathers (n)	Total (n)
Basic Tools	N/A	117	117
Opening Doors	63	N/A	63
Where's the Baby?	43	17	60
Owning It	N/A	12	12
Newborn Behavioural Observations (NBO)	9	3	12
Video Interaction Guidance	64	35	99
Inner Child	69	52	121
Healthy Expression of Feelings	112	57	169
Self-Esteem & Assertion	47	0	47
Keep Calm & Carry On Parenting	2	1	3
Other adult session	168	120	288
Protective behaviours			20
Ages and Stages Questionnaires			23
Other child sessions			7

Key: n/a = not applicable

These data indicate that content related to parenting (Where's the Baby? NBO, VIG) was more frequently delivered to women than men. Furthermore, while there were similar levels of engagement for men and women in the early modules, women were more likely to receive

content from later modules such as Healthy Expression of Feelings and Self Esteem & Assertion.

Out of the post sign-up sessions, there were 213 cancellations/Did Not Attends (DNAs); 54% of these were by fathers. Including cancellations, DNAs and attended sessions, 1290 post sign-up sessions were offered, of which 17% were cancellations/DNAs. This includes 684 sessions offered to mothers (of which, 98 [14%] were cancellations), and 434 sessions offered to fathers (of which, 115 [21%] were cancellations).

Practitioners recorded the length of individual sessions that they delivered. These ranged from 10 minutes to 205 minutes (3 hours 25 mins). [Please note, 585 post sign-up sessions (over 50%) did not have any time recorded, so this data is based on a small sample only.]

The average time that mothers and fathers spent on the programme following sign-up was also calculated, based on recorded dates of the sign-up session and the final session (see Table 2). This included those who had either completed the programme or had left the programme by the end of March 2019, and therefore does not include those who were still participating at that time.

Twenty-two mothers had a recorded date of sign-up. Of these, 13 had a recorded exit date, indicating that 9 mothers were still on the programme at the time of analysis. Of the 13 mothers with a sign-up and exit date, the average number of days on the programme was 354 (approx. 11.5 months).

Twenty-one fathers had a recorded date of sign-up. Of these, 13 had a recorded exit date, suggesting that 8 fathers were still on the programme at the time of analysis. Of the 13 fathers with a sign-up and exit date, the average number of days on the programme was 337 (approx. 11 months).

Table 2: Average time from sign-up to final session in London Three Boroughs

	Minimum Days	Maximum Days/ months	Average days/months
Mothers	65	759/ 25.0	345/11.6
Fathers	42	786/ 25.8	337/11.0

Hertfordshire

Anonymised records from all families engaged in the programme were used to calculate overall delivery of the programme. From April 2015 up to end of March 2019, 185 individuals in the Hertfordshire site had attended a Welcome Session: 88 of these were fathers (47.5%). 446 Getting Started sessions (also called Initial Assessment, consisting of several sessions, sometimes up to 11) were delivered to 168 individuals (79 fathers; 47%). 86 sign-up sessions were delivered (36 fathers; 42%) From July 2015 up to end of March 2019, 2981 post sign-up sessions were delivered (following assessment and sign-up). Of these, 1045 (35%) were men’s sessions, 1805 (60%) were women’s sessions, 119 (4%) were delivered to a child in the family; for nine sessions it was not clear who the session was delivered to. Table 3 shows the number of sessions delivered to mothers and fathers across the different modules of the programme.

As above, ‘Other adult sessions’ refers to sessions which were not categorised under a specific module, but instead were delivered flexibly to meet service user needs as they arose.

Table 3: Number of post sign-up sessions delivered between April 2015 and March 2019 in Hertfordshire

Module	Mothers	Fathers	Total
Basic Tools	9	271	280
Opening Doors	186	N/A	186
Where’s the Baby?	182	94	277
Owning It	N/A	56	56
Newborn Behavioural Observations	66	30	96
Video Interaction Guidance	193	76	269
Inner Child	102	60	162
Healthy Expression of Feelings	385	129	515
Self-Esteem & Assertion	106	6	112
Keep Calm & Carry On Parenting	45	5	50
Other adult session	491	301	792
Protective behaviours			13
Play therapy			100
Other child sessions			6

Key: n/a = not applicable

Similar to the data from London Three Boroughs, the Hertfordshire data indicate that content related to parenting (Where’s the Baby? NBO, VIG) was more frequently delivered to women than men in Hertfordshire. Furthermore, while there were similar levels of engagement for men and women in the early modules, women were more likely to receive content from later modules such as Healthy Expression of Feelings and Self Esteem & Assertion.

Out of the post sign-up sessions, there were 787 cancellations/Did Not Attends (DNAs); 356 of these were fathers (45%). Including cancellations, DNAs and attended sessions, 3768 post sign-up sessions were offered, of which 21% were cancellations/DNAs. This includes 2230 sessions offered to mothers (of which, 425 [19%] were cancellations), and 1401 sessions offered to fathers (of which, 356 [25%] were cancellations).

Practitioners recorded the length of individual sessions that they delivered. These ranged from 10 minutes to 360 minutes (N.B. the 360 minutes session was a post-incident follow-up session). 241 post-sign-up sessions (approx. 10%) did not have time recorded.

The average time that mothers and fathers spent on the programme was also calculated, based on recorded dates of the sign-up session and the final session (see Table 4). This included those who had either completed the programme or had left the programme by the end of March 2019, and therefore does not include those who were still participating at this time.

Thirty-eight fathers had a recorded date of sign-up. Of these, 24 had a recorded exit date, indicating that 14 fathers were still on the programme at the time of analysis. Of the 24 fathers with a sign-up and exit date, the average number of days on the programme was 470 (approx. 15.4 months).

Forty-three mothers had a recorded date of sign-up. Of these, 28 had a recorded exit date, suggesting that 15 mothers were still on the programme at the time of analysis. Of the 28 mothers with a sign-up and exit date, the average number of days on the programme was 559 (approx. 18 months).

Table 4: Average time between sign-up and final sessions in Hertfordshire

	Minimum Days	Maximum Days/ months	Average days/months
Mothers	86	962/ 31.6	559/18.4
Fathers	21	974/ 32.0	470/15.4

Summary of Key Findings

Analyses of data on the uptake of the programme by families, and analyses of the sessions delivered indicated that:

- Children's social care was a significant source of referrals in both sites, being by far the largest referral agency in London Three Boroughs, while in Hertfordshire children's social care referred directly and through a joint antenatal pathway, led by midwifery

- By the time of our main analysis, 101 Hertfordshire families and 62 families across the London Three Boroughs area had engaged with *For Baby's Sake*

- Over the first four years of the prototype, in London Three Boroughs, 71% of referred families either did not engage at all or disengaged at some time after initial engagement with the programme. This comprises 26% who did not engage, 35% who disengaged before sign-up and 11% who did so after sign-up. There was a similar pattern in Hertfordshire, where 71% of referred families either did not engage at all or disengaged after some engagement. This comprises 19% who did not engage, 34% who disengaged before sign-up and 18% who did so after sign-up

- The fairly even proportions of mothers and fathers participating in Welcome, Getting Started and Sign-Up sessions indicate success in attracting both co-parents onto the programme and feasibility of this novel aspect of the model

- Average length of time on the post-sign-up modules was calculated for those parents who had signed up to the full programme and completed or left programme by the end of the evaluation analysis. In London, mothers participated for an average of 11.5 months and fathers participated for an average of 11 months. In Hertfordshire, mothers participated on average for 18 months and fathers participated for 15.4 months. (These periods of participation are in addition to the time these parents spent in the Welcome and Getting Started modules before sign-up)

There were some differences observed in levels of engagement between men and women:

- In both sites, more fathers than mothers cancelled sessions following sign-up
- In both sites, fathers received considerably fewer parenting-related sessions than the mothers. Aggregating the data across both sites, fathers received 30% and mothers received 70% of the total number of 'Where's the Baby', Newborn Behavioural Observations, Video Interaction Guidance and Keep Calm and Carry on Parenting. Also, in total across the two sites, 36% of the total manualised sessions delivered to the women covered these parenting modules, whereas this parenting content constituted 26% of the manualised sessions delivered to men
- In both sites, women received substantially more sessions in later modules, including Healthy Expression of Feelings and Self-Esteem & Assertion
- The gaps in the data illustrate the challenges for practitioners to gather and record information and the importance of systems being user-friendly and minimising scope for human error and leaving records incomplete

For Baby's Sake Practitioner Experience of Delivering the Programme

Examination of *For Baby's Sake* team meeting minutes and training activities

One of the ways in which we assessed the success (and any wider impact) of the integration of *For Baby's Sake* teams within the two localities was via examination of records of correspondence and meetings in order to qualitatively explore the teams' experiences and opinions about the programme and its successful integration. The data below, describing a range of integration activities, are in addition to the contribution to integration of the two multi-agency Operational Groups, which have continued to meet roughly quarterly throughout the implementation of the programme in London Three Boroughs and Hertfordshire.

We completed an analysis of the London Three Boroughs and Hertfordshire teams' meeting minutes and training activities from March 2017 until April 2019 (data from the team minutes from 2015 to 2017 are described in years 1 and 2 reports). Below is a summary of our analysis.

London Three Boroughs

Successful integration of the programme within the London Three Boroughs

In June 2011, Westminster City Council developed a formal partnership and shared services arrangement with two neighbouring local authorities, Royal Borough of Kensington & Chelsea and London Borough of Hammersmith & Fulham, to create the Tri-Borough. The councils retained their separate statutory children's services and adult social care services but merged some functions including the commissioning of community safety and Violence Against Women and Girls (VAWG) services. Having started exclusively in Westminster, the *For Baby's Sake* team expanded its geographical coverage across the Tri-Borough area in January 2017. These Tri-Borough arrangements remained in place until April 2019, at which time it split into a Bi-Borough partnership between Westminster City Council and Royal Borough of Kensington & Chelsea and separate London Borough of Hammersmith and Fulham. Shared service arrangements continue to be unpicked to extract the London Borough of Hammersmith and Fulham elements. The *For Baby's Sake* team continues to operate across all three boroughs.

Potential opportunities that arose for the *For Baby's Sake* team in its reach across the London Three Boroughs included obtaining more referrals of families to the programme and establishing new collaborations with relevant services. Potential challenges included ensuring the programme was well embedded and known to the new areas, including the programme's integration within referral pathways in each of the areas.

The minutes of the London Three Boroughs team meetings highlight the numerous activities that the team undertook to promote and integrate *For Baby's Sake* across the three boroughs. Members of the team were tasked with identifying and engaging with relevant services within specific localities across the three boroughs, to ensure that there was coverage across each borough. Practitioners sought out opportunities to attend team meetings of relevant organisations across the three boroughs to promote the work of *For Baby's Sake* and to facilitate collaborative working partnerships. The team established co-location practices

across the three boroughs at the Westminster Children & Family Services Access and Assessment team in Frampton Street, the Children's Social Services Health Link Team at Chelsea and Westminster Hospital, the Children & Family Services Access and Assessment

Team in Hammersmith and the Portman Centre, a Children's Centre and Community Hub in Westminster.

Below is an outline of some of the key formal promotion activities that the London Three Boroughs team have undertaken between March 2017 until April 2019 (see Table 5):

Table 5: Summary of key formal promotion activities in Westminster, Kensington & Chelsea and Hammersmith & Fulham

Service	Type of Engagement Activity
Multi-Agency Safeguarding Hub	Team presentation
Westbourne Community Champion Project, Stow Centre	Team presentation
St Mary's Safeguarding Maternity Sharing meetings	Information sharing meetings
Social Care Independent Domestic Violence Advisor	Meeting to discuss service practices
Child in Need meetings	On a case-by-case basis for families on *For Baby's Sake*
Strengthening Community Identity meeting	Team attendance
Chelsea and Westminster hospital antenatal classes	Team presentation
Managers' meeting Queen's Park Children's Centre	Information sharing meetings
Multi-Agency Referral Conference meetings	On a case-by-case basis for families engaged in *For Baby's Sake*
Hammersmith and Fulham Safeguarding Partnership meeting	Team presentation
Best Start In Life Domestic Violence professionals meeting	Team attendance
Pembroke road north team	Team presentation
Team around the Child south team	Team presentation
Early Health teams	Team presentation
Stowe Centre District Safeguarding Managers meeting	Team presentation
Safeguarding Midwives meeting	Team presentation
Inter-agency safeguarding meeting	Team attendance
Hammersmith and Fulham contact and assessment team	Team presentation
Metropolitan Police	Team presentation
Malton Road Hub Team social work team	Team presentation
Royal Borough of Kensington and Chelsea social work team	Team presentation
Portobello Road Hub Meeting	Team presentation
Safeguarding Managers meeting Royal Borough of Kensington and Chelsea	Team presentation
Community Safety Unit, New Scotland Yard	Team presentation
Child Protection Unit	Team presentation
Borough Domestic Violence Forum	Team attendance

The London Three Boroughs team has been active in leafleting across children's centres in the three boroughs and has ensured that several relevant local services are aware of the programme (e.g. perinatal psychiatry teams, Best Start meetings, Team Around the Child meetings, Child Health Operational Group, Case Loading Midwife teams, Advance, Children's Centres), as well as local councillors and senior officers across the three boroughs. The team

also regularly checked in with relevant team managers across the three boroughs to identify any possible referrals to the programme.

As part of the team's initiatives to build collaborations with authority partners, they asked relevant organisations to come and present at their internal team meetings (e.g. Women's and Girls Network, Positive Interventions Project, Royal Borough of Kensington and Chelsea drug and alcohol project). This exercise helped the team to understand what other organisations were delivering across the three boroughs and helped facilitate collaborations. The team also obtained membership on key committees across the three boroughs, including the North-West London Perinatal Mental Health Network and the Hammersmith & Fulham Safeguarding Partnership Board.

Working with families

The team identified some challenges in relation to seeing new families across the three boroughs, due to the distance that some families live from the co-located offices where practitioners were based. The team, therefore, collaborated with other agencies to find feasible sites for practitioners to work from, that were closer to families. Setting up the new co-location areas across the three boroughs proved challenging, due to a limit on the capacity of the team to ensure that all the new co-locations were routinely covered and due to services across the three boroughs moving locations part-way through the co-location set-up. In addition, the team experienced some challenges in embedding the programme within pathways that had a well-established women's sector presence.

Finally, the London Three Boroughs team minutes demonstrated the team's reflections on how to manage cancellations of sessions by families. Strategies that the team developed included strengthening the consistency around holding sessions at the same time each week. The team reflected that, in attempting to accommodate families they had become overly flexible in providing less structured, ad-hoc meeting times and this had the unforeseen negative outcome of increasing cancellation rates, due to the lack of consistency in timings of the regular weekly meetings.

Hertfordshire site

Successful integration of the programme within Hertfordshire

The minutes of the Hertfordshire site team meetings highlight several activities that the team has undertaken to promote and integrate *For Baby's Sake* within local partnerships and pathways. The team worked collaboratively with local Children's Centres; a health visitor shadowed the team and they held meetings with related organisations in the area (e.g. health visitor teams, perinatal support teams, Wellfield Trust – a charity that provides grants to people/projects in Hertfordshire; WDP Hertfordshire – a charity that supports people with drug and alcohol issues).

Below is an outline of the key promotion activities that the Hertfordshire team have undertaken over the past year (see Table 6):

Table 6: Summary of key formal promotion activities in Hertfordshire

Service	Type of Engagement Activity
Monthly Maternity Sharing meetings	Attendance fortnightly at multi-agency meetings
Stevenage Against Domestic Violence Panel Meetings	Monthly attendance
Outstanding work in the community award	Won by a member of the team
Children's Social Care Teams - Stevenage, Welwyn & Hatfield, North Hertfordshire	Team presentation and collaborative working
Children's Centres/Family Hubs	Team presentations and use of rooms with service users
Health Visiting Teams - Stevenage, North Herts, Welwyn / Hatfield	Team presentations and collaborative working
Domestic Abuse Specialist Investigating Unit-DAISU	Team presentation and collaborative working
Women's Resource Centre	Team presentation
Probation Teams - CRC & NPS	Team presentations
Safer Places DA Service	Team presentations
Refuge - IDVA Service	Team presentations
Multi-Agency Safeguarding Hub (MASH)	Team presentations
Herts Young Homeless	Team presentations
The Living Room (Addiction Support)	Team presentations
Social Work Academy	Annual Presentation
Families First (Early Help)	Team presentations
North Herts & Stevenage Domestic Abuse Forum Annual Conference	Conference Presentation/ Chaired Forum
Child and Adolescent Mental Health Service	Team presentations
Citizens Advice Bureau	Team presentations
MIND	Team presentations
CRI/ Spectrum – Drug & Alcohol Services	Team presentations
University Hertfordshire DA Master Class	Presentation

Working with families

The Hertfordshire team reported on strategies that they took to engage families with the programme. These included preparing a timeline of the expected child, focusing on play activities postnatally and delivering child development training. The team investigated how to best manage repeat cancellations by families, which they reflected was particularly an issue with certain families and this could represent some resistant/avoidant strategies. The team reflected that fathers were more likely to cancel sessions, and this was felt to reflect the sporadic nature of their lives. The team agreed to engage sensitively in discussions with families in the early stages to explore their reasons for cancellations, with the understanding that there is likely a reason behind the cancellations.

The team also discussed some of the practice issues they encountered when working with families. One issue was how to flag up instances where practitioners see that mothers are doing well but the infants are not doing as well; the team implemented a traffic-light based reporting system to flag up such cases to ensure timely support is given. The team also agreed to increase the frequency of visits to families who were experiencing periods of chaos within their lives. The team explored the most effective means to manage their diaries to ensure practitioners could each see a couple of service users within each working day. A key resource issue raised by the team was the availability of creche facilities/childcare support for mothers who are attending group-based work. Practitioners reflected that group-based sessions are not suitable when children are in the room and the team agreed to ask mothers to facilitate childcare support during these sessions, as they successfully do for some of their individual-work sessions. Another key resource issue was the ability to continue to use some services that now applied a charge for use, and the ability to use public venues for sessions conducted after core-working hours (i.e. after 5pm), this need was particularly acute for the delivery of sessions for fathers which often took place after 5pm. The team discussed the possibility of setting up agreements with the partners to permit use of these services.

The Hertfordshire team reflected on the programme models and programme approaches. They discussed the gendered approach of the programme in relation to the allocation of practitioners to specific members of a family (e.g. a male Men's Practitioner for the father and a female Women's Practitioner for the mother) and queried the justification for this. The team also explored the need to ensure that discussions and preparations for the ending of the programme were introduced at an earlier point than in the manuals; the team proposed starting to work through the ending-related materials in the manual at least eight sessions before the end of the programme.

The team discussed the value in using the manual flexibly, delivering specific parts at different times from those specified in the manual, where suitable (e.g. the Healthy Expressions module may be better delivered before the Inner Child module to give families the language to express themselves during the Inner Child module). The team also reflected on the need to use the manual flexibly in relation to addressing the presenting issues for families when they attended sessions.

The team reflected on the limited focus within the manual on supporting the needs of parents who did not know their birth parents. The team also reflected on the low completion of some of the module exercises, specifically the Give it a Go (GIG) exercises. Practitioners expressed concerns that the language in these exercises was not concise and might be pitched at too

high a level for some families who had lower literacy levels. During team discussions, the group raised the issue of ensuring more focus was given to parents' own attachment experiences and how this shaped their parenting styles; the team subsequently received further training in these areas to apply in their practice. The team also reflected on the group-based activities within the manual and explored ways in which these could be delivered safely to ensure power imbalances are not acted out in the group. The team agreed to re-review these manuals before undertaking any group-based activities (N.B. this latter issue became less relevant, subsequently, once it was decided not to deliver group work and instead deliver all the material as individual sessions).

Summary of key findings

Through analyses of each site's regular team meetings, we could chart the activities that practitioners were undertaking in addition to their work with families and explore questions around practitioner capacity to implement *For Baby's Sake*. This analysis highlights some key points:

- Both sites engaged in frequent and continued promotional activities, to ensure their local partners are aware of the programme. In the London Three Boroughs, the teams were required to undertake more promotional activities over a longer period in order to establish themselves across the three boroughs and they developed clear strategies with which to do this (e.g. leafleting, team representation on Local Authority committees, attendance at partner team meetings, regular check-ins with partner agencies)

- Both teams sought out opportunities to establish joint-working practices with their local partners and engage in reciprocal learning activities with their partners

- Both sites reflected on their practices and aimed to identify effective ways to best engage families with the programme (e.g. identifying that fathers are more likely to make cancellations and exploring ways as a team in which to address this, ensuring that there is consistency regarding the routine timings of sessions)

- Both teams identified some challenges in embedding the programme in their local areas (e.g. obtaining access to local services for the delivery of sessions with families, establishing regular co-location practices across the three boroughs in London)

- The Hertfordshire site also identified some challenges in the successful delivery of the manualised programme and during the regular team meetings discussed ways in which to address these issues (e.g. the accessibility of the language in the manuals, introducing discussions about the programme ending at an earlier date, incorporating materials to support parents who did not know their birthparents, greater focus on the parents' attachments and enhanced practitioner understanding of attachment in practice).

Measuring Fidelity to the Manualised Programme

As outlined in the Chapter "*Research Evaluation Methodology*", we measured practitioner fidelity to the manualised sessions in two ways:

- A sample of audio-recordings of sessions from families in the evaluation were obtained from each site. The sample was stratified to ensure that it included sessions from a range of modules, a range of mothers and fathers and, where possible, a range of practitioners. Raters then listened to the sample of the recorded sessions to check adherence to the pre-established components in the checklists. Each component on the checklist was scored as present, not present or not applicable. This provided an overall percentage score of the extent to which the session included the intended content

- In addition, each session that was rated was assigned a score of 1, 2 or 3 based on adherence to the manualised content

London Three Boroughs

In the London Three Boroughs site, seven mothers and two fathers consented to take part in the evaluation. A total of 21 recorded sessions were available from these parents. All recordings came from sessions delivered by one female practitioner, in her work with three mothers. Recordings spanned the Getting Started (Initial Assessment) phase, Opening Doors and Healthy Expression of Feelings modules. Eight of the 21 sessions were selected for analysis (38%). The number of sessions selected for analysis was based on getting a stratified sample (i.e. ensuring coverage of all practitioners, service users and modules available).

Adherence to checklists

Ratings ranged from 0% to 80% adherence, with a mean of 44.8%. Lower ratings were given where, for example, families came wanting to discuss specific things that were happening, and practitioners spent the session discussing those topics rather than the manual content.

Overall adherence

Five sessions out of eight were rated as 2 (i.e. some deviation or unrelated content). The remaining 3 sessions were rated as 1 (i.e. large parts of session not related to manual). Session duration was between 35 minutes and 2 hours.

Hertfordshire

In the Hertfordshire site, 20 mothers and 11 fathers consented to take part in the evaluation. A total of 24 recorded sessions were available from these parents. All recordings came from two female practitioners and their work with six mothers. Recordings spanned the Getting Started (Initial Assessment) phase, Opening Doors, Basic Tools, Healthy Expression of Feelings, and Inner Child modules. Thirteen sessions were selected for analysis (54%). These

included all families and modules available. The number of sessions selected for analysis was based on getting a stratified sample (i.e. ensuring coverage all potential practitioners, service users and modules available).

Adherence to checklists

Ratings ranged from 31% to 100%, with a mean of 72.8%. Lower ratings were mainly due to items such as review of Give It a Go (GIG) exercises being missed, and sometimes because certain items almost took the whole session to go through, which left little time for further items to be completed.

Overall adherence

Six out of 13 sessions were rated as 3 (i.e. key content was delivered with few deviations). The remaining seven sessions were rated as 2. Most sessions were between 45 and 75 minutes.

Summary of key findings

Due to the small number of recordings that we obtained from both sites, reflecting the work of just three practitioners, it is not possible to extrapolate these findings to the overall manualised work that the sites are doing with families.

Focusing specifically on the recordings that we could assess, the findings demonstrate:

- In the London Three Boroughs site, slightly under half of the recorded sessions adhered closely to the manualised components of the session; reasons for deviation from the manual were largely in response to families bringing specific issues to the session which they wanted to explore. Overall adherence to the manual was fair, with some deviation observed

- In the Hertfordshire site, over 70% of the recorded sessions adhered closely to the manualised components of the session; reasons for deviation from the manual were largely due to the time taken to complete specific items which meant that others could not be completed. Overall adherence to the manual was good, with little deviation observed

For Baby's Sake Practitioner Qualitative Interviews

Practitioner interviews were carried out with all members of staff in each of the two sites, either at the end of the evaluation period (spring 2019) or when practitioners left their post during the evaluation period. A total of 21 practitioners were interviewed for this piece of work. Interviews were conducted between 10th May 2016 and 4th February 2019. Interviews lasted between 30 and 55 mins, were audiotaped and transcribed verbatim.

A topic guide, developed specifically for this research evaluation, was created to explore *For Baby's Sake* practitioners' expectations, experiences and reflections of the programme. Key topics that were explored with staff included:

- Practitioner descriptions of their role
- Practitioner views on whether the programme achieved its aims and objectives
- The successes and challenges that practitioners experienced in delivering their role
- The training and supervisory elements of the role

The results of this section are presented under the key topics that were explored in the topic guide. The format of the results will follow the same order as the bulleted list above.

Practitioner Role Descriptions

During the interviews, practitioners summarised their roles in the following ways (see Table 7).

Table 7: Description of practitioner roles

Job Title	Description of Role
Therapeutic Lead (integrated into the Hertfordshire Team Manager post)	This role was primarily defined as providing leadership in the implementation and development of the programme's trauma-informed and attachment-focused model. It has included contributing to practitioners' training, writing guidance for inclusion in the manuals and the therapeutic development of *For Baby's Sake*, in association with other Team Managers, the *For Baby's Sake* Director, and the Senior Leadership Team. The role has included helping to recruit Team Managers for new *For Baby's Sake* teams, to ensure those appointed will have the necessary skills and personal qualities to handle the therapeutic aspects of their role
Team Manager	This role was primarily defined as requiring the post-holder to oversee practitioners' case management (including risk management) of families through the programme, alongside supervision, support and guidance of practitioners in their delivery of therapeutic interventions for the different family members. The role also requires managers to be proactive in the Local Authority areas in promoting the programme, fostering collaborations and networking, and establishing/strengthening referral and operational pathways. The role includes contributing to the development of the programme and training practitioners across all sites
Programme Officer (combined with Family Support Officer role in the two prototype sites)	This role was primarily defined as taking responsibility for the collation and analysis of data from the sites in order to feed it back to relevant services in the Local Authority and within the Foundation's central oversight and development of the programme, including engagement with stakeholder Operational Group meetings. The role also involves the following key activities: liaising with other organisations to obtain more information about families; booking rooms for sessions; organising team and case management meetings; taking minutes of meetings; stepping in for practitioners in meetings where they can't attend. Both postholders hold a dual Programme Officer and Family Support Officer roles, undertaking some therapeutic skills work, with one officer training to be a play therapist and one working with older children and adults on the programme to deliver relevant aspects of the manualised programme and other materials that can support the well-being of these family members
Men's Practitioner	This role was primarily defined as requiring the post-holder to work therapeutically, motivationally and non-collusively with expectant and new fathers, delivering the programme manual in a systemic way to help them bring an end to abusive behaviour and to be a responsible, safe and attuned parent. In the prototype sites, this role has been undertaken by men (and this will mostly continue). The role requires practitioners to conduct routine assessments that form part of the manualised programme and to undertake regular

	coordinated activities with colleagues (e.g. other practitioners, under the three-way model) and other relevant professionals in response to formulating/conceptualising additional inputs that may be needed for fathers/the rest of the family. In delivering the manual, practitioners ensure that management of issues of safety are paramount, while working in a trauma-informed way to support fathers to process their past trauma within a recovery framework. The role requires them to initiate contact with the father, arrange the times and locations of sessions, deliver the therapeutic sessions, and ensure the upload of their case records on to the case management systems. Where required, practitioners attended Local Authority meetings for the families (e.g. social service meetings), family conferences and other relevant meetings. The maximum caseload for Men's Practitioners is 12-15 men and each session delivered to a father takes around one hour to one hour and half. In cases where the man's co-parent has disengaged, the Men's Practitioner delivers a bespoke package to the man, which is needs-led in content and duration The practitioner role also involves undertaking activities that seek to build collaboration and joint-working practices with other relevant services in the local area and local communities (e.g. giving presentations about the programme, delivering training)
Women's Practitioner	This role was primarily defined as requiring the post-holder to work therapeutically, motivationally and non-collusively with expectant and new mothers, delivering the programme manual in a systemic way to help them to overcome domestic abuse and to support them to provide consistent, sensitive and attuned parenting. This role is undertaken by women. The role requires practitioners to conduct routine assessments that form part of the manualised programme and to undertake regular coordinated activities with colleagues (e.g. other practitioners, under the three-way model) and other relevant professionals in response to formulating and conceptualising additional inputs that may be needed for mothers/the rest of the family. In delivering the manual, practitioners ensure that management of issues of safety are paramount, while working in a trauma-informed way to support mothers to process their past trauma within a recovery framework. In cases where the woman's co-parent has disengaged, the Women's Practitioner delivers a bespoke package to the woman that is needs-led in content and duration. The role requires them to initiate contact with the mother, arrange safe and secure times/locations in which to deliver sessions deliver the therapeutic sessions, and ensure the upload of their case records on to the case management systems. Where required, practitioners attended Local Authority meetings for the families (e.g. social service meetings), family conferences and other relevant meetings.

	The maximum caseload for Women's Practitioners is typically 12-15 people and each session delivered to a mother takes around one hour to one hour and half The practitioner role also involves undertaking activities that seek to build collaboration and joint-working practices with other relevant services in the local area and local communities (e.g. giving presentations about the programme, delivering training)
Infant Development and Family Practitioner	This role was primarily defined as seeing both parents and working with them in a trauma-informed and attachment-focused way around parenting the baby. This role has been undertaken by women. The practitioner begins this work in the antenatal period by focusing on early years development, the importance of bonding and attachment and what parents' hopes, and dreams are for their baby. In this period, relevant parts of the manualised programme are delivered to parents and these may be returned to later, if needed. Postnatally, the practitioner undertakes Newborn Behavioural Observation to empower parents to talk about what they already know about their baby, as well as providing lots of information about new babies and how to care for them. Video Interaction Guidance is delivered when the baby is around two months old; this intervention guides parents motivationally to reflect on video clips of their attuned interactions with their baby and to build on their parent-infant relationship. The role encompasses support with specific interventions, including manual modules, and ad-hoc practical (e.g. accompanying parents to children's centre appointments) and emotional support. Where required, practitioners attended local meetings for the families (e.g. social service meetings), family conferences and other relevant meetings When the team's caseload is full, the Infant Development and Family Practitioner would have a caseload of 24-30 parents (mothers and fathers) to support on an individual basis, Originally, the parenting support was designed to be delivered partly through group work, which would have made this caseload more manageable.

Practitioner views on whether the programme achieved its aims and objectives

This theme describes practitioner views on whether the programme achieved its aims and objectives. Three key themes were identified: (1) A programme that shifts the approach from me-centred to child-centred; (2) Strengths of the three-way [therapeutic practitioner] model and the whole-family approach; (3) Parents' development of knowledge, understandings and skills in relation to addressing DVA.

Overall, practitioners were enthusiastic about the programme's work and felt that the programme was meeting its aims and objectives in a variety of different ways. They also recognised that it was not possible to be definitive about this process, as it was difficult to measure. They, therefore, provided various examples of the areas where they thought the programme was working best in making a difference to families in terms of outcomes and impact.

A programme that shifts the approach from me-centred to child-centred

The theme "*shift from being me-centred to child-centred*" describes practitioners' views that the focus of the programme, which places the baby at the centre of the work and adopts a whole-family and co-parenting approach, is unique. As a mechanism of change, practitioners talked about how this model's approach provided the best opportunity to affect change in parents' lives and improve children's outcomes and their safety.

Educative work in this area was seen to have a massive impact upon parents, when they engaged well, and particularly where they had completed or were coming to the end of the two years of the programme. The programme's work was seen to positively impact on mothers' and fathers' parenting and to help raise their awareness about the impact of their behaviour during pregnancy and the brain development of the baby. As illustrated in the following quote:

'The fact that they're starting to shift their perspective from being me-centred to child-centred is almost mission accomplished for me, because all of the rest comes from that. The improved sense of personal wellbeing, the improved sense of personal self-esteem is going to be there because of the fact that they're being wholehearted with their baby, and, as co-parents, keeping their eyes on their child'

A practitioner highlighted an impressive outcome with one family, where they had gone from having a child being looked after, down to a child protection plan, to a child in need plan, with the case subsequently closed to children's services. They reflected that this was an amazing journey for that child.

Building the attachment frame and bonding with the baby was seen to provide a healing opportunity for parents to deal with their past and to start feeling safe. Practitioners said that a lot of families appreciated the focus being brought back to the baby, because it gave them a different perspective on their own actions, rather than just focusing on their co-parents' actions. Practitioners recognised that this still meant parents struggled with managing their behaviour but noted that individuals would still:

'Have an understanding that they wouldn't otherwise have had and, if we hadn't been there, things would've been worse'

Strengths of the three-way [therapeutic practitioner] model and the whole-family approach

The intensity and level of the work with families was seen to be greatly enhanced through the use of the three-way [therapeutic practitioner] model and the whole-family approach (this theme was also highlighted by families themselves see Chapter "*Qualitative Interviews with Families engaged with For Baby's Sake"*). This approach involved the Women's Practitioner (working with the mother), the Men's Practitioner (working with the father) and the Infant Development and Family Practitioner (working with both parents and around the baby). The combination of these practitioners working together with a family, was seen to have considerable impact in supporting the sharing of information/knowledge to ensure a focus is maintained on the baby and to enable parents to progress through the programme.

Many practitioners talked about the uniqueness of this model in helping to build close trusting therapeutic relationships, in an intensive, safe and consistent way. As illustrated here:

'Both parents feel important and validated, because they've got the same service working with them, hopefully in exactly the same way, offering them support'

Practitioners reflected that this model meant they were able to focus in a detailed way on a specific member of the family, without trying to focus on all members in a less concentrated way. This model also meant they could work with their counterparts (i.e. the Men's or Women's Practitioner and the Infant Development and Family Practitioner) to get a robust holistic picture of the issues involved for all members of the family. Indeed, this model also allowed practitioners to understand the range and different perspectives from family members, as illustrated below:

'Yes, it's definitely amazing, because you don't see just one angle. You see other angles as well of the story'

Practitioners described the success of this model of working as being underpinned by the close support of colleagues, regular information sharing, formal/informal communication and debriefing within the team. This set-up was felt to be extremely valuable, as illustrated by the following quotation:

'I think it's a really nice way of working. It doesn't feel so isolated, especially when you are sharing cases that are really difficult'

This model of working also helped practitioners understand much better any risks and safeguarding issues that affected families. Practitioners also reflected that having consistent and tailored support over a long period of time made a real difference to families, and the longer families stayed on the programme: *"the more embedded the work can be"*.

Parents' development of knowledge, understandings and skills in relation to DVA

The majority of practitioners thought it was doubtful anyone could leave the programme, regardless of how long they had been involved in it [and even if they dropped out], without having some idea that they needed to change and having some strategies to help them to do this. This type of change, it was noted, would not necessarily be reflected in statistics, as change '*can take years and years and years'.*

Practitioners said some families really used the opportunity provided by the programme to their advantage, whereas practitioners felt other families '*just wanted a support worker'.* One practitioner said that a third of families she was supporting at one particular time *'were going through the Public Law Outline process', which meant the ability to achieve their aims in those circumstances was very difficult'.*

Generally, it was felt that families on the programme benefitted from having space to reflect and educate themselves about what it takes to become a successful family and to receive knowledge in how to grow in self-awareness. Linked to this, the opportunity to talk about and understand what DVA is was reported to reduce feelings of isolation for several mothers. One practitioner relayed feedback from a mother, who had decided to disengage from the programme, that she thought the programme had given her somebody to talk to who made her feel like she wasn't failing, and this had made her feel more confident as a woman and as a mum. Some practitioners reflected:

'If that's the very least they leave with, I think that's really positive. We need to empower them to make decisions, and I think we need to empower them, not change them. Because they need to be ready to make their changes'

Men's Practitioners identified benefits for fathers through the work they undertook in examining men's childhood experiences. They described how this work helped fathers to understand that what happened to them as a child was not their fault but that they were responsible for the behaviours and actions they engaged in now. Practitioners reflected that fathers' motivation to change was impacted by the arrival of a child and they hoped that fathers would: *"knowing the damage that can be caused [to the child], they can hold that in mind a little bit".*

For the mothers, the mechanisms for change were perceived to be different. Key outcomes were described as learning about self-esteem, gaining a sense of empowerment, becoming more independent and more confident in making their own decisions. One way that this change was demonstrated was in building a safer relationship with their partner, through the use of the three-way [therapeutic practitioner] model, or through mothers deciding to leave their relationship:

'They know their rights more, or whatever they're doing, they're learning about themselves more with this programme….They learnt it, and they moved on'

Modules of the programme, such as the Inner Child module, were seen as really important in enabling mothers to process their experience of DVA in a different way and to think about why they were expecting the father to be part of their child's life when he was so abusive. Practitioners thought it was invaluable to have the time and space to explore different aspects of a woman's life and build self-esteem through modules such as the Inner Child, Healthy

Expressions of Feeling and Video Interaction Guidance work, so a woman was more able to understand herself, bond with her baby and express her feelings. One practitioner shared how one mother, because of her culture, tended to focus on what her in-laws wanted, until some work was done with her to encourage her to consider her own needs. The practitioner noted:

'Then finally, she did realise that it is actually not about what everyone else is thinking, but it's actually about her, where she came from, and what she believes in'

Linked to this, practitioners also described how the programme helped both mothers and fathers acquire strategies for the better management of emotions and feelings. Such learnings were perceived as being particularly important for fathers, people who had never really engaged with any services before and for those who spoke English as a second language.

Practitioners felt that being able to learn how to express feelings and to deal with them, rather than walking away, was important in improving parental and child relationships. As illustrated here:

'People are more able to manage their emotions and feelings. They have strategies in place for when there is something going wrong in their relationships, when there is an argument, what to do in the heat of the moment. I think people are more aware of their baby's needs and that the baby is affected by what's going on. They might not always be able to stop doing it, but they are aware that their child's behaviour is to do with what they've seen and heard'

This type of work also extended to parents who were going to lose their child. Practitioners reflected that, whilst this situation was extremely difficult for families, they undertook bespoke work to help these families: *'make sense of what was happening, accept it, and move through it'.*

It was felt that
for the child, because it could take some families a long time to understand what the issues were in relation to DVA. This, therefore, meant that practitioners needed to spend considerable time trying to educate families about the issues.

In thinking forward about future roll-outs of the programme, a few practitioners discussed the potential benefit of working with young people who were just getting involved in their first relationships.

Working with certain types of families

Some practitioners felt the programme was most effective with certain types of families. For example, those who had chosen to do the programme themselves rather than through any expectation by social services (this theme was also highlighted by families themselves see Chapter "*Qualitative Interviews with Families engaged with For Baby's Sake"*). Practitioners commented that parents needed to be really motivated to change or to engage in treatment, as illustrated in the following quote:

'You can't tell someone to change they just simply won't do it; they have to want to'

The three-way [therapeutic practitioner] model

Practitioners valued the three-way [therapeutic practitioner] model highly and reflected that this way of working ensured that comprehensive three-way debriefs could be carried out between practitioners. The success of this model is illustrated in the following quote:

'The way that we work together as the threesome, to produce a report where all of us have an input and then sitting down and discussing that report and then consolidating, so that we have a single voice…that has really helped a lot'

This model was seen to facilitate high-quality and timely team communication, which practitioners described as important in conducting this type of work. As exampled here:

'Really formalising that process of communication and team collaboration, having those conversations, making sure that's built into the week regularly as a way to protect everybody'

Practitioners also reflected on the benefits of having a three-way [therapeutic practitioner] model which comprised staff with a mix of experiences. As illustrated in this quote:

'You can look at our team, it's completely diverse in our backgrounds, our experience. But we've all come together as a team. None of us were therapeutically trained, but we all had something different to bring'

Establishing a team of practitioners that are passionate and invested in affecting change in families and that share the core values and beliefs of the programme's model was also felt to be a core component of the success of the three-way [therapeutic practitioner] model.

Men's Practitioner role

Linked to this, practitioners felt the Men's Practitioner role brought something distinctive to the model of the programme. The Men's Practitioner role seeks to create a non-judgemental environment and a non-punitive approach, and this was seen by practitioners as really important in *"harnessing that motivation to be different"* among fathers.

Practitioners commented that the aim was to get fathers on the programme to a place in their relationship, whether through co-parenting or an intimate relationship with co-parenting responsibilities, where they were not abusive either to the mum or the children. This approach was seen as novel and something that few other existing programmes were doing.

Families building strong relationships with practitioners

Individuals being able to build a steady consistent relationship with practitioners over a long period of time (i.e. from pregnancy until up to two years of the infant's life) was seen as a fundamental part of the programme and one of the main mechanisms for change**.** Practitioners reflected that this long-term work would help families achieve a better understanding of: '*who they are and why they are the way they are*'. In addition, the type and level of input that families receive on this programme was described by practitioners as something that families would not normally receive from other services, allowing practitioners to work at a very deep level and to really get to know someone properly. As illustrated in the following quote:

'The kind of meaningful relationship with the practitioners, where someone really cares about them'

Working with multi-cultural communities

Practitioners commented that another value of this new model of working, the whole-family approach, was in working with certain multi-cultural communities in Westminster and wider three boroughs area, where there was a big focus on *'the idea of family and culture'*. One practitioner said the programme's approach was particularly important because:

'Culturally for some of the families we're working with, leaving the marriage or leaving the relationship, doesn't feel like an option for all the reasons that we know. Not that you don't get that in families that don't have the same cultural pressure, but it's a very much entrenched value and belief system'

Part of working successfully with these communities, was seen to be reinforced by having practitioners on the programme who also came from these communities themselves. As illustrated in the following quote:

'They are very much into their cultures, so I think it really helps some of us understand their cultures as well without learning about it. We just come from that culture, so we know. So, we then talk to each other and we train each other as well'

In thinking about future roll-outs of the programme, some practitioners discussed the benefit of broadening the theory base of the programme to take on broader feminist perspectives, specifically in relation to the concept of intersectionality. It was commented that the programme could benefit from ensuring that the feminist principles adopt a wider lens, which reflect the experiences of black and minority ethic women as well as those of people not from western societies. Practitioners reflected that this could help with working with multi-cultural populations, with people who have English as a second language and with groups of women who were less likely to leave relationships due to cultural constraints.

Fathers' commitment to no longer using abuse

Practitioners talked about their experience of working with fathers and their commitment to no longer using violence and abuse. Practitioners reflected that this commitment was achieved through a greater awareness among fathers of the impact of their behaviour, their willingness to take responsibility for their actions and their desire to put the needs of their children first. This process of awareness was seen to be facilitated by the work fathers undertook with practitioners around managing emotions and conflict better in their relationships. Another key aspect of the work with fathers which facilitated this change was fathers being able to build trust and work therapeutically with practitioners, including through therapeutic work to examine their childhood through a trauma-based lens. The perceived impact of this work in facilitating change among fathers is demonstrated in the following quote about a man who had been violent since he could remember and who had decided to:

'Make the commitment for the first time to stop himself from hitting somebody…not only to stop, to reflect back on it… to understand why he behaves the way he does as a result of exploring and going through childhood experiences'

Effective management of risk and assessment

Some practitioners stated with respect to communication and information sharing on risk, that this was very good and effective and probably better than most organisations [this view was not shared by all practitioners, see evidence on challenges in the following section]. The reason given for this view was because the programme was seen as having both parents' perspectives, which could then inform what different practitioners did with those parents and the information shared, which: *"was very live"*. Practitioners said they also didn't have to email someone within a different organisation in order to share information, so this also helped to manage risk.

Working with families using a structured method

Practitioners were positive about the manualised programme, as illustrated by the following quote:

> *'I think the material is fantastic in working with service users'*

Practitioners felt that the structured manualised programme was a positive way of working in this field. They commented that for families the programme provided benefits with respect to working with material that had a clear *"beginning, middle and end"*.

Other positive aspects of working in this structured way were also described, such as having access to all of the therapeutic material in the programme from the outset. The strengths-based approach of the structured manual was also felt to be important and having a core approach throughout the modules helped to create set of key values and beliefs about the programme and what it aimed to achieve.

Flexibility and adaptability in the delivery of the manualised programme

Related to this, practitioners commented that a strength in how the programme was implemented was the ability to apply the manual in an adaptable and flexible way. Practitioners commented that the initial approach to implementing the programme was to apply the sessions in the same format in which they were laid out in the manuals. Practitioners stated that in the beginning the programme was much more formally manualised. They reflected that this approach proved too rigid and so a flexible approach was adopted to ensure that specific sections of the programme manuals could be selected by practitioners, depending on the presenting needs of families:

'So that's something about being able to be flexible enough with the programme, the manual, to be available emotionally without necessarily sticking to the format of the sessions, and so on'

'It's having the freedom and the flexibility to chop and change and cut things out that aren't appropriate'

The programme manual had also been adapted to include additional approaches that practitioners identified as lacking:

'One really good thing about the foundation, if we say this is a gap [in the manual], we need to address it….they really do listen'

Working flexibly and being able to make adaptations was also described by practitioners as important in situations when one parent disengaged or if a child was removed by social services. In these situations, a bespoke piece of work would take place. It was noted by a practitioner that it would:

'Just be so punitive, wouldn't it, to say, "Well your partner doesn't want to do this, we can't do anything with you now, you've got to go'

Instead, they described working with the parent to identify what it is that they needed to do for themselves and their baby and other children. As illustrated in the following quotation:

> *'We work together to decide what's the best thing to do with them'*

Challenges in the delivery of the programme

Eleven key themes were identified with respect to challenges: (1) Working with certain types of families; (2) Managing risks and safety issues within families; (3) Managing tensions in the practitioner role; (4) Collusion in the therapeutic relationship; (5) Different philosophical approaches within the programme; (6) Disengagement of families from the programme; (7) Referrals into the programme; (8) Measurement of outcomes for families (9) Team dynamics and team working practices; (10) Managing caseloads and covering all locality area; (11) Case management systems

Working with certain types of families

Several practitioners reflected that some families were too high risk (in terms of the nature of the domestic abuse risks) for the programme, so it was not safe for them to work with those families. They stated that in cases where the mother did not want anything further to do with the biological father then the family would not meet the criteria for the programme.

Some practitioners also explored the challenges for parents with learning difficulties, mental health problems, substance use problems or low IQ or literacy issues in completing the requirements of the programme.

A few practitioners reflected that most fathers on the programme were using non-physical forms of abuse, including coercive and controlling behaviours. Practitioners noted the importance of engaging men using a broad range of abusive behaviours and they proposed that this range of abusive behaviour should be targeted within the programme's social marketing campaigns:

'I think you really need to say something in the images that you use and really target what's going on for violent men. What kind of lifestyles do they lead? You know, what a lot of their education is like so you can really home into what kind of things they will pick up out the images that they see, and then they'll read it and maybe that will draw them in'

Managing risks and safety issues within families

Practitioners spoke about their challenges in relation to managing risks and safety issues in families. Some raised concerns that mothers and fathers might not know what they could and could not share with their co-parent, as they both moved through the programme [though some practitioners saw communication and handling of risk as distinctively effective, see earlier section on strengths]. Others spoke about the risks in working with families that have already had multiple child removals; they questioned:

'If they've had multiple removals is it ethical to be doing this work if we are pretty sure they're not going to be co-parenting? Is that the right thing to do for that family?'

Practitioners also reflected on the challenges they encountered when identifying families where the programme would be a good fit for one parent, but the other parent was not in the right space to undertake the programme. Linked to this, some practitioners explored the practice of delivering a more condensed version of the programme if one parent disengaged (N.B. practitioners stated that often it is the father that disengages). They commented that this approach could be problematic as the family member who still wanted to continue with the programme '*won't get the two years, and maybe that's what they want, and they need'.*

Practitioners commented that the guidance around how to manage cases where one parent disengaged was inconsistent and, therefore, unclear at times. This could create confusion for both practitioners and families, regarding whether they could continue the programme. Some practitioners felt that this approach could mean mothers are treated unfairly and perhaps unethically, as despite their desire to engage or continue with the programme they would be stepped-down; as illustrated in the following quote:

'I need some protocol. I need some process. Not, well, this could happen, this could happen, or this could happen, and then we might change our minds. It doesn't feel ethical and safe for the service user, and it doesn't feel ethical and safe for me'

Two themes that are related to managing risks and safety issues are: managing tensions in the role and collusion in the therapeutic relationship.

Managing tensions in the practitioner role

Practitioners commented on a key tension in their role, with respect to being empathetic and therapeutic with a parent whilst also challenging abusive behaviours and, in the case of the Infant Development and Family Practitioner, being the voice for children. Practitioners reflected that they were there to safeguard children but maintaining this balance could be difficult when working therapeutically with parents. This tension could be further compounded when practitioners received training which provided them with further insight into a child's life and what their future could be like, based on what their experiences were as a child. This, alongside training that practitioners had in understanding the experiences they went through themselves as a child, made it harder for practitioners to be empathetic to some of the parents, yet they still needed to work therapeutically and to give *"unconditional positive regard".*

Collusion in the therapeutic relationship

A related challenge in supporting families was a concern raised by several practitioners about the potential to collude with individual family members they were working with. As the following quotes illustrate:

'I understand there may be some colluding that takes place, I think that's the difficult challenge and that's the major difference in working with one practitioner'

'It's really complicated, and so we try and share only what we really need to share with each other, but it does happen naturally that we want to defend our own service users'

Other challenges included trying to plan work with one family member based upon what a practitioner observed themselves in their session and then getting a different perspective on the plans that are needed after talking to one of the other *For Baby's Sake* practitioners. Practitioners commented that their colleague might disclose something that hadn't been mentioned by their service user. This could create problems for the practitioner in terms of how to handle this issue with the service user in their next session without affecting their relationship and also in deciding how best they need to continue working with the service user. Getting this balance right was also described as difficult when juggling a therapeutic and safeguarding role.

Another aspect to these difficulties was in ensuring the team had the proper time and space to share information properly between themselves. As some practitioners left and new practitioners joined the teams, new working relationships had to be established; this alongside co-location practices in different areas meant that at times the team was not working together smoothly, making it harder to ensure that information got shared in a timely manner.

Different philosophical approaches within the programme

There was a feeling among some practitioners that there could be a tension between adopting a trauma-informed approach alongside a feminist approach. The existence of competing philosophies and values within the programme, which shaped understandings about the mechanisms behind the behaviours that families adopt, was reported by some practitioners as having the potential to create tensions in the successful delivery of the programme. Practitioners reflected on the need to fully understand these approaches and to balance any tensions between the philosophies, as without this work, this could act as a barrier to meeting the aims and objectives of the programme. An example was given that whilst it is important to respond to a violent man in a trauma-informed way, there is a need to recognise that they are:

'Choosing to do some really bad things, and we should probably focus on that, because there's a baby and a woman who are being hurt because of that'

Referrals into the programme

Various challenges were raised by practitioners regarding referrals into the programme. In Hertfordshire, at the early stages of implementation key challenges were raised in relation to engaging with the Local Authority which already had a pilot programme that involved domestic abuse workers working with families, as well as a Family Nurse Partnership programme. Whilst these other programmes did not have the same criteria as *For Baby's Sake,* they were supporting families that could have been seen by the programme. In the London Three Boroughs, key challenges were identified in relation to obtaining referrals from colleagues when there was a large and frequent turnover of staff in key services, in engaging with all the relevant communities that make up an inner-London diverse and multicultural community, and in working with the established women's sector across the three areas (the latter theme is described in more detail below).

Initially, the teams encountered some challenges in receiving referrals due to misunderstanding about how the therapeutic model worked. The whole-family approach was novel and other services were not initially clear how the programme could support people appropriately with issues of DVA when working with both parents. Early examples of misunderstandings from other services in the Local Authority included:

'Hearing from other agencies that they've been told that we work to keep mums and dads together. We're working for them to be the healthiest co-parents they can be. The together bit isn't a factor'

In the London Three Boroughs, a key challenge was in receiving referrals from the women's sector organisations. Most referrals into the programme in the London Three Boroughs have come from social services, midwifery, or self-referrals. Practitioners recognised that the programme's model of working may have encountered some resistance from the women's sector and they also appreciated that the women's sector had long been established across the three boroughs. Practitioners felt that the women's sector models of working and the programme's model of working were complementary, and each model could provide unique things for mothers. Practitioners reflected, however, that although the two groups have been in discussions about their respective programmes, some services within the women's sector continued to feel unable to endorse the programme. Practitioners commented that this outcome had affected team morale. Some practitioners reflected that the reservations raised by the women's sector groups were in relation to the work that the programme is doing with men. They acknowledged that the Foundation was a new organisation in this field and that the work with men was not accredited by the benchmark organisation, Respect. Practitioners commented that, since starting the programme, some women's sector organisations have also started to explore whole-family approaches around DVA.

Practitioners commented that referrals of families often came from the same services within the Local Authority. They concluded, therefore, that it is important that the sites understand their respective local services and pathways and the characteristics of the population served (e.g. demographic differences within Local Authority areas). Practitioners reflected that it was important to establish good working relationships with relevant services in the local area to facilitate referrals. Thinking about strategies to support collaboration, practitioners talked about preparing concise opening summary scripts about the programme when first initiating contacts. Some practitioners commented that, in the social work sector, there is often

inconsistent information given about DVA so the programme practitioners could facilitate these working partnerships by being an informed colleague about issues of DVA.

Disengagement of families from the programme

Families' disengagement from the programme was a key challenge experienced by practitioners. Practitioners made various comments on why some people disengaged with the programme:

- Fear or a lack of trust. Practitioners felt these fears may arise when practitioners seek to undertake work that looks back at parents' childhoods; this work may also be too raw for some families when they have just had a baby
- Not being ready to change or commit to the programme, particularly if parents are more committed to improving their relationship than focusing on the baby, or if they feel pressured by social services to do the programme
- Some families had too many other issues in their lives, so they do not feel able to commit to such an intensive programme. For example, families may be grappling with a range of problems during the pregnancy period (e.g. trauma and shame from childhood, as well as the problems in the relationship and other issues such as housing, debt, substance abuse etc) and feel unable to manage all these issues together. Practitioners also found this to be the case at certain points in time for families that did engage with the programme (e.g. if there was a change in their circumstances, work commitments, they had moved out of the area or their relationship had broken down)
- Some fathers being stuck in their abusive behaviour and therefore not open to undertaking work to change
- Changes in practitioner, as families may find it difficult to engage with another person and to tell all their experiences again

Measurement of outcomes for families

Several practitioners commented that it would be hard to show the successes of the programme's work if applying quantitative measures to assess outcomes for families or if seeking to identify long-term outcomes for children.

To illustrate this issue of measurement, one practitioner gave an example of the complexities of the work involved with parents when a child was removed. It was noted that a focus just on the statistics around the removal of the child would seem like a poor outcome. Whereas if a detailed report was put together of the family's story, it would show how many different complex elements were involved and intertwined, like drugs, alcohol and escort work, how the Women's Practitioner helped to manage the mother's expectations, how the Men's Practitioner helped to manage the father's expectations, and how they all worked together in an integrated way with the social worker. This work included the father maintaining contact with the Men's Practitioner even after the child was taken into care and benefitting

emotionally from that engagement. The practitioner argued that this showed how important the relationships were that were built up with families on the programme and that these elements of success could not be *"captured with raw statistics".* Some practitioners, therefore, proposed an alternative approach to measurement which would comprise preparing qualitative data reports that described families' journey through the programme, as a way to "*to show the true impact"* of the programme (N.B. the Foundation have now adopted this approach when preparing their routine programme and organisational internal reports).

Other examples given regarding difficulties with measurement of outcomes of success related to how to identify if there had been an end to abusive or harmful behaviours. As illustrated in the following quote:

'The question mark I have in my head is whether a service user has then gone on to adopt another problematic behaviour, which is not being measured'

Another factor raised by practitioners was how to successfully measure outcomes for parents who had learning difficulties and who might: *"struggle to say the simplest of stuff, let alone understand how their behaviour can impact on their child".* For these parents, practitioners reflected that outcomes are achieved in: *"really, really small steps, which are big in their lives, but they might not look big on paper or stats or whatever".*

The ability of outcome measures to account for specific incidents or episodes in people's mental health status was also raised by practitioners. Some practitioners commented that an outcome assessment taken at a single point could indicate that improvements had not been made but instead this was the result of a specific incident/time-period and the families do in fact have improved ways of managing these difficulties when they arise. Similarly, outcome assessments that are taken over time, as people develop their understandings of abuse and its impact, may show that things are getting worse for families when they actually reflect increased awareness and a confidence to report their feelings in a way they did not feel able to do before. For example, practitioners spoke about police callouts for DVA and how these incidents may go up because mothers are better at recognising the abuse and more confident to report and seek help.

Finally, some practitioners reflected that although some early gains could be measured with respect to child outcomes (e.g. secure attachment to at least one of their caregivers, meeting developmental milestones) it is too soon to assess the long-term impacts of the programme on children.

Team dynamics and team working practices

Some practitioners said they did not always feel listened to by managers and they reflected on the value of developing more team decision-making approaches with respect to the development and implementation of the programme, as illustrated in the following quote:

'We've never been particularly included in decisions and things like that'

Other practitioners referred to a perception of a defensive culture in the management levels, which left some feeling worried that if something went wrong blame would fall on them. Practitioners reflected that it was:

'Unrealistic to think that we're some immaculate thing…we can stop it all, and that things will happen'

Practitioners recognised that it was difficult managing risks in the programme and that these tensions needed to be properly assessed. It was felt, however, that this could be done in a way that does not leave staff feeling unsupported and fearful of being held wholly accountable for issues that may arise.

Practitioners' experience in conducting risk and safety assessments was also discussed. Some practitioners felt that some of the newer practitioners did not seem to know about some of the key risk assessment processes that the team put in place to manage situations of risk. This lack of knowledge was seen to have implications for practitioners, not only in terms of their safety (e.g. working out of hours in a geographical area with a high-crime rate), but also in how they interacted with families (e.g. they might feel less confident in undertaking home visits if they are unaware of safety procedures).

Managing caseloads and covering all locality areas

Some practitioners commented that due to the number of families they had on their current caseload who presented with complex needs, they did not always feel able to give sufficient support to everyone and to work as safely with families as they would like to. As the following quotation illustrates:

'It can be really overwhelming in this line of work…at one point I had five or six in crisis at the same time'

The widening geographical remit within the sites proved a challenge for practitioners, both in relation to working effectively with families on certain elements of the programme (e.g. group-based activities in a location that works for all families and in their efficiency in supporting several families due to increased travel times (N.B. group-based work is no longer undertaken).

Case management systems

Practitioners spoke of the challenges in ensuring that the case management systems are up to date alongside managing other demands in their role. They also noted challenges in resolving misunderstandings among the team about what information should be included on the databases. With respect to competing demands on time, the following quote by a practitioner describes that they are:

'Battling against our time to complete all the administration side against what's needed'

Dealing with different case management systems was also a challenge for practitioners within the London Three Boroughs, as *"every social care system is different".* It was noted that it was very hard to be systematic in the reporting of data on the case management systems when there are so many different systems to contend with.

The management of information on the case management systems was perceived to be time-consuming, even when there were: "*not that many cases".* It was hoped that introducing a new *For Baby's Sake* data system would make the process a lot smoother.

Summary of key findings

- Findings from the interviews with *For Baby's Sake* teams highlights some key strengths and areas for development within the programme; as outlined below:
- The focus of the programme, which places a central emphasis on the child, is crucial in helping to engage expectant parents and in facilitating healthy parenting behaviours and attachments
- Targeting families in the pregnancy period can capitalise on expectant mothers' and fathers' motivations to make changes to improve outcomes for their children. Initiating therapeutic work in early pregnancy ensures there is enough time for detailed therapeutic work around parents' previous experiences, their current experiences and behaviours and how these experiences can impact on their children.
- Three-way [therapeutic practitioner] model facilitates shared learnings/formulations and timely information sharing. This model, where each family member is focused on by a separate practitioner, ensures that the programme obtains a holistic understanding of the needs/issues of all members of the family and supports a comprehensive assessment and management of presenting risks
- The programme approaches and the ethnic diversity within the practitioner teams facilitate engagement of families from minority ethnic backgrounds
- The programme's approach to recruiting practitioners with a range of related experiences/backgrounds in the area helps to promote inter-disciplinary shared learnings within the team. This alongside appointing practitioners who are passionate about achieving the proposed aims and objectives of the programme was felt to be important in ensuring the success of the three-way [therapeutic practitioner] model
- The length of the therapeutic programme (e.g. delivered from pregnancy to two years after childbirth), the nature of the therapeutic work - including education around DVA, building self-esteem and modules around healthy expression of emotions, understanding and processing the impact of childhood experiences - and consistency in relation to the named practitioner that works with each family member represent key mechanisms for change among families
- The Men's Practitioner aims to harness fathers' motivations, to improve the management of emotions and to examine childhood experiences through a trauma-informed lens. It was perceived that these approaches could inspire a desire to change among fathers who use DVA
- Establishing supportive and collaborative team working environments are important in instilling stability among teams
- The risk management skills of practitioners are critical in ensuring families are adequately supported

- Permitting flexibility in the use of the manualised programme and allowing adaptations to the manual ensures the programme materials are matched to the presenting needs of families, and allows practitioners to work in a bespoke way (e.g. in cases where there is a child removal, where a co-parent disengages)

- There is a need to ensure that the programme materials are understood among families where learning difficulties are present and a review of how best to promote positive outcomes for these families. Challenges were also identified with regards to engaging men who use physical forms of DVA behaviours on the programme

- Tensions can be experienced in relation to establishing a therapeutic relationship and adopting a non-judgemental stance whilst also challenging unhealthy and harmful views and behaviours

- Protecting against collusion with service users is critical and this can mean a juggling of practitioners' therapeutic and safeguarding roles, the importance of information-sharing among practitioners and reflections by practitioners to identify defences that they may be holding about their service users

- The majority of referrals come from social care services. Engagement with other services may be enhanced through open discussions with potential partners about the different approaches adopted by the programme and how these can work alongside the partner practices

- Due to the complexity of the views/behaviours that the programme targets, it is difficult to identify how the programme can best demonstrate the outcomes achieved by families. Changes take place over a long period and, therefore, single assessments taken at a specific point in time may fail to adequately capture the changes that families have made over time. Expectations of changes achieved by families may need to be revised where a child has been removed and among families with learning difficulties. Improved outcomes for children occur over a longer time-period and may not, therefore, be adequately captured by the two-year birthday

- Time management challenges are experienced in relation to managing caseloads and documenting contacts on the case management system

The training and supervisory elements of the role

The area of training and supervision is a core aspect of the work underpinning *For Baby's Sake*. This section will first report on discussions around supervision and this will then be followed by the results of discussions around the training.

Supervision

The structure for supervision in *For Baby's Sake* is set out in the 'Staff Supervision and Support: Policy and Procedure Policy (April 2016).

Different models or ways of delivering supervision are described in the policy as:

- Internal one-to-one supervision between a supervisor and supervisee
- Group supervision in which two or more practitioners discuss their work with a supervisor
- Peer or co-supervision where colleagues discuss work with each other, with the role of supervisor being shared or with no individual member of staff acting as a formal supervisor
- External supervision with a Clinical Psychologist
- A combination of the above

More specifically the policy describes how supervision will be conducted in the following ways:

One to one supervision

- Will take place with each Team Manager in monthly one-to-one supervision, from the *For Baby's Sake* Director, which will always include restorative, formative and normative elements [e.g. restorative: to attend to the emotional impact of the work; formative: to develop the skills, understanding and learning of the team member: normative: to take responsibility for maintaining programme fidelity and quality of service and data as well as discussions around planned work

- Each Team Manager and *For Baby's Sake* Director will receive a monthly one-to-one external supervision session of an hour and a half with a clinical psychologist

- Each Team Manager will deliver regular one-to-one supervision to each member of their team, which will always include restorative, formative and normative elements. [This will be either weekly or fortnightly supervision, with the frequency determined by the *For Baby's Sake* Director in consultation with the Team Managers. At the time of approving the policy, the frequency was fortnightly, but it is noted in the policy, this could change to weekly if an ongoing need arises, for example as caseloads grow.

Group Supervision

- Each *For Baby's Sake* team will receive a monthly group external supervision session of an hour and a half with a clinical psychologist

- Each *For Baby's Sake* team will receive a monthly group safeguarding supervision session of an hour and a half with the *For Baby's Sake* Director

- Each *For Baby's Sake* team will receive monthly group case management supervision of two hours with their Team Manager

Staff experiences of supervision

Practitioners reflected on the supervisory practices within the programme and explored what works well and what areas could be further developed. All staff commented on the value and importance of having regular supervision as part of their work.

What works well

- Practitioners felt it was crucial to have space within supervisory sessions to talk about their cases with families and to receive guidance from supervisors around how they can support service users

- Practitioners highlighted the importance of supervisory sessions in addressing issues of collusion with service users

- Using one-to-one Team Manager supervision to focus on the practical side of things (e.g. case discussions, caseload planning, covering previous actions or tasks that need completing) and external group clinical supervision to focus on relationships (e.g. personal well-being and feelings), was seen as valuable to practitioners

- Group external clinical supervision sessions were described as useful spaces for practitioners to have all sorts of discussions, including talking about cases or management problems or venting frustrations about various issues: *"a useful space to talk through how you're feeling at the moment…what is nice is that you are sharing that with others who might be going through something similar or have been in the past and can, sort of, give you support"*

- The monthly group case management/safeguarding supervision sessions were seen as a vehicle for the formulation of ideas about the families that practitioners are supporting. These supervisory sessions involved practitioners working through some of the dynamics they experience in working with families and in reviewing risks for families. The group format of the sessions was felt to have evolved into positive space: *"where we really sit there and think about what's going on for service users"*

- The one-to-one supervision sessions received by Team Managers, from the *For Baby's Sake* Director, was reported to be important in supporting managers to draw upon the analytical skills of their supervisor to problem-solve. This supervisory process alongside managers' access to external clinical supervision allowed them to: *"understand more of the relationships that are going on. Instead of being an observer, being a participant, instead of having an overview only…this really gives me space to check out, 'well, what's going on with me when I have this narrative about X2 or [X3] or X4 Where am I?'…then I can sift out mine and see a lot more of what's there"*

Areas for continuous development

- The practice of maintaining confidentiality in the supervisory sessions was described as crucial by practitioners, to ensure that trust is established and upheld

- The availability for practitioners to have one-to-one external clinical supervision when personal issues/triggers arise was reported as an important set-up to implement

- Many practitioners spoke of the value of having greater focus within supervisory sessions on the cases that practitioners are managing and how they can best support families. This form of support was felt to be crucial and practitioners spoke of a need to be: *"able to go through cases that I'm having difficulty with or I'm stuck with and getting advice and support on where to take it or ideas of what to try next or where to take it".* Practitioners commented on the value of having open and reflective discussions about cases in order to facilitate discussions of challenges that may have encountered in a supportive and collaborative way

- Related to this, several practitioners spoke about the value of having greater focus within supervisory sessions on aspects of their work related to the needs of the baby and children rather than adults

- Due to the nature of the work and the topics explored in the supervisory sessions, questions could arise for practitioners that they wished to explore in individual counselling. Practitioners reflected on the importance of these discussions being managed sensitively and respectfully

- It was felt that group external clinical supervision was beneficial and that there was a need to support all practitioners to use this space. There was a sense that some discussions were not explored in sufficient depth and that some practitioners may need reassurance regarding supervisory sessions being supportive, reflective and empowering learning spaces, to encourage them to share their experiences. It was commented that that the group external clinical supervision sessions were challenging to facilitate, and that part of the problem might be that it was not part of the job of the facilitator to *"draw things out"* in the discussions

Training

Appendices 6 and 7 set out the training provided to the teams during the prototype period. Many practitioners described the training they received as positive, that it was comprehensive and that it met their needs. As illustrated in the following quote:

'I had a whole mixed bag of training. Some of it was in-house, in here. Some of it was the admin, policy type of thing. Some of it was at the council. Some of it has been out of county. So, I've found most of in really useful, actually'

Practitioners reflected that the programme provided them with opportunities to undertake ongoing training activities, which they really valued as it helped to support their progress and improve their competencies. Practitioners reflected that the initial training that staff receive about the programme needed to be constructed in such a way that it prepares practitioners to think about the complexity of the families they would be working with and the material involved. Where possible, practitioners also talked about the value of the initial programme training sessions including opportunities for new staff to draw on the expertise of the more experienced practitioners.

Practitioners who received the initial training on the manuals from the co-designers found this experience very valuable, as it took them right through from the beginning to the end of the programme. This was described as helping practitioners to get the: *"whole perspective'* of the programme and the detailed training on the moving through the programme meant that in practice it has made their journey with families "*comfortable".* The "Inner Child" training delivered by the co-designers was reported as particularly useful in shaping the work delivered by practitioners. Practitioners described how being trained by the designers of the programme was considerably beneficial for them in terms of understanding the intentions of the programme. Alongside the training from the co-designers, practitioners described other training programmes such as "Protective Behaviours" and "Talking Without Fear" which were particularly valuable in influencing practice.

Navigating through the manuals was described as a massive challenge, so the original training from the co-designers, which was experiential, was seen as a: *"brilliant part of the training".* For full details on the initial training received by practitioners see Appendix 6.

Practitioners who joined the programme at a later date received a modified training schedule, which included detailed readings of the manuals, relevant texts and training from the *For Baby's Sake* Director and Team Managers, including one designated as the *For Baby's Sake* Therapeutic Lead, as well as existing practitioners. Several practitioners reflected that the modified training schedule was not as comprehensive as the initial training schedule and it was felt that a greater intensity of training, to the level delivered at the start of the programme, would have helped upskill new joiners more effectively. Some, however, felt the modified training package was sufficient. Overall, new practitioners reported that learning from existing practitioners really helped inform their knowledge and skills to deliver the programme.

An Infant Development and Family Practitioner reflected that although the initial training for this role was good it needed to be more detailed and to cover trauma in children and attachment issues, including how to support these children therapeutically and how to work with families to understand the different parenting needs of these children. They also highlighted that the initial training did not cover work with children over 3 years of age, as during the design phase, the programme was not envisaged to work with families where the siblings of the baby would be over the age of 3 years (N.B. the programme now works with siblings without any age constraints. These elements have since been added to the training of the Infant Development and Family Practitioner role.) Infant Development and Family Practitioners reflected that the training they received could be further enhanced by skilling them in how to communicate in a parent-friendly way the work they are doing and what they aim to achieve, so that families are clear what the role is about.

It was suggested that for future training programmes, additional training time as well as integrating *"skills practices"* and role-play exercises into training sessions would be extremely useful in developing practitioner competencies, as they could try out and reflect on their delivery of the manuals. This, alongside training on the role of a practitioner and what is expected as part of that role, was also reported as beneficial in supporting the skills development of staff. In addition, practitioners talked about the value of having more training

on specific areas such as mental health, counselling skills and risk assessments. Continued availability to attend refresher training was highly valued by practitioners and they felt this aspect of the training programme should be included in any future rollouts. They reflected that training by existing practitioners was valuable to support the skills development of new staff and that protected time should be given to existing practitioners to deliver this training.

Summary of key findings

- Practitioners commented on the value and importance of having regular supervision as part of their work. Practitioners spoke of the value of having increased focus within supervisory sessions to reflect on the work they are doing with families and how best they can manage this, including their work related to the needs of the baby and children

- The elements of one-to-one Team Manager supervision that focus on the practical side of things within the practitioner roles (e.g. case discussions, caseload planning, covering previous actions or tasks that need completing) were felt to be valuable

- The monthly group case management/safeguarding supervision sessions were seen as a vehicle for the formulation of ideas about the families that practitioners are supporting, as well as how practitioners can address the presenting familial dynamics and any familial risks they may encounter

- The practice of maintaining confidentiality in the supervisory sessions was described as crucial by practitioners, to ensure that trust is established and upheld

- It was felt that group external clinical supervision was beneficial and that there was a need to support all practitioners to use this space. There was a sense that some discussions were not explored in sufficient depth and that some practitioners may need reassurance regarding supervisory sessions being supportive, reflective and empowering learning spaces, to encourage them to attend and share their experiences

- Overall, practitioners described the training they received as positive and comprehensive

- Practitioners reflected that they had been provided with ongoing opportunities to enhance their training, which they valued. They described the benefit in receiving refresher training and felt this aspect of training should be incorporated into any future roll-outs of the programme

- Practitioners who received the initial manual training from the co-designers found this experience very valuable, and highlighted the benefit of receiving experiential training as part of this training

- There were variations in the views of practitioners regarding the modified training schedule given to new members of staff. For some, this training package was not perceived to be as comprehensive as the initial training schedule that practitioners

received at the start of the prototype phase. Consequently, these practitioners commented on the need for new practitioners to receive a greater level of intensity of training on induction. Others felt the modified training schedule was sufficient, and new practitioners could further refine their learnings through shadowing and drawing on the skills of more experienced practitioners

- Areas for future development in relation to training included work around integrating the skills that practitioners had learnt, additional role-play-based exercises, and for the Infant Development and Family Practitioners training around how to communicate their work and purpose of their role in a parent-friendly accessible way. In addition, practitioners talked about the value of having more training on specific areas such as mental health, counselling skills and risk assessments [NB the practitioners have now been trained to use the SARA-V3 risk assessment framework]

Qualitative Interviews with Stakeholders

Interviews were carried out with key stakeholders in each of the two sites at the end of the evaluation period (spring 2019). Interviews were conducted in March 2019. Interviews lasted between 30 and 55 minutes, were audiotaped and transcribed verbatim. A total of 11 stakeholders were interviewed across the two sites, four in Hertfordshire and seven in London Three Boroughs. Across the two sites, the interviews had representation from police, children's services, the DVA sector, commissioning and the health service.

A topic guide, developed specifically for this research evaluation, was created to explore *For Baby's Sake* stakeholders' experiences, perceptions and expectations of the programme. Key topics that were explored with stakeholders included:

- Stakeholder understandings about the philosophies and models of *For Baby's Sake*
- Stakeholder understandings about the models of *For Baby's Sake*
- Stakeholder experiences of working with the *For Baby's Sake*

The results of this section will be presented under the key topics that were explored in the topic guide. The format of the results will follow the same order as the bulleted list above.

Stakeholder understandings of the philosophies of *For Baby's Sake*

Stakeholders shared what they thought were the key philosophies of the programme. *For Baby's Sake* was described as:

- Providing a whole-family approach, with just one organisation working with the whole family. This model, of a specific practitioner working with each parent and an Infant Development and Family Practitioner working with parents and their children to gain different perspectives on systemic issues, alongside having a three-way feedback model from the practitioners was described as enabling a *"whole rounded perspective"*
- Delivering a strengths-based approach which recognised experiences of childhood trauma and ACEs in the lives of many parents. This model was described as going: "*right down deep into people's childhoods"*
- Working one-to-one with families over a longer period, thereby allowing families to build trust and to have time and space to reflect on their experiences and behaviours through practitioners' ability to "*unpick things"*
- Working with those who experience abuse and those who use abuse. This combined model was seen as novel and something not currently existing within the Local Authority areas
- An intense programme, which required parents to attend and *"deal with what is going on for them"* as opposed to something less structured that they could drop in and out. This was described as important

- A model that provides a *"catalogue of different options*" with respect to addressing DVA among different family members. This approach was felt to give families different options and choices.

- A programme that has more resources than other services with respect to the length of time it can work with families and the depth of work it can undertake in relation to DVA, alongside resources around producing audits of the work and the detailed training programmes offered to practitioners: *"I think you'd have to go a long way, actually, to find staff that are as well trained as their staff are"*

Stakeholder understandings of the models of *For Baby's Sake*

The whole-family approach used by *For Baby's Sake* was reported as novel and valuable for families experiencing DVA, as illustrated in the following quotes:

'I don't actually think there was an option [within the Local Authority] in like a holistic family support approach'

'It does work for families. And if you do have parents that want to be together, you know, if you can eliminate the risk and eliminate that domestic abuse aspect and teach them things, you're giving those children such a better opportunity to go on in life and be happy and healthy and successful'

This model was described by some stakeholders as especially beneficial for mothers and children *"because we know that women often do go back". A* stakeholder said they had done a couple of audits on their cases and had found that *For Baby's Sake* was working with families in a lot of depth.

Linked to this, several stakeholders commented that they felt reassured that the programme's work was embedded in a research and evidence-based context and that there was an evaluation of the programme. This was seen as important by stakeholders, given the programme adopted different philosophies and models than many existing DVA programmes, as exampled in the following quote:

> *'They're working to a different method to a lot of the women's sector'*

Some stakeholders discussed how the relational aspects of the programme mirrored current research in terms of the importance of looking at the child and the family relationship as well as the parents' relationship, regardless of if the parents are together or not. In addition, *For Baby's Sake* adoption of a trauma-informed approach was described as very positive and valuable in enhancing the care provided to families: "*their model of being trauma-informed is one that I'd like us to get to across the whole of our service".*

A related theme describes some stakeholders' discussion about the programme's work around ACEs. A few stakeholders acknowledged that this area of work was something that their service had not yet focused on. Others spoke of how ACEs and their associations with DVA were described differently by *For Baby's Sake* than the women's sector and that this could be problematic in terms of thinking about adult behaviour. This is illustrated in the following quote: *"it's not that we don't recognise there is an impact [between ACEs and*

subsequent DVA victimisation or perpetration] but I think there seems to be a bit of an inevitability coming from For Baby's Sake".

Several stakeholders commented on the requirement of co-parenting for people to be eligible *For Baby's Sake.* Discussions centred around the potential for this requirement to further facilitate the abusive father's control over the mother as, if they did not agree to take part, then the mother would not be able to receive individual support. Stakeholders from the women's sector stated that their model centres on ensuring women have independent choice over their actions/decisions and this factor could be lost within the co-parenting approach, as illustrated in the following quote which role-played a potential conversation to a mother who may be interested in engaging with *For Baby's Sake*: *"There is all this support that you can have, you just have to co-parent."*

When thinking through the model of the programme, several stakeholders questioned how *For Baby's Sake* would manage instances where a male perpetrator used participation in the programme as a manipulation technique to stay within the family, rather than seeking to change their situation. Linked to this, several stakeholders explained that they were unsure whether people were ever asked to leave the programme due to risk-related issues. Whilst stakeholders were confident that the programme would have a way of dealing with these issues, they were not sure about how these would be managed and wanted to be informed about this by the teams.

Related to the eligibility criteria of the programme, some stakeholders reflected on whether, in the future, the programme might be able to recruit families both in the antenatal period and the first year after childbirth. Stakeholders commented that families in the postnatal period would likely be experiencing similar things as expectant parents. In addition, they suggested that if parents in the early postnatal period were targeted, referrals into the programme might increase, as there would be more time to explore such issues with families in their statutory postnatal appointments. Stakeholders appreciated that the programme's model focuses on the prevention of adverse physiological effects of DVA in the antenatal period but suggested that these effects also extend to the early postnatal period, so early intervention efforts would also have a place here. A few stakeholders reflected that additional changes to the programme would require a careful balance to ensure that the programme does not lose its overall focus. Finally, there was a suggestion put forward by one stakeholder regarding the future extension of the programme to include work with female perpetrators of DVA.

Stakeholders' experience with *For Baby's Sake*

Stakeholders shared their experiences of working with *For Baby's Sake*. Overall stakeholders were positive about the work of *For Baby's Sake*.

The programme efforts to embed *For Baby's Sake* in the local areas

Stakeholders gave a number of examples about how the programme had tried to embed itself within the area:

- *For Baby's Sake* embedded itself within local referral pathways

- *For Baby's Sake* established an Operational Group in each of the two sites, bringing together key stakeholders to facilitate partnerships and to inform services about the work of the programme. Stakeholders commented that these groups were *"very important"*

- *For Baby's Sake* staff attended relevant conferences, meetings and public events in the local areas to provide information on DVA and the programme. Stakeholders commented that these activities were valuable in raising the profile of *For Baby's Sake,* as illustrated here: *"They're a great team, you know, putting themselves out there publicly…People know who they are"*

Co-located working spaces

Stakeholders commented that the co-located working practices, where the *For Baby's Sake* teams were embedded within relevant Local Authority services (e.g. Children's Centres) were valuable in supporting coordinated efforts to address DVA among local families. Stakeholders who worked in these co-location spaces commented that having the *For Baby's Sake* practitioners in their organisation helped to facilitate collective discussions and helped them to enhance their understandings by collaborating with practitioners who were knowledgeable about DVA and how to support families.

Social care partnerships

For Baby's Sake was described by stakeholders as different from the social care services, because it was more specialist. The social work role was seen as broader and not able to go into the depth that *For Baby's Sake* could, including providing one-on-one time with individual family members. Indeed, stakeholders commented that having a service such as *For Baby's Sake* that could stay with a family for long enough to maximise the opportunity to engage both partners, so work could be done with whole family, was very important and something that social care services were not able to offer, as they were often crisis-focused.

Stakeholders described the social work role as assessing the current family situation in terms of DVA but not historical experiences. *For Baby's Sake* was seen as complementing and supporting social care's teams in trying to prevent children being placed on a 'child in need' or 'child protection' plan.

For Baby's Sake work with social care services was described as *"very well coordinated with the social worker's involvement".* Stakeholders explained that in some cases social workers had been able to step back from cases because the level of intensity offered by *For Baby's Sake* was so high, *"really, you don't want another professional. Although, the social work keeps that contact".*

Joint working with other Local Authority services

With respect to establishing joint-working practices, stakeholders described how the London Three Boroughs system was more complex than Hertfordshire because of the plethora of services that existed to support the wide diversity of the populations within the Local Authority areas, as well as the existence of many specialised violence-focused services within

the local areas.

Examples of where *For Baby's Sake* was able to address a gap in current service provision were outlined in relation to the Hertfordshire Intensive Family Support services and the London Three Boroughs Early Help services. These services were seen as providing similarly focused and detailed early intervention work with families, but stakeholders commented that families needed to meet a high threshold of presenting need to receive these services, whereas the criteria for access to *For Baby's Sake* were less restrictive in that sense.

Generally, stakeholders described effective joint-working practices and communication strategies with *For Baby's Sake.* For example, if through talking with a service user an issue was identified which raised concern then the various stakeholders would communicate that information with *For Baby's Sake.* This would often result in collaborative working around a safeguarding referral, facilitating safe contact between parents (if they were not together), or putting a protection order in place so that a father was not allowed to go near a mother. Stakeholders also described having direct numbers, mobiles and emails for communicating with *For Baby's Sake* practitioners. As illustrated in the following quotes:

'You can just phone them and ask them a question and they're available…because they are so passionate, and they genuinely care and believe in what they do'

'If information needs to be shared, it's shared both ways'

In contrast, some stakeholders felt more could be done to promote joint-working practices with non-health and non-social care services in the Local Authorities; as illustrated below:

'We've obviously focused a lot of the work around communication with social work and with health…maybe For Baby's Sake hasn't been sufficiently embedded with that wider, sort of, specialist service delivery that it, maybe, could have been'

Some stakeholders described initial tensions with the programme when it was first implemented in the Local Authority areas. They described how there were expectations that all potential cases be considered for *For Baby's Sake* in the first instance. However, there were referral pathways already established in the local area and the programme needed to fit within those. Stakeholders reflected that the set-up of this referral pathway may have left *For Baby's Sake* staff feeling that cases were not being referred to them, but they provided reassurance that this was not the case and that discussions about the programme were simply discussed "*a bit further down the line".*

In building joint-working relationships, a lack of communication between *For Baby's Sake* and other local partners was described by some stakeholders. Some partner organisations were not made aware in advance that *For Baby's Sake* was being implemented in the area and they felt they lacked timely information about the programme and who to link with within the programme. The importance of timely communication from *For Baby's Sake* practitioners to other local partners, regarding families they were supporting who were also engaged with partner agencies, was also highlighted. In instances when timely communication did not occur, local partners started to question their willingness to continue collaborations with the programme. Stakeholders also described the need for collaborative working agreements to be honoured in order to promote sustained joint-working partnerships.

Finding ways to establish joint working practices

Stakeholders described the *For Baby's Sake* teams as being open and willing to have honest discussions and to engage in sometimes challenging conversations with other local services about any concerns/reservations they may have had about the work. An example was given about concerns relating to the wording that was included in some of the literature generated from the programme and the ability of the teams to: *"answer all those questions and put people's mind at ease"* Other examples included the language of the programme in relation to childhood exposure to abuse and vulnerabilities to DVA victimisation and perpetration in adulthood. Discussions were had with practitioners about the importance of communicating that these outcomes were not predisposed/inevitable.

Some stakeholders further reflected that the teams did not shy away from criticisms and sought to address these head-on and to make adaptations, if relevant. As illustrated in this quotation:

'The biggest takeaway is that they have adapted [the programme]. It would have been different if they'd said 'no, this is it'. Because I know some programmes are very much about 'this is it, this is how we work…we're just going to deliver it in this way'

This view was not held by all, however, and some stakeholders' experience was that the narrative from the programme when questions were raised about their work had at times been "*no, we do it this way"*

Some of the key changes that stakeholders mentioned were the programme's decision to modify the age ranges of the children in the family that could be involved in the programme (e.g. supporting siblings of the baby who were above the age of 3 years). This degree of flexibility was commended by stakeholders, as illustrated in the following quote:

'[For Baby's Sake] have been able to change their criteria according to the needs and the types of referrals coming through. So, I think that was helpful. And, I think it has been really great to have this focused intervention, that is very specialist, that other agencies haven't been able to match'

Generating referrals

Stakeholders discussed how the programme can capitalise on building referrals. Discussions centred around where would be most effective for the programme to sit within the early intervention models in the local areas (e.g. in social care or health settings), and how best to target opportunities within these services (e.g. at antenatal booking appointments or later antenatal contacts). Within the context of health settings, the antenatal period was described as not providing plentiful opportunities to identify and approach potential families, given how few appointments expectant mothers have and how many other issues need to be covered in these appointments. The programme was seen as having more opportunities within a social care model, but this would only target families that are known to these services.

Sustainability of the programme

Several stakeholders reflected on the prototype model which involved the Foundation fully funding the programme from its own philanthropic resources. Stakeholders working in social care services described how this model has meant they have benefitted from having a large, experienced team within their service which did not require commissioning; as illustrated in the following quote:

'We've benefited from quite a large team that hasn't been commissioned…which we've had, in a way, free of charge, we provide the accommodation with a whole load of expertise embedded amongst ourselves'

Stakeholders acknowledged that over the longer period, it was unlikely that this funding model would be sustainable and, therefore, if commissioning was provided by Local Authorities then this may lead to adaptations to the programme. Some stakeholders described that many other services directly commissioned by the Local Authorities tended to be: *"more-higher volume, crisis-focused and lower intensity"*. They felt that if Local Authorities were to take on responsibility for commissioning a service then discussions would focus on: *"do you want lower volumes, like a more intensive service…or do you want to continue with higher volumes?*". Stakeholders reflected that, given the current financial climate, Local Authorities may seek to provide support to as many families experiencing DVA as possible; this approach may not instinctively match the *For Baby's Sake* model, which by its nature of working intensively over a long-period with families may not be able to hold very high caseloads.

Finally, stakeholders discussed how commissioners put a lot of weight on the number of referrals into a programme, as a key means of determining value for money of a service. Stakeholders commented commissioners may question: *"the cost of provision over that time versus the number of families worked with"* In addition, they commented that if the number of referrals were deemed to be too low by commissioners then this could make it harder to continue funding of the service.

Another theme described by stakeholders in relation to sustainability was a discussion around changing political priorities. Indeed, in one of the sites stakeholders commented that the Local Authorities were now encouraged to put a lot of focus on managing gang and knife/gun crime. The consequence of this could be that the focus on DVA becomes less of a priority.

Summary of key findings

The findings from the interviews with stakeholders highlight their views and experiences of the programme and some important considerations for the Foundation with respect to future roll-outs of the programme. These key points are outlined below:

- The programme was felt to be novel in that it provided holistic support to the whole family

- Key beneficial aspects of the programme are that it can work long-term with individual members of a family, that it adopts strengths-based approaches and that it provides comprehensive training to its staff. In addition, this programme can work with families

that are not ready to separate

- A key factor for the endorsement of the programme is that the manual is evidence-based
- The *For Baby's Sake* teams were reported to be highly trained and skilled
- The co-parenting model has many benefits and can help to engage numerous families, but this approach requires careful implementation to ensure that abusive fathers are engaging with a commitment to make changes and not simply extending their control over mothers and children
- The communication with stakeholders and families about the therapeutic work around ACEs needs to be handled carefully in order to convey how traumatic childhood adversity is understood within *For Baby's Sake* i.e. that families have control over the behaviours they use as an adult and that the programme work seeks to empower them to take responsibility for their actions
- The programme model of co-location within social care services is beneficial in building collaborative and joint-working practices. Future roll-outs of the model would benefit from maintaining the co-location models
- The establishment of local Operational Groups alongside practitioners' proactive approach to undertaking promotional and engagement activities facilitates the successful embedding of the programme within the Local Authority areas
- For the programme to continue to build strong working practices with relevant services already in existence with Local Authority areas, *For Baby's Sake* teams need to ensure the programme remains embedded within current service provision. This includes continuing the practice of detailed exploration of relevant services already in existence within the locality areas and how *For Baby's Sake* can best fit within those established models of care. In addition, the *For Baby's Sake* teams could provide more training to Local Authority partners on DVA, including adopting trauma-informed approaches
- *For Baby's Sake* teams should continue the current approach to facilitating collaboration with other services, by being open, reflexive and adaptable to locally-identified concerns/priorities and the needs of local families
- *For Baby's Sake* teams could provide further information to their partner organisations about how the programme manages instances when fathers use participation on the programme as a means of controlling other family members and how they manage situations when families need to be stepped-down from the programme, particularly in cases where there are risk issues of these families
- In future roll-outs of the programme, *For Baby's Sake* teams should continue in their efforts to proactively explain to partner organisations how their model can complement existing models (e.g. *For Baby's Sake* is a long-term intervention that works with the whole family and supports both perpetrators and survivors), to ensure

success with embedding the programme with existing Local Authority structures, and to address the potential tensions of their working model against the feminist women's sector models

- Going forward, the programme needs to continue its focus on getting more referrals in to *For Baby's Sake* in the London site. This is particularly important in terms of demonstrating the cost benefit of the programme

Social Marketing Activities

Social Marketing Survey

Key stakeholders in Westminster and Hertfordshire were invited to participate in a brief electronic survey (developed by Jill Domoney, Nicky Stanley and Kylee Trevillion) about the impact of the *For Baby's Sake* social marketing campaign. The survey explored the following areas:

- Stakeholders' knowledge of the *For Baby's Sake* social marketing campaign, including what types of marketing materials they had seen
- Stakeholders' opinions and views on the messages of the advertising materials
- Stakeholders' understanding of the criteria of *For Baby's Sake*
- Stakeholders' knowledge of how to make a referral to *For Baby's Sake*
- Stakeholders' confidence to explain *For Baby's Sake* to eligible families

The electronic survey ran from 28th March to 30th April 2017. Stakeholders were sent an initial email invitation asking them to take part on 28th March and were sent further prompting emails on the 10th April to encourage their participation during the evaluation study. The evaluation team also encouraged *For Baby's Sake* Operational Group representatives to disseminate the survey to their colleagues, during face-to-face meetings.

The survey was sent out to a total of 50 individuals, who were asked to forward the survey to their teams, where appropriate. A total of 13 stakeholders participated in the survey, with representation from the following professionals (see Table 8 below).

Table 8: Professional roles of those completing the online social marketing survey

Professional Role	Number
Domestic violence worker	2
Children's services worker	4
Police	1
Social services	2
Vulnerable adults	1
General Practitioner (GP)	1
Health Visitor	2

In total, over two-thirds of stakeholders who participated were aware of the *For Baby's Sake* social marketing activities and approximately a third were not. Stakeholders had seen a number of the *For Baby's Sake* programme materials, including leaflets (75%); posters (63%); newsletters (25%) and wallet cards (13%). These materials were seen in public spaces such as

children's services buildings and council offices, and also in staff offices and via email circulars. Nearly two-thirds of stakeholders had seen presentations by *For Baby's Sake* staff.

Over three-quarters of the stakeholders felt that the current *For Baby's Sake* advertising materials provided clear contact information for families, and felt the materials included appropriate images. Two-thirds felt that the materials provide clear information on what the programme entails.

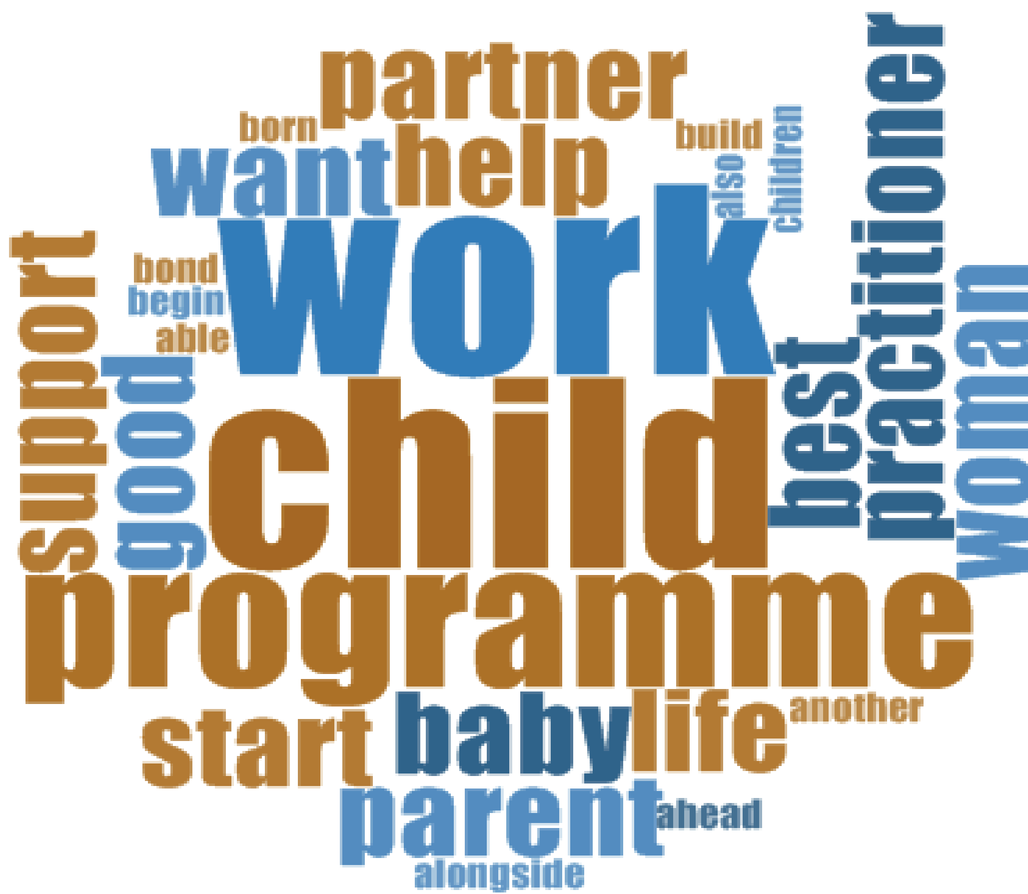
Just over half of stakeholders indicated that they felt very clear about the *For Baby's Sake* criteria, while only a small minority felt only somewhat clear or completely unclear about this. Over three-quarters of stakeholders felt somewhat or completely confident about describing the *For Baby's Sake* to eligible families, and more than two-thirds said that they would refer families to the programme.

Figure 6 presents a visual map of stakeholder summaries of their understanding of the criteria of the programme. Stakeholders used the terms *"pregnancy"* and "*expectant parents*" to describe the type of people they understand to be eligible. They understood that the programme is for families using "*harmful*", "*hurtful*" or "*unhealthy*" behaviours in their relationship and there is a commitment to "*co-parent*".

Figure 7: Word-cloud of stakeholders' understanding of the For Baby's Sake criteria

Figure 7 presents a visual map of stakeholder summaries regarding how they would tell families about the programme. Stakeholders explained that they would tell families that the programme will support co-parenting and will help to give their children "*the best start in life*" by helping them work on their relationship issues. They described that *For Baby's Sake* practitioners would work with mothers and fathers to ensure that their child has a "*safe*" and "*secure*" start in life.

Figure 8: Word-cloud of stakeholder statements on what they would tell families about the programme



Quantitative Data on Families Participating in the Evaluation

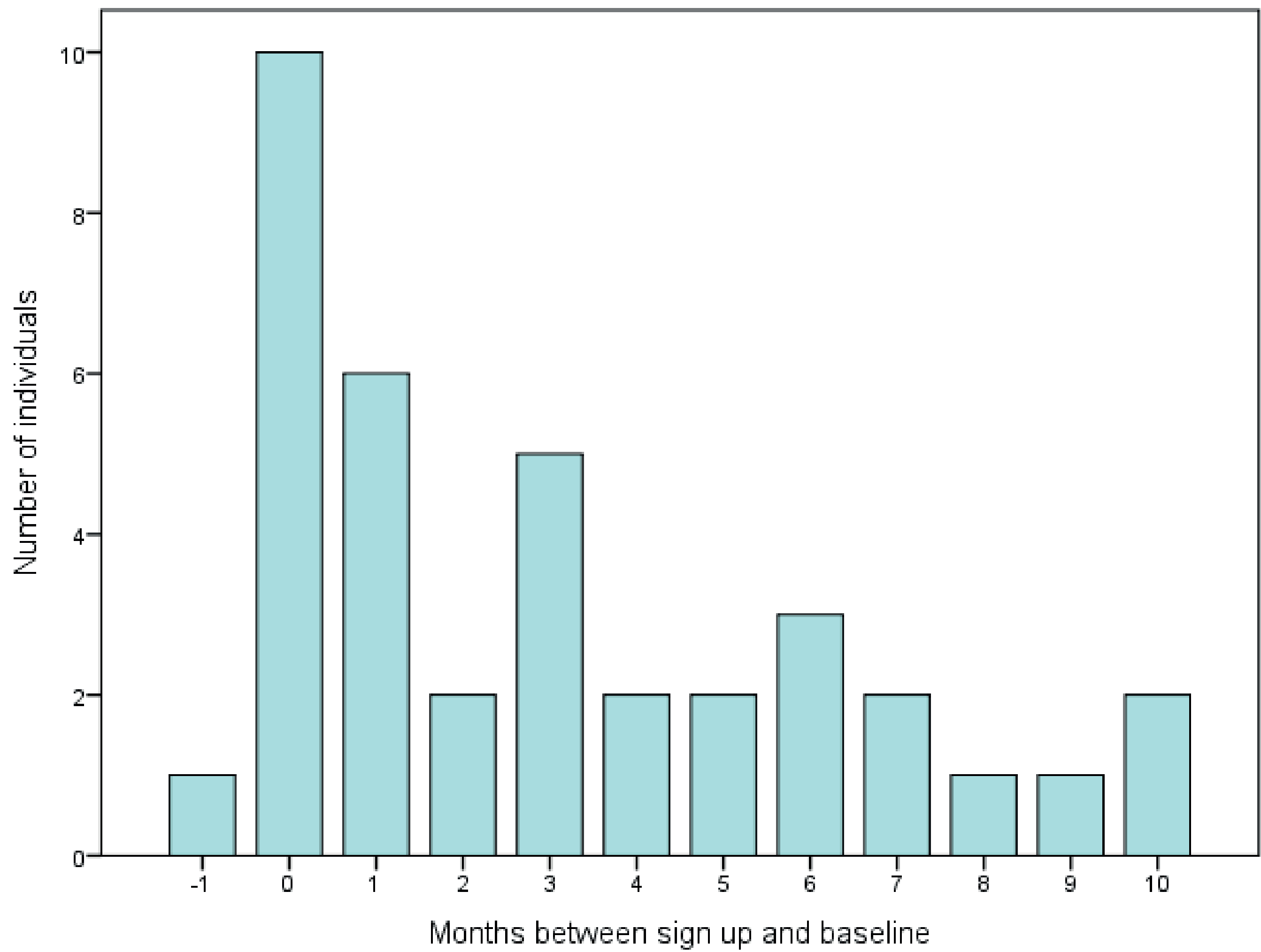
Baseline findings

Baseline interviews were completed with 40 individuals between July 2016 and August 2017. These 40 individuals represent 28 families; 31 participants were from the Hertfordshire site and 9 from the London Three Boroughs site. Of the 40 participants at baseline, 27 were mothers and 13 were fathers.

During recruitment, we received contact details for a total of 88 individuals. We were unable to complete a baseline interview with 48 individuals. Reasons for non-completion included withdrawal of consent (n=11), too much time passed before an interview could be arranged (n=4), persistent non-response to attempts at contact (n=12), withdrawal from *For Baby's Sake* and unable to contact/declined baseline (n=21).

The intention was to complete all baseline interviews during pregnancy. This was not always possible, however. Initially, there were some delays with recruitment to the evaluation due to the need to wait for ethical approvals and the establishment of an information sharing agreement between the university and the local authority. This meant that some service users who had provided consent to be contacted could not be recruited immediately. Furthermore, inclusion criteria for the programme extended to be any time during pregnancy, which sometimes provided a smaller window within which to recruit people to the evaluation. As it often took the research team several weeks to engage with participants and arrange a convenient time and location to undertake the interview (particularly in the case of male participants), this could mean that participants were in the postnatal period at the time of the baseline interview. In total, 14 out of 40 individuals completed baseline interviews antenatally (9 women and 5 men) with the remainder completing them postnatally. We aimed to complete baseline interviews as close to sign-up to the programme as possible. Figure 9 shows the date at which baseline interviews were completed in relation to the date of sign-up. Approximately 50% of baseline interviews were completed within 2 months of sign-up.

Figure 9: Date baseline was completed in relation to sign-up to the programme



Demographic characteristics of evaluation participants

One aim of the evaluation was to describe the characteristics of individuals and families who are attracted to and retained on the programme. This section provides details of the demographics of the participants in the evaluation alongside other key characteristics including mental health symptoms, trauma histories, gynaecological details, and social service status. This data provides an indication of the complexity of the individuals who are referred to the programme. Key demographic and clinical details of the 40 participants in the evaluation are outlined in Tables 9 and 10 below and the subsequent paragraphs of this section.

Table 9: Sociodemographic characteristics of mothers (n=27)

Socio-demographics of mothers (n=27)**	
Age (mean (SD))	27.8 (7.5)
N (%)	
Education level	
No formal qualifications	2 (7.4)
GCSE	2 (7.4)
A-Level/NVQ/BTEC	14 (52.8)
HND/Bachelor's degree/MSc	8 (29.6)
Ethnicity	
White British	20 (74.1)
White other	5 (18.5)
Black Caribbean	1 (3.7)
Mixed white and Asian	1 (3.7)
Self-reported mental illness (yes)	12 (44.4)
Current smoking (yes)	8 (29.6)
First time mother	11 (40.7)
Relationship status*	
Single	5 (18.5)
Partner, not cohabiting	8 (29.6)
Married or cohabiting	10 (37.0)
Separated/divorced	3 (11.1)
Physical health problems	9 (33.3)

*N=26 due to missing data
** Employment status not included due to mix of antenatal and postnatal interviews

Table 10: Sociodemographic characteristics of fathers (n=13)

Socio-demographics of fathers (n=13)	
Age (mean (SD))	29 (7.7)
N (%)	
Education level	
No formal qualifications	2 (15.4)
GCSE	4 (30.8)
A-Level/NVQ/BTEC	5 (38.5)
HND/Bachelor's degree	2 (15.4)
Employment status	
Full time paid work	7 (43.8)
Not working/unemployed	6 (46.2)
Ethnicity	
White British	11 (84.6)
White other	1 (7.7)
Mixed other	1 (7.7)
Self-reported mental illness (yes)	7 (53.8)
Current smoking (yes)	10 (76.9)
First time fathers	5 (38.5)
Marital status	
Partner, not cohabiting	6 (46.1)
Married or cohabiting	7 (53.8)
Physical health problems	4 (30.8)

Mental health status

During baseline interviews we collected self-report questionnaire data on a range of mental health disorders (full details and psychometric details of these measures are provided in Appendix 1. Brief descriptions are provided under the heading, 'Post sign-up findings'). The small sample size for these outcomes means it is not possible to draw conclusions from this data. However, the evaluation indicated that it was feasible to collect these measures from participants and the responses suggest high levels of symptoms of mental health disorders among this sample.

Among fathers, six (46%) had moderate to severe symptoms of anxiety and five (38%) had symptoms of depression, while among mothers, ten (40%) had moderate to severe symptoms of anxiety, and eleven (45%) had symptoms of depression. These rates are higher than population prevalence rates for perinatal depression and anxiety, which are around 10-12% (Howard et al, 2014; Paulson and Bazemore, 2010; Leach et al, 2016), suggesting that participants in the evaluation may be at increased risk of common mental health disorders.

Similarly, four men (30%) and five women (18.5%) had symptoms of post-traumatic stress disorder. There is not currently prevalence data on PTSD in perinatal men, but past year prevalence of PTSD among normal populations of men is estimated to be around 1.8% (Harvard Medical School, 2005). For women, population prevalence of postpartum PTSD is around 4%, but 18.5% in high-risk samples i.e. those with traumatic births, severe

complications, or a history of interpersonal violence (Yildiz *et al.*, 2017). Therefore, rates of PTSD for women in this sample were in line with those expected of high-risk samples, while rates for men were rather higher.

Participants also completed a researcher-administered instrument to assess the presence of personality dysfunction (measured using the Standardised Assessment of Personality – Abbreviated Scale (SAPAS) scale). Based on this scoring system, at baseline 10 (77%) fathers and 14 (52%) mothers met criteria for disordered personality traits. The epidemiology of personality disorders is poorly described, but community-based surveys report a prevalence of between 4% and 15%, with higher rates reported in samples in contact with mental health services or the criminal justice system (Tyrer *et al.*, 2015). The rates reported in this sample are substantially higher than this and are indicative of the complex needs of these participants.

Gynaecological histories of mothers

At baseline, mothers were asked about their gynaecological history and details about the current pregnancy. Fifteen mothers (55%) reported having a previous miscarriage or stillbirth; eleven mothers (40%) reported having had a termination. In the UK it is estimated that around 1 in 5 pregnancies end in miscarriage (Sagili and Divers, 2007), while the abortion rate in 2018 was around 1.75% (17.4 per 1000 resident women) (Department of Health and Social Care, 2019). These rates may be higher where women are experiencing domestic abuse (e.g. Alio *et al.*, 2009) (and indeed, rates in the current sample were high compared to normal populations.

Three out of the 27 mothers (11%) reported actively trying to become pregnant with the current baby. 16 (59%) were not trying but were pleased to be pregnant, while 8 (29%) described an unwanted pregnancy.

DVA experiences of mothers and fathers

At baseline, men and women completed measures of DVA victimisation and perpetration, including both recent and non-recent abuse.

In terms of perpetration, 5 out of 13 fathers (39%) reported that they had never perpetrated abuse against their current partner. The remaining eight (61%) reported some lifetime perpetration. Five of the eight fathers reporting some perpetration stated that this had occurred in the 6 months prior to completing the questionnaire. Two fathers reported having had contact with the police due to incidents with their current partner. Four fathers (31%) reported having previously perpetrated abuse against someone other than the current partner. Three of these were previous female partners.

Low reports of abuse perpetration in this sample could be due to minimising, denial, or to not identifying their behaviour as abusive. These have been highlighted as common responses by domestic violence offenders (e.g. Henning *et al.*, 2005).

Men also reported on experiences of victimisation. Nine out of 13 fathers (70%) reported that they had never experienced any abuse from their current partner. The remaining four (30%) fathers reported some lifetime experience of abuse from this partner. Three of these fathers

reported abusive incidents in the last 6 months. This included feeling frightened of the behaviour of their partner, being physically hurt by their partner, and having force used against them. No fathers reported having had injuries that required medical treatment as a result of abuse. Five fathers (39%) reported having experienced previous abuse from someone other than the current partner; three of these experiences were from ex-partners.

For women, at baseline, 10 out of 17 mothers (59%) reported that they had never experienced any abuse from the partner with whom they signed up (data was missing on ten mothers as the evaluation study questionnaire was updated part-way through the recruitment period to ensure that the questions focused on abuse from the co-parent). Seven mothers (41%) reported some lifetime experience of abuse from their current partner. Three of the seven reported abusive incidents in the 6 months prior to completing the questionnaire. This included a range of incidents spanning physical and sexual abuse and coercive control. Three mothers reported having had injuries that required medical treatment as a result of previous abuse.

Twenty-one out of 24 (88%) mothers reported having experienced lifetime abuse from someone other than the current partner; 18 of these were previous partners.

Low reports of recent abuse victimisation in this sample may be due to not identifying their partner's behaviour as abusive, or to minimising experiences due to fear or shame (Trevillion et al, 2014).

Women also reported on perpetration. Thirteen out of 21 (62%) mothers reported that they had never perpetrated abuse against their current partner. The remaining eight (38%) reported some lifetime perpetration. Four of the eight reported that this had occurred in the 6 months prior to completing the questionnaire. Eight out of 23 (35%) mothers reported having perpetrated abuse against someone other than the current partner; all of these incidents were previous male partners.

In addition to reports of recent abuse perpetration by the male partner, this data indicates that just over a third of the sample had experienced abuse in previous relationships, and similar numbers of men reported perpetration by the female partner. This points to the complexity of interpersonal traumas that the families in this sample are experiencing.

Adverse childhood experiences of mothers and fathers

The two programme sites collected data on adverse childhood experiences (ACEs). This included recording whether mothers and fathers had experienced any of the following 14 adverse experiences: verbal abuse, physical abuse, sexual abuse, parental separation, DVA, parental mental illness, parental alcohol abuse, parental drug abuse, parental incarceration, bereavement, chronic/serious illness of close relative, foster care/social services involvement.

Table 11 shows the number of participants reporting each ACE. The majority of mothers and fathers reported experiencing verbal and physical abuse. Many participants also reported experiencing parental separation, domestic violence, parental mental illness and parental alcohol abuse.

Table 11: Adverse Childhood Experiences reported by mothers and fathers

Adverse Childhood Experiences	**Mothers (n=27)**	**Mothers %**	**Fathers (n=13)**	**Fathers %**
Verbal Abuse	23	85	10	77
Physical Abuse	14	52	10	77
Sexual Abuse	9	33	3	23
Parental Separation	22	81	6	46
Domestic Violence (Male perpetrator)	17	63	7	54
Domestic Violence (Female perpetrator)	0	0	0	0
Mental Illness of Parent/Carer	13	48	2	15
Alcohol Abuse in Household	9	33	7	54
Drug Abuse in Household	3	11	3	23
Incarceration of Family Member	1	4	1	8
Childhood Bereavement	2	7	1	8
Chronic/Serious Illness of Close Relative	6	22	1	8
Foster Care/Children's Social Care involvement	7	26	4	31

Follow-up rates

The evaluation aimed to follow-up families at two time points: at one year post sign-up and again at two years post sign-up.

One-year post sign-up to the programme

A total of 27 participants completed the one-year follow-up interview, representing an overall follow-up rate of 68%. This includes 19 out of 27 (70%) mothers and 8 out of 13 (62%) fathers. These 27 participants represent 20 families. The mean number of months from sign-up to the programme and completion of the one-year follow-up interview was 13 months (SD 1.7), with a range from 11 - 17 months.

Two years post sign-up to the programme

A total of 18 participants completed the two-year follow-up interview, representing an overall follow-up rate of 45%. This includes 12 out of 27 (44%) mothers and 6 out of 13 (46%). The 18 participants represent 13 families. The mean number of months from sign-up to the programme and completion of the two-year follow-up interview was 24 months (SD 2.2), with a range from 21 - 28 months.

See Table 12 for details on the percentage follow-up rates of participants across each of the two sites.

Table 12: Follow up rates of mothers and fathers by locality

	Mothers		**Fathers**		**Total**
	Herts	London Three Boroughs	Herts	London Three Boroughs	
Baseline (n)	20	7	11	2	40
One-year post sign-up (n %)	14 (70%)	5 (71%)	7 (64%)	1 (50%)	27 (68%)
Two-years post sign-up (n %)	9 (45%)	3 (43%)	5 (45%)	1 (50%)	18 (45%)

Post sign-up findings

The evaluation aimed to test the feasibility of collecting outcomes from families using a range of self-report, observational and research-administered measures (Appendix 1 provides details on the psychometric properties of the standardised measures). This is important data to inform future evaluations of the programme as it indicates which types of measures and instruments can be successfully administered to families with multiple complex needs, and

whether outcomes can be collected from multiple members of the family across time. Our previous reports outlined the changes that were made to initial interview schedules in order reduce the burden on participants and increase uptake for follow-up interviews.

Below, we report details of the administration and outcome of these assessments. For assessments which were administered at multiple time points, we report on the outcomes over time. However, the sample size is not sufficient to indicate whether engagement in the programme has an impact on these outcomes and therefore this data should be interpreted with caution. Where assessments were administered at a single time point, we report the outcome and how this relates to data from normal populations, where available.

Parenting and infant measures

Obstetric outcomes

We extracted obstetric data from the site case management systems on information regarding birth weight, gestational age of the baby, and APGAR scores. Twenty-three out of 27 mothers had data on birth weight and gestational age of the index baby. Two mothers (8.5%) gave birth prematurely (one of these was a twin pregnancy). The median infant birth weight was 7lb 4oz, with a minimum of 5lb 2oz (for one of the twins) and a maximum of 9lb. The twins and one other infant (8.5%) were classed as having a low birth weight (below 5lb 8oz). APGAR scores were available for 12/27 participants. At the one-minute and five-minute APGAR readings, scores of between seven and ten are considered normal. All 12 infants for whom scores were available were between 7-10. These outcomes are in line with low-risk groups.

Infant temperament

The Infant Behaviour Questionnaire -Revised Very Short Form (IBQ-R VSF) was administered at the one-year follow-up interview and was completed by 17 mothers. This is a widely used, 37-item, parent-report measure of infant temperament. Parents report on specific dimensions of infant temperament over the last two weeks on a 7-point Likert scale, and scores are combined to create three subscales: negative emotionality, positive affect/surgency, and orienting/regulatory. Means and standard deviations for this sample were: 4.48 (1.33), 5.99 (0.57), and 5.64 (0.7) respectively. The IBQ-R is often used in predictive models of later child outcomes and therefore does not have population norms. Rather, our evaluation indicates that this self-report measure is feasible to administer to mothers and may be useful for future longitudinal evaluations of *For Baby's Sake.*

Maternal attachment

Nine mothers completed the Prenatal Attachment Inventory (PAI). This is a self-report measure of attachment during pregnancy. It is composed of 21 items on a 4-point Likert scale ranging from "almost always" to "almost never". Scores range from 21 to 84 with higher scores indicating higher levels of prenatal attachment. It was not possible to administer this questionnaire to 17 mothers as they were interviewed postnatally (please see details above regarding recruitment). The mean score was 66.33 (SD 11.25), with a range of 47-83. This is comparable to low risk samples (e.g. Barone *et al.*, 2014). This measure is often used in predictive models of later parent-child relationships and may be useful to include in future evaluations.

Parent-child interaction

The CARE Index was used to measure the quality of parent-infant interactions at each time point. The CARE Index assesses parental sensitivity, control and responsiveness alongside infant cooperativeness, compulsivity, difficultness and passivity from birth to 15 months, based on short videos of around 3 minutes. Scores range from 0-14 for each scale; scores below 5 are considered high risk i.e. in need of intervention.

At baseline, a total of 14 mothers and 7 fathers consented to provide video data of parent-infant interaction. Of these, 12 mothers and 6 fathers had data which could be coded (some data could not be coded as the filmed interaction was too short to get valid scores). This data was collected through two methods: researchers videoed parents with their infant during the interview, and researchers asked for consent to use videos taken during the Video Interaction Guidance intervention. At the one-year follow-up interview, 12 mothers and 3 fathers had parent-infant interaction data; all filmed interactions could be coded. Reasons for not having filmed interactions included that some mothers did not want to be filmed and some fathers did not have unsupervised contact with their children or did not want to be filmed.

Table 13 shows mean scores on the sensitivity scale at baseline and the one-year follow-up interview, along with the number of individuals who scored in the high-risk range (4 or below).

Table 13: Mean CARE Index sensitivity scores at baseline and at the one-year post sign-up follow-up interview

	Mothers		**Fathers**	
	Baseline (n=14)	One-year post sign-up (n=12)	Baseline (n=7)	One-year post sign-up (n=3)
Sensitivity				
Mean (SD)	3.50 (2.27)	5.17 (2.62)	5.00 (2.82)	7.00 (1.73)
High risk (n)	9	3	3	0

At baseline, mean sensitivity for mothers was 3.5 (SD 2.27), with a minimum of 1 and a maximum of 8. Mean sensitivity for fathers was 5.00 (SD 2.82) with a minimum of 2 and a maximum of 10. Nine mothers and 3 fathers scored in the high-risk range.

At the one-year follow-up interview mean sensitivity for mothers was 5.17. (SD 2.62), with a minimum of 2 and a maximum of 10. Mean sensitivity for fathers was 7.00 (SD 1.73) with a minimum of 5 and a maximum of 8. Three mothers and no fathers scored in the high-risk range.

It should be noted that different individuals contributed to the means at each time point and, therefore, an increase in the mean does not necessarily represent an improvement in the quality of interactions within the sample. Indeed only 9 individuals had data at both baseline and one year. Of these, five showed improvements in scores, one remained the same, and three showed decreases in scores.

Interactions were also filmed at the two-year follow-up interview. Eight mothers and one father had parent-infant interaction data. Mean sensitivity for mothers was 6.25 (SD 3.61), with a minimum of 2 and a maximum of 12. Three mothers scored in the high-risk range (these were the same mothers who had scored in the high-risk range at one-year interviews). As only one man had data at the two-year follow-up interview, we have not reported the findings here because the data could be identifiable. It is important to note that the CARE Index has only been validated for infants up to 15 months old and therefore these scores may not accurately reflect the quality of the interaction, as the infants were older than 15 months (N.B. we are not aware of any other validated filmed-interaction coding systems that we could have used instead to assess this data point).

The evaluation indicated that it is feasible to collect parent-infant interaction data from some individuals within this population. However, there are some challenges to this, as some individuals do not wish to be filmed and some fathers may not have access to their children at each time point. Furthermore, there are few validated measures for coding interactions which can be used across different age groups, making it challenging to assess change over time. Nevertheless, filmed interactions are the gold standard for assessing the quality of parent-infant relationships and future evaluations should seek to collect this data where possible.

Child functioning, emotions and behaviour

A range of self-report and researcher-administered measures of child development were assessed for feasibility. Scores are reported here and are compared with normal ranges.

The Ages and Stages Questionnaire (ASQ) was completed at the one-year follow-up interview. This is a parent-completed child development screening tool covering five domains; communication, gross motor function, fine motor function, problem solving, and personal-social development. Each domain is assessed by 6 questions and responses are given as “yes”, “sometimes” and “no”. ‘Yes’ answers are given 10 points, ‘sometimes’ answers are accredited 5 and ‘no’ answers are accredited 0 points. Cut-off scores are set at 2 standard deviations below the mean (this varies depending on the child’s age).

The ASQ was completed at the one-year interview with nineteen mothers. Fifteen babies scored within the normal range across all domains. Four babies obtained scores which were below the cut-off for their age group in one or two domains, suggesting a possible delay. The domains were different for different families; no baby scored low across all domains. Mothers were familiar with this measure at is often used by health visitors and therefore it was straightforward to administer. Furthermore, it can be used with children up to 5.5 years of age and so could potentially be used at different time points.

The Bayley’s Scales of Infant Development (BSID-III) were completed at the two-year follow-up interview. This is a researcher-administered scale which assesses functioning across cognitive, motor and language domains, and provides a composite score for each domain. Scores equal to and higher than 85 are within normal limits, scores between 70 and 84 signify mildly delayed performance, and scores under 69 significantly delayed performance.

This was completed with eleven infants. Mean cognitive score was 93.64 (SD 10.51), with a minimum of 80 and a maximum of 110. Two infants scored below 85, indicating mild delay. Mean language score was 97.55 (SD 8.81), with a minimum of 85 and a maximum of 112. Mean motor score was 88.18 (SD 8,91), with a minimum of 74 and a maximum of 100. Four infants scored below 85, indicating mild delay. This included the two infants who showed a delay on the cognitive scale. Those infants indicating mild delay were not the same as those indicating delays on the ASQ at year 1.

The Bayley scales are complex to administer at 2 years and can take up to 90 minutes. However, they are well-validated and comprehensive. Our evaluation indicated that it is feasible to deliver this assessment to some families, although others were unable to provide the time commitment necessary or were unable to bring their infants to the research interview.

The Child Behaviour Checklist (CBCL) is a parent-report questionnaire measure which assesses both internalising (i.e. anxious, depressive and over-controlled) and externalising (i.e. aggressive, hyperactive, noncompliant and under-controlled) child behaviours. It is composed of 100 items. For each item parents circle 0 if the item is not true of their child, 1 if the item is sometimes true and 2 if the item is very true. Scores below the 95th percentile (equivalent to a scaled score of 67) are in the normal range, and those that are above the 98th percentile are in the clinical range.

This was completed at the two-year follow-up interview with ten mothers and two fathers. In one family both the mother and father completed the CBCL for the same child – the mother's scores are reported here for consistency with other families. Therefore n=11 in total. Mean scaled score for internalising problems was 40.7 (SD 10.06, min 29, max 60), for externalising problems was 45.4 (SD 12.96, min 28, max 63), and for total problems was 44.2 (SD 12.69, min 28, max 63). All scores were below clinical cut-offs. This scale is straightforward to administer and can be used with children between 1.5 and 5 years, allowing it to be potentially repeated over time. For future evaluations, it may be advantageous for both co-parents to complete it in order to produce a mean score within the family.

Parenting Stress

The Parenting Stress Index (PSI - Short Form) was completed at the one-year follow-up interview and the two-year follow-up interview. This parent self-report questionnaire assesses a range of domains of stress and provides a composite 'total stress' score. The normal range of scores for total stress is within the 16th to 84th percentile. Scores within the 85th to 89th percentile are considered high, and scores above the 90th percentile are considered clinically significant. The Parenting Stress Index scoring system also identifies 'defensive responding' (i.e. unexpectedly low scores).

Seventeen mothers and three fathers completed this at the one-year follow-up interview. For mothers, mean percentile rank was 34.12 (SD 24.8) with a range from 1 to 74. Five mothers scored below the 16th percentile, which is considered low. For fathers, mean percentile rank was 28.4 (SD 27.5) with a range from 1 to 58. Two fathers scored below the 16th percentile, which is considered low. Three mothers and two fathers scored for 'defensive responding'.

Twelve mothers and five fathers completed this at the two-year follow-up interview. For mothers, the mean percentile rank was 30.92 (SD 29.4) with a range from 1 to 84. Six mothers scored below 16th percentile, which is considered low. For fathers, the mean percentile rank was 26 (SD 10.08) with a range from 2 to 52. One father scored below 16th percentile, which is considered low. Four mothers and no fathers scored for 'defensive responding'.

Total stress mean scores changed very little across the two time points and no one scored in a range suggesting problematic parenting stress. In contrast, several respondents had particularly low scores, including some being identified as 'defensive responding'. As described in the PSI manual, interpretation of this could be that the parent is trying to portray themselves as competent, or that the parent is not invested in the parenting role, or that the parent is coping extremely well with the role of parent.

Social care status

Sites collected regular data on social care status. We used this data to record social care status at the three time points of the evaluation. Table 14 shows level of social care involvement at each time point.

Table 14: Social care involvement at the three time points

	Baseline (n=27)	**One-year post sign-up (n=23)**	**Two-years post sign-up (n=15)**
Universal (no services involved)	6	2	4
Early help	2	12	6
Child in need	10	4	2
Child protection plan	5	4	1
Unborn baby assessment	3	NA	NA
Care proceedings/interim care Order	1	1	1
Looked after child	0	0	1

At baseline, 70% of the babies had some level of children's social care involvement (either unborn baby assessment, child in need, child protection plan, care proceedings or looked after child). At the one year post sign-up stage, 39% had social care involvement and at two years post sign-up, 33% had social care involvement.

Domestic abuse experiences

The evaluation used two measures of abuse experiences: the Composite Abuse Scale and the Abuse Experiences questionnaire.

The Composite Abuse Scale (CAS) is a 30-item self-administered questionnaire assessing the frequency/severity of abuse and harassment in the previous year. Items are rated from 1= 'Never' to 5 = 'Daily', with total scores ranging from 0-150. A cut-off score of three is assigned, with scores of three or more indicating domestic violence. This measure was completed by women only.

Table 15 shows mean scores on the CAS at each time point, alongside the number of women scoring at or above the cut-off of 3.

Table 15: Composite Abuse Scale scores

Composite Abuse Scale Scores			
	Baseline (n=26)	One-year (n=16)	Two-years (n=12)
Mean score (SD)	16.42 (SD 20.39)	14.31 (SD 17.57)	14.92 (SD 26.73)
No. (%) mothers meeting cut-off	16 (59%)	10 (63%)	4 (33%)

Overall, the percentage of mothers in the sample reporting abuse at levels above the cut-off reduced from 59% at baseline to 33% at two-years post sign-up to the programme. Among the women reporting ongoing abuse, however, the level of abuse remained the same (i.e. mean scores of 14.92). As stated elsewhere in this report, the low self-reports at baseline in tables 15 and 16 may be due to mothers not being ready at that time to recognise explicitly or to disclosure experiencing domestic abuse by their co-parent, perhaps because of minimisation, fear or shame.

The Abuse Experiences Questionnaire is a measure developed for this study to capture both recent and non-recent experiences of abuse victimisation and perpetration in both mothers and fathers. It includes measures of changes in frequency, severity and impacts of abuse over the course of the programme and assesses a range of physical and non-physical forms of abuse – i.e. physical, sexual, psychological, emotional and financial abuse – including forms of controlling and coercive behaviours.

Table 16 below presents the findings from the Abuse Experiences questionnaire. Detailed baseline data from this measure can be see under heading ‘Baseline findings’.

Table 16: Abuse experiences questionnaire responses

Abuse Experience Questionnaire	Mothers			Fathers		
	Baseline (n=17-23)	One-year follow-up (n=19)	Two-year follow-up (n=12)	Baseline (n=13)	One-year follow-up (n=8)	**Two-year follow-up (n=6)**
Never experienced abuse from current partner	10 (59%)	7 (37%)	4 (33%)	9 (69%)	6 (75%)	**4 (66%)**
Some lifetime abuse from current partner	7 (41%)	11 (58%)	8 (66%)	4 (30%)	2 (25%)	**2 (33%)**
Abuse in last 6 months/1 year	3 (17%)	9 (47%)	5 (42%)	3 (23%)	1 (13%)	**2 (33%)**
Lifetime abuse from someone else	21 (88%)	13 (68%)	6 (50%)	5 (38%)	2 (25%)	**2 (33%)**
Never perpetrated abuse against current partner	13 (62%)	12 (63%)	8 (66%)	5 (38%)	3 (38%)	**3 (50%)**
Some lifetime perpetration with current partner	8 (38%)	6 (31%)	4 (33%)	8 (61%)	5 (63%)	**3 (50%)**
Perpetration in last 6 months/1 year	4 (19%)	4 (21%)	2 (17%)	5 (38%)	5 (63%)	**2 (33%)**
Lifetime perpetration against someone else	**8 (35%)**	**1 (5%)**	**0**	**4 (30%)**	**1 (13%)**	**1 (17%)**

One-year interview

At the one-year follow-up interview, nine mothers (47.3%) reported abusive incidents since the last interview (approximately 1 year ago). These spanned the full range of examples provided by the questionnaire, including physical, emotional and sexual abuse, and coercive control. One woman reported having had injuries that required medical treatment as a result of abuse. Four mothers (21%) reported having been abusive to their partners since the last interview.

One father (12.5%) reported experiencing abuse since the last interview (approximately 1 year ago). This involved feeling frightened and having force used against him. Five fathers (62.5%) reported perpetrating abuse against their partner since the last interview. One man reported having had contact with the police due to incidents with their current partner (data not reported in the Table).

Two-year interview

At the two-year follow-up interview, five mothers (41.6%) reported abusive incidents since the one-year interview (approximately 1 year ago). These spanned the full range of examples provided by the questionnaire, including physical, emotional and sexual abuse, and coercive control. One woman reported having had injuries that required medical treatment as a result of abuse. Two (16.6%) mothers reported having been abusive to their partners since the last interview. One of these mothers had also reported abuse against her partner at one-year.

Two fathers (33%) reported experiencing abusive incidents since the last interview (approximately 1 year ago). This included feeling frightened, being physically hurt, being threatened, and having force used against them. Two fathers (33%) reported incidents of perpetration since the last interview. One man reported having had contact with the police due to incidents with their current partner.

The figures at baseline, one-year post sign-up and two-years post sign-up indicate self-reported presence of bi-directional abuse within the cohort of *For Baby's Sake* families. As described earlier in this report, some of the low reports of abuse may be due to minimisation, to not recognising certain behaviours as abusive, or to reluctance to disclose due to fear or shame.

Mental health

Summary of scores from mental health screening measures at the three time points can be seen in Table 17. We present scores on the Edinburgh Postnatal Depression Scale, Generalised Anxiety Disorder Scale-7, and Posttraumatic Diagnostic Scale.

Table 17: mean and cut-off scores for mental health screening questionnaires

		Mothers			**Fathers**		
		Baseline (n=27)	One-year post sign-up (n=19)	Two-years post sign-up (n=12)	Baseline (n=13)	One-year post sign-up (n=8)	Two-years post sign-up (n=6)
EPDS	Score > 12 (n %)	11 (45%)	7 (37%)	2 (17%)	5 (38%)	3 (38%)	3 (50%)
(depression)	Mean (SD)	10.0 (4.8)	11.0 (5.1)	10.3 (3.7)	9.3 (5.5)	9.8 (7.8)	10.7 (7.9)
GAD-7	Score >11 (n %)	2 (7%)	4 (21%)	1 (8%)	3 (23%)	1 (13%)	3 (50%)
(anxiety)	Mean (SD)	5.1 (4.5)	5.4 (5.2)	5.5 (4.03)	7.0 (7.08)	6.0 (6.8)	9.1 (7.7)
PDS (PTSD)	Meets criteria (n)	5	1	2	4	0	0

Depression

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-administered questionnaire assessing depression during the postpartum period. It has also shown to be valid during pregnancy and in men. Items are rated from 0 – 3 with total scores ranging from 0 -30. A score over 12 is used to indicate possible depression in women. Several different scores have been used for men with some researchers suggesting that lower scores should be used (Matthey and Agostini, 2017, Matthey *et al.*, 2001). In this study we used the same cut-off score for both men and women, recognising that there are limitations to this.

At baseline interviews, five fathers (38%) and 11 mothers (45%) scored in the clinical range (indicating possible depression). At the one-year follow-up interview, scores were similar for fathers and mothers (37% versus 39% in clinical range). At the two-year follow-up interview, fathers' scores had increased somewhat, and mothers' scores had reduced (50% versus 17%).

Anxiety

Generalised Anxiety Disorder Assessment (GAD-7) is a 7-item self-administered questionnaire to assess the presence of current generalised anxiety symptoms. Items are scored on a 4-point scale, with total scores of 0 – 21. Scores over 10 are used to indicate moderate – severe anxiety.

At baseline, three fathers (23%) and two mothers (7%) scored in the clinical range (indicating possible generalised anxiety disorder). At the one-year post sign-up follow-up interview one man (8%) and four mothers (22%) scored in or above the clinical range; at the two-years post sign-up follow-up interview, three fathers (50%) and one mother (8%) scored in or above the clinical range.

Post-traumatic stress

The Posttraumatic Diagnostic Scale (PDS) is a 49-item self-administered questionnaire screening for the presence of PTSD. The PDS assesses DSM-IV criteria for PTSD, with questions relating to the experience of a traumatic event, the frequency of distressing and intrusive thoughts, post-traumatic avoidance and hyper-arousal, and the impact on daily functioning.

A diagnosis of PTSD can be made with an algorithm that requires that the individual's responses meet the following criteria: The traumatic event involves either injury or life threat; the person felt helpless or terrified during the event, endorsement (rating of 1 or higher) of at least one re-experiencing symptom, three avoidance symptoms, and two arousal symptoms; duration of at least one month; and impairment in at least one area of functioning.

A total of four fathers (30%) and five mothers (19%) met criteria for PTSD at the baseline interview. At the one-year post sign-up follow-up interview, three mothers and one father reported a traumatic event since the baseline interview; one mother (5%) met criteria for PTSD from this event. At the two-years post sign-up follow-up interview, three mothers and one father reported a traumatic event since the one-year interview; two mothers met criteria for PTSD from this event.

Summary

The individuals scoring about cut-off on these three questionnaires were different across time points and the small sample size means it is not possible to investigate change across time in meaningful way. However, these scores indicate that *For Baby's Sake* continues to engage families who have multiple mental health needs.

Substance use

At the baseline interview, participants were asked whether they currently use alcohol or recreational drugs as part of the initial health questions. This served as a screen to determine whether they should complete the further questionnaires on alcohol and drug use. At the two follow-up interviews, women followed the same procedure of being screened, while all men were asked to complete the full questionnaires.

The Alcohol Use Disorders Identification Test (AUDIT) is a questionnaire designed to identify hazardous and harmful patterns of alcohol consumption. It is composed of 10 items covering 3 domains; 1) Hazardous alcohol use, 2) Dependence Symptoms, 3) Harmful Alcohol use. Each question is scored 0-4, with a total score of 8 or more indicate harmful/dependent drinking.

At baseline six out of 25 mothers and six out of 13 fathers reported currently drinking alcohol and therefore completed the full AUDIT questionnaire. The mean score on the AUDIT scale for mothers was 1.8 (SD 4.9) and for fathers was 3.7 (SD 6.6). One mother (4%) and two fathers (15%) scored over 8 on the AUDIT scale, indicating harmful/dependent drinking.

At the one-year follow-up interview, five mothers reported current alcohol use and completed the AUDIT; the mean score was 5 (SD 2.74). No mothers indicated harmful/dependent drinking patterns. All eight fathers completed the AUDIT. The mean score was 6.25 (SD 8.23). Two fathers (25%) indicated harmful/dependent drinking patterns.

At the two-years post sign-up follow-up interview, two mothers completed the AUDIT; the mean score was 3 (SD 2.82). No mothers indicated harmful/dependent drinking patterns. All six fathers completed the AUDIT; the mean score was 6.0 (SD 6.89). Two fathers (33%) indicated harmful/dependent drinking patterns.

Drug Use Disorder Identification Test (DUDIT) is a questionnaire designed to identify substance misuse problems. It is composed of 11 items and with scores ranging between 0-44. Scores of 25 or more indicate heavy, dependent drug use.

At baseline, no mothers and two fathers reported currently using recreational drugs. However, one mother had used drugs in the past year and another mother reported having previously used drugs, so these two women completed the full DUDIT questionnaire. No mothers or fathers scored over 25 on the DUDIT questionnaire, which suggests that none of them had problematic relationships with substances at baseline.

At one-year three mothers completed the DUDIT; all had scores of 0 indicating no use of substances. All eight fathers completed the DUDIT; the mean score was 4.25 (SD 7.4). No fathers scored as having problematic relationships with substances.

At two years no mothers completed the DUDIT as they reported no substance use. All six fathers completed the DUDIT; the mean score was 3.33 (SD 5.75). No fathers scored as having problematic relationships with substances.
Overall, within this sample, one woman indicated harmful alcohol use at baseline, and no women indicated harmful use at the follow up time points. Two men indicated harmful alcohol use at all time points; this represents three men in total, with one man scoring high across the study period. None of the participants' scores indicated problematic substance use at any time point.

Social support

The Social Provision Scale is a 24-item questionnaire which examines the degree to which respondent's social relationships provide social support, across six domains. Four items look at each of the six domains: Attachment, social integration, reassurance of worth, reliable, alliance, guidance and opportunity for nurturance. Answers are provided on a 4-point scale; (1) "Strongly Disagree" to (4) "Strongly Agree" with a maximum score of 96 and higher scores indicating a greater degree of perceived support. Table 18 shows mean scores at each time point.

Table 18: perceived social support among mothers and fathers

		Mothers			**Fathers**		
		Baseline (n=27)	One-year post sign-up (n=19)	Two-years post sign-up (n=12)	Baseline (n=13)	One-year post sign-up (n=8)	Two-years post sign-up (n=6)
Social provisions scale	Mean	78.6	65.28	81.75	77.17	64.14	76.50
	(SD)	(9.41)	(7.28)	(8.17)	(10.87)	(10.02)	(10.61)

Men's and women's reports of perceived social support are very similar at each time point. Looking at reports of social support over time, both mothers and fathers reported lower levels at the one-year follow-up interview, in comparison to the baseline interview. By the two-year follow-up interview, perceived levels of social support are similar to baseline levels. There are no norms for this scale; instead changes in perception of social support can be compared over time as a potential moderator of other outcomes.

Relationship status

Participants were asked about their relationship status at each time point. Table 19 shows the number of mothers and fathers who were in a relationship with their co-parent, versus separated, single, or with a new partner.

Table 19: Relationship status of mothers and fathers

	Mothers			**Fathers**		
	Baseline (n=26)	One-year post sign-up (n=19)	Two-years post sign-up (n=12)	Baseline (n=13)	One-year post sign-up (n=8)	Two-years post sign-up (n=6)
In a relationship with their co-parent	18 (69%)	8 (42%)	4 (33%)	13 (100%)	7 (87.5%)	2 (33%)
Single	5 (19%)	10 (53%)	6 (50%)		1 (12.5%)	3 (50%)
Separated	3 (11%)	1 (5%)				1 (16%)
New partner			2 (16%)			

Over two thirds of women and all of the men were in a relationship with their co-parent at baseline interviews. This reduced across time, with only a third of both men and women remaining in this relationship at the two-year follow-up.

Comparison of the participants in the evaluation against all families engaged with *For Baby's Sake* during the evaluation period

Key demographics

Forty individuals were recruited to take part in the evaluation. In order to establish if these individuals were representative of the wider cohort of families who engaged with *For Baby's Sake,* the key characteristics of the evaluation sample were compared with the wider sample the families.

Key characteristics of those who took part in the evaluation in the Hertfordshire site were as follows:

- For mothers (n=20), mean age 27.1, 85% white British, 16% GCSE or no formal qualifications
- For fathers (n=11), mean age 28.27, 100% white British, 54% GCSE or no formal qualifications

These characteristics were similar to those of the families who were referred to *For Baby's Sake* in Hertfordshire, although the mothers in the evaluation sample had higher educational achievement:

- For mothers, mean age 25.7, 75% white British, 36% GCSE or no formal qualifications
- For fathers, mean age 28.25, 69% white British, 42% GCSE or no formal qualifications

In the London Three Boroughs site, the characteristics of the families who took part in the evaluation were as follows:

- For mothers (n=7), mean age 31, 43% white British, 14% GCSE or no formal qualifications
- For fathers (n=2), mean age 35.5, 0% white British, 0% GCSE or no formal qualifications

It is more difficult to compare these families to the wider sample of those being referred to *For Baby's Sake* in the London Three Boroughs, due to less data being available. However, there are similarities in age and in the proportion of white British individuals in both groups:

- For mothers, mean age 31.45, 10.2% white British, not enough data to report educational attainment
- For fathers, mean age 31.36, 6% white British, not enough data to report educational attainment

The evaluation recruited substantially more participants from Hertfordshire than the London Three Boroughs and this is likely why the demographics of people in our evaluation more closely match the Hertfordshire population overall. It is important to bear in mind these differences when interpreting results, as some outcomes may not be representative of the London Three Boroughs population.

Summary of key findings

Analyses of quantitative outcomes among families engaged with *For Baby's Sake* and recruited to the evaluation indicate:

- A sample of families who engaged with *For Baby's Sake* were willing to sign up to and engage with the evaluation across time. Recruitment was slower than anticipated due to some initial delays and it was not possible to recruit families who dropped out of the programme. Nevertheless, the evaluation demonstrated that it is feasible to obtain questionnaire and observational measurements from families across time, covering a range of domains
- The characteristics of those recruited to the evaluation were similar to the wider sample of service users in Hertfordshire, but less similar to those in London Three Boroughs. This is reflective of the fact that more families signed up to the evaluation from the Hertfordshire site
- The baseline characteristics of individuals recruited to the evaluation highlight the complex needs of the families who are attracted to the programme. A substantial proportion of men and women had symptoms of depression, anxiety and PTSD, while over 70% of the sample scored above cut-offs for disordered personality traits.

Similarly, around 80% of the sample reported ACEs, with over half having experienced DVA as children

- The evaluation found that around 40% of fathers did not identify with using DVA behaviours at the baseline assessments, and around 60% of mothers did not identify as experiencing DVA at these assessments, suggesting that families may not be at the stage of acknowledging abuse at the time that they sign-up. This could be because of minimisation, not recognising certain behaviours as abusive or reluctance to disclosure because of fear or shame. However, those who remained in the evaluation were more likely to acknowledge abuse at later time points

- We had a good retention rate for the one-year post sign-up interviews, retaining around 70% of mothers and fathers. At the two-year post sign-up interviews, we retained slightly under half of mothers and fathers. It proved more difficult to retain fathers in the programme over time. These rates mirror, to some extent, recruitment and retention in the programme itself, and are reflective of the challenges in engaging whole families with complex needs across time

- Co-parents often separated during their participation in the programme. While over two thirds of women and all of the men in the evaluation were in a relationship with their co-parent at baseline interviews, this reduced over time, with only a third of both men and women remaining in this relationship at the two-year follow-up interviews

- Child development outcomes at one- and two-years post sign-up were largely in the normal range, while parent-child interaction data was more mixed, with some families continuing to score in the high-risk range at two years. However, 67% of families who remained in the evaluation did not have children's social care involvement at the two-year time point

The small size of the sample and the attrition across the three time points means it is not possible to explore statistical changes across time or associations between the quantitative variables. Therefore, any apparent changes should be interpreted with caution. However, an important outcome of this evaluation relates to the willingness of families to undertake detailed and complex assessment and outcome measures, particularly regarding child development and parent-infant interaction. These findings indicate that it is feasible and acceptable to collect these outcomes from families.

Qualitative Interviews with Families engaged with *For Baby's Sake*

This data is taken from interviews conducted with families at one year and two years after signing up with *For Baby's Sake*. At the one-year interviews, 19 mothers and eight fathers across the two sites were interviewed (i.e. 68% of the original evaluation sample population). At the two-year interviews, 12 mothers and six fathers across the two sites were interviewed (i.e. 45% of the original evaluation sample population). At the two-year interviews, some families were no longer with the programme, either because they had completed the programme or because they had dropped out; several others were in the final stages of the programme.

A topic guide, developed specifically for this research evaluation, was created to explore families' experiences, perceptions and expectations of the programme. Key topics that were explored with mothers and fathers included:

- Mothers' and fathers' experiences and expectations of the programme
- Mothers' and fathers' views on whether the programme helped to improve their situation
- Mothers' and fathers' views about potential improvements for the programme
- Mothers' and fathers' experience of ending the programme

The findings presented here are broken down into sections which illustrate the main themes arising from the interviews. These sections are titled: (1) Experience of the programme; (2) Expectations and key reflections; (3) Mechanisms of change; (4) Participants' perceptions of the programme impact; (5) Ending the programme. Within each theme, sub-themes are highlighted to demonstrate the multitude of factors discussed by parents. The results are also presented in a way which seeks to highlight where the responses of mothers and fathers vary.

Experience of the programme

Mothers and fathers participating in *For Baby's Sake* were asked to describe their experiences of the programme. In general, the responses were encouragingly positive with mothers and fathers exploring the successes that they had achieved, including gaining confidence and challenging abusive behaviours. These learnings were perceived as particularly poignant among some women from minority ethnic backgrounds, who described how certain behaviours may not be considered DVA and that cultural expectations of women meant they should not speak out:

'*It [For Baby's Sake] has improved my situation, it has improved my confidence, which was an important part of it and setting healthy boundaries, my ability to set healthy boundaries. It's been amazing*' *(female respondent)*

'I'm in a different frame of mind to be like, "this is unacceptable." Beforehand, I was like "oh well, if you think that that's right, okay." Now, I'm like, "no, I've had an enormous amount of training and I know what's right for these children; I know how to be reasonable. I know how

to do this that and the other, and unless you fall into line it’s not happening’ (female respondent)

‘*I feel that I am a lot less angry, I feel I am able to communicate my emotions a lot better. Rather than hiding behind anger…Any emotion that I don't like, anger is normally the one that I default to. Doing this work has made me go, "Okay, if I'm getting angry then, actually, what's going on internally for me?" Then, I can actually communicate what's going on internally a lot better’ (male respondent)*

Mothers and fathers focused on how they perceived the programme had an impact on them. Indeed, one mother described it as a “*wake-up call*” to how she previously reacted to abusive behaviours. Whilst, one father described how he’ll “*still be establishing a link between [his] behaviour in the future*”. The benefits also extended to the co-parenting relationship:

‘Always the communication part, me and him struggled. Now we sit down and talk about stuff a lot more than what we did. We used to brush it under the carpet. Then it will come out the wrong way when something triggered it, like something I’ve said, or he’s said, and it would go off’ (female respondent)

Additionally, many described how the programme had positive impacts on the whole family and on their children:

‘We were so, so lucky to be part of it…because our life, I think, would be completely different, in a negative way. I don’t think the girls would be as happy as they are, I don’t think we would be as happy as we are’ (female respondent)

‘The problem with the relationship was the fact of me putting these children as a priority and that’s what they [For Baby’s Sake practitioners] continuously reinforce. The children are the priority’ (female respondent)

Some mothers described that their male co-parent had little to no engagement with the programme as it progressed. This experience left them feeling frustrated about the co-parent’s actions and, for some, made them question the value of continuing with the programme:

‘It’s him that’s hurt, it's him that needs the inner child work, and he's just totally come off the programme’ (female respondent)
‘I wasn't the reason for having to do the programme, and he wasn't doing the programme, so why should I have to do it?’ (female respondent)

Reflecting on why their co-parents disengaged with the programme, one mother believed it was due to the intensity of the programme which was delivered over a long time-period. The other, felt that their male co-parent may have disengaged due to a fear of judgement:

‘From what my husband felt very much at the beginning, I imagine this would stop a lot of men and women, not just men…that fear of being blamed, the fear of it being all your fault. The fear of being pointed a finger at, saying, “You’re this,” and, “You're that,” and, “this happened because of you’ (female respondent)

Expectations and key reflections

Participants were asked to reflect on what they expected from the programme and whether these expectations were met. Many mothers and fathers recalled how the programme exceeded their expectations:

'It's exceeded. I didn't think it would do anything. I thought I was alright in everything that I did. And, obviously, I came to For Baby's Sake, and wow, little did I know' (male respondent)

Interestingly, many discussed how whilst the programme did not match their initial expectations, it exceeded in other ways. This mainly arose from individuals who expected to stay in their relationship but found personal growth instead:

One father expected *'to have a happy, loving relationship. Instead [I've] learnt how to self-regulate better and have more self-restraint and communicate more effectively' (male respondent)*

'When I signed up, I just wanted to save my relationship. Somewhere in the middle of the course I was completely open with my partner and I was actually able to stand up and say I don't need a man' (female respondent)

For Baby's Sake is an innovative programme dealing with a series of complex issues including DVA within parents' relationships, childhood experiences of abuse, as well as healthy parenting practices. Therefore, unsurprisingly some parents had difficult experiences of the programme. When one father was asked whether his expectations were met, he responded: "*no, not all of them, no",* as he did not *"know whether it [For Baby's Sake] did help or not" (male respondent).* In this case incidents of DVA persisted throughout the two years. This example demonstrates how there is only so much an individual can gain from being on the programme, and that not all participants are able to stop using abusive behaviours.

Mechanisms of Change

Throughout the interview mothers and fathers were asked to focus on specific aspects of the programme which they found beneficial. The following section explores the various features which arose, including the therapeutic model, the therapeutic relationship and comparisons to other professional services.

The therapeutic model

Whole-family approach

Parents talked about the value of the whole-family therapeutic approach, which provides support for an individual's needs, the needs within the intimate/co-parenting relationship and the needs of children in relation to DVA, as illustrated below:

'The fact that it integrates everything here from children, work life and personal life. It's not just about being in a relationship, it's about co-parenting. Even if you're not together it's about being able to co-parent your child, which is massive' (male respondent)

Therapeutic tools and strategies

The therapeutic model of the programme includes providing parents with tools and strategies to manage and improve their situation/feelings. These tools include learning about visualisation and mindfulness, as well as practising time-outs and counting where you are on an anger scale. Many fathers reflected on how the tools helped to instil healthy coping mechanisms, thus reducing the likelihood of getting caught up in negative situations. In addition, several fathers spoke of how a key component of the programme was the ability of the therapeutic model to allow them space to acknowledge their own emotions and to work on developing methods in which to cope with these emotions:

'It's given me so many tools to apply to different situations. I've done so much personal work…got out of some really bad habits and ways of thinking, and breaking the negative self-talk stuff' (male respondent)

'I think some of the visual things are really useful, about visualising a pressure pot that you're constantly either filling up or taking the top off and letting it breathe, and empty, and the way in which you do that. It's either shaking up a bottle and the cork flies out and is a bit eruptive and negative, or you can be more mindful about it. Those sorts of things are quite useful' (male respondent)

'Yes, there was a session that I did with [male practitioner] that was about steps towards anger, sort of thing, and where you balance yourself out before getting really angry...It helped me see where I stand where I feel a bit angry, and that I don't go all the way to the top and to the extreme of being angry. I, sort of, stay down on the step that I want to stay on' (male respondent)

Strategies and tools for fathers around their use of DVA were also discussed. Some fathers spoke about how these strategies had helped them stop using abusive behaviours. Others reflected on the challenges in overcoming these learnt behaviours:

'When they [practitioners] say, "Before you hit, stop and think." If you're at the point where you're going to hit somebody you're already past that point. It's too late to stop and think because you've lost control if you're at that point' (male respondent)

Mothers and fathers also emphasised the value of having access to the worksheets created within sessions. This allowed them to return to specific components during times of need, therefore, allowing them to continuously practice the skills they learnt:

'Having them there to hand, being able to reflect on things and going back through them has been really helpful' (female respondent)

Inner Child module

Throughout the interviews, multiple parents specifically identified the Inner Child module as particularly beneficial. Despite initial cautions, mothers and fathers learnt to distinguish between different aspects of themselves (e.g. a parent, an adult and a child) and acknowledged that feeling happy requires listening to and taking care of these three components:

‘Whether I’m speaking to my inner child or from my critical parent or from my adult self… I found that useful, just to differentiate, kind of, where I’m at’ (female respondent)

Many of the mothers and fathers in this programme had experienced various forms of abuse and traumas throughout their childhood. By understanding this parent-adult-child interaction, individuals became aware that the way people treat you can affect how you treat yourself, and in turn influence your parenting style. Consequently, parents detailed how they were motivated to change their parenting style in order to prevent their children having the same upbringing as they did:

‘The Inner Child…had the most effect on me, personally, in terms of being reflective and thinking about what I need to change and what I need to do’ (female respondent)

‘I didn’t realise that the way I [was] brought up has an effect on the way I will bring my child up, which really shocked me. So, I’ve made a lot of changes on my parenting efforts, because I don’t agree with the way I was brought up’ (female respondent)

Interestingly, by reflecting on their childhood experiences, the Inner Child module could allow fathers to become free of their inner burdens – to “*put upstairs to sleep*” – including in relation to the messages they had been given as a child and their anger towards their parents:

‘For me, the Inner Child module was useful, understanding how I have taken on certain things that my parents had sort of put onto me. And actually, being able to separate myself from their opinions or judgements’ (male respondent)

‘Originally, I thought I’d hate him [father] and, at the end of it, I didn’t really hate him so much, as weird as that sounds’ (male respondent)

Psychoeducation about the impact of DVA on children and parenting support

Many families also spoke of the value in receiving psychoeducation around how DVA impacts children and in receiving general parenting support. Parents reflected on some of the key learning they have gained from the programme. This included teachings on how the brain develops in a child and how this is altered if they are victim or witness to abuse, as well as understanding how attachments form:

‘To understand my attachment with my girls, and [their partner’s] attachment, and what good attachment is and what not so good attachment is’ (female respondent)

Additionally, mothers and fathers commented on how learning to understand different crying signals was particularly beneficial:

One mother described how she *‘never used to like it when she [baby] cried… it made me feel bad as a parent’* now she recognises that crying is a form of communication *(female respondent)*

Parents focused on a few perceived key outcomes, these included being more confident in their parenting skills. Additionally, many parents felt there were improved communications in their family, and this also allowed their children to identify and discuss their emotions in an open manner:

‘It’s improved my parenting skills, in a way of just how to relate to them, how to speak to them, how to teach them to express themselves’ (female respondent)

‘I’ve noticed that [daughter 1] can identify her emotions more, and even [daughter 2], at a very young age. If we read a book, she’ll notice when someone’s sad… So, it’s helped us to be more honest and open about our emotions with the kids’ (female respondent)

Practical parenting work was also perceived as valuable for first-time parents, as illustrated below:

‘Some of the stuff, like showing me how to use all the stuff and how to change a baby’s nappy. Like the simple stuff like that, they’ve helped me. At first, I just felt like the baby is too small, I don’t want to hurt her or anything, you know what I mean? …Now I don’t worry about picking her up at all’ (male respondent)

Video Interaction Guidance (VIG)

Video Interaction Guidance forms part of *For Baby’s Sake*; it focuses on attachment and sensitive, attuned parenting. All mothers and fathers who undertook the Video Interaction Guidance intervention within the programme perceived it to be helpful. Parents perceived that this work allowed them to see the bonds that they had developed with their child and provided them with reassurance about their parenting abilities:

‘I couldn’t believe how much she [baby] loves me and how much she looks at me. The way she smiled at me, the way I smiled at her, because you don’t see yourself with your child’ (female respondent)

‘I was a bit anxious about it at first, I didn’t really want to be recorded and stuff, but after seeing it and going back…to watch...it helps you see what kind of bond you’ve got with your child and stuff like that.’ (male respondent)

The therapeutic relationship

A key theme which arose throughout the interviews regarded mothers’ and fathers’ opinion of their practitioners. Descriptions of the practitioners included “*invaluable*”, “*amazing*”, “*special*”. When one father was asked what they thought had made the biggest difference, he responded *“[practitioner] outright, [practitioner], definitely*”. Many mothers and fathers developed a close therapeutic relationship and formed a strong bond with their practitioners:

‘She was quite flexible with me in terms of what we did… there was a lot of talking through some things, which was really helpful for me at the start…I think she judged that really well, because it helped to build my relationship with her, it introduced me to the programme…it felt very natural… [didn’t] feel like I had to fit in with a module that they’d come up with’ (female respondent)

‘There were times where I was falling apart, and just to be able to pick up the phone and speak to [practitioner] was really, really helpful’ (male respondent)

‘I think the practitioners were just amazing. I felt really heard, I felt really seen, I felt really supported, I felt like I had a safety net’ (female respondent)

'I trust him [practitioner] so it's good to work with someone who you trust, that's quite key. I suppose the other positive is the fact that he is quite challenging, and he will call me out on certain things' (male respondent)

Analysis of the attributes of families indicated that those who struggled with mental health difficulties placed greater emphasis on the value of building a relationship with their practitioner than those without mental health difficulties.

Experience of the programme and experience with social services

Families in this programme have histories of violence in their relationship and/or childhood and they have or will soon have young children in the picture. Most of them, therefore, had past and/or present experiences with social services. In many cases, parents voiced fear and/or anger towards social services' involvement and explicitly stated how they valued *For Baby's Sake* for being different from social services. This is depicted in one mother's description of the two services:

'With social [social care services], it felt like they were very attacking… it [For Baby's Sake] was just very welcoming and inviting with me, not making me feel nervous or anything' (female respondent)

One mother was referred to *For Baby's Sake* by social services. She reflected that social services made it seem that her engagement with *For Baby's Sake* was compulsory. This left her feeling resentment and anger, as though she was being punished for the behaviour of her partner. These feelings extended into her feelings about *For Baby's Sake*:

'He'd [the male co-parent] had an incident which obviously made the social come. They said, if we work with these [For Baby's Sake] they would go. I didn't ask him to do this incident, I didn't know this was going to be my life. It happened, and I did the right thing. It was like, me getting rid of him and doing the kids on my own, I was being punished still' (female respondent)

Participants' Perceptions of the Programme Impact

Awareness and recognition of abuse

Many of the mothers reflected on how they "*wouldn't have known [they] were being the victim of it [DVA], if it hadn't been for the programme*". Specifically, one mother credited the 'Power and Control Wheel' as a key resource used in the programme which helped her identify the abuse. The 'Power and Control Wheel', developed by the Duluth Model, explains various types of abuse, some of which are less easily identifiable (i.e. coercion and threats, male privilege, economic abuse, using children, minimisation and denial, isolation, emotional abuse, intimidation).

Many mothers commented that the programme taught them about different types of abuse; as well as how they can detect "*red flags*" in relationships. This resulted in some of them identifying abusive behaviours in their friends' partners. They also described, through their learnings in the programme, having the tools to look out for signs of abusive tendencies within new relationships.

A few fathers also expressed some recognition of abuse. One described how he used to ignore it when he saw a parent being verbally abusive to a child but now, he felt uncomfortable being around it. Another noted that he now recognised that his actions have consequences and by changing himself everything else changes accordingly. Some fathers also commented that the programme helped them recognise which behaviours are abusive:

'Doing this programme made me realise I was very controlling without realising. To me it was normal' (male respondent)

Building self-esteem

A key difference which emerged when comparing the perceived impacts of the programme between mothers and fathers, was mothers' tendency to discuss how their feelings of self-esteem had improved. Many of them described how the abusive relationship led them to develop low-self-esteem. When it came to the self-esteem module of the programme, they, therefore, either found it the most challenging part or had difficulty understanding what the word self-esteem meant. Many mothers commented on how beneficial the programme was for building their self-esteem:

'I was in an abusive relationship because my self-esteem was low. I thought I didn't deserve any better. Going through the worksheets and being able to speak with my practitioner has taught me a lot about myself, how to build my self-esteem up and how to teach myself how to build myself up, as well' (female respondent)

Parenting aspects

Mothers and fathers described how *For Baby's Sake* had facilitated step-changes in their parental style. This included identifying their motivation for change and their mechanisms of change, including awareness building and learnings around parenting practices. Many of the mothers and fathers focused on how their motivations for change stemmed from their desire to provide a better life for their children:

'No matter what happens to us, we're always very mindful of the children, and what impact we're having on them' (female respondent)

'I'm putting my kids first, instead of myself. I don't know, just trying to be a better me' (male respondent)

Parents discussed how the programme helped them reflect on their childhood, through the Inner Child work, and how this influenced their parenting style. Consequently, they felt they now understood what a healthy family relationship should look like and were making efforts to alter their parenting style accordingly:

'So, with my family, it's literally like the Addams family. So, for me, that was normal, because I didn't know anything else, but now that I've seen how a family relationship should be, it's completely different' (female respondent)

'I've never really been a loving dad, maybe because of my past. My dad wasn't loving; he was very strict and very controlling… Doing this programme made me realise I was very controlling without realising. To me, it was normal' (male respondent)

Relationship aspects

Of the 18 mothers and fathers who completed the two-year follow-up interviews, six individuals reported that they were in an intimate relationship with their co-parent. Among these six individuals, mothers and fathers talked about re-building a healthy relationship. Several mothers described how they were now able to explore healthy ways of processing and managing emotions, thus allowing them to be more assertive within the relationship. Some fathers discussed how the programme helped them to become aware of others:

'I'm a lot different person from the person I used to be. I used to think about number one and I don't anymore, I think about little number one first, and then obviously everyone else at the same time' (male respondent)

Additionally, mothers and fathers described the importance of developing strategies and tools that they can use to help prevent situations from escalating in to abuse:

'Tools allows you to not get swept up when things get really tricky, or to catch yourself when things get really tricky emotionally; also in circumstances like, for instance, having a time out plan together with your partner, which is really useful… if we have certain things in place that we agree on, then it very much calms the situation down much quicker' (female respondent)

'Having the, I guess, areas and topics that we would explore and go deeper and deeper into, that was also really really helpful. I picked up lots of tools that helped me regulate myself in the relationship'. (male respondent)

Mothers and fathers also described how the communication between themselves and the partner had improved:

'We're laughing more together… talking more together… liked each other more… [and] weren't arguing anymore' (female respondent)

When fathers discussed how communication had improved with their partner, they tended to focus on how they noticed themselves getting wound up and then took some time to think about what they were about to say against what their partner required of them in that situation:

'It feels good to be able to do that, and kind of take a step back, and think, 'What does this person need in this situation?'…it's being able, I suppose, to have a bit more objectivity… and then to think, 'what role am I playing in improving this…or am I making it worse? What do I want to do?' and then thinking of how to articulate that' (male respondent)

The twelve mothers and fathers who were no longer in an intimate relationship with their co-parent at the two-year interviews expressed both positive and negative opinions regarding the perceived impact of the programme on their relationship. Whilst the relationship may not have worked out, many were grateful to the programme for helping them become aware that they were in an abusive relationship:

'If it wasn't for this course, I'd probably still be in that situation, trying to please him and not being happy with myself. Still being in a dangerous situation, so I'm very grateful for that' (female respondent)

Among mothers who were now in new relationships, they described how they were now able to acknowledge and discuss what they want in a relationship, to be assertive without being aggressive, as well as knowing how to "*how to treat a person, and how to show them love*".

Some fathers felt that the programme did not provide adequate support in relation to building a stronger relationship with their co-parent. It was suggested that there should be more focus on the relationship because no element of the programme specifically addressed "*here's how you have a good relationship*".

Finally, a few mothers did not identify any DVA in the co-parenting relationship at the end of the programme:

'Because there's been no abuse or anything' (female respondent)

Ending the programme

An important feature of the two-year interviews involved gathering an understanding of how mothers and fathers felt once the programme came to an end, and what changes they would suggest based on their personal experiences. Mothers' and fathers' comments on their feelings about the ending of the programme were shaped by the timing of the interview (i.e. whether they were still on the programme and coming towards the end or whether they had already left the programme). Mothers and fathers who were still on the programme voiced concerns when thinking about the end:

'I don't want to go. I don't know what I'll do. I think it should go on longer. I think they should stay until the child is like five' (female respondent)

'That's my worry when I go. If we have a breakdown, I can wait two weeks for the social worker, which might be two weeks too late' (male respondent)

Some families who had already left the programme described how initially they were concerned about ending the programme, but the practitioners made the transition easy, by gradually reducing support or providing them with the confidence to continue to implement the changes they had learned independently:

'As we were coming to the end of the programme, I was really like, 'I'm really scared. I'm going to leave this and I'm not going to have any other supporting structures,' so we did slowly phase it… we talked about next steps … I felt very supported and held throughout it' (male respondent)

There were, however, some who had finished the programme and were upset regarding the ending. This mainly occurred when individuals did not complete the full two-year programme; they described feeling that the support was removed from them before they were ready. This was specifically the case for mothers whose partner did not commit to the programme and, therefore, the support was removed early. Whilst it is evident that early removal of support can be distressing, even the mothers who received the full two-year support wished they could extend the support they had received:

'I think the fact that they say a two-year programme is a bit stupid, because not everyone can do everything in two years. I think it should be like a guideline, that if people still need extra support, why are you leaving them?' (female respondent)

One mother described how when ending *For Baby's Sake* she lost her support worker at the same time and she found the sudden lack of support overwhelming:

'I was very upset that it was ending, I wasn't quite ready. Because at the same time I was losing my… support worker. I was losing a lot of professional support at the same time and it was quite overwhelming' (female respondent)

Potential improvements for the programme

Both mothers and fathers discussed their views on how the programme could be improved. These thoughts included some mothers' views that the programme could have a greater focus on the child, and some fathers' views that the programme could have a greater focus on the relationship. Indeed, some mothers reflected on how they wished the programme had focused more on the child:

'I think the programme needs to be more baby-focused. I do agree that you do need to do work on the parents and stuff, but it seems to be more parent-focused than baby-focused. Maybe back off on the parents a little bit and put more on the baby, because they're the most important ones' (female respondent)

Some fathers discussed how they wished the programme was more tailored to building the relationship; reflecting that during the programme they had drifted apart from their co-parent. One reasoning for this outcome, they believed, was because they had different relationships with their practitioners. Another was that the programme put a strain on the relationship. When suggesting how to improve the programme, some fathers reflected on how simply improving themselves would not necessarily have an impact the relationship and how they wanted joint counselling sessions to address how to have better communication within their intimate relationships.

Another key theme raised by a few respondents was a concern about the use of language in the programme, in relation to ‘perpetrators’ and ‘victims’ of DVA:

‘I don't ever feel that having a ‘victim’ or ‘perpetrator’ is a healthy thing to label people as’ (male respondent)

The main voice of concern about this point came from fathers. Some described how they struggled with the language which was perceived to frame them as being the bad guy who needed to change, and the mother as being the person who needed to be supported and protected. Among mothers, discussions around this issue focused solely on explaining their understanding of their co-parents’ opinion about the language used in the programme. Indeed, few described their own concerns about the language used in the programme.

A few mothers reflected on how it would be nice for just one parent to continue with the programme and for single mums to receive support. This point was particularly important for some mothers because they had experienced their male co-parents disengage from the programme and, as a result, they were stepped down from the programme.

Linked to this, one mother commented that the ‘whole-family’ element of *For Baby’s Sake* may be misinterpreted, with women reluctant to separate from their partner due to feeling like they are “*doing it with their partner*”. They therefore proposed that the programme could be extended to include families that do not co-parent. Some mothers queried the target audience of the programme, and suggested that *For Baby’s Sake* might be better suited to first-time younger mothers:

‘If you were just a young mum, a typical young mum, then yes it would be very helpful. I've got quite a lot of education behind me, and I'm not the typical young parent. So, to me, it was like "I know”. They were wasting their time with me when there are other people that genuinely need their help, I was quite happy to be like “bye”’

In contrast, several mothers and fathers felt that *For Baby’s Sake* should be disseminated to all parents irrespective of their experiences of DVA.

Summary of key findings

Key learnings reported by mothers and fathers regarding their experiences and perceptions about the impact of the programme are:

- Overall, mothers and fathers discussed how valuable they found the programme and how they were lucky to be a part of it. They described building skills around boundary setting, healthy communication in intimate and familial relationships, self-regulation and anger management

- Mothers and fathers identified key components in the programme which they perceived to act as mechanisms for positive change. Specific concepts of the therapeutic model such as the whole-family approach - which focuses on individual members of the family as well as the family unit as a whole - the Inner Child module, the Video Interaction Guidance and the model’s tools and exercises were described as

key in facilitating changes. Individuals were able to adopt the tools they had learnt in the sessions and apply them successfully in the home to help improve communication and to de-escalate challenging situations.

- Some parents identified that Learnings from the Inner Child work enabled them to reflect on and acknowledge how past traumatic experiences affected how they viewed themselves and consequently how this influenced their parental style. Some mothers and fathers perceived that this work taught them to distinguish between different aspects of themselves (e.g. a parent, an adult and a child) and the need to take care of these three components. By reflecting on their childhood experiences, it could be postulated that the Inner Child module allowed some fathers to become free of their inner burdens, including in relation to the messages they had been given as a child and their anger towards their parents, however further evidence is needed

- The Video Interaction Guidance work also allowed some parents to identify the bonds they had developed with their child and provided them with reassurance about their parenting abilities

- The importance of receiving support from practitioners was emphasised, with mothers and fathers highlighting how they would not have engaged with the programme if it was not for the bond they formed with their practitioner. Finally, mothers and fathers appeared to value *For Baby's Sake* because it did not elicit fear or anger of which is often associated with other professional services

- Mothers and fathers also reflected on differences in relation to their experience of *For Baby's Sake* and their experience of social services. Most parents reported past and/or present experiences with social services which were largely not positive, and they contrasted this with the positive experiences of *For Baby's Sake*

- Some mothers and fathers were able to identify abusive behaviours which previously they had not considered to be examples of DVA. Many of the mothers highlighted how they previously had low self-esteem and how the programme helped them to re-build this. When considering parents' perceptions of how the programme had impacted on their parental style, mothers and fathers identified a step-like change. This involved identifying what their motivations for change were - typically the child - as well as the mechanisms for change, including their awareness of their childhood traumas and the impact this has on parenting behaviours, psychoeducation around managing and communicating feelings and emotions, and receiving guidance and feedback on their parenting.

- Some mothers and fathers also described how they perceived the programme had an impact on the co-parenting relationship. Views tended to differ depending on whether the couples had stayed together or not. Those who stayed together praised the programme for helping them to implement strategies and tools to de-escalate difficult situations, as well as improving their ability to communicate with their co-parent. For those whose relationship ended, some showed gratitude towards the programme for helping them to have a safe break-up, as well as achieving personal growth for instance recognising anger. Some individuals, however, blamed the programme for

the relationship coming to an end.

- Mothers and fathers had mixed experiences of the end of the programme. Many highlighted that they wished the support would continue. Those who had already left the programme were likely to feel that the gradual step-down of support was successful. For some mothers the end of the programme meant the end of overall support from all services for the family. It may be important for the programme to consider what support the individual is currently receiving and how long this will continue for when they are thinking about ending the programme

- Fathers on the programme voiced concerns regarding the language of the programme in relation to describing DVA. Some found the use of the terms 'perpetrator' and 'victim' blaming

- Mothers' and fathers' descriptions about future perceived improvements to the programme included more focus on the relationship or a greater focus on the child. A few mothers suggested that the full two-year programme should be available to parents whose co-parent disengages, and one mother suggested that the programme should be available to single mothers

Economic Analyses

Data availability

Availability of data necessary for the economic analyses (*For Baby's Sake* programme data, AD-SUS, CAS and EQ-5D-5L) is summarised in Table 20. Data on the number and duration of each *For Baby's Sake* session were available for all contacts participants had with the programme, with some assumptions made about the duration of sessions (described below). Data availability on the AD-SUS, CAS and EQ-5D-5L at baseline (when participants have their first interview to collect research data), was above 90% for all mothers and fathers. This dropped to around 60-70% at the one-year post baseline follow-up interview and around 45% at the two-year post baseline follow-up interview.

To be included in the cost-offset analysis, each family needed to have complete *For Baby's Sake* data and a completed AD-SUS and CAS at both follow-up points. This was complete for 12/27 mothers and 6/13 fathers and, when combined, represented full data for only 4 families. To be included in the short-term (2-year) cost-effectiveness analysis, each family needed to have the data required for the cost-offset analysis, plus a completed EQ-5D-5L for the mother at all three time points. This was complete for 11/27 mothers and 5/13 fathers and, when combined, represented full data for only 3 families. As a result of these very small samples, particularly for fathers, it was not possible to undertake analyses by family and thus all analyses focused on the data collected from the mother (which covered the mother's outcomes and costs for the mother and her baby, plus other children in the family, if relevant). This means that we were unable to undertake an economic analysis of the *For Baby's Sake* programme as a whole (i.e. the programme as it relates to the family as a whole – mothers, babies and fathers) and instead we were only able to carry out an economic evaluation of part of the programme.

Table 20: Data availability for economic measures

	Baseline n (%)	**One-year post baseline n (%)**	**Two-years post baseline n (%)**
Mothers (n=27)			
For Baby's Sake data	27 (100%)	27 (100%)	27 (100%)
AD-SUS	25 (93%)	19 (70%)	12 (44%)
CAS	26 (96%)	17 (63%)	12 (44%)
EQ-5D-5L	25 (93%)	19 (70%)	12 (44%)
Fathers (n=13)			
For Baby's Sake data	13 (100%)	13 (100%)	13 (100%)
AD-SUS	13 (100%)	8 (62%)	6 (46%)
EQ-5D-5L	12 (92%)	8 (62%)	6 (46%)

Table 21 shows a comparison of the baseline characteristics of the sample of mothers with full data for the cost-effectiveness analysis and the full study sample. Mothers with full data had higher health-related quality of life (EQ-5D-5L) scores at baseline and reported lower abuse scores than the full sample of study participants. In addition, mothers with full data

were more likely to be white British, in a relationship, living with a spouse or partner and unemployed. These results are a potential source of bias, with, for example, mothers with lower EQ-5D-5L scores and higher abuse scores at baseline being more likely to drop-out of the study. To reduce the impact of this bias, all analyses were conducted using comparison (baseline) data from those who were followed-up only.

Table 21: Comparison of baseline characteristics of mothers with and without full economic data

	Full sample (n=27)	**Sample with full data for cost-effectiveness analysis (n=11)**
	Mean (SD)	**Mean (SD)**
Age	28.11 (7.59)	27.00 (9.00)
EQ-5D-5L score	0.850 (0.223)	0.898 (0.102)
Total CAS score	16.42 (20.39)	9.45 (10.62)
	n (%)	**n (%)**
Relationship status		
Single/Separated/Divorced/Widowed	8 (29.63)	1 (9.09)
Has partner	18 (66.67)	9 (81.82)
Missing data	1 (3.70)	1 (9.09)
Living Situation		
Alone	15 (55.56)	3 (27.27)
Spouse/Partner	10 (37.04)	6 (54.55)
Parents	2 (7.41)	2 (18.18)
Employment		
Employed	17 (62.96)	6 (54.55)
Unemployed	10 (37.04)	5 (45.45)
Ethnicity		
White British	20 (74.07)	9 (81.82)
Other	7 (25.93)	2 (18.18)
Abuse disclosed at baseline (CAS≥3)		
No	10 (38.46)	4 (36.36)
Yes	16 (61.54)	7 (63.64)

Cost of *For Baby's Sake*

Contacts with *For Baby's Sake*

For Baby's Sake is structured so that parents participate in a Welcome session and a number of Getting Started sessions before signing up to the full programme. We conducted our baseline interviews for the evaluation study as close as possible to the sign-up point. As the sessions before sign-up are used to enable the parents to decide if they would like to sign up and also to assess their appropriateness for the programme, we did not include these in the total contacts.

Data were provided on 1644 sessions. Two of these were missing an ID number and could not be used and one session had 0 entered as the duration of the contact so was removed, leaving data on 1641 sessions. Of the 40 mothers and fathers who entered the study, 39 received at least one post enrolment session, including 26 mothers and 13 fathers. The mean number of sessions for any person (mother or father) was 41.03 (range 0-87). For mothers this was 41.37 (range 0-87) and for fathers this was 40.31 (range 5-84). Group sessions were provided to 11 out of the 39 individuals who received *For Baby's Sake* (28.2%). All of these were with mothers, with no group sessions being attended by fathers. The average number of mothers per group session was 3.92.

Information on whether each session was a one-to-one or group session was available for 65.9% of the data (1081/1641). Out of those 1081, only 9.07% (n=98) were group sessions with the remaining 90.93% (n=983) being a one-to-one session. We therefore assumed that where information on session format was missing, it was a one-to-one session.

The length of each contact was available for 86% (n=1405) of the 1641 contacts recorded. The average duration of each session was 77.76 minutes (range 10-240). This was 75.23 minutes (SD 22.16, range 10-240) for one-to-one sessions and 111.53 minutes (range 20-140) for group sessions. In order to calculate the cost of *For Baby's Sake* for each participant, missing duration was imputed using the mean length of all contacts for the sample where duration data were available (75.23 for one-to-one sessions and 111.53 for group sessions).

Ratio of direct to indirect time

Six practitioners returned questionnaires for inclusion in the costing estimates of the ratio of direct to indirect work, but only four had usable data. The average number of hours each practitioner spent in direct face-to-face contact with service users per week was 10.75 hours (range 8-12 hours). The average number of indirect hours each practitioner spent in conducting service user-related work was 25.63 per week (range 23.50-29.00 hours). This resulted in a direct to indirect time ratio of 2.38. In other words, for every hour a practitioner spent in direct contact with *For Baby's Sake* families, they spent an addition 2.38 hours on other *For Baby's Sake* activities.

Unit cost of *For Baby's Sake*

Estimation of the unit cost of *For Baby's Sake* is shown in Table 22. The unit cost per hour was calculated by summing the total cost of wages, employer on-costs, materials, training and overheads and dividing by the total number of hours worked per year (1590), giving an estimate of £49.95 per hour. The unit cost of providing the service per hour of direct contact was estimated by applying the ratio of direct to indirect work, giving a unit cost of £168.83 per hour of direct contact time. The unit cost per one-to-one session was approximately £211 (£168.83 per hour of direct contact divided by 60 minutes and multiplied by 75.23 minutes). The unit cost per group session was approximately £80 (£168.83 per hour of direct contact divided by 60 minutes, multiplied by 111.53 minutes and divided by 3.92, the average number of people per group).

Table 22: For Baby's Sake unit cost schema

Costs and Unit Estimation	Unit Cost 2017/18	Notes
Wages/salaries	£36,126 per year	Based on the mean full-time equivalent basic salary for practitioners provided by the Stefanou foundation.
Salary on-costs	£9,054 per year	Employer's national insurance is included plus 14.38 per cent of salary for employer's contribution to superannuation (Curtis and Burns, 2018). Employer on-costs are in line with the approach taken to calculate national unit costs of health and social care professionals employed by statutory services to provide unit costs relevant to a national roll-out (Curtis and Burns, 2018), and thus are not reflective of the Stefanou Foundation's actual costs as a charity.
Qualification		No available information.
Materials	£ 111 per year	Based on the manual cost (£1,670) taken from the Stefanou Foundation.
Training	£ 955 per year	Based on the total training cost of £14,326 per team taken from the Stefanou Foundation. One team included five full-time practitioners and it is assumed that each practitioner will provide the services for approximately three years after the training.
Overheads Management and administration staff Non-staff	 £ 11,069 per year £ 17,259 per year	 Management and other non-care staff costs were 24.5 per cent of direct care salary costs and included administration staff (Curtis and Burns, 2018). Non-staff costs were 38.2 per cent of direct care salary costs (Curtis and Burns, 2018). They include costs to the provider for office, travel/transport, publishing, supplies and services. (clinical and general), and utilities such as water, gas and electricity.
Capital Overheads	£ 4,846 per year	Based on the new-build requirements of NHS facilities, capital costs have been annuitized over 60 years at a discount rate of 3.5 per cent, declining to 3 per cent after 30 years (Curtis and Burns, 2018). Based on the assumption that there is one office per team, inflated up to 2017/18.
Working time	37.5 hours per	Unit costs are based on 1,590 hours per year: 225 working days minus sickness absence and training study

	week; 42.4 weeks per year.	days as reported for all NHS staff groups (Curtis and Burns, 2018).
Ratio of direct to indirect time on face-to-face	1:2.38	Based on data from the four *For Baby's Sake* practitioners who provided data.
Length of one-to-one session	75.23 minutes	Average duration of one-to-one sessions from the *For Baby's Sake* study.
Length of group sessions	111.53 minutes	Average duration of group sessions from the *For Baby's Sake* study.
Unit costs available 2017/18		
£49.95 per hour; £168.83 per hour of direct service user contact; £211.04 per one-to-one session; £80.06 per group session.		

Cost of *For Baby's Sake* for the study cohort

The cost of each one-to-one session was calculated by multiplying the number of minutes of each session by the unit cost per minute of direct service user contact. For group sessions, this was calculated by multiplying the number of minutes of each session by the unit cost per minute of direct service user contact and then dividing by the average number of people attending each group session (3.92). The mean cost per one-to-one session for the *For Baby's Sake* study participants was £211.39 (range £28.10-£674.40). The mean cost per group session was £79.95 (range £14.34-£100.36). The total cost of *For Baby's Sake* was £8,159.52 (range £0-£15,110.35) for mothers.

Other resource and service use

At baseline, 61.64% (16/26) of mothers reported domestic abuse as indicated by a score of 3 or more on the CAS (see sensitivity analyses in economic methods for discussion on identification of abuse). Reports of domestic abuse over the first year post baseline were similar (62.50%; 10/16) but dropped substantially over the second year post baseline (33.33%; 4/12).

The use of all health and social services by mothers and their baby (and other children, where relevant), are reported in Table 23. Hospital admissions (relating to both the mother and/or baby), day hospital attendances, A&E attendances and community health and social service use changed little over time. Outpatient appointments fell over time and the use of hostels and shelters was higher at 1-year follow-up compared to baseline, but lower over the second year of follow-up.

Table 23: Service use of mothers and their baby as reported by mothers at each time point

	Baseline (n=25)	One-year post baseline (n=19)	Two-years post baseline (n=12)
	Used service n (%)	**Used service n (%)**	**Used service n (%)**
Hostel or Shelter	4 (16%)	6 (32%)	1 (8%)
Hospital admissions (related to mother and/or baby)	10 (40%)	6 (32%)	5 (42%)
Day hospital	7 (28%)	4 (21%)	3 (25%)
Outpatient appointment	18 (72%)	5 (58%)	6 (50%)
A&E	8 (32%)	5 (26%)	4 (33%)
Community services	25 (100%)	18 (95%)	12 (100%)

Total cost of the cohort

Costs for mothers and their baby (and other children, where relevant) for each time period are reported in Table 24. The table shows that the total cost per participant over the 2-year period was £30,626, with non-programme costs being much higher in the first year than in the second year post baseline.

Table 24: Total costs for mothers and their baby for each time point

Cost component	**N**	**Mean**	**SD**
6 months pre-baseline			
AD-SUS	25	8236.10	10246.50
Domestic abuse	26	4357.36	0
Baseline to 1-year post baseline			
AD-SUS	19	11486.78	19354.28
Domestic abuse	17	4904.40	4061.04
Between 1- and 2-years post baseline			
AD-SUS	12	3470.13	3859.76
Domestic abuse	12	3077.73	4566.42
Baseline to 2-years post baseline			
AD-SUS	12	12208.95	14254.53
Domestic abuse	12	8429.92	7210.45
For Baby's Sake	27	8159.52	4165.79
Total costs over 2-years post baseline	**12**	**30626.03**	**16724.90**

Outcomes in the cohort

Table 25 reports the EQ-5D-5L outcome data for mothers at each time point. EQ-5D-5L scores slightly increase between baseline and one-year post baseline, but then drop to lower than baseline levels by two-years post baseline. Total QALYs were 1.583 over the two-year follow-up.

Table 25: EQ-5D-5L outcomes for mothers at each time point

	N	Mean	SD
EQ-5D-5L scores at baseline	25	0.850	0.223
EQ-5D-5L scores at one-year post baseline	19	0.874	0.135
EQ-5D-5L scores at two-years post baseline	12	0.784	0.227
QALYs between baseline and one-year post baseline	18	0.757	0.226
QALYs between one-year and two-years post baseline	12	0.775	0.205
Total QALYs between baseline and two-years post baseline	11	1.583	0.299

Cost-offset analysis

Full details of the costs for each cost component at each time point for mothers and their baby (and other children, where relevant) in the *For Baby's Sake* group and the hypothetical comparison group (see *Economic Evaluation Methods* for further information on the hypothetical comparison group) are presented in Table 26. The total cost in the *For Baby's Sake* group over 2 years was £30,626 compared to £32,971 in the hypothetical comparison group, illustrated in Figure 10.

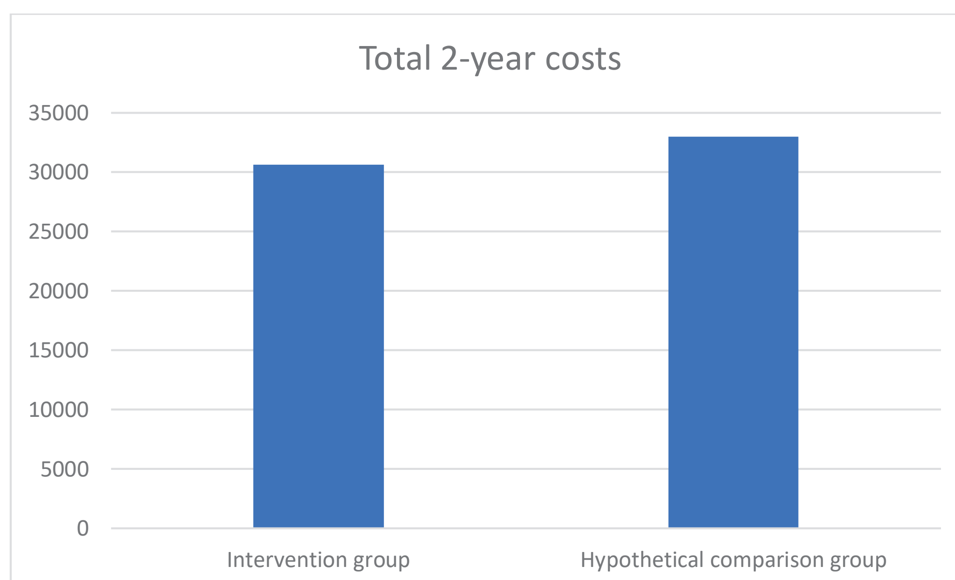
These cost savings were £2,345 over the two-years follow-up, with a 95% confidence interval of -£18,408 to £13,718. However, given the wide confidence intervals, which cross zero, we cannot exclude the possibility of *For Baby's Sake* being more costly or cost neutral when compared with the hypothetical comparison group.

Table 26: Cost offset analysis

	For Baby's Sake			Hypothetical comparison group		
Cost component	**n**	**Mean**	**SD**	**n**	**Mean**	**SD**
Baseline to 1-year post baseline						
AD-SUS	19	11486.78	19354.28	18*	13593.52	19370.77
Domestic abuse	17	4904.40	4061.04	17	7568.68	0
Between 1- and 2-years post baseline						
AD-SUS	12	3352.79	3729.24	11*	8945.42	11296.09
Domestic abuse	12	3077.73	4566.42	12	8281.61	0
Baseline to 2-years post baseline						
AD-SUS	12	12208.95	14254.53	11*	17120.76	21619.74
Domestic abuse	12	8429.92	7210.45	12	15850.28	0
For Baby's Sake	27	8159.52	4165.79	27	0	0
Total 2-year costs	**12**	**30626.03**	**16724.90**	**11***	**32971.05**	**21619.74**

*One less hypothetical comparison group member for AD-SUS data as one mother had a missing AD-SUS at baseline so no data to estimate from but completed the AD-SUS at both follow-ups

Figure 10: Total cost in the For Baby's Sake and hypothetical comparison group



Sensitivity analyses for cost-offset analysis

Imputed data

Table 27 shows the total costs based on imputed data. The cost in the *For Baby's Sake* group was £30,981 compared to £45,810 in the hypothetical comparison group, a cost saving in the *For Baby's Sake* group of £14,829 with a 95% confidence interval of -£29,117 to £540. As noted above, given these wide confidence intervals which cross zero, we cannot exclude the possibility of *For Baby's Sake* being more costly or cost neutral when compared with the hypothetical comparison group.

Table 27: Cost offset analysis with missing data imputed

	For Baby's Sake			**Hypothetical comparison group**		
Cost component	**n**	**Mean**	**SD**	**n**	**Mean**	**SD**
Baseline to 1-year post baseline						
AD-SUS	27	11486.78	16103.73	27	14305.99	17099.78
Domestic abuse	27	4904.40	3185.74	27	7568.68	0
Between 1- and 2-years post baseline						
AD-SUS	27	3352.79	2425.66	27	15653.55	18710.50
Domestic abuse	27	3077.73	2970.20	27	8281.61	0
Baseline to 2-years post baseline						
AD-SUS	27	14839.56	16368.46	27	29959.53	35810.28
Domestic abuse	27	7982.13	4950.16	27	15850.28	0
For Baby's Sake	27	8159.52	4165.79	27	0	0
Total 2-year costs	**27**	**30981.21**	**17045.99**	**27**	**45809.81**	**35810.28**

Composite Abuse Scale (CAS) cut-offs

The original cost-offset analysis assumed all mothers were experiencing domestic abuse at study entry, given that *For Baby's Sake* was a domestic abuse programme and this was clearly communicated in the programme's advertising material and cohort criteria. However, the cost-offset analysis was re-run using the CAS cut-off of three at all timepoints as recommended in the literature (Hegarty, 2007), in order to reduce the risk of false positives (i.e. the risk of overstating the prevalence of abuse). We recognise that the sensitivity analysis using the cut-off of three at baseline would introduce the inverse risk of false negatives (i.e. the risk of understating the prevalence of abuse) at that stage, especially as the research found that some mothers and fathers were not yet ready at baseline to disclose abuse. However, the 'true' level of abuse is likely to lie somewhere between the two analyses.

Table 28 shows the total costs based on this sensitivity analysis. The cost in the *For Baby's Sake* group was £29,882 compared to £26,591 in the hypothetical comparison group. In this scenario, the *For Baby's Sake* group was more costly by £3,291 with a 95% confidence interval of -£11,978 to £18,561. Given these wide confidence intervals which cross zero, we cannot exclude the possibility of *For Baby's Sake* being less costly or cost neutral when comparing it with the hypothetical comparison group.

Table 28: Cost offset analysis using a CAS cut-off of three

	For Baby's Sake			**Hypothetical comparison group**		
Cost component	**n**	**Mean**	**SD**	**n**	**Mean**	**SD**
Baseline to 1-year post baseline						
AD-SUS	19	11486.78	19354.28	18*	13593.52	19370.77
Domestic abuse	17	4904.40	4061.04	17	4006.95	3894.05
Between 1- and 2-years post baseline						
AD-SUS	12	3352.79	3729.24	11*	8945.42	11296.09
Domestic abuse	12	2333.77	3565.70	12	4265.76	3765.53
Baseline to 2-years post baseline						
AD-SUS	12	12208.95	14254.53	11*	17120.76	21619.74
Domestic abuse	12	7685.96	6491.48	12	8680.82	7662.86
For Baby's Sake	27	8159.52	4165.79	27	0	0
Total 2-year costs	**12**	**29882.07**	**16283.62**	**11***	**26590.75**	**20312.76**

*One less hypothetical comparison group member for EQ-5D-5L scores as one mother had a missing AD-SUS at baseline so no data to estimate from but completed the AD-SUS at both follow-ups.

Short-term (2-year) cost-effectiveness analysis

Table 29 shows the EQ-5D-5L outcome data at each time point for mothers in the *For Baby's Sake* group and the hypothetical comparison group. EQ-5D-5L scores are slightly higher in the hypothetical comparison group (1.633) than the *For Baby's Sake* group (1.583) at one- and two-year follow-up. Based on complete case data, the mother's QALYs were 0.049 lower in the *For Baby's Sake* group compared to the hypothetical comparison group with a 95% confidence interval of -0.247 to 0.148. Therefore, we cannot exclude the possibility of *For Baby's Sake* having higher or equal QALYs when comparing it with the hypothetical comparison group.

Table 29: Outcomes for For Baby's Sake and hypothetical comparison women at each time point

	For Baby's Sake			Hypothetical comparison group		
	N	Mean	SD	n	Mean	SD
EQ-5D-5L scores at baseline	25	0.850	0.223	25	0.850	0.223
EQ-5D-5L scores at 1-year post baseline	19	0.874	0.135	18	0.910	0.088
EQ-5D-5L scores at 2-years post baseline	12	0.784	0.227	11	0.867	0.098
QALYs between baseline and 1-year post baseline	18	0.757	0.226	18	0.790	0.077
QALYs between 1-year and 2-years post baseline	12	0.775	0.205	11	0.853	0.096
Total QALYs between baseline and 2-years post baseline	11	1.583	0.299	11	1.633	0.185

Figure 11 presents the cost-effectiveness plane for cost and outcome pairs based on complete case data (n = 11). The different quadrants of the cost-effectiveness plane show the points where costs for the intervention under evaluation (in this case, *For Baby's Sake*) are higher than the comparison group (above the x-axis) or lower than the comparison group (below the x-axis) and where outcomes for the intervention under evaluation are higher than the comparison group (to the right of the y-axis) or lower than the comparison group (to the left of the y-axis). In Figure 10, approximately 45% of the scatter points lie to the right of the vertical axis (where the *For Baby's Sake* group is more effective than the hypothetical comparison group) and approximately half of the scatter points lie below the horizontal line (where the *For Baby's Sake* group is less costly than the hypothetical comparison group).

Figure 11: Cost-effectiveness plane for For Baby's Sake versus the hypothetical comparison group based on complete case data (n = 11)

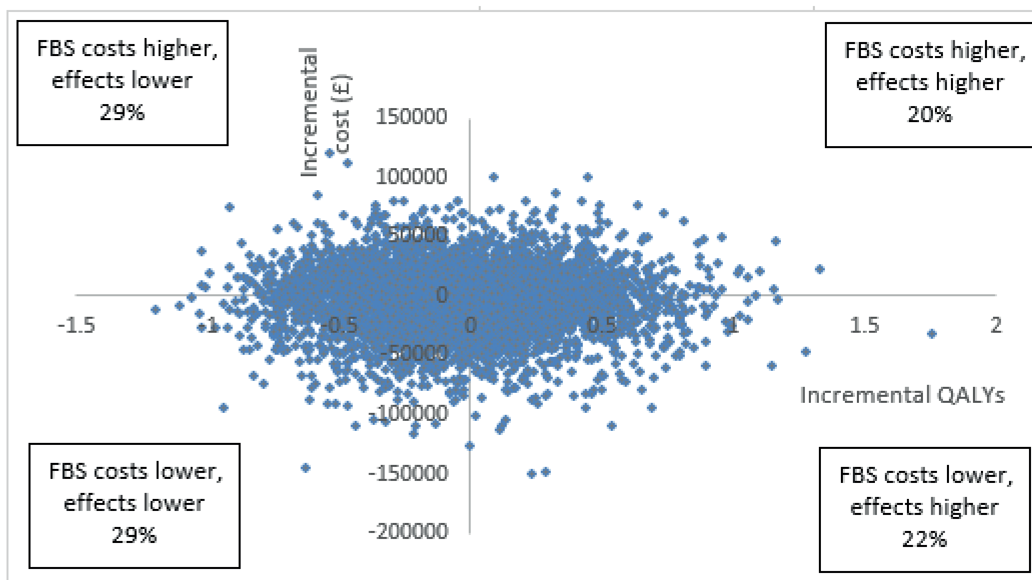
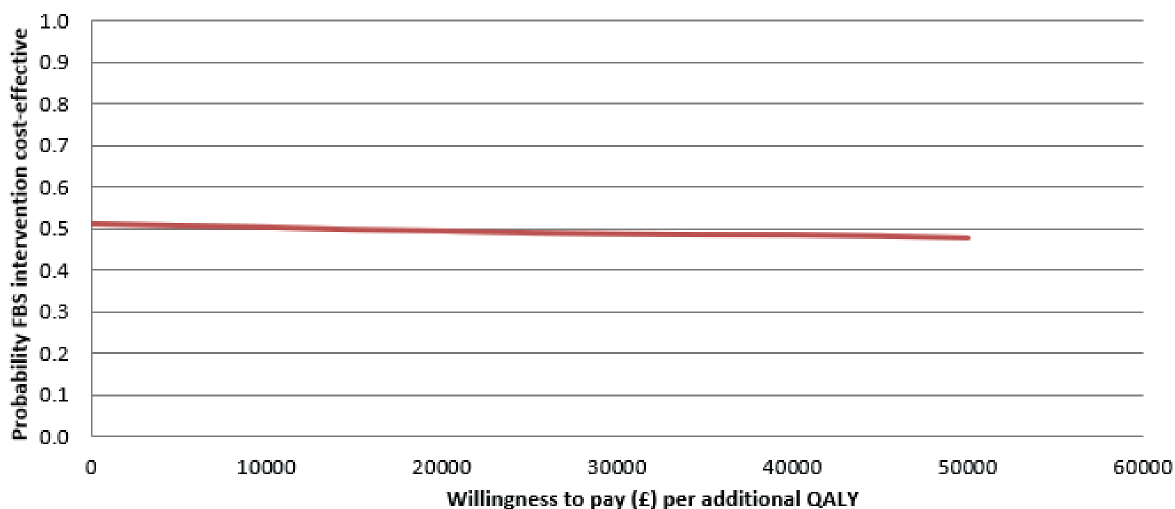


Figure 12 (see below) shows the cost-effectiveness acceptability curve, which demonstrates the probability that *For Baby's Sake* is cost-effective compared to the hypothetical comparison group for different values of willingness to pay for improvements in outcome (QALYs). This suggests that the probability of *For Baby's Sake* being cost-effective compared to the hypothetical comparison group is around 50%. In other words, there is little difference between the two groups (50% probability of either being cost-effective) at the NICE threshold of £20,000-£30,000 per QALY when using complete case data (n=11).

Figure 12: Cost-effectiveness acceptability curve for For Baby's Sake versus hypothetical comparison group based on complete case data (n = 11)



Sensitivity analyses for the short-term cost-effectiveness analysis

Imputed data

Table 30 shows the total QALYs based on imputed data. As with the complete case analysis, QALYs in the *For Baby's Sake* group were slightly lower (1.545) than in the hypothetical comparison group (1.623) when missing data was imputed. The difference between the groups was 0.078 QALYs with a 95% confidence interval of -0.183 to 0.027. Therefore, we cannot exclude the possibility of the *For Baby's Sake* group having higher or equal QALYs when compared with the hypothetical comparison group.

Table 30: EQ-5D-5L outcomes for mothers based on imputed data

	For Baby's Sake			**Hypothetical comparison group**		
	N	**Mean**	**SD**	**N**	**Mean**	**SD**
EQ-5D-5L scores at baseline	27	0.850	0.215	27	0.850	0.215
EQ-5D-5L scores at 1-year post baseline	27	0.874	0.112	27	0.910	0.071
EQ-5D-5L scores at 2-years post baseline	27	0.784	0.147	27	0.867	0.061
QALYs between baseline and 1-year post baseline	27	0.748	0.210	27	0.764	0.108
QALYs between 1-year and 2-years post baseline	27	0.797	0.136	27	0.859	0.062
Total QALYs between baseline and 2-years post baseline	27	1.545	0.237	27	1.623	0.151

Combining this imputed outcome data with imputed cost data (Table 30), Figure 13 presents the cost-effectiveness plane for cost and outcome pairs based on imputed data (n = 27). Approximately 40% of the scatter points lie to the right of the vertical axis (where *For Baby's Sake* is more effective than the hypothetical comparison group) and approximately 60% of the scatter points lie below the horizontal line (where *For Baby's Sake* is less costly than the hypothetical comparison group).

Figure 13: Cost-effectiveness plane for For Baby's Sake versus the hypothetical comparison group based on imputed data (n = 27)

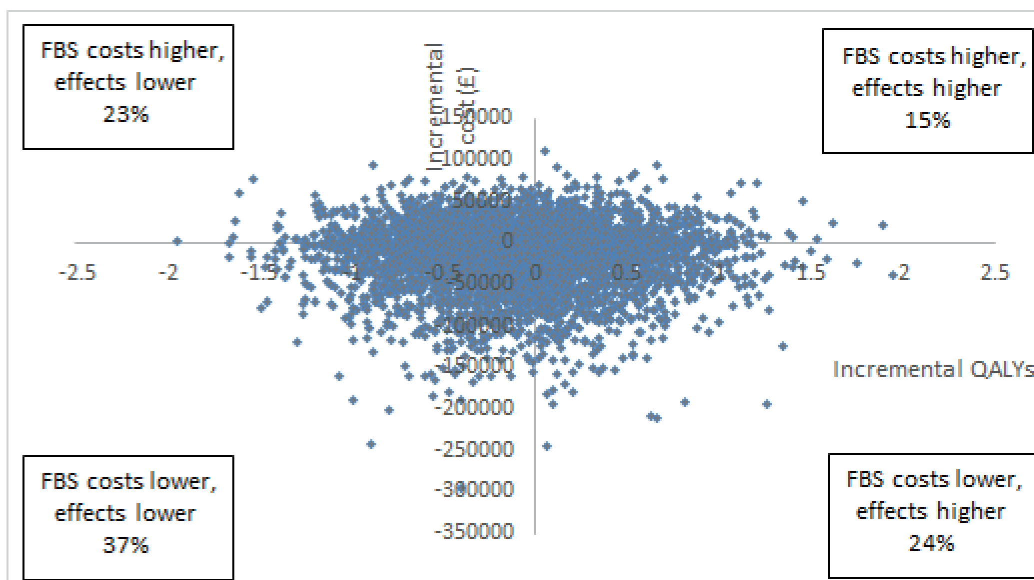
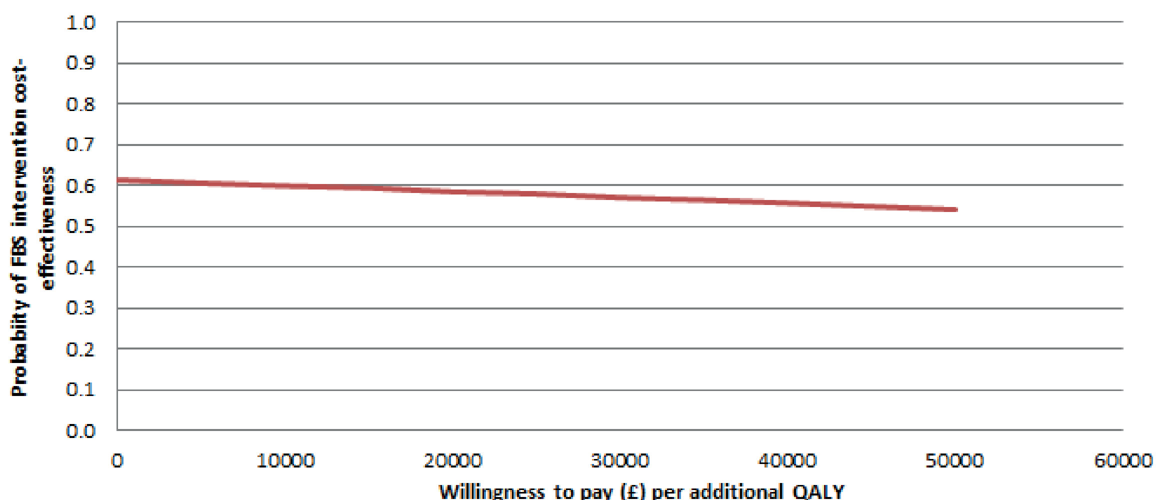


Figure 14 shows the cost-effectiveness acceptability curve based on imputed data (n = 27). This suggests that *For Baby's Sake* has around a 60% probability of being cost-effective compared to the hypothetical comparison group over a willingness-to-pay per QALY range of £0 to £50,000. In other words, there is a higher probability of *For Baby's Sake* being cost-effective (better value for money) than the hypothetical comparison group at the NICE threshold of £20,000-£30,000 per QALY when using imputation for missing data.

Figure 14: Cost-effectiveness acceptability curve for For Baby's Sake versus the hypothetical comparison group based on imputed data (n = 27)



Composite Abuse Scale (CAS) cut-off

Figure 15 presents the cost-effectiveness plane for cost and outcome pairs using the CAS cut-off of three (n = 11). Approximately 45% of the scatter points lie to the right of the vertical axis (where *For Baby's Sake* is more effective than the hypothetical comparison group) and approximately 40% of the scatter points lie below the horizontal line (where *For Baby's Sake* is less costly than the hypothetical comparison group).

Figure 15: Cost-effectiveness plane for For Baby's Sake versus the hypothetical comparison group using a CAS cut-off of three (n = 11)

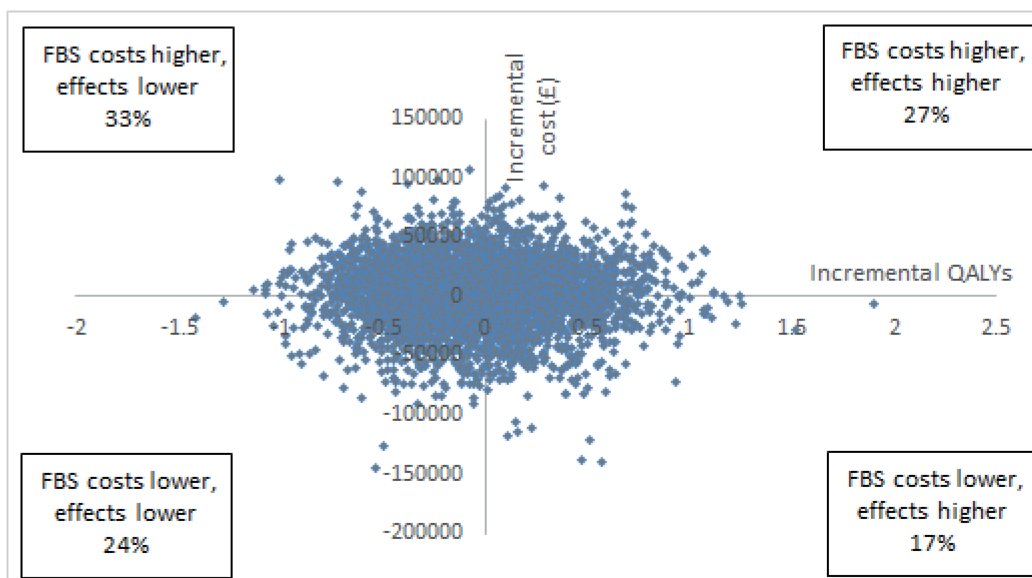
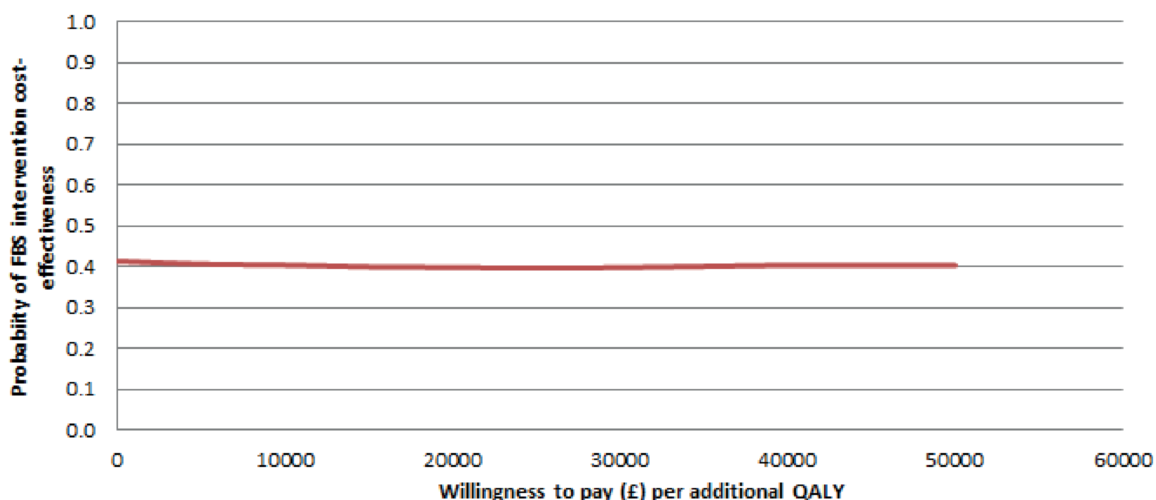


Figure 16 shows the cost-effectiveness acceptability curve based on complete case data (n = 11). This suggests that the *For Baby's Sake* group had around a 40% probability of being cost-effective compared to the comparison over a willingness-to-pay per QALY range of £0 to £50,000. In other words, there is a lower probability of *For Baby's Sake* being cost-effective than the hypothetical comparison group at the NICE threshold of £20,000-£30,000 per QALY when using a CAS cut-off score of three.

Figure 16: Cost-effectiveness acceptability curve for For Baby's Sake versus the hypothetical comparison group using a CAS cut-off of three (n = 11)



Medium-term (5-year) cost-effectiveness analysis

A five-year model required additional data to fill the data gaps not available from the *For Baby's Sake* study. Literature reviews were undertaken to try and identify appropriate alternative data sources to populate the model, including data on suitable comparison interventions, mortality rates for victims of domestic abuse and probabilities of domestic abuse, but no suitable data were identified. Data available were based on very different populations receiving very different interventions.

Given this lack of appropriate data, the high level of uncertainty in the cost-effectiveness results reported (with main results suggesting no difference in cost-effectiveness between *For Baby's Sake* and the hypothetical comparison group, and sensitivity analyses demonstrating these results were sensitive to the assumptions made), the small sample sizes, the extensive loss to follow-up, the use of a hypothetical comparison group and the gaps in the evidence in relation to the comparison group, it was not considered appropriate to run the 5-year model. Extrapolation of the results over a five-year period would be subject to an extremely high level of uncertainty, dependent on a high number of assumptions which are not evidence-based, and reliant on the limited data available, with associated biases, and thus confidence in the results would be low.

Summary of key findings

Cost-offset analysis

Results of the cost-offset analysis suggest an advantage for *For Baby's Sake* in terms of costs, with the costs of *For Baby's Sake* being more than offset by cost savings through lower levels of service use and lower rates of domestic abuse. This advantage was even greater when missing data were imputed. However, application of the recommended CAS cut-off of three at baseline resulted in a reversal of this cost advantage such that the cost-offset analysis favoured the hypothetical comparison group.

Cost-effectiveness analysis

Results for the short-term cost-effectiveness analysis were also found to be sensitive to the assumptions applied. The main analysis, based on complete case data (n = 11), found little difference between *For Baby's Sake* and the hypothetical comparison group, with a probability of either group being cost-effective of approximately 50% at the NICE threshold of £20,000-£30,000 per QALY. When missing data were imputed, the probability of *For Baby's Sake* being cost-effective compared to the hypothetical comparison group increased to approximately 60%, suggesting *For Baby's Sake* is better value for money than the control group. However, this probability reduced to approximately 40% when a CAS cut-off of three was applied, suggesting the hypothetical comparison group is better value for money.

Limitations

Uncertainty in the economic results is most likely to be due to the very small number of participants included in the study and the loss of follow-up data meaning that we didn't have the statistical power to detect a difference between *For Baby's Sake* and the hypothetical comparison group. This lack of data was particularly acute for fathers undertaking *For Baby's Sake*, with only 13 fathers participating in the study and less than half of these having full data necessary for economic analyses. When combined with data from mothers in the *For Baby's Sake* study, full data were only available for 3 to 4 families (depending on the economic analysis in question), making it impossible to analyse the full effect of *For Baby's Sake* on the family as a whole. Instead, we have conducted an economic evaluation of part of the programme with analyses, focused on the impact on mothers and their babies: it must be understood that we are not presenting full cost-offset or full cost-effectiveness analyses of *For Baby's Sake*.

A comparison of characteristics at baseline between mothers with full data for economic analysis and the full sample of mothers in the study revealed some differences, with mothers with full data having higher EQ-5D-5L scores and lower abuse scores at baseline than the full sample of study participants. Those with full data were also more likely to be white British, in a relationship, living with a spouse or partner and unemployed. This suggests that more disadvantaged women were more likely to drop-out of the study and thus the results presented may not be generalisable to the full range of participants for whom *For Baby's Sake* is of relevance. In addition, simple mean imputation of missing data had to be applied, rather than more sophisticated statistical approaches, as a result of the small sample size. This method is not robust and open to bias and error.

The lack of a comparison group, requiring assumptions to be made about costs and effects in the absence of *For Baby's Sake*, was also a major limitation of the study. In addition, the intervention aimed to recruit women experiencing domestic abuse. However, the research assessment of abuse at baseline using the CAS did not always provide evidence of abuse. As stated elsewhere in this report, the low self-reporting of abuse through the CAS could reflect a tendency for women not to disclose, through lack of awareness, minimisation, shame or fear. This calls into question the accuracy of self-report abuse status, not just at baseline but also at both follow-up points.

Final Summaries and Reflections

This report summarises the results of a four-year evaluation of the prototype of *For Baby's Sake.* Given the timing of this evaluation, which examined *For Baby's Sake* at the prototype stage, it is not possible to make a quantitative assessment about the effectiveness of the programme. This evaluation does, however, confirm that *For Baby's Sake* is the first programme, to our knowledge, to fill an important gap in provision. The evaluation also provides useful data on the feasibility and acceptability of the programme. In addition, this evaluation provides useful data regarding areas for future development, and considerations for roll-outs of the programme.

Key summary findings are presented throughout the report. This final summary chapter will outline the key overarching findings and reflections from the evaluation, as they align with the main aims of this evaluation.

Does the programme operate as anticipated?

The approach of the programme

For Baby's Sake is filling a key gap in current service provision, by adopting a whole-family approach to addressing DVA that works with both parents from pregnancy and combines evidence-based treatments for DVA, trauma and adult mental health alongside parenting interventions focused on infant mental health and parent-infant attachment. The intervention is at the earliest stage of life for children - in utero and through the first two years - while working therapeutically and intensively over an extended time with parents with longstanding complex needs and childhood trauma histories. This unique approach is evidenced through a review of the existing academic literature (see Chapter "*Background to Research Evaluation*"), and in the evaluation interviews with *For Baby's Sake* practitioners, stakeholders and families (see Chapters "*For Baby's Sake Practitioner Qualitative Interviews*" / "*Qualitative Interviews with Stakeholders*" / "*Qualitative Interviews with Families engaged with For Baby's Sake"*). Since the inception of *For Baby's Sake*, the value of supporting the whole-family and adopting a trauma-informed lens has been increasingly recognised. Indeed, other organisations and research teams have begun to develop programmes that adopt a whole-family approach and/or seek to work with both women who experience DVA and men who use DVA. To our knowledge, however, these other interventions do not target the impacts of DVA in utero, or combine trauma-informed DVA support with attachment-focused parenting support for both parents; key gaps that *For Baby's Sake* is addressing within this programme.

The delivery of the programme

The three-way [therapeutic practitioner] model is novel and data from the practitioner and stakeholder interviews highlight key strengths in this approach, including, for example, shared learnings/formulations and timely information sharing. In addition, this model of working can promote holistic understandings of the needs/issues of families which can in turn support comprehensive assessment and management of presenting risks. Specialist and independent work with fathers who use DVA is vital, as it is not always appropriate for one practitioner to

work with all family members (Stanley and Humphreys, 2017). Indeed, practitioners taking part in this evaluation highlight the importance of protecting against collusion in the therapeutic relationship. Having a dedicated specialist practitioner who has the competencies to work with fathers who use DVA, as in *For Baby's Sake*, can facilitate engagement of fathers as they establish a positive therapeutic relationship with a practitioner who carefully balances the tensions between providing non-judgemental support whilst challenging harmful behaviours. *For Baby's Sake* also facilitates engagement of both mothers and fathers through providing consistency of care in relation to having a dedicated practitioner that works with each parent separately, as well as a practitioner that supports them with their parenting.

Embedding in the Local Authority Sites

Prior to the launch of *For Baby's Sake,* the Foundation spent considerable time exploring ways to ensure the programme became well-embedded within the two prototype areas. For example, they engaged key local stakeholders, established an overarching Steering Group and site-specific Operational Groups and undertook a social marketing review. The Foundation also sought to create co-located working practices between the *For Baby's Sake* teams and their Local Authority partners, alongside ensuring *For Baby's Sake* reporting systems were the same as their co-located partners. This evaluation highlights that the co-location model is valued by Local Authority partners.

The Foundation purposely selected sites that had different population characteristics, different levels of urbanicity, different public sector structures, and different local government, health and policing structures. This led to unique experiences in the two sites, in relation to the establishment of referral pathways and multi-agency partnerships. Before beginning to design *For Baby's Sake,* the Foundation already had established links in Hertfordshire. Based on how many referrals each of the sites received and the reflections of practitioners and stakeholders in the two sites it appears that the process of embedding was smoother in Hertfordshire. In relation to engagement with relevant Local Authority and other partners, it appears that both sites engaged well with social care, midwifery, police and mental health partners. This may reflect the proactive approach that both teams took in seeking out opportunities to establish joint-working practices with their Local Authority partners and engaging in reciprocal learning activities with their partners.

The nature of families attracted to and retained on the programme

Data from the programme

During this evaluation time-period, a total of 101 families in Hertfordshire and 62 families across the London Three Boroughs engaged with *For Baby's Sake.* Around 70% of referred families in both sites either did not engage at all with *For Baby's Sake* or disengaged sometime after initial engagement. *For Baby's Sake* is structured so that parents participate in a Welcome session and Getting Started module before signing up to the full programme.

Among mothers and fathers who signed up and had completed or left the programme during our evaluation (so that we had an end date for them), the average duration on the programme following sign-up was 18 months for mothers and 15.4 months for mothers and

fathers respectively in Hertfordshire and 11.5 and 11 months for mothers and fathers respectively in London.

Similarities in the proportions of mothers and fathers participating in Welcome, Getting Started and Sign-Up sessions of *For Baby's Sake* indicate success in attracting both co-parents onto the programme and the feasibility of this novel aspect of the model. There were some interesting differences observed in levels of engagement between men and women. In both sites, more fathers than mothers cancelled sessions following sign-up and fathers received considerably fewer parenting-related sessions than the mothers. In both sites, women received substantially more sessions in later modules, including Healthy Expression of Feelings and Self-Esteem & Assertion. The lower engagement rates of men in the programme align with other interventions that seek to address men's use of DVA, which highlights the challenges of retention and sustained engagement of men undertaking therapeutic work for their DVA behaviours (Babcock *et al.*, 2004).

Data from this evaluation

The characteristics of individuals recruited to this evaluation highlight the complex needs of families engaged with *For Baby's Sake*. A substantial proportion of men and women had symptoms of depression, anxiety and PTSD, as well as high numbers of disordered personality traits. In addition, the majority of parents reported ACEs, with over half having experienced DVA as children. These findings highlight that the *For Baby's Sake* teams successfully attracted the target population of families in this prototype phase and could, therefore, match the therapeutic models of the programme to the specific needs of families.

For Baby's Sake targets families in the transition to parenthood. The literature demonstrates that this is a key time to engage families, who are motivated to make changes and establish healthy behaviours/lifestyles in preparation for the arrival of their infant(s). The experience of the *For Baby's Sake* practitioners demonstrates that this period encourages engagement from both expectant mothers and fathers and parents themselves describe how their child is a key factor that drives their willingness to engage with the programme. Given that several parents terminated the intimate relationship with their co-parent during their time on the programme, it appears important for the programme to continue to adopt the approach that staying together is not a goal of the programme.

For Baby's Sake practitioner capacity and skills to deliver the programme

Multi-disciplinary teams

The programme's approach to recruiting practitioners with a range of related experiences and professional backgrounds (e.g. domestic violence sector, child development, social care, substance misuse, probation) helps to promote inter-disciplinary shared learnings within the team. To ensure the continued success of the multi-disciplinary team model going forward, the organisational climate in which teams work cut-across vertical hierarchies and bring decision-making closer to front-line workers and service users (Humphreys and Stanley, 2006). This approach will help to ensure services effectively meet the needs of those affected by DVA.

Practitioner work to embed the programme within the study sites

Both sites engaged in frequent and continued promotional activities to ensure their local partners were aware of the programme. Both sites also sought out opportunities to establish joint-working practices with their local partners and engage in reciprocal learning activities. These activities helped to successfully embed the programme within the two sites and to encourage referral of families to the programme; future roll-outs of the programme would benefit from adopting a similar approach.

The teams identified some challenges in embedding the programme in their local areas (e.g. obtaining access to local services for the delivery of sessions with families, establishing regular co-location practices across the three boroughs in London) and during the prototype phase have sought out ways to address these challenges. These learnings could be useful knowledge to impart to new teams in any future roll-outs.

Practitioner training and supervision

During this prototype phase, practitioners have received detailed training to build their capacity and skills. Practitioners described this training as positive and comprehensive and they reported on how they had been provided with ongoing opportunities to enhance their training throughout the evaluation period. There were variations in the views of practitioners regarding the modified training schedule given to new members of staff. For some, this training package was not perceived to be as comprehensive as the initial training schedule that practitioners received at the start of the prototype phase. Others felt the modified training schedule was sufficient, and new practitioners could further refine their learnings through shadowing and drawing on the skills of more experienced practitioners.

Areas for future development in relation to training, to inform future roll-outs of the programme, include work around integrating the skills that practitioners have learnt and additional role-play based exercises. The Infant Development and Family Practitioners had suggested further training around how to explain their role in a parent-friendly accessible way; the evolution in staffing could help to address this issue, as each parent will receive the totality of the programme from one practitioner, integrating all elements of support. Further training on mental health, counselling skills and risk assessments were also highlighted as key in enhancing the competencies and skills of practitioners.

Practitioners reported on the tensions that can be experienced in relation to establishing a therapeutic relationship and adopting a non-judgemental stance whilst also challenging unhealthy and harmful views and behaviours. Protecting against collusion with service users is critical and this can mean a juggling of practitioners' therapeutic and safeguarding roles. It is essential, therefore, that the programme ensures there is timely and effective information-sharing among practitioners. Another approach to ensuring practitioners have the skills to address these challenges is through clinical supervision, which allows practitioners to identify defences that they may be holding about their service users. During the prototype phase, *For Baby's Sake* established formal and regular supervisory structures for practitioners. Practitioners reflected on the value and importance of having regular supervision as part of their work. This, alongside the monthly group case management/safeguarding supervision sessions and regular line management supervision, helped support practitioners to address the presenting familial dynamics and risks encountered. Moving forward, maintaining (and

increasing where necessary) the focus within line management and supervisory structures to reflect on the work practitioners are doing with families and how best they can manage this, including their work with children and presenting familial risks, could further enhance the skill-set of practitioners.

The balance and content of the therapeutic interventions

Due to the small number of recordings we obtained from both sites, we were not able to demonstrate overall adherence levels to the manual among practitioners. It is not possible at this stage, therefore, to clearly outline the overall manualised work that the sites are doing with families. As this evaluation was conducted in a prototype phase of the programme, *For Baby's Sake* teams had the opportunity to test out and reflect on how the manual worked with families and the Foundation made a number of suitable edits and additions over the course of the prototype phase in light of this learning.

From the data we collected, our findings demonstrate that in the London Three Boroughs site, slightly under half of the recorded sessions adhered closely to the manualised components of the session; reasons for deviation from the manual were largely in response to families bringing specific issues to the session which they wanted to explore. Overall adherence to the manual was fair, with some deviation observed. In the Hertfordshire site, over 70% of the recorded sessions adhered closely to the manualised components of the session; reasons for deviation from the manual were largely due to the time taken to complete specific items which meant that others could not be completed. Overall adherence to the manual was good, with little deviation observed.

Going forward, it will be important that fidelity to the manual is formally assessed among all practitioners throughout the programme. This will ensure that key elements of the programme are not watered-down, which can be a risk when programmes are rolled out on a bigger scale. Indeed, it has been found that the fidelity with which an intervention is implemented affects how well it succeeds (Elliott and Mihalic, 2004, Mihalic, 2004). In the absence of a rigorous fidelity assessment, it cannot be determined whether any observed positive impacts could be improved (e.g. in cases where a programme was not implemented fully) or if a lack of impact may be the result of poor implementation rather than inadequacies in the programme itself (Carroll *et al.*, 2007). Indeed, evaluation of an augmented partner violence intervention within several USA nurse home visitation programmes found that that fidelity to the augmented intervention was low among nurses, and this may have influenced the findings that the augmented model did not lead to significant improvements for families (Jack *et al.*, 2019).

In practice-based settings, as opposed to in controlled research settings, it can be harder to implement formalised fidelity assessments but strategies in which to do this should be prioritised. Reflecting on the fact that the programme has undergone some adaptations and is delivered flexibly, future fidelity assessments may benefit from being based more on adherence to key principles of the programme rather than specific manual activities.

Stakeholder, *For Baby's Sake* practitioner and family experiences and views of the programme

Stakeholder experiences and views

The findings from the interviews with stakeholders highlight that *For Baby's Sake* is novel in its approach to providing holistic support to the whole family, in working with families that are not ready to separate and in working with individual members of a family over a two-year period. The *For Baby's Sake* teams were reported to be highly trained and skilled, and the programme's presence within the two sites was well established by the end of this evaluation period.

Going forward, the London site needs to continue its focus on getting more referrals in to *For Baby's Sake* in order to make full use of the team's resources and demonstrate the cost benefit of the programme there.

The teams' work in building collaborative and joint-working practices was reported to be important in fostering the success of the programme. Future roll-outs should adopt the same approach as the teams in this prototype, in developing strong joint- and collaborative working practices with relevant services already in existence within Local Authority areas. This approach will ensure the programme remains embedded within current service provision. This includes continuing the practice of detailed exploration of relevant services already in existence within the locality areas and how *For Baby's Sake* can best fit within those established models of care.

In future roll-outs of the programme, *For Baby's Sake* teams should continue in their efforts to proactively explain to partner organisations how their model can complement existing models (e.g. *For Baby's Sake* is a long-term intervention that works with the whole family and supports both the father using abusive behaviour and the mother experiencing the abuse), to ensure success with embedding the programme with existing Local Authority structures. For example, communication with stakeholders and families about the therapeutic work around Adverse Childhood Experiences (ACEs) in order to convey how traumatic childhood adversity is understood within *For Baby's Sake* (i.e. that families have control over the behaviours they use as an adult and that the programme seeks to empower them to take responsibility for their actions). In addition, given the growing interest in trauma-informed responses, the programme could undertake activities to promote an ongoing dialogue within sites about developing trauma-informed interpretations of Heise's ecological model across all dimensions (individual, personal relationships, community, society). It could be useful for the programme to clarify its stance on continuing to work with one parent when the other disengages, so that the remaining parent can be confident about the support they will receive. It could also be useful for the programme to be clearer about what it means by co-parenting and particularly that there is no prescriptive definition of this (just as there is no requirement for parents to stay together as a couple).

Practitioner experiences and views

Practitioners described how the length of the therapeutic programme (e.g. delivered from pregnancy to two-years after childbirth), the nature of the therapeutic work (e.g. education around DVA, understanding and processing the impact of childhood experiences, building self-esteem and modules around healthy expression of emotions and bonding with their baby) and the trust and consistency within the practitioner's relationship with each family member represented key mechanisms for change among families.

Practitioners reflected that the ability to apply flexibility in the use of the manualised programme and allowing adaptations to the manual during the prototype phase helped to ensure the programme materials were matched to the presenting needs of families.

Key learnings from analyses of the practitioner interviews include how to support families with complex needs, how to effectively demonstrate any successes achieved by families, balancing theoretical underpinnings of the programme, protecting against collusion, and appropriate management of risk. Indeed, practitioners described potential tensions that can arise in relation to establishing a good therapeutic relationship and adopting a non-judgemental stance whilst also challenging unhealthy and harmful views and behaviours. Future roll-outs of the programme would gain from ensuring staff are skilled in managing these tensions and they may benefit from the learnings of the practitioners in this prototype.

Practitioners reflected on the careful balance that is required of them in carrying out their role effectively, in ensuring that risks experienced by families are adequately and robustly managed alongside developing a strong therapeutic relationship with families through providing non-judgemental support. Indeed, practitioners reflected that the risk management skills of staff are critical in ensuring families are adequately supported. Future roll-outs of the programme would, therefore, benefit from ensuring that staff are adequately trained around effective risk management in light of the fact that there are ongoing risks for families, and these can change quickly.

Practitioners reflected that the focus of the programme, which places a central emphasis on the baby, is crucial in helping to engage expectant parents and in facilitating healthy parenting behaviours and attachments. Indeed, targeting families in the pregnancy period can capitalise on expectant mothers' and fathers' motivations to make changes to improve outcomes for their children. Initiating therapeutic work in early pregnancy also ensures there is enough time for detailed therapeutic work around parents' previous experiences, their current experiences and behaviours and how these current and past experiences can impact on their children.

The role of the Men's Practitioner was seen to inspire a desire to change among fathers who use DVA and to improve the management of their emotions. Practitioners outlined challenges with regards to engaging men who use physical forms of DVA. The Foundation may, therefore, want to focus on ways to enhance engagement and uptake of the programme by these men when concentrating on further developments.

Practitioners reflected that due to the complex issues that the programme seeks to address (e.g. DVA, ACEs, impaired parenting practices) and how embedded these behaviours may be

among families, using quantitative-based assessments can make it hard to demonstrate positive changes experienced among participants. Due to the small sample sizes, the main sources of informative data on the families who participated in the evaluation are indeed qualitative. We advise that future roll-outs/evaluations seek to formally establish whether positive changes have occurred, and measurement of quantitative outcomes are essential in achieving this. Indeed, participants need to know that positive outcomes have been achieved by those who have undertaken the programme previously, commissioners will want evidence of demonstrable hard outcomes, and the academic and third-sector audiences will need evidence of quantitative improvements across different outcomes, so that this programme can be assessed relative to others. Our evaluation has demonstrated that it is feasible to collect a range of quantitative outcomes from mothers and fathers participating in this programme over a two-year period.

Practitioners also reflected on the challenges when identifying families where the programme was perceived to be a good fit for one parent but not for the other parent. Linked to this, while some practitioners highlighted how they worked flexibly with one parent (usually the mother) when the other parent (usually the father) disengaged, other practitioners sought clearer guidance on how much more work they could do with the remaining parent when their co-parent disengaged. Similar views were expressed by some stakeholders. A few mothers, particularly those whose co-parents had disengaged or who learnt through their participation in the programme that they did not want to co-parent, reflected on how it would be nice for just one parent to continue with the programme and for single mums to receive support. Routine data collected as part of *For Baby's Sake* indicates that referrals are being made for families that do not wish to co-parent and that, following sign-up, a co-parent may disengage or that the desire or ability to co-parent may change.

Therapeutic work around women's empowerment and self-esteem building were perceived to achieve key positive outcomes among mothers; a view expressed by both practitioners and mothers. Empowerment models have been tested in other DVA-focused programmes (see Chapter "*Background to Research Evaluation*") and have been shown to be effective in reducing DVA and in improving safety and mental health symptoms.

Future roll-outs of the programme could explore the potential of delivering the programme to a single parent, given the perceived impact that the therapeutic work had among some mothers in facilitating the ending of their intimate relationship with their co-parent.

Family experiences and views

Parents who participated in the evaluation, and who completed the programme, were positive about their experiences of *For Baby's Sake* and the difference it had made to them and their babies. They described specific perceived gains they had achieved in the programme and the impact of these gains on theirs and their family's well-being (e.g. skills around boundary setting, healthy communication in intimate and familial relationships, self-regulation and anger management).

Mothers and fathers identified key components in the programme which they perceived to act as mechanisms for positive change. Specific concepts of the therapeutic model such as the whole-family approach - which focuses on individual members of the family as well as the

family unit as a whole - the Inner Child module, the Video Interaction Guidance and the model's tools and exercises were described as key in facilitating changes. Individuals reported being able to adopt the tools they had learnt in the sessions and apply them successfully in the home to help improve communication and to de-escalate challenging situations.
Some parents reported that learnings from the Inner Child work enabled them to reflect on and acknowledge how past traumatic experiences affected how they viewed themselves and consequently how this influenced their parental style. The Video Interaction Guidance work also was reported by some parents as allowing them to identify the bonds they had developed with their child and provide them with reassurance about their parenting abilities. Based on the findings of the families in this evaluation, we suggest that any future roll-outs of the programme ensure that the above therapeutic models are retained.

The importance of receiving support from practitioners was emphasised, with mothers and fathers highlighting how they would not have engaged with the programme in the absence of the bond they formed with their practitioner. The importance of establishing strong therapeutic relationships is often argued as a key driver of the success of an intervention (Paley *et al.*, 2001). Future roll-outs of the programme would benefit from also focusing on the value and importance of building good therapeutic relationships with families.

Those taking part in the evaluation who dropped-out of the programme generally perceived that they did not require the type of therapeutic work offered by *For Baby's Sake.* A few others who dropped-out also described how they felt perceived pressure from social services to engage with the programme. Their experiences, along with those completing the programme, highlight the benefit of the programme in being optional and non-mandatory. Indeed, parents felt that the voluntary approach meant that they did not feel coerced into participating and found the interactions with the *For Baby's Sake* teams to be non-judgemental, inviting and welcoming. Similar findings have been found in a recent evaluation of a whole-family intervention in the north of England, and the voluntary nature of the programme was seen to promote engagement (Stanley and Humphreys, 2017).

Given the nature of the programme, collecting measurements of DVA experiences over time is important. The quantitative data that this evaluation has gathered on DVA experiences, among those that completed the programme, indicates some reductions in mothers' experience of DVA over time. It is however not possible in a non-RCT study to establish whether this can be attributed to the programme. Drawing on the qualitative data provided by mothers in this evaluation, disclosure of experiences of DVA may be affected by the therapeutic work that mothers are undertaking. As they develop improved understanding and awareness of what DVA means and the types of behaviours it comprises, they begin to link this to their own experiences. Related to this, a measure of changes in the intimate relationship status with the co-parent can represent a useful outcome assessment; although the programme does not focus on separation, our evaluation indicates that among those completing the programme a number chose to separate from their co-parent. Any outcome indicator regarding changes in parents' relationship status would be most meaningful if supplemented with outcome indicators regarding parents' perceptions of safety and risk of harm, both for themselves and for their child(ren). The latter measure permits a formal measurement of changes in levels of risk and safety over the course of the programme, a key indicator in demonstrating the success of the programme in harm reduction.

to the programme, and the characteristics of those who are referred, who engaged with the programme and reasons for disengagement. We also undertook fidelity assessments (see details below) and gathered routinely collected data from *For Baby's Sake* teams regarding, for example, birth outcomes and the social care status of families over time. The way in which the teams are set up within the two prototype areas (e.g. embedded within children's social care services and utilising local shared reporting systems) means that it was easy to collect this data and, indeed, the teams collected this data as part of their routine practice. In addition, the *For Baby's Sake* teams collected, and continue to collect, other extensive data on families for the Foundation's in-house internal management and programme development purposes. If the teams continue to collect such data this could provide a useful indicator, as part of an effectiveness evaluation, as to the impact of the programme on outcomes for each family member. Such data will also further support the operation and development of the programme, alongside informing any future roll-outs of the programme.

Due to the complexity of the views/behaviours that *For Baby's Sake* targets, it is a challenge to identify how the programme can best demonstrate the full range of outcomes achieved by families. Changes take place over a long period and, therefore, single assessments taken at a specific point in time may fail to adequately capture the changes that families have made over time. Expectations of changes achieved by families may need to be revised where a child has been removed and among families with learning difficulties. Improved outcomes for children occur over a longer time-period and may not, therefore, be adequately captured by the two-year birthday. In addition, our evaluation highlights that some parents may not identify the DVA they are experiencing or perpetrating when starting the programme and their awareness of the abuse develops over time as they work through the programme. This finding highlights the challenges with respect to gathering accurate assessments of ongoing forms of DVA among families.

The findings from this evaluation highlight that assessments of parent-child relationships and children's development are important to measure, as *For Baby's Sake* seeks to assess the impact of the programme on healthy parenting practices, attachments and positive child development. Our evaluation demonstrates that it is feasible to collect self-completed and researcher-administered assessments from both mothers and fathers regarding parenting practices/behaviours and child development. Collection of parent-child interactions may be more difficult for fathers, however, as some of them may have limited/no access to their children at some point(s) during their participation in *For Baby's Sake,* as a result of their DVA behaviours. Furthermore, low self-esteem and low parenting self-efficacy can mean that parents are reluctant to consent to these measures. However, our evaluation found that providing options for the collection of this data (e.g. videos being taken by practitioners or family members rather than researchers) can help to overcome some of these barriers.

Collection of both self-complete and researcher-administered data on parent-child relationships and children's development are important, as evidence indicates inconsistencies in relation to parents' perception of their parenting practices/behaviours against objective assessments of their practices/behaviours. The challenge for this programme in determining the right measures to use are that work is being targeted in utero all the way through to the child's second birthday. Assessments for infants/toddlers are often tailored for specific age and developmental time-points, to reflect the changing developmental and cognitive stages

of young children. This, therefore, creates potential challenges in assessing changes over time, as measures may only cover a short time-period and different measures may not be easily pooled together to provide an aggregate assessment of the outcomes achieved. For child developmental outcomes, therefore, a way to assess whether the programme has an impact is to have a comparison group who receives standard support offered by Local Authorities, or alternative treatment as usual care.

Considering measurement of potential impacts past the two-year birthday of children, future evaluations of the programme may wish to explore the value of examining readiness for school assessments.

Finally, future assessments of the programme may want to adopt realist methodologies, utilising both quantitative and qualitative techniques, to examine what works best for whom, when and in what circumstances (Pawson *et al.*, 1997). Such techniques permit examination of interacting personal, interpersonal and environmental/contextual factors to explore and understand how these factors impact on the success of a programme (Cooper *et al.*, 2017). Indeed, the qualitative data collected in this evaluation provided useful indications about mechanisms of change for families in different contexts, and the ways in which manualised components of the programme interacted with practitioner skills and individual family needs.

What is the evidence that the benefits delivered would outweigh the costs of the programme in the short, to medium term and to explore initial indications of cost-effectiveness?

The economic evaluation provides information on the cost of *For Baby's Sake*, initial indications about the range of other health and social care services accessed, and the total cost of supporting mothers and their babies over the two years they were involved in the *For Baby's Sake* study. Evidence of cost-savings generated by the programme and value for money were uncertain because the conclusions changed when assumptions and methods were adjusted in sensitivity analyses. Additionally, a number of important limitations, particularly the small sample sizes and lack of a comparison group, limit our confidence in the results. Further research is needed on a larger sample.

Evaluations, whether clinical or economic, in the early stages of a newly developed service are often tentative as new services require time to adapt, adjust and embed within the wider health and social care system. Many of these adaptations will impact upon the efficiency of service delivery and thus the cost and cost-effectiveness of the service, as the experience of managers and practitioners develops. However, early-stage evaluations are useful from a feasibility point of view to get initial indications of the cost of the intervention in comparison to other services and information on other services participants use which the new service may be able to impact upon as it develops. This gives an indication of whether interventions could be cost-effective when rolled out and fully embedded and give an indication of where costs might be reduced to increase the likelihood of cost-effectiveness in the future.

Conclusions

This report summarises the results of a four-year evaluation of the prototype of *For Baby's Sake.* Data were collected from a wide range of sources across time to evaluate whether the programme operates as anticipated, whether it is able to deliver positive short-term outcomes, and whether there is evidence that benefits would outweigh the costs. Results indicate that the programme has been successful in embedding in the local authority sites, receiving appropriate referrals and engaging families who meet the target population criteria. Families who remain engaged across time report a positive experience of the programme. Information from parents, practitioners and stakeholders indicated some potential change mechanisms, namely the whole family approach, the therapeutic relationships between parents and practitioners, and the therapeutic content, but further evidence from larger sample sizes is needed. The collection of quantitative data demonstrates that it is feasible and acceptable to collect a range of self-report and researcher-administered measures from different members of the family and the data we collected at this early prototype stage of the programme provides initial indications of positive outcomes amongst some families. Evidence of cost-savings generated by the programme and value for money were uncertain, as is often the case in the early stages of a newly developed service, and therefore further research is needed on a larger sample size.

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Appendix 1 - Measurement details

- The Revised Infant Behaviour Questionnaire (Gartstein & Rothbart, 2003) is a widely used parent- report measure of specific dimensions of infant temperament. It is composed of 191 items and 14 subscales including approach, vocal reactivity, high pleasure, smile/laughter, activity level, perceptual sensitivity, sadness, distress to limitations, fear, falling reactivity, low pleasure, cuddliness, duration of orienting and soothability. Parents are asked to report on these aspects during specific events over the last two weeks on a seven-point Likert scale from (1) “Never” to (7) “Always”. Internal reliability for each subscale was adequate (Cronbach α = > 0.70) for both mothers and fathers (Parade & Leerkes, 2008)

- Video-taped interactions of mothers/fathers and infants are independently rated by trained professionals using the CARE Index (Patricia M Crittenden, 1979; P.M. Crittenden, 2003). The CARE index assesses parental sensitivity, control and responsiveness alongside infant cooperativeness, compulsivity, difficultness and passivity from birth to around 15 months of age via short, videotaped play interactions of approximately 3-5 minutes. The CARE index also assesses dyadic synchrony (DS) which captures the quality of the interaction between the parent and infant. Scores range from 0-14 for each scale. Generally, scores below 5 on the sensitivity or dyadic synchrony scales are considered to indicate interactions of high risk (i.e. parents are in need of intervention) (Patricia M Crittenden, 1979; P.M. Crittenden, 2003). The collection of this data had been found feasible in research with mothers with perinatal mental illness (Pawlby et al., 2010). An important note on the interpretation of filmed interactions with mothers and fathers, the CARE Index manual states that: “*Mothers’ and fathers’ scores should be interpreted differently. When mothers are the primary caregivers, their interactions with their infants have predictive value. This appears to be less true for those fathers who are secondary caregivers. Often such fathers’ interactions are more sensitive than the mothers’ without being indicative of a substantially better relationship. In these cases, the fathers seem to function more as novel playmates that as attachment figures.*”(P.M. Crittenden, 2003, p19)

- The Prenatal Attachment Inventory is a self-report measure of attachment during pregnancy. It is composed of 21 items on a 4 point Likert scale ranging from “almost always” to “almost never”. Scores range from 21 to 84 with higher scores indicating higher levels of prenatal attachment. The measure demonstrated good internal consistency (Cronbach α = > 0.85) (Muller, 1989, 1993). This measure assesses thoughts, feelings and relationship of the mother to the foetus and takes around 5 minutes to complete

- The Child Behaviour Checklist (Achenbach & Edelbrock, 1983) is a parent-report measure assessing both internalising (i.e. anxious, depressive and over-controlled) and externalising (i.e. aggressive, hyperactive, noncompliant and under-controlled) child behaviours. It is composed of 64 items with each item parents circle 0 if the item is not true of their child, 1 if the item is sometimes true and 2 if the item is very true. Scores below the 95th percentile are in the normal range, and those that are above the 98th percentile are in the clinical range. The measure demonstrated excellent

internal consistency (Cronbach α = > 0.94) (Braet, 2011)

- The Ages and Stages Questionnaires (Squires & Bricker, 2009) are a series of parent-completed child development screening tools covering five domains; communication, gross motor function, fine motor function, problem solving, and personal-social development. Each domain is assessed by 6 questions and responses are given as “yes”, “sometimes” and “no”. Yes answers are given 10 points, sometimes answers are accredited 5 and no answers are accredited 0 points. Cut off scores are set at 2 standard deviations below the mean**.** The Ages and Stages Scales have been widely used in research and are found to be feasible for use with high risk populations (Enlow, Egeland, Blood, Wright, & Wright, 2012; McKelvey et al., 2011)
- Bayley’s Scales of Infant Development (Bayley, 2006) examines young children (aged 1-42 months) in five key developmental domains of cognition, language, social-emotional, motor and adaptive behaviours. It involves interaction between the child and examiner and observations in a series of tasks. The examiner rates the child’s performance on each task, and scores are totalled. The Bayley’s composite scores range from 40 to 160, with a mean of 100 and a standard deviation of 15. Scores equal to and higher than 85 are within normal limits, scores between 70 and 84 signify mildly delayed performance, and scores under 69 significantly delayed performance. Raw scores are compared to tables of scores for other children the child’s age. This process yields a standard score that enables the examiner to estimate the child’s development compared to other children their age. The Bayley Scales have been widely used in research and are found to be feasible for use with high risk populations (Enlow et al., 2012; McCrae, Cahalane, & Fusco, 2011; McKelvey et al., 2011)
- The Parenting Stress Index (Abidin, 1997) is a parent self-report screening measure for evaluating the parenting system and identifying issues that may lead to problems in the child’s/parents behaviour. It is a 120-item questionnaire that can be used with children aged 3 months to 10 years of age. It assesses six child behaviour domains; distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, acceptability; alongside seven parent domains including competence, social isolation, attachment to child, health, role restriction, depression, and spouse. Answers are given on a 5-point scale from (1) ‘Strongly Agree” to (5) “Strongly Disagree”. The measure has demonstrated excellent internal consistency for composite Total stress (Cronbach α = > 0.96)
- The Experiences in Close Relationships-Revised (Fraley, Waller, & Brennan, 2000) is a self-report measure of attachment related anxiety and avoidance. It is composed of 36 items with two subscales; Anxiety and Avoidance. Answers are given on a seven point Likert scale from (1) “Strongly Disagree” to (7) “Strongly Agree”. Scores are given for both anxiety and avoidance. The measure has demonstrated excellent inconsistency for both subscales (Cronbach α = > 0.90) (Sibley & Liu, 2004). This is a widely used measure and has been administered to assess adult attachment among people experiencing and perpetrating domestic violence (Follingstad & Rogers, 2012; Goldenson, Geffner, Foster, & Clipson, 2007)
- The Composite Abuse Scale (CAS) (Hegarty, Fracgp, Bush, & Sheehan, 2005) is a 30-item self-administered questionnaire assessing the frequency/severity of abuse and

harassment in the previous year. Items are rated from 1= 'Never' to 5 = 'Daily', with total scores ranging from 0-150. A cut-off point of three is assigned, with scores of three or more indicating domestic abuse; the measure demonstrated strong internal consistency (Cronbach α = > 0.90) (Hegarty et al., 2005). The CAS has been used in previous research with both women and men in clinical and non-clinical populations

- We developed a composite abuse questionnaire - Abuse Experiences Questionnaire (AEQ) – based on previously tested/gold-standard questionnaires that have been used with similar population groups (Hegarty et al., 2005; M Hester et al., 2015). The questionnaire includes measures of changes in frequency, severity and impacts of abuse over the course of the programme. The composite measure assessed a range of physical and non-physical forms of abuse – i.e. physical, sexual, psychological, emotional and financial abuse – including forms of controlling and coercive behaviours. It includes questions on both victimisation and perpetration
- Edinburgh Postnatal Depression Scale (Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009; S. Matthey, 2008) is a 10-item self-administered questionnaire assessing depression during the postpartum period. It has also shown to be valid during pregnancy and in men. Items are rated from 0 – 3 with total scores ranging from 0-30; the measure has demonstrated good internal consistency in pregnant women (Cronbach α = > 0.82) (Bergink et al., 2011) and in men (Cronbach α = > 0.81) (Stephen Matthey, Barnett, Kavanagh, & Howie, 2001). A score over 12 is used to indicate possible depression in women. Several different cut-off scores have been used for men (Stephen Matthey & Agostini, 2017; Stephen Matthey et al., 2001). In this study we used the same cut-off score for both men and women (i.e. ≥12)
- Generalised Anxiety Disorder Assessment (GAD-7) (Löwe et al., 2008) is a 7-item self-administered questionnaire to assess the presence of current generalised anxiety symptoms. Items enquire about the degree to which the patient has been bothered by feeling nervous, anxious or on edge, not being able to stop or control worrying, worrying too much about different things, having trouble relaxing, being so restless that it is hard to sit still, becoming easily annoyed or irritable and feeling afraid as if something might happen (Williams, 2014). Items are scored on a four-point scale, with total scores of 0 – 21. Taking the brevity of the scale into account, the measure has demonstrated good internal consistency (Cronbach α = 0.89)
- Posttraumatic Diagnostic Scale (Foa E.B., 1997) is a 49-item self-administered questionnaire screening for the presence of PTSD in patients who have identified themselves of a victim of a traumatic event as well as to assess the severity and functioning in those already identified as suffering with PTSD. Questions related to the frequency of distressing and intrusive thoughts, post-traumatic avoidance and hyper-arousal. Items are rated on a four-point scale, with total scores of 0– 51. The measure has demonstrated excellent internal consistency (Cronbach α = > 0.92). A diagnosis of PTSD can be made with an algorithm that requires that the individual's responses meet the following criteria: The traumatic event involves either injury or life threat; the person felt helpless or terrified during the event, endorsement (rating of 1 or higher) of at least one re-experiencing symptom, three avoidance symptoms, and two arousal symptoms; duration of at least one month; and impairment in at least one area of functioning. At follow up, as responses are dependent on identifying a specific

traumatic event, participants were first asked if they had experienced such an event since the last interview. Where they responded no, they were not required to complete the rest of the questionnaire. If they responded yes, they were asked about any symptoms

- The Smoking Questionnaire utilises items administered in other studies examining smoking use in pregnancy and from our own research with pregnant women (Kharrazi et al., 1999; Mullen, Carbonari, Tabak, & Glenday, 1991). The questionnaire consists of three items that examine the average number of cigarettes smoked (per day) in the period leading up to and including pregnancy, changes in smoking use during pregnancy and the use of nicotine replacement methods

- The Alcohol Use Disorders Identification Test (Babor, Higgins-Biddle, Saunders, & Monterio, 2008) is a questionnaire designed to identify hazardous and harmful patterns of alcohol consumption. It is composed of 10 items covering 3 domains; 1) Hazardous alcohol use, 2) Dependence Symptoms, 3) Harmful Alcohol use. Each question is scored 0-4, with a total score of 8 or more indicate harmful/dependent drinking. It can be delivered as an oral interview or as self-report. In a review of the measure, Reinert & Allen (2002) found that the median Cronbach's Alpha fell into the .80's (Reinert & Allen, 2002)

- Drug Use Disorder Identification Test (Berman, Bergman, Palmstierna, & Schylter, 2003) is a questionnaire disorder Identification test designed to identify substance misuse problems. It is composed of 11 items and with scores ranging between 0-44. Scores of 25 or more indicate heavy, dependent drug use. The measure has demonstrated good internal consistency (Cronbach α = >0.80)

- The Camberwell Assessment of Need for Mothers (Short version) (CAN-M(s) (Howard et al., 2007)) is a researcher-administered questionnaire that incorporates the full 22-items of the original CAN measure, plus four additional items measuring the needs of pregnant women and mothers experiencing mental illness (i.e. pregnancy care, practical/emotional demands of childcare); the 22 generic domain items are applicable to men. Scores of either 1 = 'Met need', 2 = 'Unmet need' or 0= 'No problem' are assigned per item; Spearman's r correlation coefficients were moderate with the GAF-S (-0.36) and GAF-D (-0.52). The CAN-M(S) has been used in research with victims of domestic violence (K Trevillion et al., 2014)

- The Social Provision Scale (Cutrona & Russell, 1987) is an interviewer-administered questionnaire which examines the degree to which respondents' social relationships provide various dimensions of social support. It is composed of 24 items with 4 items looking at each of the six domains: Attachment, social integration, reassurance of worth, reliable, alliance, guidance and opportunity for nurturance. Answers are provided on a 4 point scale; (1) "Strongly Disagree" to (4) "Strongly Agree" with higher scores indicating a greater degree of perceived support. The measure demonstrated acceptable internal consistency (Cronbach α = > 0.70)

- The five level version of the EuroQol (EQ-5D-5L) (Herdman et al., 2011) is a standardised, generic measure of health-related quality of life. It consists of five dimensions of health: mobility; self-care; usual activities: pain/ discomfort; and anxiety/depression. Each of these dimensions has 5 levels; (1) No problems, (2) Slight

problems (3) Moderate problems (4) Severe problems (5) Extreme problems. These response are used to generate individual health states that can be converted into a weighted health index score, based on values derived from general population samples (Devlin, Shah, Feng, Mulhern, & Van Hout, 2017).

- The Work and Social Adjustment Questionnaire (Mundt, Marks, Shear, & Greist, 2002) is a 5-item self-report measure which assesses the impact of a person's mental health difficulties in their ability to function in terms of work, home management, social leisure, private leisure and personal/family relationships. Maximum score is 40 with scores above 20 suggesting moderately severe or worse psychopathology. The measure has demonstrated good internal consistency at baseline with Cronbach α = > 0.81

- The Standardised Assessment of Personality – Abbreviated Scale (SAPAS) is an 8-item researcher-administered screening questionnaire which provides a validated measure of personality dysfunction (Moran et al., 2003). The eight items correspond to a descriptive statement about the person and are scored either 0 = "no" or 1 = "yes"; the eight items are added together to produce a total score of between 0 and 8. A score of 3 or more on the SAPAS indicates probable personality disorder. The measure demonstrated good sensitivity and specificity (0.94 and 0.85, respectively) with the SCID

- The Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007) is a 14-item self-administered questionnaire covering both hedonic and eudiamonic aspects of mental health, including positive affect (e.g. feelings of optimism, cheerfulness), satisfying interpersonal personal relationships and positive functioning (e.g. energy, self-acceptance, personal development, competence and autonomy). Items are rated on a five-point scale, with total scores ranging from 14-70; the measure demonstrated strong internal consistency (Cronbach α =>0.89). The scale has been used in research with mental health service users (Slade et al., 2011)

- The Adult Service Use Schedule (AD-SUS) is an economic evaluation questionnaire measuring use of resources (i.e., the number and length of contacts with health and social services) (Kuyken et al., 2008). The questionnaire is described in detail in the section above (page 68), titled "Economic Evaluation of *For Baby's Sake"*

Appendix 2 - Summary of the characteristics of studies included in the systematic review

Author and Publication Date	Country and Setting	Study design	Treatment model (including no. of sessions and duration)	Population under investigation	Personnel	Allocation (if applicable), timing of assessments and type of outcome assessments
Ammerman et al 2016	USA, Home visitation	RCT	The In-Home Cognitive Behavioural Therapy plus Every Child Succeeds home visitation programme [*utilising either the Nurse Family Partnerships visitation model or the Healthy Families America visitation model*] was compared to a standard home visitation programme [*Nurse Family Partnerships or Healthy Families America*] In-Home Cognitive Behavioural Therapy (IH-CBT), to address depression. IH-CBT combines the principles and techniques of CBT with strategies that seek to: (1) promote engagement, (2) make content relevant to the needs of mothers (e.g. addressing primary concerns of young, low income new mothers who are socially isolated), (3) facilitate delivery in the home, and (4) engender collaborative relationships between the therapist and home visitor through regular written/telephone communication and a joint treatment session. IH-CBT consists of fifteen 60-minute weekly sessions plus a booster session one-month post-treatment The Nurse Family Partnerships model provides monthly home visits from 28 weeks of pregnancy until the child turns two years of age. The Nurse Family Partnerships model seeks to support health behaviour change, improve understandings of positive relationships, promote consistent and positive caregiving towards children and increase opportunities for community, education and employment.	N=93 new mothers, aged 16 years or older, who were 3 months post-delivery and were taking part in Every Child Succeeds home visitation programme. The 93 mothers met diagnostic criteria for major depressive disorder and disclosed child maltreatment Women were excluded from the study if they had bipolar disorder, current substance dependence, psychosis, intellectual disability, suicidality, or homicidality requiring acute intervention, or current use of psychotropic	The Nurse Family Partnerships home visiting programme is delivered by nurses. The Healthy Families America home visiting programme is delivered by social workers, related professionals or paraprofessionals The IH-CBT model is delivered by trained therapists	Mothers were randomly allocated to IH-CBT plus home visiting (n=47) or to standard home visiting (n=45) Assessments were taken pre-treatment, post-treatment and 3 months follow-up. Depression was assessed using the Beck Depression Inventory-II Impaired social functioning was measured using the Social Network Index Lower nurturing and stimulating parenting behaviours were measured using the Home Observation for Measurement of the Environment Inventory

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Ammerman et al 2016	USA, Home visitation	RCT	The In-Home Cognitive Behavioural Therapy plus Every Child Succeeds home visitation programme [*utilising either the Nurse Family Partnerships visitation model or the Healthy Families America visitation model*] was compared to a standard home visitation programme [*Nurse Family Partnerships or Healthy Families America*] In-Home Cognitive Behavioural Therapy (IH-CBT), to address depression. IH-CBT combines the principles and techniques of CBT with strategies that seek to: (1) promote engagement, (2) make content relevant to the needs of mothers (e.g. addressing primary concerns of young, low income new mothers who are socially isolated), (3) facilitate delivery in the home, and (4) engender collaborative relationships between the therapist and home visitor through regular written/telephone communication and a joint treatment session. IH-CBT consists of fifteen 60-minute weekly sessions plus a booster session one-month post-treatment The Nurse Family Partnerships model provides monthly home visits from 28 weeks of pregnancy until the child turns two years of age. The Nurse Family Partnerships model seeks to support health behaviour change, improve understandings of positive relationships, promote consistent and positive caregiving towards children and increase opportunities for community, education and employment.	N=93 new mothers, aged 16 years or older, who were 3 months post-delivery and were taking part in Every Child Succeeds home visitation programme. The 93 mothers met diagnostic criteria for major depressive disorder and disclosed child maltreatment Women were excluded from the study if they had bipolar disorder, current substance dependence, psychosis, intellectual disability, suicidality, or homicidality requiring acute intervention, or current use of psychotropic	The Nurse Family Partnerships home visiting programme is delivered by nurses. The Healthy Families America home visiting programme is delivered by social workers, related professionals or paraprofessionals The IH-CBT model is delivered by trained therapists	Mothers were randomly allocated to IH-CBT plus home visiting (n=47) or to standard home visiting (n=45) Assessments were taken pre-treatment, post-treatment and 3 months follow-up. Depression was assessed using the Beck Depression Inventory-II Impaired social functioning was measured using the Social Network Index Lower nurturing and stimulating parenting behaviours were measured using the Home Observation for Measurement of the Environment Inventory

				criterion were eligible for inclusion. Fathers were involved in the intervention, where possible, but only 30 fathers participated so the paper focuses solely on mothers. Half of all mothers reported childhood abuse.		
Cripe et al, 2010	Peru, Hospital materni ty setting	RCT	An empowerment intervention for partner violence was compared to a standard care model comprising an abuse assessment and referral card of agencies providing support for partner violence The empowerment intervention comprises supportive counselling, education and advice, including safety planning, delivered over a single session lasting 30 minutes. Participants received supportive care, validation of feelings, empathetic listening, and information on what to expect when seeking help from legal resources, shelters, law enforcement, or counselling services. During the session participants were also given with details of agencies that provide support for partner violence and the social workers offered to assist participants with making calls to services	N=220 women, between 12-16 weeks gestation, attending hospital-based perinatal care and who reported partner violence victimisation in the last 12 months. Women were excluded if they if they did not speak or understand Spanish and if they were below age 18 years or above age 45 years	Hospital-based trained social workers	Women were randomly assigned to either: (1) the empowerment intervention (n=110) (2) the standard care model (n=110) Assessments were taken Pre-intervention and then again in the immediate period post-childbirth. Safety behaviours were assessed using the Safety Behaviour Checklist (modified for the study)
Fergusson et al, 2005	New Zealand ,	RCT	An Early Start home visitation programme was compared to a control condition (i.e. families not participating in programme)	N=427 at-risk families, with two or more of these risk factors (i.e. *young age, low social support, unplanned*	Trained family support workers, all workers had a nursing or social work qualification	Families were randomly assigned to either: (1) the Early Start home visitation programme

	Home visitation		The Early Start home visitation programme is based on social learning models and comprises: (1) assessment of family needs, issues and strengths/challenges and resources; (2) problem-solving of family challenges; (3) mentoring, advice and support to mobilise the strengths and resources of families and to support families during the pre-school childhood years. A key component of the programme is the development of a positive relationship between families and the workers delivering the intervention.	*pregnancy, substance use, low socio-economic status and family violence*). Over half of families participating in the intervention reported childhood abuse and around one in four reported current partner abuse		(n=206) (2) or the control condition (n=221) Assessments were taken pre-intervention, 12, 24 and 36 months after enrolment. Positive and non-punitive parenting behaviours were assessed using the parenting questionnaire derived from a Child Rearing Practices report Child abuse and neglect was measured using the Conflict Tactics Scale sub-scales Parent-Child Conflict as well as reported contacts with Child, Youth and Family social care services Child behaviour was measured using the Infant Toddler Social and Emotional Assessment Scale
Lavi et al, 2015	USA, Hospital setting in a general women'	Pre- and Post-study design	A perinatal child-parent psychotherapy programme was delivered to pregnant women The child-parent psychotherapy programme is a relationship-based treatment that integrates theories of attachment, psychoanalysis and complex trauma with clinical strategies derived from cognitive-behavioural and	N=64 pregnant women, aged 18 to 40 years, who reported feeling unsafe in their relationship and who did not have psychosis, current use	Perinatal child-parent psychotherapy trained clinicians at masters or doctoral level	Prenatal assessment and at last post-natal session Maternal-infant attachment was assessed using the Maternal Fetal Attachment Scale

	s health clinic		social learning theories. The perinatal adaptation of the programme seeks to promote self-care; attunement and responsiveness to infant's signals; address negative maternal attributions of infant and potential maladaptive caregiving by exploring these attributions/behaviours in relation to mother's own experience of current/past abuse victimisation. The intervention comprises 27 weekly one-hour sessions provides psychoeducation on infant development and the impact of DVA on a child; mindfulness strategies, reflective developmental guidance and insight-orientated interpretation. During pregnancy the perinatal intervention focuses on the women's' experiences of pregnancy and their hopes and fears. At two-four weeks post-childbirth the intervention involved dyadic sessions with the infant and focuses on mother's experience of childbirth, her perception of the newborn and moment-to-moment mother and child interactions	of drugs or alcohol or intellectual disability		Depression was assessed using the Center for Epidemiological Studies-Depression Scale Post-traumatic stress was assessed using The Davidson Trauma Scale
McFarlane et al 2000	USA, Hospital prenatal clinics setting	RCT	Three treatments: (1) a brief intervention comprising giving participants a wallet-sized resource card on partner violence including phone numbers of local support services and information about personal safety planning; (2) a counselling intervention, consisting of unlimited counselling sessions focused on providing participants with support and education around partner violence; (3) an outreach intervention comprising unlimited counselling sessions plus the services of "mentor mother" who offered support, education and referral for partner violence. The counselling intervention was delivered throughout the pregnancy period and administered within a maternity clinic and participants could "drop-in" for unscheduled meetings. Supportive counselling and education were delivered, alongside referral to partner violence support services and assistance for participants in accessing support services	N=329 pregnant Hispanic women suffering from abuse from current or former partner abuse in the past year	The counselling intervention was delivered by experienced counsellors with expertise in domestic abuse 'mentor mothers' were non-professionals who were mothers themselves and resided in the local community served by the hospital services. Mentors received training in how to assist abused women and in conducting	Women were randomly assigned to either: (1) a brief intervention (n=113), (2) a counselling intervention (n=98), or (3) an outreach intervention (n=118) Assessments were taken pre-intervention, and then at 2, 6, 12 and 18 months post-delivery The Severity of Violence Against Women Scales questionnaire was used

			The outreach intervention component of the "mentor mother" was throughout the pregnancy period and administered via in-person visits or over the telephone.		prenatal education classes that included information on abuse	to measure partner violence
Mejdoubi et al 2015	Netherlands, Home Visitation	RCT	The VoorZorg intervention nurse home visitation programme was compared to usual care. The VoorZorg intervention comprise ten visits during pregnancy, 20 in the first year post childbirth and 20 in the second year post childbirth. During each visit, topics in six domains (i.e. personal health, environmental health, life-course development, maternal role, family and friends, statutory services) were addressed using well-structured manuals – the manuals were taken from the Nurse Family Partnership model and translated into Dutch. pre-birth health education, physical examinations.	N=460 at-risk pregnant women, under the age of 26 years, with a low-education level, a first time pregnancy, at a maximum of 28 weeks gestation and some understanding of Dutch. At risk-women were defined as having one or more risk factors (i.e. *single parent, historical or current partner violence, psychosocial symptoms, unwanted pregnancy, financial problems, housing difficulties, no employment and/or education, alcohol and/or drug use*). Over half of the women participating in the intervention reported lifetime partner violence	Nurses were trained in delivering the VoorZorg intervention	Women were randomly assigned to either: (1) the VoorZorg intervention (n=237), (2) or usual care (n=223) Assessments were taken pre-intervention, and then at 6, 18 and 24 months post-delivery Child behaviour was measured using Child Behavior Checklist The Home environment was measured using the Home Observation for Measurement of the Environment Inventory Children's safety was measured using documented Child Protection Services reports
Parker et al 1999	USA, Hospital setting	Non - randomised	An empowerment intervention, with or without three additional counselling and information sessions was compared against a group of participants who were given a	N=199 pregnant women who have been	Masters or doctorate nurses with 4 hrs minimum training	A total of n=132 women received the empowerment

	in public health clinics for women and children	controlled experimental study	wallet-sized resource card on partner violence including phone numbers of local support services The empowerment intervention was delivered three times during pregnancy and consisted of developing a safety plan, information on the cycle of DVA, information on legal protections and details on community support services. Each session took approximately 30 minutes. Some participants also received three additional counselling and information sessions, although uptake was low.	physically/sexually assaulted by their partners in the year prior or during their pregnancy and who considered themselves to still be in a relationship.	delivered the empowerment intervention The additional counselling and information sessions were taught by workers at the local DVA shelter	intervention and n=67 received the comparison condition (i.e. resource card only) Assessments were taken pre-intervention and then 6 and 12 months post-delivery The Severity of Violence Against Women Scales questionnaire and the Index of Spouse Abuse questionnaire was used to measure partner violence
Sharps et al 2016	USA, Home Visitation	RCT	A Domestic Violence Enhanced Home Visitation Programme (DOVE) was compared to a standard home visitation programme The DOVE intervention is a structured brochure-based empowerment model comprising six sessions between 15-25 minutes in length and delivered as part of the routine home visitation sessions. DOVE focuses on providing information on the cycle of violence, safety planning, and local partner violence support services The standard home visitation programme consists of around 4-6 visits antenatally and 6-12 sessions up to two years post-childbirth. This model does not focus on partner violence but includes a protocol for discussion of partner violence and referral on to support services, if required	N=239 pregnant English-speaking women, aged 14 years and older, with a low-income who experienced partner violence from a current or former partner and who were deemed to be at high-risk (*i.e. single parent, low-birth weight/pre-term birth*). For inclusion in the study, women needed to be less than 32 weeks gestation and enrolled	Home visitor nurses had two 4-hour training sessions on partner violence before delivering DOVE	Women were randomly assigned to either: (1) the DOVE intervention (n=124), (2) or standard home visitation (n=115) Assessments were taken pre-intervention, and then at 1, 3, 6 12, 18 and 24 months post-partum Partner violence was measured using the Abuse Assessment Screen, the Conflict Tactics Scale-2 and the

				in a perinatal home visitation programme		Women's Experience in Battering Scale Depression was measured using the Edinburgh Postnatal Depression Scale
Taft et al 2011	Australia a Home setting	Cluster RCT	A MOtherS' Advocates In the Community domestic violence mentoring intervention (MOSAIC intervention) was compared against usual care MOSAIC intervention comprises three to twelve months of weekly/fortnightly mentoring, delivered by trained non-professionals who provide befriending, domestic violence advocacy, support for depression, parenting, safety and self-care and information on legal and parenting services All participating clinicians in the primary care clusters undertook six hours of professional development to enhance their capacity to identify, respond to and refer women who were psychosocially distressed (at-risk) or who were experiencing partner violence. Clinicians were also provided with referral booklets for partner violence services; posters for waiting rooms; pocket-sized cards for women with local referral options and opportunities for further training	106 primary care clinics in Australia participated N=215 pregnant women or women with a child aged 5 years or younger who were aged 16 years or older and who reported partner violence or psychosocial distress. Over 70% of the sample reported partner violence	Trained and supervised local mothers	Primary care clinics were randomly assigned to either: (1) the MOSAIC intervention (n=49), (2) or the usual care comparison arm (n=57) Assessments were taken pre-intervention and then 12 months follow up. Partner violence was measured using the Composite Abuse Scale Depression was measured using the Edinburgh Postnatal Depression Scale Social support was measured using the Medical Outcomes Scale Short Form
Tiwari et al 2005	Hong Kong,	RCT	An empowerment intervention (based on Parker et al 1999 model) was compared against a group of participants who	N=110 pregnant women, over 18 years	Senior research assistant who was a midwife with	A total of n=55 women received the

	Hospital antenatal clinic		were given a wallet-sized resource card on partner violence including phone numbers of local support services The empowerment intervention consisted of a single 30-minute session which included advice in relation to safety planning, choice-making and problem-solving. The intervention also added a client-centred therapeutic approach (Roger's) to ensure participants received empathic responses that acknowledged women's perceptions and feelings. At the end of the session, participants are given a brochure reinforcing the information provided	of age and less than 30 weeks gestation who have been physically, emotionally and/or sexually assaulted by their male partners in the previous year	master's degree in counselling	empowerment intervention and n=55 received the comparison condition (i.e. resource card only) Assessments were taken pre-intervention and then at 6 weeks post-delivery Partner abuse was assessed using modified phrasing on the Conflict Tactics Scale Depression was measured using the Edinburgh Postnatal Depression Scale Quality of life was measured using the Short-Form Health Survey (SF-36)
Zlotnick et al 2011	USA, Primary care clinics	RCT	An Interpersonal Psychotherapy intervention was compared against standard care The Interpersonal Psychotherapy intervention consisted of four 60-minute sessions, delivered over one month, followed by a "booster" session at 2 weeks post childbirth. The intervention seeks to decreased isolation and enhance participants' social networks, improve their interpersonal relationships and change their expectations of them, and master their role transition to parenthood. Education is	N=54 Pregnant women, aged between 18 and 40 years, who disclosed abuse from a partner in the previous year. Women were excluded if they met criteria for current	Trained interventionists in the model	A total of n=28 women received Interpersonal Psychotherapy and n=26 received usual care Assessments were taken pre-intervention, 5-6 weeks post-allocation

			provided around relationships, the transition to parenthood, the cycle of abuse and consequences of abuse. Strategies are delivered around stress management skills, goal-setting, resolving conflicts and safety planning	affective disorders, post-traumatic stress disorder and substance use		and then at 4 weeks and 3 months post-delivery Partner abuse was assessed using modified phrasing on the Conflict Tactics Scale Symptoms of depression and PTSD were assessed using the Longitudinal Interval Follow-Up Examination questionnaire as well as the Edinburgh Postnatal Depression Scale and The Davidson Trauma Scale

Appendix 3 – PRISMA Flow Diagram of Theory of Change Systematic Review

PRISMA 2009 Flow Diagram

Identification

Records identified through database searching
(n = 6918)

Additional records identified through other sources
(Citation tracking n = 7)

Records after duplicates removed
(n = 4383)

Screening

Records screened
(n = 4383)

Records excluded
(n = 4198)

Eligibility

Full-text articles assessed for eligibility
(n = 185)

Full-text articles excluded
(n =173)

Not perinatal period: 38
Not assessing interpersonal abuse: 96
Not psychosocial intervention: 1
Ineligible study design: 26
Ineligible article type: 6
Data of interest not available in the paper: 6

Included

Studies included in review
(n = 12):

Studies reporting outcomes only for parents:
Studies reporting outcomes on children:
Studies reporting outcomes on parents and children:

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Appendix 4 – Introducing the Research Evaluation Team

Professor Louise M. Howard - Institute of Psychiatry, Psychology & Neuroscience, King's College London

Dr Louise M. Howard (PhD, MRCP, MRCPsych) is Professor of Women's Mental Health and Consultant Perinatal Psychiatrist at the South London and Maudsley NHS Foundation Trust. Professor Howard's research expertise is in perinatal mental health and domestic abuse; she currently leads a NIHR programme grant examining the effectiveness and cost-effectiveness of health services for pregnant women and mothers with mental illness and has successfully led on several large health studies on domestic abuse and human trafficking. Professor Howard chaired the NICE Guideline Development Group on Antenatal and Postnatal Mental Health and was a member of the WHO and NICE guideline groups on Violence Against Women

Professor Harriet MacMillan – McMaster University, Canada

Dr Harriet MacMillan (MD, MSc, FRCPC) is Distinguished University Professor in the Departments of Psychiatry and Behavioural Neurosciences, and of Pediatrics at McMaster University, Canada. Professor MacMillan is a paediatrician and child psychiatrist with extensive research experience in family violence research, including trials of interventions aimed at the prevention of child maltreatment and domestic abuse, and was a member of the WHO guideline development group on responding to intimate partner violence and sexual violence against women.

Professor Paul Ramchandani – Cambridge University

Dr Paul Ramchandani (BM BCh, MSc, DPhil, MRCPsych) is Lego Professor of Play in Education, Development and Learning at the University of Cambridge. Dr Ramchandani is a Consultant Child and Adolescent Psychiatrist and his research investigates the link between parents' and children's health

Professor Debra Bick – Warwick University

Dr Debra Bick (RM, BA, MMEdSci, PhD) was Professor of Midwifery at King's College London, but is now Professor of Clinical Trials in Maternal Health at Warwick Clinical Trials Unit, University of Warwick. Professor Bick has research expertise in public health and epidemiology. She has completed several UK wide studies of complex interventions to improve maternal physical and psychological health and well-being. Professor Bick was midwife adviser to the Children's and Young People's Health Outcomes Forum, clinical advisor to the NICE postnatal care guideline and Chair of the NICE postnatal quality standards group. She is currently chair of the RCOG Intrapartum Clinical Studies Group

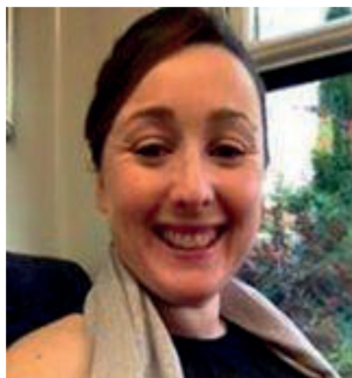
Professor Nicky Stanley – University of Central Lancashire

Dr Nicky Stanley (BA, MA, MSc and CQSW) is Professor of Social Work and a co-director of University of Central Lancashire's Connect Centre for international research on interpersonal abuse and harm. She has considerable experience of research on domestic abuse, child protection and maternal mental health and has undertaken reviews of the evidence on interventions for children and victims of domestic abuse. She led the evaluation of the Strength to Change service for perpetrators of domestic abuse as well as undertaking the formative research on the social marketing campaign that preceded the service. She was Principal Investigator on a Government commissioned study of innovative approaches in social work with looked after children conducted across 11 sites

Professor Sarah Byford - Institute of Psychiatry, Psychology & Neuroscience, King's College London

Dr Sarah Byford (BSc, MSc, PhD) is Professor of Health Economics fellow at the Institute of Psychiatry, Psychology & Neuroscience, King's College London. Professor Byford has extensive experience of utilising a range of economic methodologies to accurately evaluate the costs and economic implications of complex interventions, including health-based interventions for domestic abuse and interventions in early childhood and adolescence. She has been a member of the NICE/SCIE programme development groups for looked after children and for preventing and reducing domestic violence

Dr Margaret Heslin - Institute of Psychiatry, Psychology & Neuroscience, King's College London



Dr Margaret Heslin (BSc, MSc, PhD) is an experienced epidemiologist and health economist who works at the Institute of Psychiatry, Psychology & Neuroscience, King's College London. Dr Heslin conducts economic assessments of a number of complex interventions, including Professor Howard's study on the effectiveness and cost-effectiveness of services for mothers with mental illness

Dr Kylee Trevillion - Institute of Psychiatry, Psychology & Neuroscience, King's College London

Dr Kylee Trevillion (BSc, PhD) is a Lecturer at the Institute of Psychiatry, Psychology & Neuroscience, King's College London. Dr Trevillion's primary research interests are on the practice and policy responses to violence against women and perinatal mental disorders. She has successfully completed several domestic abuse research studies and conducted her PhD thesis on mental health service responses to domestic abuse. Dr Trevillion programme managed a five-year National Institute for Health Research funded grant examining the effectiveness and cost-effectiveness of perinatal psychiatry services in the UK

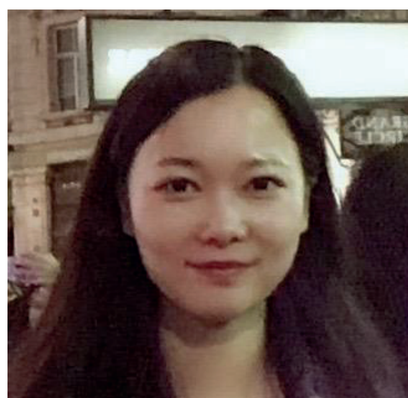
Dr Jill Domoney - Institute of Psychiatry, Psychology & Neuroscience, King's College London

Dr Jill Domoney is a Research Clinical Psychologist in the Section of Women's Mental Health, specialising in perinatal and infant mental health. Her research interests include developing and evaluating psychosocial perinatal interventions, paternal mental health and father-inclusive practice. Jill was recently awarded a Churchill Travelling Fellowship to explore evidence-based practice in perinatal mental health services in Australia. She is also a member of the pPOD research group and the South London Clinical Network for Perinatal Mental Health.

Dr Josephine Ocloo - Institute of Psychiatry, Psychology & Neuroscience, King's College London

Dr Josephine Ocloo is a senior researcher at King's College London. Josephine is experienced in conducting complex evaluations (recently at the King's Fund where she was evaluating a national project on patient and family centred care), and working with diverse communities, including for many years in her capacity as coordinator and women's worker in a community project in Tower Hamlets focussing on domestic violence, amongst other issues. Josephine's work in Tower Hamlets brought her into community-based social work and eventually to taking up a senior lecturer position in Social Work at London Metropolitan University. She went on to complete a PhD in patient safety as a result of a personal experience of medical harm in 2008. Josephine has a strong interest in the work of the voluntary sector and has sat on the board of many community initiatives as well as been the project director of some high-profile initiatives in the past such as the Patients for Patient Safety Project run by the National Patient Safety Agency.

Ms Xiaoxiao Ling - Department of Statistical Science, University College London



Xiaoxiao Ling joined King's Health Economics, King's College London as a research associate in 2018. Her research focused on trial-based economic evaluations. She assisted the *For Baby's Sake* study and ESMI-MBU study. Xiaoxiao has a BA in public health from Fudan University, China, and an MSc in Health Economics from University College London (UCL). She now is a first-year PhD student at the Department of Statistical Science, UCL. Her PhD project is to construct a semi-parametric Bayesian structure to handle missing data in within-trial cost-effectiveness analysis (CEA).

Appendix 5 – Extract from Standard Operating Procedure

OVERVIEW OF SAFETY GUIDELINES FOR RESEARCHERS

These guidelines, and the referenced supporting guidelines, cover five areas:

- Procedures for telephone contacts with participants;
- Procedures for face-to-face contact with participants (including safety at off-site visits) based on: (i) Safety Guidelines for Community Interviewing (Institute of Psychiatry, 2008), (ii) Home Visits Policy (Health Service and Population Research Department, Institute of Psychiatry, 2010), (iii) Lone Working Protocol (Institute of Psychiatry, 2015);
- How to manage participant distress and what to do if you feel concerned or distressed by anything arising from an interview;
- How to manage a loss of pregnancy experienced by female participants;
- What to do if you feel there is a serious risk to the participant or another person (including responses to suicide-related questions, domestic violence and potential risks to children)

ESTABLISHING CONTACT WITH PARTICIPANTS

Prior to any contact, you should refer to the evaluation study specific protocol and ethics submission for the approved methods of approaching participants. This is to ensure that your actions strictly adhere to what has been agreed in the protocol. Researchers must be familiar with all research responsibilities regarding Information Governance, the Data Protection Act and General Medical Council guidance on obtaining consent and managing confidentiality. If in doubt, you should review the primary guidance and consider undertaking refresher training via the HSCIC and Good Clinical Practice e-learning refresher courses.

If participants are already recruited to the evaluation study, you should check their preferred method of communication and contact times by referring to the contact preference form. If there are no instructions regarding participants' preferred methods and times for contact, you should establish these on your first contact.

It is important to be mindful that women taking part in *For Baby's Sake* may experience a loss of pregnancy (e.g. termination, miscarriage/stillbirth) before the time you make contact so you will need to sensitively initiate discussions about the study and not assume anything about the pregnancy **(see section 6.0 Conduct with Participants Who Have Experienced a Loss of Pregnancy).**

Telephone contact is likely to be the predominant method for communication with potential and recruited participants. All telephone contact attempts, including SMS messages, made to participants need to be recorded on the contact log, which includes details of the date and time of calls and its outcomes. Phone calls to participants should only be made using the work mobile telephones or work landlines (**see Section 3.0 Conduct for Telephone Contact with Participants**).

CONTACTS WITH PARTICIPANTS

On initial contact, identify/confirm with participants their preferred methods and times for future communication and record this on the contact preference form**.** For all contacts made to participants, use the contact log to document the date and time of the call and the purpose and outcomes, including whether or not there is a reply. Store all this information within the electronic study site file. When seeking to establish contact with participants you need to be aware of the frequency of repeated contact attempts.

ESTABLISHING INTERVIEW LOCATIONS

Research interviews can be conducted at an approved Local Authority site or at participants' homes (following prior risk assessment). Most interviews will be conducted at a Local Authority site but if participants prefer, and a risk assessment of safety has been done, then interviews can be carried out at participants' homes. In the case of home visits, before agreeing to conduct the interview you should discuss with the research team and a responsible practitioner (e.g. *For Baby's Sake* staff, GP, social worker) to confirm that there are no apparent dangers associated with a home visit **(see Section 4.0 Conduct For Face-To-Face Contact With Participants).** If it is not felt to be safe to interview a participant at their home, then contact them to ask if they would agree to be interviewed at an approved Local Authority site.

PLANNING YOUR TRAVEL TO/FROM INTERVIEWS

Check the address of the interview venue, and that you know exactly where to go. If an area is felt to be threatening locate the number of a licensed minicab company in advance e.g. via https://www.tfl.gov.uk/tfl/gettingaround/findaride/default.aspx Phone the participant to confirm the interview and, for home interviews, check the address and directions with the participant.

SHARING INTERVIEW LOCATIONS WITH YOUR STUDY CONTACT

For all interviews conducted in non-clinical settings you must identify a suitable contact person (e.g. your administrator or research colleague) and provide them with the following details:

- the address that you are going to
- your mobile telephone number
- the mobile and landline telephone number of the participant (if applicable)
- the time that the interview is likely to start and be completed
- the details of who to contact if you do not confirm completion of the interview (you may also want to give them your home telephone number, in case you forget to inform them that you have ended the interview)
- the details of your next of kin

On the day of the research interview, confirm with your contact person that they have the details of the interview location, key contact numbers and times (leaving a message is not sufficient) and that they will be available to receive your call on completion of the interview or act if they do not receive a call. Ensure that they know the steps to take if you do not contact them on time (**see Section 4.0 Conduct for Face-To-Face Contact with Participants).**

GOING TO INTERVIEWS

Ensure that the location(s) where an interview is taking place is where others cannot overhear or where the interview cannot be easily interrupted. If conducting interviews at non-clinical settings, you may want to set an alarm on your work mobile telephone to remind you to check in with your designated contact person after the interview has finished. At your discretion, you may wish to use an authorised minicab service rather than public transport if you feel that an area is threatening**.** When meeting a person for the first time on their doorstep, if you are worried for any reason, arrange to come back another day with someone else.

UNDERTAKING INTERVIEWS

Explain exactly what is going to happen during the interview and how long you expect it to take. Ensure that you discuss issues of privacy and confidentiality, including the limits of confidentiality (as outlined in the Participant Information Sheet), prior to taking consent. Be aware of the impact of body language, gender dynamics and cultural norms/traditions. **FOR FURTHER GUIDANCE SEE SECTION 4.0 - Research Conduct for Face-To-Face Contact with Participants**

MANAGING POSSIBLE RISKS TO/FROM PARTICIPANTS

If you have any concerns about potential risks to/from participants, including risks to participants' children, you should contact the nominated clinical contact person to discuss your concerns and decide on what action to take**.** You should also contact the nominated clinical contact person in situations when you may be unclear about potential risks. If a situation arises whereby you are unable to get in contact with the clinical contact person and you believe the level of potential harm to be serious then contact the relevant mental health liaison service within the NHS Trust**.**

In line with GMC guidance, if participants disclose information which indicates a risk of death or serious harm (e.g. suicidal attempt), either to themselves or others (e.g. their children), you should let the participant know that information needs to be disclosed in accordance with the limits of confidentiality explained at the beginning of the interview. If discussing these concerns causes any confrontation or hostility, then do not push this issue. Move on and end the interview as soon as possible. You should discuss all situations where confidentiality may need to be broken with the nominated clinical contact person within the same working day. If advised by the nominated clinical contact person, you should then disclose the information to the responsible practitioner. In all cases where a serious risk is identified this should be recorded together with the action taken, and the Project Manager informed. **FOR FURTHER GUIDANCE SEE THE FOLLOWING SECTIONS: 2.0 "Conduct With Participants Experiencing Domestic Violence" / 7.0 "Conduct For Managing Potential Risks To Children" / 8.0 "Conduct For Risks Of Abuse Harm or Neglect To Participants"**

MANAGING YOUR SAFETY

Keep your mobile turned on so that you can receive calls but set to silent. If you feel at all uncomfortable, trust your gut instinct and **LEAVE**. You can always come back with someone else another day. If you find that you are in difficulty during an interview at a non-clinical setting and are unable to safely remove yourself from the situation, inform the participant that you need to call a colleague and clarify a point on the interview materials. Use your work mobile to telephone your contact person and inform them that you require assistance. If you encounter difficulties in an authorized Local Authority setting you should make an excuse to leave the room and tell reception that you require assistance from a member of staff. If available, you may also use the panic button available in the rooms, and someone will come to your assistance. Be aware of exit routes and position yourself so that the interviewee is not between you and the exit.

CLOSING INTERVIEWS

Ask participants how they feel and if they would like to discuss anything further with their responsible practitioner. Provide participants with a list of relevant national and local support services. If you are conducting an interview in a non-clinical setting, make sure you call your contact person to confirm that you have left the meeting place of the interview.

If you have any concerns at all at the end of the interview - which fall outside of risks to/from participants – then discuss your concerns with the Project Manager. If you feel concerned or distressed by anything about the interview, then report this to the Programme Chief Investigator (Louise Howard). A supervision session, or informal discussion, with a member of the *For Baby's Sake* team can be arranged to discuss this further.

INCIDENT-REPORTING

Should an untoward incident occur to you, either going to or from an interview or in a participant's home, then this must be reported in the Local Authority site or HSPR department Incident Book. If appropriate, the police should be informed. Formal discussion of the incident might be of benefit.

Appendix 6 – Practitioners' initial training schedule for the *For Baby's Sake* manuals

When	Training Sessions (for whole *For Baby's Sake* team unless stated otherwise)	By whom
16 - 27 Feb 2015 10 days	Induction: Introduction to Stefanou Foundation Policies and procedures / staff handbook; Overview of safeguarding Overview of toxic trio (each in turn and the combined effect); Team building including stepping out of old roles and building trust in preparation for working together to deliver a therapeutic programme Introduction to localities Introduction to *For Baby's Sake* and Orientation	Jessica Barclay (then *For Baby's Sake* Director) with some input from Stefanou Foundation colleagues and external experts
2 - 6 Mar 2015 4 days	Introduction to supporting Women through *For Baby's Sake* Women's Initial Assessment; Opening Doors Hearing from all 3 co-designers	Roxane Agnew-Davies training, Mark Coulter in support all week; plus, Christine Puckering on Friday
9-12 Mar 2015 4 days	Introduction to supporting babies and parents through *For Baby's SakeS* Where's the Baby Introduction to supporting men through *For Baby's Sake*	Christine Puckering training, Mark Coulter in support
16 – 20 Mar 2015 5 days	Men's Initial Assessment; Basic Tools Men's Owning It	Mark Coulter
23-24 Mar 2015 2 days	Consolidating Initial Assessment 2 male and 2 female actors played 4 pairs of co-parents and *For Baby's Sake* practitioners delivered elements of Initial Assessment with coaching including support and feedback from co-designers, peers and the actors	Roxane Agnew-Davies and Mark Coulter
20-24 April 2015 4 days	Coaching – Owning It Consolidation re Orientation, Initial Assessment and Sign Up	Mark Coulter and Roxane Agnew-Davies

30 Apr-1 May 2015 2 days	Keep Calm and Carry On Parenting	Christine Puckering
18-19 May 2015 2 days	Demonstration & filming of Women's Initial Assessment Roxane delivered 4 Initial Assessment Sessions to "Karen" (played by actor) The *For Baby's Sake* Women's Practitioners observed the sessions and discussed each session afterwards with Roxane and the actor. The sessions and discussions were filmed to be a training resource Mark coached the Men's Practitioners	Roxane Agnew-Davies and Mark Coulter
20-22 May 2015 3 days	Coaching – mostly Women's Initial Assessment, also touching on 'Opening Doors' Roxane coached the Women's Practitioners, Early Years Development and Parenting Practitioners and Programme Officers in delivering elements of the material Demonstrating & filming Men's Assessment Sessions Reflections and Feedback	Roxane Agnew-Davies and Mark Coulter
13 July 2015 1 day	Where's the Baby? refresh	Christine Puckering
14-15 July 2015 2 days	Keep Calm and Carry on Parenting	Christine Puckering
20-24 July 2015 5 days	Inner Child	Roxane Agnew-Davies and Mark Coulter
29 Sept 2015 1 day	Healthy Expression of Feelings: Introduction to Healthy Expression of Feelings (RAD) Addressing Guilt and Shame (MC)	Roxane Agnew-Davies and Mark Coulter
16 Oct 2015 1 day	Healthy Expression of Feelings: Dissociation, Guilt and Shame	Roxane Agnew-Davies and Mark Coulter

4 Nov 2015 1 day	Healthy Expression of Feelings (adult-focused): Introduction to the Healthy Expression of Feelings module Play, Chat or Lonely, Hungry or in Pain	Roxane Agnew-Davies and Mark Coulter
9-13 Nov 2015 5 days	Healthy Expression of Feelings (adult-focused) continued: Tired or Sleep; Frustrated or Angry; Frightened or Anxious; Sad; Happy Healthy Expression of Feelings (Parenting): Covering the parallel content on each emotion listed above (from Play, Chat or Lonely through to Happy) supporting parents to respond to their baby's different emotions	Roxane Agnew-Davies and Mark Coulter Christine Puckering

As part of their induction to the programme, all staff initially employed in the two *For Baby's Sake* prototype teams plus the *For Baby's Sake* Director received a total of 52 days training on the programme manuals from the three co-designers. The Foundation's Director also attended some of this training.

Appendix 7 - Training activities of the two sites

Below is a summary table of some of the key training activities that practitioners in both the London Three Boroughs and Hertfordshire teams have undertaken between the start of the evaluation period in May 2015 to the end of April 2019.

***For Baby's Sake* Developments during the prototype phase**	**Date**
VIG training & 2-year supervision for *For Baby's Sake* Director and two Infant Development & Family Practitioners	October 2015
Practitioners trained in Outcome Stars (Family Star Plus and My Star); Co-funded, co-designed, piloted and implemented Parent & Baby Outcome Star; piloted and introduced Change Star	February 2016 January 2018-December 2019
Staff appraisals implemented (tailored to context of delivering and managing *For Baby's Sake*)	February 2016
Service user End of Module review implemented	August 2016 - updated January 2017
Monthly team coaching by co-designers commissioned following completion of initial co-designer training; continuing support to deliver manual flexibly	January 2016-17
Updates to manual following meetings with co-designers, including streamlining Initial Assessment/Getting Started and bringing forward Healthy Expression of Feelings material	January 2016-17
ASQs (infant development revised Practitioner Guidance)	January 2017
Angels in the Nursery and Ghosts in the Nursery: practitioner guidance added to Where's the Baby?	April 2017
Therapeutic Lead role added to Hertfordshire Team Manager role	June 2017
Expansion of dataset collected by Practitioners and analysed/reported: new data on service users' Adverse Childhood Experiences (ACEs) and expanded data on Complex Needs	July 2016-June 2017
GAD7 & PHQ-9 tools introduced to manual, for assessing service users' anxiety and depression	July 2017
Inner Child and attachment: Practitioner Guidance added to manuals	November 2017
APPT Attachment Workshop 2 days: all Practitioners	January 2018

Practitioner Guidance and material on Resilience (including Resilience Questionnaire) added to Manual	February 2018
Maternal & Paternal Antenatal and Postnatal Attachment Questionnaires introduced	March-May 2018
Service user End of Programme Review implemented	April 2018
Post-Incident Response Practitioner Guidance	July 2018
Shame Lens tool introduced to manual material	October 2018
Intimate Relationship Spectrum (now Parental Relationships Spectrum) tool added to manual material	April 2019
Three Men's Practitioners trained in Video Interaction Guidance and commenced monthly supervision	April 2019
Practitioner 2-day training in SARA-3 (Spousal Assault Risk Assessment) Tool and SARA-3 implemented into programme delivery	August 2019
Remaining Men's and Women's Practitioners trained in Video Interaction Guidance and commenced monthly supervision	October 2019

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