



Department
for Education

SafeCORE

Evaluation report

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Julian Edbrooke-Childs

Luís Costa da Silva

Tim Allan

Chloe Edridge

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Useful acronyms

DVA – Domestic Violence and Abuse

CSC – Children’s Social Care

CIN – Child in Need

CLA – Child Looked After

CPP – Child Protection Plan

RCT – Randomised Control Trial

MASH – Multi-Agency Safeguarding Hub

Key messages

Results from the evaluation showed that when compared to families who were disengaged (did not complete the intervention) with SafeCORE, families who were engaged with SafeCORE achieved more goals (for example, goals around family and social relationships, safety and emotional and behavioural development) and improved in more problem areas (for example, problems relating to conflict, violence, mental health and education) throughout the course of the intervention. Additionally, it was noted from the qualitative data that setting goals was a helpful way to check in with families and plan the next steps and interventions ensuring care was tailored to their individual needs.

Other aspects that contributed to the engagement of families were the preconceptions and expectations of SafeCORE, the team approach and the practical support offered. These were important factors that enabled the quality of support for children and families. A positive view of the service and the quality of SafeCORE was particularly important, as most families had not previously received any support from similar or other services.

Equally, staff morale, autonomy to adapt the programme to the needs of service users, confidence in delivering the programme and ability to work effectively together were important factors in enabling improvements to the quality of support or care for families taking part in SafeCORE. The role of team collaboration was also found to be important to improving the quality of the service, with staff learning from and being supported by multidisciplinary approaches.

This report also outlines recommendations for the continuation of SafeCORE and makes suggestions for wider roll out of the programme that would help overcome some of the barriers to engagement identified by the evaluation (such as preconceptions about the service, logistical problems around working schedules and difficulties with language). Specifically, it is suggested that SafeCORE is introduced to families in a clear and detailed way and that a more flexible schedule around parents' work commitments are considered and that SafeCORE consider how best to engage families for whom English is not the first language. Additionally, we highlight the components achieved by SafeCORE that were deemed as facilitators to engagement, such as the ongoing work to maintain balance in working with the whole family as well as maintaining the excellent relationships staff are able to build with service users whilst retaining respect for boundaries.

The cost saving exercise looked at families which, at the start of their support from SafeCORE, had the potential to improve against one or more of the outcomes identified by the goal-setting activities of the families (12 of those families were classed as having engaged with SafeCORE, whereas the other 25 were classed as having disengaged). The cost analysis showed an average saving per family of £14,701 for the 12 engaged families and £9,459 for the 25 disengaged families as a result of SafeCORE. Additionally,

if it is assumed that the characteristics and needs of the two sets of families are broadly equivalent, then the annual additional saving to the State of remaining engaged with SafeCORE is £5,242 per family.

Executive summary

Introduction

SafeCORE (Compassion, Openness, Relationships and Engagement) is a project implemented by the Royal Borough of Greenwich, supported through the Department for Education's Children's Social Care Innovation Programme (Innovation Programme hereafter). It was aimed at families in Greenwich with Domestic Violence and Abuse (DVA) as a presenting need that fall below the threshold for statutory services. Prior to SafeCORE, these families were signposted to community projects but did not receive any active help from statutory services. As stated in the Theory of Change (ToC) for the SafeCORE project, Greenwich has a high rate of repeat contacts, referrals and child and family assessments where DVA is a presenting factor. In Greenwich, 862 families had two or more contacts to Children's Social Care (CSC) services for DVA, equating to 2044 contacts for 2015/16. Greenwich Social Care Services also have a high rate of Looked After Children and Chowdry & Fitzsimons (2016) estimate the cost of late intervention to be the second highest in London¹. This report presents the findings of the evaluation of SafeCORE conducted by the Evidence Based Practice Unit (EBPU) at Anna Freud National Centre for Children and Families.

The project

SafeCORE fosters compassion, openness, responsibility and engagement in an approach addressing feedback from children and families that individuals should not only be seen as a 'perpetrator' or a 'victim'² by taking a whole family approach and challenging the normalisation of 'threat' based behaviours in families. SafeCORE aims to break the cycle of referrals and re-referrals by working with the whole family, addressing the causal factors of violence by breaking the cycle of shame, threat and violence using principles from the Science of Compassion to support children and families to engage in collaborative problem-solving by increasing capacity to engage in altruistic behaviour³.

SafeCORE staff are organised in units allocated to families, allowing for high practitioner consistency and flexibility around the needs of families. SafeCORE started training staff and working with families in February 2018. Before the family is enrolled in SafeCORE,

¹Chowdry, H., & Fitzsimons, P. (2016). The cost of late intervention: EIF analysis 2016. Technical report. Early Intervention Foundation.

² Stanley, N., Miller, P., Foster, H. R., Thomson, G. (2011). A Stop–Start response: social services' interventions with children and families notified following domestic violence incidents. *The British Journal of Social Work*, 41(2), 296–313, <https://doi.org/10.1093/bjsw/bcq071>

³Weng, H. Y., Fox, A. S., Shackman, A. J., Stodola, D. E., Caldwell, J. Z., Olson, M. C., Rogers, G. M., & Davidson, R. J. (2013). Compassion training alters altruism and neural responses to suffering. *Psychological science*, 24(7), 1171–1180. <https://doi.org/10.1177/0956797612469537>

the families' suitability for work with SafeCORE is assessed using the following eligibility criteria: the couple intends to stay together and no "coercive control"⁴ is present. As SafeCORE is a voluntary service, some families decline work with SafeCORE after assessment or do not engage once work has started, which has led to SafeCORE teams working with a lower than expected number of families. Consequently, SafeCORE expanded the range of families they support to include those recruited from school settings.

Between the beginning of February 2018, when the project started working with families, and 3rd March 2019, SafeCORE received 122 referrals, of which 71 met the assessment criteria. Of these 71 families, 17 subsequently did not start work with SafeCORE due to lack of engagement. SafeCORE started working with the remaining 54 families. A total of 14 families subsequently did not engage and by 29th March 2019 had unplanned closures or withdrew their consent (after an average of 93 days, between 15 days and 7.7 months). By 29th March 2019, work with 27 families was still ongoing, 10 families had experienced planned closures, 1 family had been stepped up to social care, 1 family had been transferred to Early Help and 1 family had moved to another local authority. Completed interventions usually took around 6 months on average, varying between 68 days and 10.3 months. By 29th March, ongoing families (27) had been in the programme on average for 107 days (between 30 days and 10.2 months). As of January 2020, SafeCORE had worked with 179 families with 248 children.

The evaluation

The evaluation is a Realist Evaluation to assess SafeCORE's theory of change (Pawson & Tilley, 1997). Stage 1 ran from 15th February 2018 to 14th January 2019 and served as a feasibility phase, establishing research procedures, ascertaining acceptability of the programme by service users and assessing the early impact of the project through collecting staff surveys and interviews/ focus groups and family surveys and interviews. Stage 2 ran from 15th January 2019 to 31st January 2020 and consisted of a longitudinal case series design with staff and service user interviews to support a robust evaluation.

Key findings

The complexity and importance of the therapeutic relationship and rapport with SafeCORE workers, which was described as highly positive by service users, impacted engagement and the views of the service. Additionally, the majority of families interviewed had not previously received any support from similar or other services. Barriers to engagement appear stem from negative preconceptions of CSC services, lack

⁴ Robertson, K., & Murachver, T. (2011). Women and men's use of coercive control in intimate partner violence. *Violence and Victims*, 26(2)

of previous awareness of the service, language barriers and accommodating sessions with service user's work schedules.

Results from the evaluation also showed that when compared to disengaged families (did not complete the intervention), engaged families achieved more goals and improved in more problem areas, suggesting that the engagement with the programme is an important factor to make improvements in areas that would otherwise not improve to the same extent.

Results from the qualitative data indicate that service users improved in their emotional regulation as a result of SafeCORE. Specifically, SafeCORE was helpful for service users to understand and utilise strategies to manage their feelings and emotions, alongside strategies to manage their own behaviour and to react to the behaviour of others. Additionally, results from the qualitative data show that SafeCORE was also helpful for service users to feel calm in situations of conflict and therefore, reduce conflicts in relationships and increase relational closeness. Service users highlighted that the improvement in communication skills as a result of SafeCORE was instrumental to this improvement. As a result of improved emotional regulation and relational closeness, service users reported that children were happier with healthier home environments.

High staff morale, multidisciplinary team collaboration, autonomy to adapt the programme to the needs of the service user, confidence in delivering the programme and ability to work effectively together with the whole family were important factors in enabling improvements to the quality of support or care for families taking part of SafeCORE.

Lessons and implications

The therapeutic nature of service users' relationships with SafeCORE workers, and service users' preconceptions of the service, emerged as important factors that impact the success of SafeCORE interventions. Service users described an initial resistance to engaging with SafeCORE, due to the perceived association with CSC services, lack of awareness of the service and what it offers and concerns about judgement from others. Future roll out of the service should introduce SafeCORE to families in a clear and detailed way, demystifying any preconceptions, clarifying any doubts and adjusting expectations of future service users.

Future roll out should also consider some aspects highlighted by disengaged service users, in particular the practical factors that hindered engagement (such as work commitments or the frequency of the intervention). We suggest that future endeavours allow for more flexible sessions around families' schedules. Another barrier was related to language, which was identified by service users as a barrier to completely engaging with the service. To mitigate this, SafeCORE could seek to employ staff that speak other

languages commonly used in the local population, as this may be preferable to having an interpreter (as mentioned by service users).

Overall, we found that staff morale, autonomy to adapt the programme to the needs of the service user, confidence in delivering the programme and ability to work effectively together were important factors in enabling improvements to the quality of support or care for families taking part of SafeCORE. The role of team collaboration was also found to be important, with staff learning from and feeling supported by multidisciplinary approaches, which were deemed as aspects that improved the quality of the service.

It is equally important to aim for the continuity of a balance in working with the whole family, considering family dynamics and individual service user characteristics. Our findings show that SafeCORE is providing a service with a successful whole family approach, characterised by service users as unique and enabling the whole family's needs to be met. Our recommendation is that this effort is sustained as a core feature of SafeCORE.

Additionally, it is important to note that a flexible approach to the programme gives staff the autonomy to account for different backgrounds, needs and engagement styles, which may be crucial when working with a wide range of families and could mitigate some of the issues associated with disengagement. It is therefore recommended that the flexible approach employed by SafeCORE staff is sustained as it is continued in Greenwich, as this is particularly relevant when addressing issues that lead to disengagement and consequently may lead to fewer improvements, goals being harder to achieve and worse outcomes for families.

1. Overview of the project

Project context

About 1 in 5 children in the United Kingdom experience Domestic Violence and Abuse (DVA) during their childhood⁵, which may lead to the impairment of a range of developmental, social and health outcomes⁶. SafeCORE is being implemented by the Royal Borough of Greenwich to address DVA in families that fall below the threshold to receive statutory services. Greenwich has a high rate of repeat contacts, referrals and child and family assessments where DVA is a presenting factor, with 862 families with two or more contacts to CSC for DVA, equating to 2044 contacts for 2015/16. Greenwich also has a high rate of Looked After Children and Chowdry & Fitzsimons (2016) estimate the cost for late intervention to be the 2nd highest in London⁷.

Project aims and intended outcomes

The aims of the SafeCORE programme are the reduction of re-referrals of families to Greenwich CSC for incidents of DVA and ultimately the reduction of escalation that requires statutory intervention. To do so, the project seeks to work with the whole family in which DVA is an issue, with staff working in units of practitioners bringing a multi-disciplinary skill set. As stated in SafeCORE's Theory of Change, SafeCORE aims to break through a cycle of shame and emotional dysregulation that could lead to incidents of DVA. The key intermediate aims of SafeCORE are the creation of a compassionate stance among the self and others as well as giving family members skills for better emotion regulation and interpersonal communication. In summary, SafeCORE applies the Science of Compassion (SoC), which informed Compassion Training (CT), to a child and family context, combining it with family led systemic concepts, relational approaches and practical support to engage families in addressing the causal factors of DVA specifically 'situational couple violence' (SCV), which can be defined as arguments between a couple that may escalate to the point of violence⁸. SafeCORE is an innovative approach as it differs from siloed practices that do not deliver a contextualised response

⁵ Radford, L., Aitken, R., Miller, P., Ellis, J., Roberts, J., & Firkic, A. (2011). Meeting the needs of children living with domestic violence in London: Research report

⁶ Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., et al. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*, 2(8), e356–e366.

⁷ Chowdry, H., & Fitzsimons, P. (2016). The cost of late intervention: EIF analysis 2016. Technical report. Early Intervention Foundation

⁸ Leone, J. M., Johnson, M. P., Cohan, C. L. (2007). Victim helping seeking: differences between intimate terrorism and situational couple violence. *Family relations*, 56, 427-439

and see people only as ‘victims’ and ‘perpetrators’⁹. SafeCORE works with the ‘whole family’, using all available support within the child’s life by taking an ecological approach¹⁰ to create change.

Project activities

SafeCORE has hired staff to work with families who have been referred through the Greenwich CSC referral process and who do not meet the threshold for statutory care intervention. The project works with CSC services to receive referrals of families with DVA below the threshold for statutory intervention. Families who have been referred are further assessed as to whether they are suitable for work with SafeCORE.

In year 1, SafeCORE hired staff to form 2 units that started working with families from February 2018. Staff received an induction programme and training to deliver the key components of SafeCORE, which are underpinned by the ‘Science of Compassion’, encompassing both education around the three-circles brain organisation system and the concept of compassionate self to improve emotion regulation within this system to break through the shame-threat system. The three circles refer to: 1) the ‘drive’ system when an individual is likely to experience desire, focus and achievement-orientation due to feelings of motivation toward resources or desired states, 2) the ‘soothing’ system when an individual is likely to experience trust, contentment and feelings of safety to manage distress and promote belonging and 3) the ‘threat’ system when an individual is likely to experience anxiety, anger and disgust in response to situations that are perceived as threatening and aversive.

Practitioners share knowledge with children and families about how brains work and, through an integrated practice framework, strategies to increase children and families’ capacity to operate in their ‘compassionate self’ system, in which the brain’s organisational system is in balance. Feelings of shame can cause families to become stuck in their ‘threat’ system. To create balance, children and their families need to increase the feelings and behaviours that occur when the brain is in the ‘drive’ and ‘soothing’ systems to create their own Compassionate Foundations. The brain’s organisation system is often referred to during Compassion Therapy as the ‘Three Circles’ (threat, drive and soothing) making it an accessible concept for children, families and professionals.

The induction and training encompassed an experiential component of the SafeCORE model, in which a compassionate stance to the self and others as well as self-awareness

⁹ Stanley, N., Miller, P., Foster, H. R., Thomson, G. (2011). A Stop–Start Response: Social Services’ Interventions with Children and Families Notified following Domestic Violence Incidents. *The British Journal of Social Work*, 41(2), 296–313, <https://doi.org/10.1093/bjsw/bcq071>

¹⁰ McLaren, L, Hawe, P. (2005). Ecological perspectives in health research. *Journal of Epidemiology & Community Health*, 59, 6-14

around shame and emotion regulation are fundamental components. The training included specific techniques (for example, breathing techniques) and a systemic component that aims to improve relationships within the family in order to create change.

SafeCORE teams worked with the families for 5.9 months on average, using a whole-family approach and teaching the Science of Compassion approach, using systemic tools such as genograms to improve families' understanding of their wider context and using their background training, for example from social work. The whole family approach includes direct work with couples or work with a mother and child in order to achieve agreed goals, outcomes and sustain change and progress made by families. Units worked with families in a way that adapted the intervention to their needs and circumstances, for example depending on availability and scheduling requirements, depending on the willingness of individual family members to engage. Units also supported the development of new skills and training materials for families. SafeCORE's work with families also relies on collaborative work within the families to learn and have positive social experiences. It is important to note the change in scope of SafeCORE, in which a movement to work with a wider range of families (recruited from school settings) took place so the service could offer support to more families.

From January 2019, SafeCORE hired new staff and currently comprises 23 staff working across 5 units, in addition to 2 clinicians and the SafeCORE lead. Each unit can work with up to 20 to 25 families at any one time. As of January 2020, SafeCORE had worked with 179 families, with 248 children.

2. Overview of the evaluation

Evaluation questions

The main questions this evaluation explored were:

- What are the baseline circumstances of the families taking part of SafeCORE and what is the emerging impact?
- What factors enable or hinder the achievement of better outcomes for children and families?
- What is the impact of SafeCORE on the quality of support or care for children and families?
- What factors enable or hinder improvements to the quality of support or care for children and families?
- What are the key mechanisms of change and how do these relate to observed impact?
- What are the cost implications of SafeCORE? Is it cost-effective?
- What lessons are there for wider roll out of SafeCORE?
- What needs to happen at the organisational and community levels for SafeCORE to be a success?
- What are the necessary and sufficient legal and policy conditions of SafeCORE success?
- Is there sufficient flexibility in the system for SafeCORE to be implemented successfully?
- What is lacking (or present) in the system that hinders the success of SafeCORE?

Evaluation methods

The evaluation took place in two stages. Stage 1 ran from 15th February 2018 to 14th January 2019 and served as a feasibility phase, establishing research procedures, ascertaining acceptability of the programme by service users and assessing the early impact of the project through collecting staff surveys and interviews/ focus groups with staff and family surveys and interviews. Stage 2 ran from 15th January 2019 to 31st January 2020 and consisted of a longitudinal case series design with staff and service user interviews to support a robust evaluation.

Quantitative methodology

As part of the quantitative methodology, data from CSC services from families who actively engaged with SafeCORE were analysed with a focus on the following indicators: number of Child in Need (CIN) plans, number of Child Protection Plans (CPP), number of Child Looked After (CLA) and number of referrals to Multi-Agency Safeguarding Hub (MASH) in which DVA was present, for the 12 months pre and post-allocation to SafeCORE.

Additionally, the research team analysed data from SafeCORE case notes which focused on goals and problems identified by 43 families. For this analysis, we compared goal achievement and problem improvement between families who engaged (all those who completed the intervention) and families who disengaged (all those who did not complete the intervention).

Lastly, data from a staff survey ($N = 13$) collected at two time points (time 1 and time 2) were analysed. The staff survey included the Copenhagen Burnout Inventory (CBI)¹¹, the Compassionate Engagement and Action Scales (CEAS)¹² and questions relating to workload and stress experienced by SafeCORE staff.

Qualitative methodology

A total of $N = 36$ interviews with service users were conducted, with 5 of these in Stage 1 and 31 in Stage 2. Service users were invited to take part in the evaluation by SafeCORE staff during face-to-face sessions or over the telephone. Interviews were conducted by the evaluation team face-to-face at the service users' home or a community centre, or over the phone. Interview discussions with service users were not shared with SafeCORE staff.

A total of $N = 27$ interviews and focus groups with staff were conducted, with 22 of these in Stage 1 and 5 in Stage 2. Staff were invited to take part in an interview or focus group, which was carried out by a member of the evaluation team face-to-face or over the phone.

Data collection continued until saturation of themes was achieved and a heterogeneous range of views and experiences were captured¹³. Although only 3 interviews with disengaged service users were conducted, saturation of themes was still achieved, given

¹¹ Kristensen, S. T., Borritz, M., Villadsen, E., & Christensen, C. B. (2005) The Copenhagen Burnout Inventory: A new tool for the assessment of burnout. *Work & Stress*, 19(3), 192-207, DOI: [10.1080/02678370500297720](https://doi.org/10.1080/02678370500297720)

¹² Gilbert, P., Catarino, F., Duarte, C. et al. (2017). The development of compassionate engagement and action scales for self and others. *Journal of Compassionate Health Care* 4(4). <https://doi.org/10.1186/s40639-017-0033-3>

¹³ Morse, J. (2000). Determining sample size. *Qualitative Health Research*, 10(1), 3-5.

the similarities in views expressed both within disengaged services users and between disengaged and engaged service users.

Interviews and focus groups were semi-structured in format, allowing the researcher to guide the conversation in terms of research questions, whilst giving space for the participant to raise the issues around these topics that they felt were most pertinent to them. The topic guide was developed to capture the components of the logic model (please see Appendix 1). The interview transcripts were analysed using thematic analysis¹⁴ to examine similarities and differences in themes across participants' experiences, perspectives and opinions. The thematic analysis involved five stages: familiarisation with the collected data involving reading and re-reading the transcripts and listening to the audio recordings, generating initial codes based on a priori expectations (e.g., from the logic model) in a process of deductive coding and based on codes derived from the data in a process of inductive coding, searching for themes by grouping codes, defining and naming themes and presenting the results. Although conducted sequentially, analysis was also conducted iteratively, as for example initial themes from groups of codes were discussed by the research team, resulting in refinements to the coding and then the definitions and names of themes being generated. Quality standards for ensuring the trustworthiness of qualitative data analysis were adhered to throughout¹⁵. The main research questions answered in part by the qualitative data were: the impact of SafeCORE, barriers and facilitators to impact, factors which enable or hinder achievement of better outcomes for families, factors which enable or hinder improvement to the quality of care for families and key mechanisms of change.

Changes to evaluation methods

An addendum to the evaluation was agreed with DfE, Opcit, SafeCORE and the evaluation steering group to focus on secondary analysis of routinely collected data (CSC data described above) rather than a randomized trial design given the barriers to recruitment. There were no changes to the outcome indicators for this evaluation for SafeCORE staff.

Limitations of the evaluation

A limitation of the evaluation relates to the use of routinely collected CSC services data and in particular, the limited availability of CSC services data (for example, no incidents recorded for some of the indicators), which restricts the interpretation of the figures.

¹⁴ Labra, Oscar & Castro, Carol & Wright, Robin & Chamblas, Isis. (2019). Thematic Analysis in Social Work: A Case Study. 10.5772/intechopen.89464.

¹⁵ Yardley, L. (2017) Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, 12(3), 295-296, DOI: [10.1080/17439760.2016.1262624](https://doi.org/10.1080/17439760.2016.1262624)

However, to complement these data, we analysed goal attainment and problem improvement data from the case notes of service users taking part in SafeCORE in order to understand the impact of the programme on children and families. Another limitation of the evaluation is the difficulty in obtaining interviews from disengaged users. Notwithstanding, the evaluation team gathered extensive and rich qualitative data from service user and staff interviews, which offer important and helpful findings to complement the quantitative methodology of the evaluation.

3. Key findings

Evaluation questions

What are the baseline circumstances of the families taking part of SafeCORE and what is the emerging impact?

To answer this evaluation question, the evaluation team has analysed CSC service data from families who actively engaged with SafeCORE (number of CIN, number of CPP, number of CLA and number of referrals to MASH) to ascertain any change over time in these numbers (before and after allocation to SafeCORE). To this end, we examined the number of CIN, CPP, CLA and referrals to MASH of children who had 12 month post-allocation data and 12 month pre-allocation data. We also analysed quantitative data from case notes as well as qualitative data from service user and staff interviews and focus groups to ascertain the impact of SafeCORE on the mental health and wellbeing of children, families and staff.

Children's Social Care Services data

There were data on 29 children from families who actively engaged with SafeCORE for which there were data for the 12 months pre and post-allocation to SafeCORE. No child had incidents of CIN, CPP or CLA within the 12 months pre and post-allocation to SafeCORE. The lack of incidents prior to allocation can be explained by the fact that SafeCORE is aimed at families with Domestic Violence and Abuse (DVA) as a presenting need that fall below the threshold for statutory services. Although there were no incidents of CIN, CPP or CLA recorded within the 12 month period of post-allocation to SafeCORE, it is not possible to comment on these findings, as the reasons why this may be the case were not the focus of our analysis. Additionally, when looking at referrals to MASH within the same time periods, 3 children had a MASH referral in the 12 months pre-allocation to SafeCORE and no children had referrals to MASH in the 12 months post-allocation to SafeCORE. Equally, it is not possible to address the reasons for these numbers as our additional analyses focused on other aspects of the SafeCORE intervention, such as co-production of goals and problem improvement.

Goal attainment and problem improvement from SafeCORE families

Additionally, data from case notes were analysed to examine the impact of SafeCORE on the progress made by families on their goals. Data from case notes addressed the goals and problems identified by 43 families. SafeCORE staff classified the families into different levels of service engagement and completion. For this analysis, SafeCORE staff grouped families into engaged (all those who completed the intervention regardless of

their level of engagement, $N = 17$) and disengaged (all those who did not complete the intervention, $N = 26$). This grouping will be used for the comparisons described in this section.

The 43 families set a total of 95 goals. SafeCORE staff organised these goals into the category types displayed below. Families set an average of 6 goals, ranging from 1 to 14 (Standard Deviation = 3.1, Median = 6). The most common goal type was Family and Social Relationships, with 29% (28) of goals set by families belonging to this category. SafeCORE staff also categorised the goals as follows: applicable to the whole family, applicable to parents and carers only and applicable to children only. Out of all the goals set by families taking part in SafeCORE, 44% (42) were classed as applicable to the whole family, 46% (44) were applicable to parents/carers only and 9% (9) were applicable to children only. SafeCORE staff also tracked and reported the attainment of these goals using three options: achieved, almost achieved and not achieved. A total of 58% of the goals were achieved, 22% were almost achieved and 17% were not achieved. Table 2 (below) shows the types of goals set and how many were achieved by the families.

Table 2: Types of goals set by all families receiving SafeCORE

Types of goals	N	Achieved (%)	Almost (%)	Not achieved (%)
Family & Social Relationships	28 (29%)	20 (71%)	5 (18%)	2 (7%)
Safety	9 (9%)	6 (67%)	2 (22%)	1 (11%)
Emotional & Behavioural Development	8 (8%)	6 (75%)	0 (0%)	2 (25%)
Emotional Warmth	8 (8%)	5 (63%)	3 (38%)	0 (0%)
Education – attainment	6 (6%)	5 (83%)	1 (17%)	0 (0%)
Health	5 (5%)	2 (40%)	0 (0%)	3 (60%)
Self-Care Skills	5 (5%)	2 (40%)	1 (20%)	1 (20%)
Accessing Community Resources	4 (4%)	2 (50%)	2 (50%)	0 (0%)
Stimulation & Positive Activities	4 (4%)	3 (75%)	1 (25%)	0 (0%)
Guidance and Boundaries	3 (3%)	1 (33%)	1 (33%)	1 (33%)
Housing	3 (3%)	0 (0%)	1 (33%)	1 (33%)
Stability	3 (3%)	0 (0%)	2 (67%)	1 (33%)
Education – other	2 (2%)	2 (100%)	0 (0%)	0 (0%)
Employment	2 (2%)	1 (50%)	0 (0%)	1 (50%)
Wider Family	2 (2%)	0 (0%)	1 (50%)	1 (50%)

Basic Care	1 (1%)	0 (0%)	1 (100%)	0 (0%)
Financial	1 (1%)	0 (0%)	0 (0%)	1 (100%)
Social Integration	1 (1%)	0 (0%)	0 (0%)	1 (100%)

Source: Case note data.

When compared against disengaged families, engaged families achieved more goals (see Table 3 below), suggesting that families who engaged with SafeCORE to a greater extent also achieved their goals of working with SafeCORE to a greater extent.

Table 3: Goal achievement by engaged and disengaged families receiving SafeCORE

	Achieved	Almost achieved	Not achieved
Engaged	76 (88%)	6 (7%)	4 (5%)
Disengaged	17 (39%)	15 (34%)	12 (27%)

Engaged: all those who completed the intervention, $n = 17$. Disengaged: all those who did not complete the intervention, $N = 26$. $\chi^2 = 35.41$, $p < .001$. Source: Case note data.

Families also identified 244 problems, which were categorised by SafeCORE staff into the types displayed in Table 3 (below). The most common type of problem related to Conflict (17%, $N = 42$) and the least common related to Negative Peer Group/Associations (0.4%, $N = 1$). Overall, 73% (177) of Problems improved over the course of SafeCORE's intervention, 25% (61) had no change and 2% (6) deteriorated. Table 4 below details the type of problems and the rates of improvement for each type as noted by SafeCORE staff in the course of the intervention.

Table 4: Types of Problems identified by families receiving SafeCORE

Type of Problems	N (%)	Improved (%)	No change (%)	Deteriorated (%)
Conflict	42 (17%)	31 (74%)	10 (24%)	1 (2%)
Family & Social Relationships	29 (12%)	18 (62%)	10 (34%)	1 (3%)
Violence	28 (11%)	23 (82%)	0 (0%)	1 (4%)
Safety	21 (9%)	19 (90%)	0 (0%)	0 (0%)
Mental Health	17 (7%)	8 (47%)	8 (47%)	1 (6%)
Education	13 (5%)	11 (85%)	2 (15%)	0 (0%)
Emotional & Behavioural Development	12 (5%)	8 (67%)	4 (33%)	0 (0%)
Housing	11 (5%)	7 (64%)	4 (36%)	0 (0%)
Financial	9 (4%)	5 (56%)	4 (44%)	0 (0%)

Guidance & Boundaries	8 (3%)	5 (63%)	3 (38%)	0 (0%)
Accessing Community Resources	7 (3%)	7 (100%)	0 (0%)	0 (0%)
Social Integration	7 (3%)	6 (86%)	0 (0%)	0 (0%)
Substance Misuse	7 (3%)	1 (14%)	4 (57%)	2 (29%)
Physical Health	6 (2%)	3 (50%)	2 (33%)	0 (0%)
Wider Family	6 (2%)	4 (67%)	2 (33%)	0 (0%)
Employment	5 (2%)	5 (100%)	0 (0%)	0 (0%)
Stimulation & Positive Activities	4 (2%)	4 (100%)	4 (100%)	0 (0%)
Basic Care	3 (1%)	3 (100%)	0 (0%)	0 (0%)
Self-Care Skills	3 (1%)	3 (100%)	1 (33%)	0 (0%)
Stability	3 (1%)	3 (100%)	0 (0%)	0 (0%)
Emotional Warmth	2 (1%)	2 (100%)	0 (0%)	0 (0%)
Negative peer group / associations	1 (0.4%)	1 (100%)	0 (0%)	0 (0%)

Source: Case note data.

When compared against disengaged families, engaged families improved in a greater number of problem types (see Table 5 below), suggesting that families who engaged with SafeCORE to a greater extent also improved in problems to a greater extent.

Table 5: Problem improvement from engaged and disengaged families receiving SafeCORE

	Improved	No change	Became worse
Engaged	89 (85%)	15 (14%)	1 (1%)
Disengaged	88 (63%)	46 (33%)	5 (4%)

Engaged: all those who completed the intervention, n = 17. Disengaged: all those who did not complete the intervention, N = 26. $\chi^2 = 13.96$, $p = .0009$. Source: Case note data.

Qualitative data

Three themes were identified in the analysis of the impact of SafeCORE as described by service users and staff: emotion regulation, relational closeness and happier children.

Service users described having improved emotion regulation in terms of better understanding of, and ability to use, strategies to manage feelings and emotions, including the ability to manage one's own behaviour and reactions to situations and the behaviours of others. Critical to this was an ability to identify emotion regulation systems and, in particular, when an individual was in the 'threat system' meaning they were likely

to experience anxiety, anger and disgust in response to situations that were perceived as threatening and aversive¹⁶, as described by service users. Service users described SafeCORE as helping them to feel calmer during situations of conflict. Service users also reported that the focus on self-care strategies and general well-being helped them to manage feelings and emotions. Mirroring this, service users, as described by staff, had increased ownership of regulating their own emotions. Staff also reported that service users had improved management of feelings and emotions, due to better understanding and insight in relation to the self, better coping mechanisms and better ability to understand causes of emotions from a situational perspective.

Service users reported an improved relationship with their partner due to reduced conflict in relationships and increased relational closeness. Key to increased relational closeness was improved communication skills, which resulted in more open and less aggressive interactions. Service users described that relationships with their partner had “benefited from [SafeCORE]” and that they “improve as parents and partners as well” (Service User or SU). Improved communication skills were described as particularly helpful in preventing escalation of arguments or conflicts. Service users described specific communication strategies, that they had learned from SafeCORE, which they had used to de-escalate conflict, such as agreeing safe words that indicated the individual wants a break from a challenging conversation. Moreover, some service users reported an increased capacity for “doing things together” (SU) following work with SafeCORE. Similarly, staff described improved relational closeness and a reduction in relationship conflict, reduced couple violence and breaking the routine or pattern of arguments.

The above impact on improved emotion regulation and relational closeness resulted in service users’ perception of their children being happier. Service users described this as occurring as the family was calmer, with a renewed focus on the impact of aggressive situations on children, particularly avoiding children’s exposure. Service users reported feeling like better parents as a result of SafeCORE and that the service had also helped to enable children to better manage their feelings and emotions, such as managing anger, anxiety and stress. Service users described the family as being closer and that parent-child relationships were improved as a result of SafeCORE, with home environments being described as healthier. Service users described children as being more open and better able to talk about emotions with involvement from SafeCORE; for example, “the kids wouldn’t talk about how they’re feeling and stuff. But now they are” (SU). Children’s well-being and engagement with education were described by service users as having improved after engaging with SafeCORE, with children benefitting from feeling “a little bit more supported” (SU). Staff described children who had taken part in SafeCORE as being happy to be involved and experiencing it as enjoyable. Similar to service users, staff reported that parent service users showed improved parenting skills

¹⁶ Gilbert (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology*, 53, 6-41

and a greater awareness of their child's needs and feelings, with improved communication between partners in front of children building less conflicted home environments. Staff described children as having increased emotion regulation skills, including compassion and mindfulness, in addition to improved engagement in education.

What factors enable or hinder the achievement of better outcomes for children and families?

Three themes emerged in the analysis of factors that enable or hinder the achievement of better outcomes for children and families as described by service users and staff: access to support (reported by service users only), working with the whole family and openness.

Importantly, service users described an inability to access support before SafeCORE due to not meeting thresholds for statutory services, with one commenting that they feel they "kept getting written off, saying the family were alright" (SU). SafeCORE was described by service users as providing a crucial service to fill this gap.

Working with the whole family was described by service users as unique and as enabling the whole family's needs to be met. Working together as a couple with SafeCORE staff in a safe environment, in which feelings could be surfaced and coping strategies practiced, was described by service users as an important mechanism by which SafeCORE helped reduced conflict and increased relational closeness. Moreover, bringing families together for SafeCORE sessions was described as beneficial to reflect as a whole family on each other's work and progress. Similarly, staff described the importance of ensuring work was led by the whole family and their goals, not just those of one family member.

Lack of willingness to be open to discuss sensitive issues was described by service users as hindering the achievement of better outcomes, however developing and maintaining an effective relationship with staff was described as mitigating this (see below). Service users described the perception of staff building a stronger relationship with one partner than the other as a barrier to building effective relationships with all partners. In addition, some service users described that staff encouraged work with the children too strongly or too early on in the relationship building processes as being a barrier.

Staff described their experience of service users feeling uncomfortable discussing sensitive issues as "whatever skeleton is in the closet is going to come out" (Staff or S). On a related note, staff described service users as being more able to cope with conflict and negative situations, through a greater capacity for openly discussing issues and feelings. Similarly, staff described that ensuring balanced participation could be challenging, particularly with partners who may initially be resistant. Staff described engaging families with different levels of understanding of their own emotional processes as a challenge, as was an increased risk of conflict when working with both partners

together in session. Nevertheless, focusing on the situational violence approach was described as particularly beneficial to ensuring balanced participation, in which confrontations or violent events are discussed with a focus on identifying strategies for change as opposed to attributing blame.

What is the impact of SafeCORE on the quality of support or care for children and families?

Three themes were identified in the analysis of the quality of support for children and families as described by service users and staff: problem-solving support, flexibility (reported by staff only) and language.

An important impact of SafeCORE described by service users was practical problem-solving, which was described in a range of areas: finances and help with applying for benefits or grants and budgeting; employment and support when looking for work; housing and help with living conditions, managing moves and communications with councils or landlords; access to other services and help with attending appointments and other areas such as identifying well-being activities. In addition, staff described helping families with issues related to immigration. On a related note, staff described service users as having made proactive progress in a variety of areas following involvement of SafeCORE, ranging from increased self-care activities through to increased engagement with education, employment or training.

Staff described the importance of a positive and flexible approach to the assessment of an individual family's needs. Staff also described the importance of identifying mutually agreed goals and work plans, which in their view had an important impact on the quality of support for children and families. Flexibility was described by staff as helping to maintain engagement by, for example, structuring sessions around service user preferences, meaning that activities or elements of the approach service users were more comfortable with were conducted in the first instance.

Language and learning styles were described as a factor that hindered the quality of support for children and families. In particular, a disengaged service user described the challenges of explaining feelings and understanding staff as English was not their first language. Similarly, service users who had been supported with an interpreter commented that this added complexity as they also had to feel comfortable opening up with the interpreter, not just SafeCORE staff, and that they had to ensure they were "happy with the way they translate" (SU). Moreover, complex and abstract concepts, such as compassion, were described by service users and staff as challenging to explain and, in particular, to translate for service users for whom English was not their first language.

What factors enable or hinder improvements to the quality of support or care for children and families?

Three themes were identified in the analysis of factors that enable or hinder improvements to the quality of support as described by service users and staff: preconceptions and expectations of SafeCORE, the team approach (reported by staff only) and practical support.

Preconceptions and expectations based on accessing previous services were described as mixed, although predominantly as hindering the achievement of better outcomes for children and families. Service users described initial resistance to engaging with SafeCORE, especially due to the perceived association with CSC services and knowing people who had “lost children through social services” (SU), with a concern being that SafeCORE would “take [child] away” (SU). Initial resistance was also described as arising from a general lack of awareness of the service and what it would entail, with one participant explaining that they “didn’t have a clue what they were or who they were” (SU). Other service users described a concern about being judged as a bad person or parent. Service users described in time being reassured that SafeCORE was not a part of CSC services. Some service users described initial resistance due to the perception that help from an external agency was not required; for example, “I thought I didn’t need any help” (SU).

Mirroring service users, staff described previous experiences of CSC services as hindering engagement, recounting service users who had commented that “we’re not going to get the social care...[...] to take the children away” (S). Some staff noted that despite explaining to families that SafeCORE was voluntary, they perceived involvement as being “kind of forceful way or statutory” (S) or that there was pressure to engage from referrers. In addition, staff noted that when “there is a lot of blame on each other” (S) it was challenging for service users to engage. Staff described strategies to help families engage with the service as being beneficial, particularly around ensuring families understood that the service was voluntary, non-judgemental and would help the family to make safer decisions. Flexible engagement strategies were described as helping to reinforce these messages, such as keeping in touch texts or calls and ‘compassionate cards’ (correspondence sent to the families by SafeCORE staff as a way to signal an “open door” and that support is available when the families are ready to engage more).

Some services users were not hopeful that SafeCORE would be beneficial as they perceived little control during times of conflict; for example, “once you argue and your anger’s hitting the roof, that’s that” (SU). Some services users expected SafeCORE to be a form of couple’s counselling and had not expected it to involve taught activities such as mindfulness. Other service users described not expecting SafeCORE to be a whole family approach and that they “didn’t think it would be to do with the kids” (SU).

Nevertheless, some services users were clear about the role of SafeCORE as helping families to understand each other and resolve conflict and that “nobody was in trouble” (SU). These findings suggest that having clear introductions at the beginning of SafeCORE interventions to manage preconceptions and expectations would be particularly useful, especially considering some families’ previous experiences with CSC services. Staff also described the importance of informing service users about the role of SafeCORE at the beginning of work and taking time to ensure a comprehensive understanding was achieved before families decided whether or not to engage.

The team approach was described by staff as not only supportive to staff but also as enabling the quality of support for services users. One staff member described that “it’s a unit model, so one unit consists of the practice lead, a children’s social worker and a coordinator. I guess what is different to, I guess more sort of traditional social work, is that whereas sort of one worker would have case responsibility, in the unit the practice lead...holds case responsibility but all practitioners, in a way, support the family worker” (S). Staff described having a team around them as promoting reassurance and confidence and as being especially useful to draw on when queries arose or additional support was required. The team approach was described as helping to bring together different views and perspectives; for example, reminding team members that “we don’t know the whole picture, and can we give him (the perpetrator) an equal chance” (S). Moreover, staff described the multi-disciplinary skills, afforded by the team approach, as increasing the expertise, perspectives and experiences that underpin care. Some staff noted that prioritising unit meetings and time to collectively discuss family needs requires particular attention as caseloads increase.

Disengaged service users in particular discussed practical factors that hindered engagement with SafeCORE, such as work commitments: “working on this programme means I will have to take time off work every week, which is not possible...it is very attractive but it’s just, timewise, I just can’t commit to it” (Disengaged SU). Another disengaged service user described the frequency of work as a barrier, in that more sessions during times of conflict were needed as were alternatives if a specific tool or approach was not helping. Staff also commented that time commitment and balancing this with work was a barrier to some families.

Additionally, data from the staff survey was analysed to examine the views of staff on their work with SafeCORE, as well as their levels of compassion, burnout and self-efficacy. The results showed that none of the staff members surveyed reported taking sick leave due to stress. Staff also reported that their caseload was adequate. Burnout scores did not differ between the two time points of the survey and were lower than an

empirical comparator sample of 1,720 social workers¹⁷. These findings suggest that SafeCORE staff have adequate workloads and burnout levels that do not differ from those of social workers. Although no causal effect can be ascertained, these data give no indication of a detrimental effect of working for SafeCORE in staff's stress and burnout levels. These findings are detailed in the Appendix 2.

What are the key mechanisms of change and how do these relate to observed impact?

Three themes were identified in the analysis of the key mechanisms of change reported by service users and staff: cognitive change, relationship between service users and staff and the situational couple violence approach (reported by staff only).

Building on the aforementioned theme of emotion regulation, service users described changing their way of thinking about words, actions and reactions of their partner by using increased compassion, considering how they interpret what their partner is saying and re-visiting attributions of blame. Moreover, staff also described cognitive change as important in terms of service users having increased understanding and insight of their relationship and interactions with their partner. For example, instead of blaming arguments and issues on external factors, staff described service users' as attending more to problem-solving strategies that could be actioned within the household. This understanding and insight enabled service users to "stop this loop of getting agitated and acting upon his feelings" (S).

Helpful cognitive change strategies described by service users included the ability to take a step back from situations of conflict and physically and cognitively remove oneself from the situation or "have a little walk away" (SU). In addition, learning the importance of the use of language was described as a particularly helpful strategy, such as avoiding "just letting it all come out and not thinking" (SU) and taking "a moment before you do anything" (SU). New tools, approaches and strategies for managing situations required learning, testing and reflection. For example, learning how to be compassionate and connect with partners was described as a learning process, with one service user reflecting on how "little gestures can make changes, can make some impactful changes" (SU).

Overall, service users described a very positive experience of SafeCORE, particularly of staff and the relationship they developed with staff. Service users described staff as friendly, approachable, open, empathetic and respectful. Service users described the reassurance from SafeCORE staff that they were not part of CSC services as an

¹⁷ Walters, Brown, & James (2018). Use of the Copenhagen Burnout Inventory with Social Workers: A Confirmatory Factor Analysis, *Human Service Organizations: Management, Leadership & Governance*, 42:5, 437-456, DOI: [10.1080/23303131.2018.1532371](https://doi.org/10.1080/23303131.2018.1532371)

important precursor to building an effective relationship with staff (also see preconceptions about SafeCORE). Building a bond with service users and children was described as especially important, with service users describing that their children “love having [SafeCORE staff] around” (SU). Building the bond with staff and the relaxed, non-judgemental atmosphere were described as important to enable service users to establish trust and feel like “I can trust him...for me that’s a big deal, because I don’t trust anyone” (SU) and “never felt criticised, never judged” (SU). The relaxed and non-judgemental atmosphere appeared well-balanced with professionalism, as service users described feeling confident that SafeCORE staff were skilled and qualified. Although guidance and support were given by SafeCORE staff, these were received in a way that did not feel pressured or enforced. Moreover, the calm, patient and flexible approach of staff was described as particularly beneficial, especially as it is “what people who are stressing out need” (SU). Staff placed a similar emphasis on the importance of building and maintaining relationships with service users, whilst maintaining clear boundaries (e.g., in relation to contact through social media) and obligations (e.g., in relation to times when confidentiality may need to be broken due to safeguarding).

The approach of situational couple violence was described by staff as taking some time to learn; in particular, the complexity of the approach meaning that there may not be clear roles of perpetrators and victims or even physical violence. In light of this approach, the role of language was described by staff as particularly important, avoiding terms such as perpetrator, and instead discussing the situation in which a confrontation occurred, understanding why the family was in that situation and how staff could help “them to change and getting to know them as a person and changing the behaviour” (S). Similarly, new concepts and approaches (such as compassion) were described as requiring time to assimilate. Unit meetings (also see the team approach) and sufficient time to plan ahead of sessions were some of the strategies staff described as helpful, especially in relation to adopting new practices. In addition to the aforementioned importance of flexible practice, goal setting and monitoring with service users was described as helpful for ensuring that the intervention remains focussed and that care is continuously aligned to the needs of the family.

What are the cost implications of SafeCORE? Is it cost-effective?

The estimated savings generated by SafeCORE have been calculated by assigning financial proxies to improvements against those outcomes that most naturally lend themselves to monetisation. These outcomes and the corresponding proxy indicators are shown in Table 6 below (further detail is provided in Appendix 3). Other outcomes recorded by the project, such as guidance and boundaries, social isolation and basic care, have been excluded from the analysis. This is because there is a risk of overlap with the outcomes listed below, because they less easily translate into financial savings, or because they would belong in a Social Return on Investment exercise.

Table 6: Proxy saving per family per year

Outcome	Indicator	Proxy saving per family per year
Education	Reduction in truancy for one child.	£1,965
Employment	One workless adult in the family enters work and no longer claims Jobseeker's Allowance.	£13,139
Housing	An eviction has been avoided.	£7,770
Mental Health	One member of the family does not require a mental health treatment programme.	£2,303
Physical Health	The family visits their GP three fewer times over a 12-month period.	£67
Safety	One Child in Need plan has been avoided.	£2,330
Substance Misuse	One family member reduces/stops their substance misuse and does not require a treatment programme.	£3,994
Violence	Reduction in domestic violence episodes. An average of three episodes per family has been assumed.	£8,904

Source: Case note data.

The data available for the cost saving exercise included 37 families which, at the start of their support through SafeCORE, had the potential to improve against one or more of the outcomes listed in Table 6. Twelve of those were classed as having engaged with SafeCORE. The other 25 were classed as having disengaged.

For each of the outcomes, Table 7 shows the number of engaged families for whom an improvement was recorded. Table 8 does the same for the disengaged families. The

figures in the 'Total saving (no deadweight)' columns are calculated by multiplying the number of families with a recorded improvement by the corresponding proxy saving figure in Table 9. This then allows the calculation of an average saving per family: £14,701 for the 12 engaged families and £9,459 for the 25 disengaged families.

Table 7: Results by outcome: engaged families

	No. families with an improvement	Total saving (no deadweight)
Education	7	£13,755
Employment	3	£39,417
Housing	2	£15,400
Mental Health	5	£11,515
Physical Health	2	£134
Safety	9	£20,970
Substance Misuse	2	£3,994
Violence	8	£71,232
	Average saving per engaged family: £14,701	

Table 8: Results by outcome: disengaged families

	No. families with an improvement	Total saving (no deadweight)
Education	4	£7,860
Employment	2	£26,278
Housing	5	£38,500
Mental Health	3	£6,909
Physical Health	1	£67
Safety	10	£23,300
Substance Misuse	0	£0
Violence	15	£133,560
	Average saving per disengaged family: £9,459	

If it is assumed that the characteristics and needs of the two sets of families are broadly equivalent, then the annual additional saving to the state of remaining engaged with SafeCORE – based on the eight indicators above – is £5,242 per family. This compares with an estimated average cost of supporting a family through SafeCORE of £19,918 (calculated as the total project funding (£1,950,000), minus 10% to allow for start-up costs, divided by the total number of families supported (89)). However, it is important to see this in the context of the following:

- Benefits realisation and costs of delivery: SafeCORE is an early intervention programme which seeks to prevent high cost episodes occurring in the future. These episodes could include children becoming looked after or placed on Child

Protection Plans. It would only be possible to fully assess the longer-term fiscal savings of SafeCORE via an evaluation that took place over a considerably longer period and which tracked a cohort(s) of beneficiaries alongside an appropriately selected comparator group(s). The very nature of SafeCORE dictates that fiscal savings observed in the short-term (for example, within the lifespan of this evaluation) will be outweighed by the costs of delivery.

- **Deadweight:** the calculations assume 100% attribution, i.e. that all of the savings can be attributed exclusively to SafeCORE. In practice that may not be the case, although in the absence of a comparator group it is difficult to accurately assess the deadweight of SafeCORE (the extent to which the improvements recorded against the various outcomes would have occurred anyway). The qualitative evidence generally suggests that SafeCORE has an impact on the families, hence deadweight is likely to be relatively low. By way of illustration therefore, were it assumed that 66% of the recorded improvements could be attributed to SafeCORE, the difference between the averages for an engaged and a disengaged family becomes £3,512.
- **Benefits period:** the cost saving calculations present annualised results, but in practice the fiscal benefits of SafeCORE could persist for longer. This would be the case if, for example, SafeCORE successfully reduced domestic violence in a family and there was no subsequent return to the pre-SafeCORE levels. In cases like that, the savings to the state would be greater than those presented here.

It is also important to make clear that the results from this exercise are likely to be conservative estimates of SafeCORE's savings to the public purse. Whilst the other outcomes recorded by the project are less easy to monetise, they could, over time, lead to fiscal savings. Improvements in basic care, for example, may mean fewer interactions with the health service. Improvements in social isolation could lead to reductions in loneliness, a subject on which there is a growing body of evidence regarding costs to the state¹⁸.

¹⁸ Holt-Lunstad, Layton (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS Medicine*, 7; Marmot et al (2010). Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010.

4. Summary of key findings on 7 practice features and 7 outcomes

As reported in the Children's Social Care Innovation Programme Round 1 Final Evaluation Report (2017), evidence from the first round of the Innovation Programme led the DfE to identify 7 features of practice and 7 outcomes to explore further in subsequent rounds.¹⁹

Strengths-based practice frameworks

In staff and service user interviews/ focus groups, we found that the work conducted as part of SafeCORE was instrumental to the development and practice of coping strategies which enabled service users to reduce conflict and increase relational closeness. Service users also highlighted the benefits of an approach that brought families together, allowing for a joint reflection of each other's progress. The SafeCORE work around practical problem-solving was also identified by service users as an important aspect of the programme, allowing for an increase in engagement with education, employment and training, for example. A focus on both building strengths by teaching SafeCORE techniques of awareness, compassion and emotion regulation, as well as drawing on strengths of families, was identified by service users as particularly beneficial.

Systemic theoretical models

SafeCORE staff training includes systemic components. Data from interviews/ focus groups shows that systemic work translates into, for example, genograms being generated at meetings with family members, as well as in systemic thinking about how family members interact both with each other and in the wider context of their extended network. SafeCORE staff actively engage with the family system to generate sustainable change, for example in working on goals that appear to often involve several family members (whole-family approach). The systemic component is also one of the aspects mentioned by families when interviewed about their involvement with the programme.

Multi-disciplinary skills sets

SafeCORE teams bring a range of different professional backgrounds to their work with families. Staff report good teamwork in their multi-disciplinary teams. Members of SafeCORE units with different skill sets engage with family members in an adaptive way. Staff jointly decide at unit meetings which SafeCORE unit members engage with which

¹⁹ Sebba, J., Luke, N., McNeish, D., and Rees, A. (2017) *Children's Social Care Innovation Programme: Final evaluation report*, Department for Education, available [here](#).

family members next, to meet needs of the families as they are perceived jointly by the team. Our observation of a unit meeting indicated contributions from all unit members, sharing their different perspectives in a collaborative way.

Group case discussion

Members of each SafeCORE unit discuss any ongoing work with families. Data from this evaluation suggest that all unit members contribute to this discussion, bringing their different perspectives, both from their different backgrounds as well as their understanding of the family dynamics and of the application and helpfulness of SafeCORE techniques. Past work with the family and their current circumstances are reflected on, as are the current circumstances for the SafeCORE unit and how the techniques of Compassionate Minds apply to the SafeCORE unit members and their interactions with the family. Group members decide jointly who sees family members next, with goals for each visit.

Family focus

SafeCORE units engage with all members of the family, and this appears to have a positive impact on family members' interactions with each other. This emerged from family and staff interviews/ focus groups. From the qualitative data, it appears that family members apply emotion regulation and compassionate techniques when interacting with each other, and the learning from these techniques is also a point of communication between family members, leading to different patterns of communication, including more awareness (for example, of levels of emotional arousal and how this may affect the interaction). The use of emotion regulation techniques and their effect on communication and behaviour are notable in the qualitative data from families. SafeCORE units also apply systemic approaches to their understanding of families. The family focus is strongly integrated into the SafeCORE approach: for example, the form for entering unit meeting notes prompts unit members to think of the "voice of the child or young person" for each family.

High intensity and consistency of practitioner

SafeCORE units are small teams of 5 members. Different team members work with family members, so there is no single practitioner who is the family's point of contact. However, qualitative data indicates that SafeCORE teams build up good relationships with the whole family, with continuity being considered when deciding who works next with family members. Because of updates at the unit meeting, SafeCORE members are also aware of each other's work. While the small SafeCORE teams do not meet a particular definition of a single high intensity practitioner, they may be a viable alternative.

Findings from family interviews also indicate the consistency and good relationships between SafeCORE staff and families, particularly with children.

Skilled direct work

SafeCORE unit members bring different skills to the families (for example, child and adult practitioners, social workers and psychologists). Matching staff with family members is decided by the team at unit meetings in a flexible, needs-based way. At some meetings with families, the two different SafeCORE unit members visiting the family split up during the visit to work with different members of the family (for example, the child practitioner works with the children, whereas the adult practitioner works with the parents). From staff interviews, it seems that staff members value their training in the SafeCORE techniques and see themselves as providing a form of therapy, which is indicative of their approach to the family using skilled direct work. Data from the staff survey showed that most staff agreed or strongly agreed that they had the skills needed to work effectively with children and young people, fathers and whole families at both surveyed time points. Most staff also reported that SafeCORE training had improved their confidence in working with these three groups.

Reducing risk for children

The impact on improved emotion regulation and relational closeness was deemed as beneficial to the happiness of children, as reported by service users. The renewed focus on the impact of situations of conflict on children was also highlighted as a consequence of SafeCORE work, contributing to the avoidance of children being exposed to conflict and violence. SafeCORE work on the management of stress and anxiety also contributed to a calmer home environment, leading to an increase in children's wellbeing. From the quantitative data on types of problems families and staff identify, it was noted that most problems related to conflict, violence and safety, which generally improved over the course of SafeCORE.

Creating greater stability for children

Findings from family interviews suggest that the techniques used within SafeCORE contribute to a more stable environment at home for the children involved, with families also reporting improvements in their children's behaviour and emotion regulation. Additionally, families that engaged with SafeCORE achieved more goals and improved in more problems than families who did not engage with SafeCORE.

Increasing wellbeing for children and families

Staff interviews/ focus groups indicate a high engagement with the programme and a feeling of being well accepted by family members. This finding also emerged from interviews with families. Staff report positively on work in units with collegial and inter-disciplinary support. Some staff members also emphasise meaningful personal development as a result of their induction, especially the meditation and compassion components. These may work indirectly by creating an open and supportive team working environment. Family interviews also indicate that families generally experience better wellbeing after being part of SafeCORE, highlighting the work with staff leading to this improvement. Most goals set out by families around family and social relationships, emotional and behavioural development and emotional warmth were also achieved over the course of SafeCORE.

Reducing days spent in state care

No child had incidents of CIN, CPP or CLA within the 12 months pre and post-allocation to SafeCORE. Additionally, when looking at referrals to MASH within the same time periods, 3 children had a MASH referral in the 12 months pre-allocation to SafeCORE and no children had referrals to MASH in the 12 months post-allocation to SafeCORE. The lack of incidents prior to allocation could be explained by the fact that SafeCORE is aimed at families with Domestic Violence and Abuse (DVA) as a presenting need that fall below the threshold for statutory services. It is important to note that caution is advised when interpreting these figures without further context, and inferring any impact from the intervention on the reduction of days spent in care state would require additional information which was not the focus of our analyses.

Increasing workforce wellbeing

Staff interviews indicate a high engagement with the programme. Staff report positively on their own work wellbeing and some members of staff also emphasise meaningful personal development as a result of their induction, especially the meditation and compassion components. These may work indirectly by creating an open and supportive team working environment. Findings from the staff survey also highlight that SafeCORE staff did not report any work-related stress nor felt their workload was inadequate.

Increasing workforce stability

Staff survey data showed that no staff were absent due to stress and reported their workload as adequate. The burnout levels of SafeCORE staff did not differ to those of

social workers from an empirical sample, suggesting no detrimental impact of SafeCORE on burnout levels.

Generating better value for money

Results from the Cost-Benefit Analysis suggest the following average savings per family: £14,701 for the 12 engaged families and £9,459 for the 25 disengaged families. If it is assumed that the characteristics and needs of the two sets of families are broadly equivalent, the annual additional saving to the state of remaining engaged with SafeCORE is £5,242 per family.

5. Lessons and implications

The families' positive view of the service and the quality of SafeCORE were particularly important, as most families had not previously received any support from similar or other services. The complexity and importance of the therapeutic relationship with SafeCORE workers, and the impact and importance of service users' preconceptions of the service, were also findings that emerged from the qualitative data as important aspects that impact the success of SafeCORE interventions.

Overall, we found that staff morale, autonomy to adapt the programme to the needs of the service user, confidence in delivering the programme and the ability to work effectively together were important factors in enabling improvements to the quality of support or care for families taking part of SafeCORE. The role of team collaboration was also found to be important, with staff learning from and being supported by multidisciplinary approaches, which were deemed as aspects that improved the quality of the service.

Results from the evaluation also showed that when compared against disengaged families, engaged families achieved more goals and improved in more problems identified at the outset of work with SafeCORE. It was also noted from the qualitative data that setting goals was a helpful way to check in with families as well as planning the next steps and interventions for each family.

In this section we will discuss the lessons and implications of the evaluation, answering evaluation questions 7 and 8, which will also allow to answer questions 9, 10 and 11 (collapsed to avoid repetition).

What lessons are there for a wider roll out of SafeCORE?

Service users described an initial resistance to engaging with SafeCORE, which was particularly due to the perceived association with CSC services, the lack of awareness of the service and what it offers and concerns about judgement from others. Future and wider roll out of the service should take this into account and introduce SafeCORE to families in a clear and detailed way, demystifying any preconceptions, clarifying any doubts and adjusting expectations from future service users. Future roll out should also consider some aspects highlighted by disengaged service users, in particular the practical factors that hindered engagement (such as work commitments or the frequency of sessions). To this end, we suggest that future endeavours allow for more flexible working around the families' schedules. Another barrier related to language, which was identified by service users as a barrier to fully engaging with the service. To mitigate this, SafeCORE could seek to employ staff that speak other languages commonly used in the local population, as this may be preferable than having an interpreter (as pointed out by service users).

The programme should also continue to build on the work to prioritise and develop ways of optimising the often-complex nature of relationships with these populations, including concerns that parents have of an external service working with their children. It is equally important to aim for the continuity of a balance in working with the whole family, considering family dynamics and individual service user characteristics. The results from our analysis suggest that SafeCORE is providing a service with a successful whole family approach, deemed by service users as unique and enabling the whole family's needs to be met. Our recommendation is that this effort is sustained as a core feature of SafeCORE.

Additionally, it is important to note that a flexible approach to the programme gives staff the autonomy to account for different backgrounds, needs and engagement styles, which may be crucial when working with a wide range of families and could mitigate some of the aforementioned challenges associated with disengagement. It is therefore recommended that the flexible approach employed by SafeCORE staff is sustained in future roll out, as this is particularly relevant when addressing issues that lead to disengagement and consequently may lead to less improvements, goals being harder to achieve and worse outcomes for families.

What needs to happen at the organisational and community levels for SafeCORE to be a success?

From the perspective of assessing outcomes, looking at CIN and CPP indicators, while important, these may alone not capture the rich impact of SafeCORE. To this end, we sought other types of data to inspect SafeCORE's impact on the lives of children and families, for example, data from case notes and qualitative data from both service users and staff involved in the delivery of the programme. To fully assess the impact of SafeCORE and to further understand the mechanisms of change, a longitudinal study would be needed. Tracking families over time would allow us to see changes, especially outcomes that may occur with a low frequency, and would offer more insight into the impact of SafeCORE.

We recommend that attempts to increase awareness of the programme at the community level should be prioritised. This would help with acceptability, engagement and uptake. Equally, ensuring that both internal and external referrers to CSC and those professionals introducing the service (such as referrers or SafeCORE staff on an initial contact) clearly state its aims, what is expected from the service users, its voluntary nature and the focus on supporting families rather than being a part of CSC. Moreover, we highlight the value of supporting of a greater number of families who are not coming to the attention of social care yet but still need help, as it is evidenced by the literature on DVA that early intervention could lead to the reduction of escalation to social care

services, the reduction of mental health problems²⁰ and saving money from the public purse²¹.

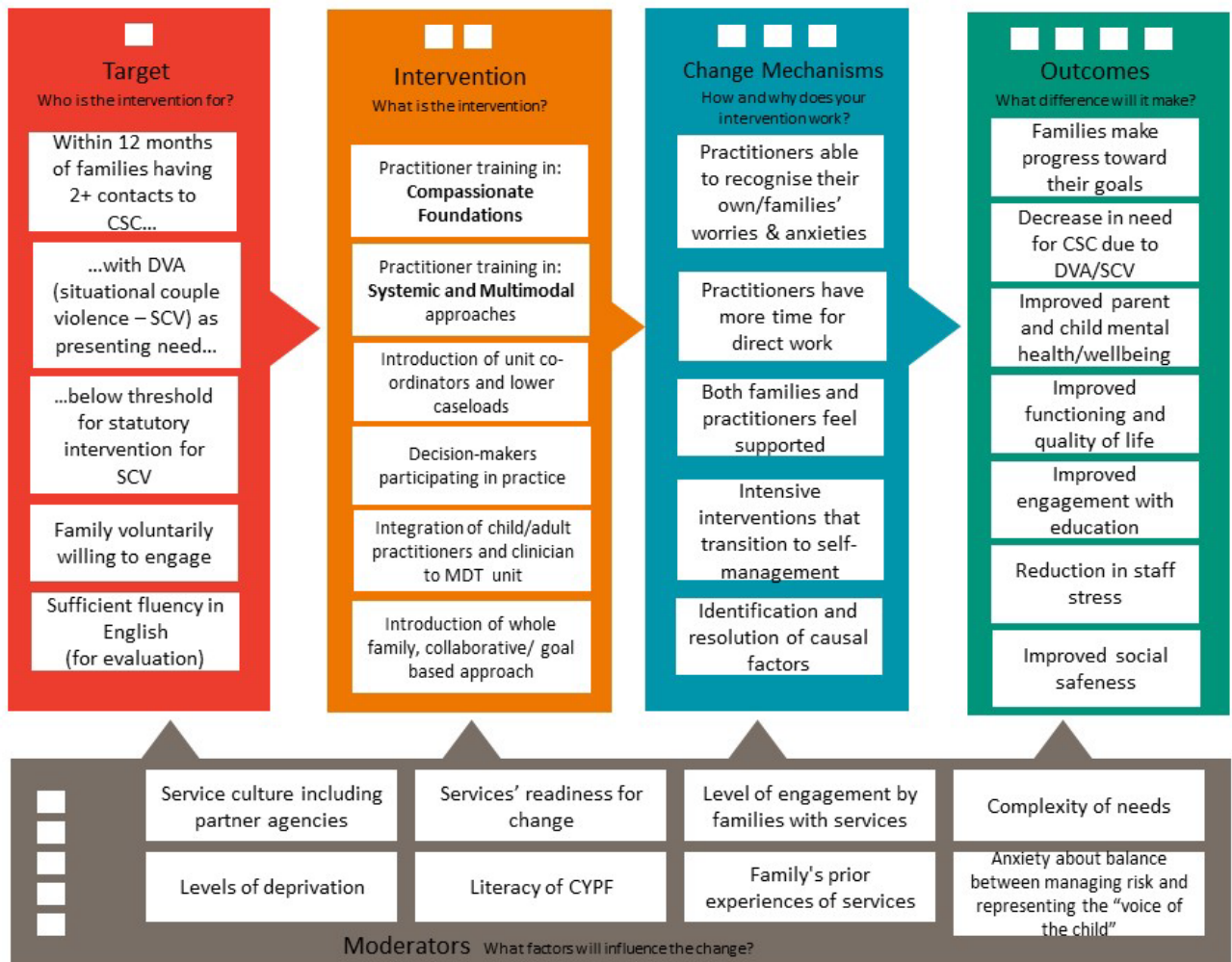
Additionally, we recommend the maintenance of staff confidence in the delivery of the model and its concepts, particularly as this may be a new approach not used by them before. This could be achieved by maintaining the already existing ongoing and initial training and team support. We also note that the prioritisation of team collaboration, particularly of a multidisciplinary nature, is crucial for the success of SafeCORE.

It is also pertinent to note the importance of building rapport between key SafeCORE workers and families, as this was found to be helpful and beneficial by both service users and staff. This could be achieved, as our data suggests, by working with a positive and flexible approach to the assessment of an individual family's needs (for example, by identifying mutually agreed goals and structuring sessions around service user preferences). We also found that SafeCORE staff reported acceptable levels of burnout and adequate levels of workloads. We recommend that the maintenance of staff wellbeing, by assigning adequate workloads, for example, is continued, as it may impact the work conducted with the families and contributes to the protection of time and resources for staff to build and maintain effective relationships with families.

²⁰ Trevillion, K., Oram, S., Feder, G., & Howard, L. M. (2012). Experiences of domestic violence and mental disorders: A systematic review and meta-analysis. *PLoS One*, 7(12), e51740.

²¹ Guy, J., Feinstein, L., & Griffiths, A. (2014). *Early intervention in domestic violence and abuse*. London: Early Intervention Foundation.

Appendix 1: Project theory of change



Appendix 2: Staff survey

Results from this analysis should be interpreted with caution, as the sample sizes are small and therefore statistical testing is unlikely to detect change. At time 1, most staff members were assigned between 6 and 15 cases, with only a small proportion being assigned 16 or over, or 5 or less. At time 2, more staff reported being assigned 16 or more cases. Most staff strongly disagreed that they had too many cases at both time points. None of the staff members surveyed reported taking sick leave due to stress.

Burnout scores at time 1 and time 2 were measured using the Copenhagen Burnout Inventory (CBI) and were calculated according to the subscales of the measure (Personal burnout, Work burnout and Client burnout). Descriptive statistics (means, 95% confidence intervals and standard deviations) are displayed in Table 9 (below). Overall there were no significant changes in the mean scores of CBI between time 1 and time 2, although the small absolute numbers mean the analysis is likely to be underpowered to detect change. All burnout scores were lower than an empirical comparator sample of 1,720 social workers, in which the mean for personal burnout was 57.9, the mean for work burnout was 52 and the mean for client burnout was 31.9²². These findings suggest that burnout levels are constant over time and similar to those of other social workers, suggesting no detrimental effect of SafeCORE work on the burnout levels of SafeCORE staff.

Table 9: Copenhagen Burnout Inventory (CBI) scores (time 1 and time 2) for SafeCORE staff

	Time Point	N	M [95%CI]	SD
Personal burnout	Time 1	11	37.5 [31.9, 43.1]	11.3
	Time 2	10	34.2 [25.2, 43.1]	17.9
Work burnout	Time 1	12	26.5 [20.5, 32.5]	8.9
	Time 2	10	30.7 [24.1, 37.4]	13.9
Client burnout	Time 1	12	18.1 [12.2, 23.9]	11.7
	Time 2	10	21.7 [15.7, 27.6]	11.9

Source: Staff survey data.

Results from the adapted Compassionate Engagement and Action Scales show no significant differences in the subscales of Others Action, Others Engagement, Self-Action and Self Engagement between time 1 and time 2. The Compassionate Engagement and Action Scales measures two orientations of compassion: self-compassion (divided into action and engagement) and the ability to be compassionate towards others (divided into action and engagement). Descriptive statistics are displayed in Table 10 (below). Results show that scores from the 4 subscales did not differ statistically from time 1 to time 2,

²² Walters, Brown, & James (2018).

suggesting that the levels of the compassion facets of SafeCORE staff remained stable over time.

Table 10: Compassionate Engagement and Action Scales (CEAS) scores (time 1 and time 2) for SafeCORE staff

	Time Point	N	M [95%CI]	SD
Others – action	Time 1	12	34.6 [32.8, 36.4]	3.6
	Time 2	9	35.9 [33.8, 37.8]	4.0
Others – engagement	Time 1	12	51.8 [50.2, 53.5]	3.3
	Time 2	10	50.8 [47.8, 53.8]	6.0
Self – action	Time 1	12	30.2 [27.4, 33.1]	5.8
	Time 2	10	31.4 [28.4, 34.4]	6.1
Self – engagement	Time 1	12	45.2 [41.1, 49.2]	8.1
	Time 2	10	45.3 [41.4, 49.2]	7.9

Source: Staff survey data.

Equally, no significant differences between the scores of self-efficacy were found between time 1 and time 2 ($M_{\text{Time 1}} = 118.2$, 95% CI [106.1, 130.4], $SD_{\text{Time 1}} = 24.4$; $M_{\text{Time 2}} = 123.7$, 95% CI [115.3, 132.2], $SD_{\text{Time 2}} = 16.9$) (again, the analysis is likely underpowered). Most staff agreed or strongly agreed that they had the skills needed to work effectively with children and young people, fathers and whole families at both surveyed time points. Most staff also reported that SafeCORE training had improved their confidence in working with these three groups, at both time points. These findings suggest that SafeCORE staff are well equipped to deliver the intervention.

Appendix 3: Cost benefit analysis

The analyses included in this Appendix used case note data.

Selection of indicators

The data available for the cost saving analysis indicated, in a binary ‘yes or no’ way, whether an improvement had been recorded for a family against any or all of the following outcomes:

- Education
- Employment
- Housing
- Mental health
- Physical health
- Safety
- Substance misuse
- Violence

The data did not indicate what specifically had improved within these outcomes, which family member(s) were involved or on what scale. This has unavoidably constrained the granularity and objectivity of the cost saving analysis.

Indicators have been assigned to each of the outcomes, meaning that assumptions have been made about the changes that might plausibly occur as a result of the outcomes improving. The selected indicators, their corresponding annual fiscal savings and the sources of those savings are shown in Table 11.

Table 11: Cost saving indicators

Outcome	Indicator	Proxy saving (per family)	Source
Education	Reduction in truancy for one child.	£1,965	Average annual cost of persistent truancy. Based on <i>Misspent Youth: the costs of truancy and exclusion (NPC, 2007)</i> and adjusted for inflation.
Employment	One workless adult in the family enters work and no longer claims	£13,139	Average fiscal benefit of a JSA claimant entering work. Based on DWP

	Jobseeker's Allowance.		modelling (unpublished).
Housing	An eviction has been avoided.	£7,770	Average fiscal cost of a complex eviction. Based on <i>Research briefing: Immediate costs to government of loss of home (Shelter, 2012)</i> and adjusted for inflation.
Mental Health	One member of the family does not require a mental health treatment programme.	£2,303	Average annual cost of service provision for people suffering from mental health disorders. Based on <i>Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008)</i> and adjusted for inflation.
Physical Health	The family visits their GP three fewer times over a 12-month period.	£67	Average cost of a GP appointment. Based on <i>Unit Costs of Health & Social Care 2018 (Curtis, 2018)</i> and adjusted for inflation and 15-minute minimum consultations, continuity of care through 'micro-teams', and an end to isolated working: this is the future of general practice (Royal College of General Practitioners, 2019).
Safety	One Child in Need plan has been avoided.	£2,330	Average cost of a CIN plan for 250 days. Based on <i>Extension of the cost calculator to include cost calculations for all children in need (Department for</i>

			<i>Education, 2010)</i> and adjusted for inflation.
Substance Misuse	One family member reduces/stops their substance misuse and does not require a treatment programme.	£3,994	Average annual savings resulting from reductions in drug-related offending and health and social care costs as a result of delivery of a structured, effective treatment programme. Based on <i>Estimating the crime reduction benefits of drug treatment and recovery (National Treatment Agency for Substance Misuse, 2012)</i> and adjusted for inflation.
Violence	Reduction in domestic violence episodes. An average of three episodes per family has been assumed.	£8,904	Average cost per domestic violence incident. Based on <i>The Cost of Domestic Violence, Update (Walby, 2009)</i> and adjusted for inflation.

Cohorts

The cost saving analysis has compared data for two cohorts of families:

- Those that are classed by the local authority as having engaged with SafeCORE: 12 families.
- Those that are classed as having disengaged from SafeCORE: 25 families.

All 37 families had at least one of the outcomes listed in Table 11 as a potential area for improvement at the outset of their support through SafeCORE. As shown in Tables 12 and 13, against the majority of outcomes and across the cohorts as a whole, improvements were more prevalent amongst the engaged families. Indeed, the engaged cohort had an average of 3.7 potential improvements per family and an average of 3.1 actual improvements. This compares with an average of 2.6 potential improvements per family for the disengaged cohort and an average of 1.6 actual improvements.

Table 12: Outcomes and improvements – engaged families

	No. families with this outcome as a potential area for improvement	No. families recording an improvement	% families recording an improvement
Education	7	7	100%
Employment	3	3	100%
Housing	4	2	50%
Mental Health	6	5	83%
Physical Health	3	2	67%
Safety	10	9	90%
Substance Misuse	2	2	100%
Violence	9	8	89%
Totals	44	38	86%

Table 13: Outcomes and improvements – disengaged families

	No. families with this outcome as a potential area for improvement	No. families recording an improvement	% families recording an improvement
Education	6	4	67%
Employment	2	2	100%
Housing	7	5	71%
Mental Health	11	3	27%
Physical Health	3	1	33%
Safety	11	10	91%
Substance Misuse	5	0	0%
Violence	19	15	79%
Total	64	40	63%

Assigning cost saving estimates

Estimated cost savings have been calculated by multiplying the number of families recording an improvement against a given outcome by the proxy saving for that outcome. The results are shown in Tables 7 and 8 (also shown in the main body of the report). The average annualised saving per engaged family is £14,701 compared with £9,459 per disengaged family. The difference between the two (£5,242) could be taken as the net effect of remaining engaged with SafeCORE across the outcomes in scope.

However, this assumes that the characteristics and needs of the engaged and disengaged families are very similar. Likewise, any non-SafeCORE support services with which they have interacted. It is not possible, through the data available to the evaluation, to assess the extent to which this is true.

Table 7: Results by outcome: engaged families

	No. families with an improvement	Proxy saving (per family)	Total saving (no deadweight)
Education	7	£1,965	£13,755
Employment	3	£13,139	£39,417
Housing	2	£7,770	£15,400
Mental Health	5	£2,303	£11,515
Physical Health	2	£67	£134
Safety	9	£2,330	£20,970
Substance Misuse	2	£3,994	£3,994
Violence	8	£8,904	£71,232
		Total:	£176,417
		Average saving per family (12 families):	£14,701

Table 8: Results by outcome: disengaged families

	No. families with an improvement	Proxy saving (per family)	Total saving (no deadweight)
Education	4	£1,965	£7,860
Employment	2	£13,139	£26,278
Housing	5	£7,770	£38,500
Mental Health	3	£2,303	£6,909
Physical Health	1	£67	£67
Safety	10	£2,330	£23,300
Substance Misuse	0	£3,994	£0
Violence	15	£8,904	£133,560
		Total:	£236,474
		Average saving per family (25 families):	£9,459

Comparing savings with the cost of delivering SafeCORE

A cost-benefit exercise would usually compare the financial savings of an intervention with the cost of delivering it. The challenge of doing that for SafeCORE is that it is an early intervention programme which seeks to prevent high cost episodes occurring in the future. It is not designed to reduce costs in the short-term in the same way as an intervention that aims to step children down from residential care, or prevent those on the edge of care from becoming looked after, for example.

To accurately compare the costs of SafeCORE with its full cost saving potential would require a longer running evaluation with an appropriately selected comparator group(s). To compare the costs of delivery with the outcomes observed to date risks presenting a very inaccurate assessment.

Attribution and deadweight

The qualitative evidence generally suggests that deadweight is likely to be relatively low. In other words, it suggests that most or all of the difference in average savings between the engaged and disengaged families can be attributed to SafeCORE. The absence of a comparator group prevents this from being tested more objectively.

For illustrative purposes, were it the case that SafeCORE was responsible for 66% of the reported differences between engaged and disengaged families, the difference in average cost savings between the two groups would reduce from £5,242 to £3,512.

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Any enquiries regarding this publication should be sent to us at:

CSC.Research@education.gov.uk or www.education.gov.uk/contactus