

**Barnardo's**

**Opening Closed Doors**

**Year Two Interim Evaluation  
Report**

**October 2020**



# Barnardo's Opening Closed Doors

## Year Two Interim Evaluation Report

### Executive Summary

The Opening Closed Doors Programme, funded by a grant from the Home Office, was established by Barnardo's in March 2019 in five local authority areas in South East Wales. The Programme aims to support children and families who have experienced domestic abuse, including help to recover and build sustainable change in their lives.

The Institute of Public Care at Oxford Brookes University carried out an evaluation of the Programme's first year of operation and published a [report](#) in February 2020, and has been commissioned to conduct a similar evaluation of the second year of operation.

This interim report focuses on the experience of adapting the Programme so that it could continue to be delivered during the Covid-19 pandemic. It outlines findings and recommendations of a small-scale study of how staff and participants experienced new ways of working, in particular the use of remote and digital methods of service delivery, and links these to wider research findings from elsewhere before the pandemic. To complete the small-scale study, the Institute carried out the following activities during September 2020:

- A rapid research review of the evidence relating to digital/remote delivery of family support/domestic abuse programmes, pre-pandemic.
- A focus group with staff.
- Interviews with participants on the Programme.
- A review of materials and content that has been developed to support online delivery.

#### Context

As domestic abuse worsened during the pandemic the corresponding need for support increased and become more intensive, complex and required over a longer period. The restrictions imposed during lockdown meant that services had to adapt and find new ways of working to replace 'in person contact', described by Martin, J et al (2020) as:

- Moving resources and programme content online
- Using phones
- Using messaging services such as WhatsApp
- Using video conferencing services such as Skype, Zoom and Microsoft Teams to deliver actual sessions

#### The pros and cons of using remote or digital methods

Drawing both on previous research studies, mainly of therapeutic interventions for mental health, and a recent study by Women's Aid (2020) as well as the experiences of staff and participants on the Programme, some of the benefits identified include:

- Not having to travel to a venue may make it easier for participants to engage *“less stress just using the phone, more convenient – not having to travel”* (parent).
- Programme content and support may be delivered and accessed more flexibly, fitting more conveniently around the participant's day *“he checked in when is the best time for me. He can do it when kids are in school”* (parent).
- Some people may prefer remote and digital methods as it helps them to feel less self-conscious and more inclined to open up and consequently their engagement is better (particularly in 'hard to reach' groups) *“we've had almost 100% engagement in the Domestic Abuse Perpetrators Programme during Covid one to one work”* (worker).
- One to one support can be more tailored around the individual's needs. Theoretically, remote support can be provided 24/7, meaning that if a crisis occurs individuals can access services at crucial times.
- More potential to provide resources and materials electronically means people are better prepared and key learning can be reinforced *“I like getting them ahead of the session so I can read them. I always have them on my phone then. I've always got it to refer to”* (parent).
- There is evidence from research elsewhere to suggest that a therapeutic alliance can be effectively established through remote and digital methods (for example Pihlaja et al 2018). Barnardo's staff also talked positively about relationship building during this period and early success with *“getting people onside”* and the positive impact this was having *“people are more ready to do the work now. There is better retention”* (worker).

However, on the negative side:

- Some people may not be able to access remote and digital platforms because they cannot afford to buy the equipment, or they live in areas where connectivity is poor.
- Another barrier may be the lack of an available, quiet and safe physical space in which to engage in a telephone or online intervention.
- Some people may have a strong preference for traditional face-to-face interaction and having to navigate an unfamiliar digital service may increase anxiety for some *“they wanted me to do a group, on-line, but I am no good with other people or computers”* (parent).
- It may be more difficult to safeguard children and adult survivors as workers may not be able to observe people and their surroundings as closely as during an 'in person' session or visit.
- It may be harder to pick up on 'disguised compliance' as observation of body language and visual cues are less available.
- The potential to offer more flexible support, 24/7 through digital and remote methods could blur the boundaries between work and personal life *“no break between home and office, bringing trauma into your personal space”* (worker) which could impact negatively on the mental health and wellbeing of the workforce.

## Recommendations

Both the literature and our own findings highlight some important considerations to keep in mind as the Opening Closed Doors Programme continues to develop and adapt to the changing environment. Key recommendations include:

Provide a **choice of different options** for engaging in the programme to include phone, online, social media etc as well as more traditional face to face methods to suit personal preferences.

Consider **broadening digital and remote methods and tools**, for example self-help apps and interactive online content that could support 'live' sessions.

**Prioritise human contact**, as research suggests that remote and digital support is most effective when it involves live communication between practitioner and participant.

Offer **training and guidance** to staff to optimise their skills and competences in building effective relationships and ability to do safeguarding online and by telephone.

Adapt interventions carefully, consider **working with experts in digital delivery** to ensure content is appropriate and engaging for the target cohort.

Ensure that **staff wellbeing** is maintained and work life balance is not compromised by the 'ever present' nature of remote and digital working methods.

## 1 Introduction

The Opening Closed Doors Programme, funded by a grant from the Home Office, was established by Barnardo's in March 2019 in five local authority areas in South East Wales. The Programme aims to support children and families who have experienced domestic abuse, including help to recover and build sustainable change in their lives. A key feature of the Programme is that it takes a holistic approach by offering a whole family intervention that includes: Integrated Women's Support (IWS), a children and young people's intervention based on the Safety, Trust and Respect (STAR) Programme, and the Domestic Abuse Perpetrator Programme (DAPP). The key target outcomes identified for the programme were:

- A safe and stable home environment.
- An improvement in parent-child relationships.
- Children and young people experiencing a reduction in emotional stress.
- Development of positive peer relationships.
- An improvement in school attendance.
- Families able to recover from domestic abuse/violence.
- Families stay together safely following a reduction in violence/abuse.

The Institute of Public Care at Oxford Brookes University carried out an evaluation of the Programme's first year of operation and published a report in February 2020 (Institute of Public Care, 2020b), and has been commissioned to conduct a similar evaluation of the second year of operation, from April 2020 to March 2021.

Given the very different environment in which the programme is being delivered this year due to the Covid pandemic, it was agreed that the first phase of evaluation would focus on exploring the experience of adapting the Programme so that it could continue to be delivered during lockdown. In particular, it will explore how this has been experienced by staff and participants, what the strengths and weaknesses have been and what the implications are for the ongoing development of the Programme.

The evaluation activities that were carried out, in September 2020, include:

- A rapid research review of the evidence relating to digital/remote delivery of family support/domestic abuse programmes.
- A focus group with staff.
- Interviews with participants on the Programme.
- A review of materials and content that has been developed to support online delivery.

The report includes the following sections:

- **Context:** an overview of the impact of Covid-19 on domestic abuse and how service providers have responded.
- **Rapid research review:** highlighting what is known about the strengths and weaknesses of remote and digital delivery of family support including domestic abuse services.

- **Findings of the study:** the benefits and challenges of new ways of working using remote and digital methods to deliver the Barnardo's Opening Closed Doors Programme during the pandemic.
- **Recommendations:** what has been learnt from the findings to inform ongoing development of the Programme.

## 2 Context: What has been the impact of Covid-19 on domestic abuse?

A recent report from Women's Aid (August 2020) paints a stark picture in its summary of what has happened since the UK went into lockdown at the end of March 2020:

- Domestic abuse has got worse during the pandemic.
- Access to escape and support networks was restricted.
- Child survivors also experienced worsening abuse during lockdown.
- Services have seen a mixed impact on demand for services and expect to see a spike in demand in the future.
- Availability of refuge spaces has been reduced during the pandemic.
- Support services are facing funding challenges.
- Community is increasingly important to survivors.
- Services are finding new ways of working with survivors.

The report notes that not only has the need for support increased, but it has become more intensive, complex and needed over a longer term than before the pandemic. This may be attributed in part to the absence of other sources of support during lockdown, for example extended family, school and other community services like children's centres. Although these are now more available, the current picture of local lockdowns (for example, South East Wales has recently had restrictions re-imposed) suggests that domestic abuse survivors will continue to rely more heavily on specialist services like Barnardo's that have kept their doors open throughout this period.

Observations by Barnardo's staff about how need has changed during this period include:

- An awareness of the increase in prevalence of domestic abuse, for example perpetrators using Covid as a reason to isolate victims.
- An increase in substance misuse (alcohol/drugs) and mental health problems.
- Parents being very receptive to the offer of support but needing reassurance that it will be consistent.
- Parents wanting regular contact in the absence of other normally available supports, for example extended family, other professionals, schools.

### 2.1 How are providers (including Barnardo's) adapting to the new environment?

Many providers of targeted family support, either of a general or a specialist nature have been rapidly re-designing their offer during this period (Institute of Public Care, 2020a).

A survey of 88 providers conducted by the Early Intervention Foundation in the first two weeks of lockdown identified that approximately three quarters were already making major adaptations to standard delivery (Martin, J et al. 2020), by:

- Moving resources and programme content online
- Using phones
- Using messaging services such as WhatsApp
- Using video conferencing services such as Skype, Zoom and Microsoft Teams to deliver actual sessions

Some had also begun to redesign the content and format of specific interventions to make them easier to deliver remotely. This has clearly been a huge leap forward for many providers as, prior to the lockdown, only about a third of all providers (including national providers) were delivering their programme predominantly through remote methods and in only 3% of cases were such programmes being delivered in this way on a one-to-one basis.

Surveys of providers of domestic abuse services carried out in April and June by Women's Aid (2020) suggest that community-based providers have been impacted by the need to change their ways of working and find temporary alternatives to face-to-face delivery. Their findings suggest that many such services are now offering online or telephone support and delivering remotely.

Barnardo's responded to the restrictions imposed during lockdown by quickly reviewing their service delivery. An interview with the manager of Opening Closed Doors carried out in the very early days of the crisis revealed that they had been "*thinking a little differently about our offer*" (Institute of Public Care, 2020a) and had rapidly switched to using video calls or other forms of digital communication to carry on providing much needed support to families.

Staff we spoke to in the focus group agreed that "*the whole approach has had to shift, we couldn't do anything face-to-face*". They quickly adapted to online and telephone support, mostly one to one, apart from a few small sibling groups. Given that interventions are usually carried out in groups, this was a significant change. At the time of the focus group in September, online groups for adults were only just starting, the first being an IWS group. Staff were hoping to begin working with children/young people in school spaces, but the logistics had yet to be negotiated. The Service Manager made it clear that bringing back face to face working would be a slow, careful and uncertain process, given the ever-changing environment and the predicted rises in Covid-19 infection rates going into autumn and winter.

### 3 What does the literature say about digital/remote delivery of family support including domestic abuse programmes?

The use of digital and remote methods of providing health and social care support in the UK has been slow to develop up until now, particularly in the domestic abuse sector. It follows that there have not been many studies carried out to investigate the potential benefits and challenges of this approach and how it compares with face to face delivery. However, **a rapid review of the literature** has uncovered some interesting findings from recent Women's Aid research and from more established studies of therapeutic

interventions for mental health, which may be helpful reference points for the continuing development of the Opening Closed Doors Programme.

### 3.1 What do we mean by digital / remote delivery methods?

Berger (2017) highlights the different types of approaches that sit under the general heading of 'digital/remote' methods of health and social care delivery as follows:

**Remote delivery of programmes delivered on a one-to-one basis:** the provision of services to individuals via virtual or digital mediums allowing synchronous communication, such as phone or videoconference for audio- and / or video-based communication, or chatrooms for real-time messaging with a practitioner. Includes, for example, individual counselling and psychotherapeutic services delivered digitally.

**Remote delivery of group-based programmes:** moving or adapting programmes traditionally delivered to groups of children, young people or parents – and which rely in part on group dynamics and peer interaction – into a virtual or digital setting.

**Digital delivery of guided self-help content:** programmes that make use of reading material, slides, videos, quizzes and exercises to deliver content and which are supplemented with some contact with a practitioner, by videoconferencing, email or phone.

**Digital delivery of unguided self-help content:** programmes that provide reading material and explanatory videos for individuals to work through independently and that do not include contact with practitioners.

**Digital delivery of interactive content:** programmes that provide interactive content above and beyond reading materials and watching videos, such as quizzes, activities, tasks or other gamified content that is provided and conducted digitally, including via apps, games and computerised interventions.

**Brief text-based messaging interventions:** interventions that enable asynchronous communication to young people or parents via text, email or other technologies, of content including information, tips, exercises or reflective questions, with the aim of driving behaviour change.

### 3.2 What does research tell us about the pros and cons of using remote or digital methods?

Research studies highlight both positives and negatives of using remote and digital delivery. Key themes include:

**Accessibility:** Not having to travel to a venue may make it easier for participants to engage (and achieves a saving on venue hire for the provider). Vigerland et al (2016), found that it is also easier for practitioners to reach people regardless of geographical distance and removing travel time potentially increases the number of participants they can reach in any given period of time. The same study found that for those taking part in therapy, online delivery may remove the stigma involved in visiting a therapist. There is also some evidence that remote and digital interventions reach difficult to target

subgroups and address a treatment gap in traditional delivery (Abuwalla et al 2017, Ebert et al 2015 and Lindahl et al 2006).

On the negative side, some people may not be able to access remote and digital platforms because they cannot afford to buy the equipment, or they live in areas where connectivity is poor. Another barrier may be the lack of an available, quiet and safe physical space in which to engage in the intervention. This is particularly pertinent to families experiencing domestic abuse, particularly in a lockdown situation where the perpetrator may be in the home and may be preventing contact with support services via telephone and internet.

**Flexibility over delivery:** Content may be delivered and accessed more flexibly, fitting more conveniently around the participant's day. This applies particularly to apps and other forms of digital delivery of 'self help' resources or materials that support a specific programme.

Another possibility is that one to one support can be more tailored around the individual's needs. Theoretically, remote support could be provided 24/7, meaning that if a crisis occurs individuals may be able to access services at crucial times. The following feedback from a domestic abuse practitioner illustrates this:

*"More flexible ways of working, perhaps less focus on 9-5 and more early or evening sessions and support delivered remotely which could better meet victims needs and can be accommodated by staff (working around childcare etc.)"* (Women's Aid 2020)

**Personal preference:** In the therapy field, researchers have found that some individuals may prefer videoconference therapy as opposed to 'in person', as it makes them feel less self conscious and intimidated and more inclined to open up (Simpson and Reid, 2014). Participants have also described finding videoconference therapy more convenient and confidential, as it provides them with an increased sense of control (Simpson et al 2005).

Other studies reflect this finding, that participants who experience high levels of shame or self consciousness, who require high levels of control, or who exhibit avoidant coping styles may find that videoconferencing provides the environment they need to develop and maintain a positive therapeutic alliance (Simpson and Reid, 2014).

However, while some people are comfortable with or may even prefer remote and digital modes, others will have a strong preference for traditional face-to-face interaction and having to navigate an unfamiliar digital service will increase anxiety for some individuals (Martin J, et al 2020).

**Workforce wellbeing:** This is an area that seems to generate very mixed responses. For example, during the pandemic, some people have found home working using remote and digital tools an advantage, cutting out the daily commute and time spent travelling to meetings and home visits which has enabled them to enjoy better work life balance. However, in the domestic abuse sector a number of concerns have been raised (Women's Aid 2020). These include:

- The difficulties of having to adjust to new methods and new technology in their own homes, without the support of colleagues.

- Worries about interacting with service users through online systems including safeguarding concerns. For example, assessing child and parent wellbeing remotely being much more difficult for practitioners than it is in a face-to-face situation.
- The tendency to work longer hours “...*living at work rather than working from home*”.
- The negative impact on mental health of dealing with traumatic work in the home environment.

**Establishing the ‘therapeutic alliance’:** For many interventions in the health and social care arena, building a trusted relationship between a practitioner and participant is an essential element of effective delivery. For example, evidence from the field of face-to-face psychotherapy suggests that this relationship – the therapeutic alliance – accounts for more of the variation in therapeutic outcomes than specific therapy components (Lambert and Barley, 2001), and there is substantial evidence to indicate that the quality of this relationship is positively correlated with improving outcomes across a variety of therapeutic approaches and mental health issues (Bickmore et al., 2005; Castonguay et al., 2006; Horvath et al., 2011).

The question then is whether a strong, collaborative and purposeful relationship can be established when services are working remotely with individuals.

Some practitioners have raised concerns that the ‘virtual’ environment (which includes the relatively poorer quality of the video and sound) may interfere with the development of a ‘bond’ with the participant and weaken their engagement / retention and the potential to improve outcomes (Simpson and Reid 2014), (Rees and Stone 2005). Recent guidance from the Principal Social Worker Network and Social Work England (2020) reiterates this concern:

*“The reduced non-verbal cues can affect the practitioner’s ability to make full use of self and establish and maintain a more in-depth emotional and empathic professional relationship”.*

Given these concerns, it is encouraging that there is evidence to suggest that a positive therapeutic alliance can be formed remotely. For example, a systematic review of six studies examining guided internet based cognitive behavioural therapy for the treatment of anxiety and depression in adults found that all the reviewed studies demonstrated a high level of therapeutic alliance (Pihlaja et al 2018).

The association between therapeutic alliance and outcomes is however, less clear. Recent research assessing remote and digital delivery suggest that it may be the **mutual agreement on therapeutic tasks and goals** (a component of the therapeutic alliance) that predicts outcomes, more than the practitioner-participant relationship (Berger 2017).

### 3.3 Emerging best practice

The extent to which using a remote or digital medium helps or hinders service delivery is an evolving field of enquiry. What is clear, is the strong desire from practitioners for more **bespoke training**. According to an online survey of 106 practitioners delivering mental health interventions remotely, training in developing and maintain a strong therapeutic alliance remotely was described as necessary to enhance practitioner

confidence and skill (Sucala et al., 2013). The research by Martin J, et al 2020, identified some practice literature on delivering therapeutic services remotely, but this tended to focus on logistical issues, such as software familiarity and the use of headphones, or legal and ethical issues, such as confidentiality or the use of social media.

Further evidence based suggestions to support best practice include:

**Delivering the first session in person.** Clearly, this is difficult to do under the conditions imposed by the Covid-19 crisis. However, individuals who feel less comfortable opening up to a practitioner through videoconference therapy may benefit from an initial in-person meeting. The practitioner can use this first meeting as a way of establishing a comfortable rapport with the participant, enabling them to overcome initial anxieties about the use of videoconferencing as the therapy proceeds (Simpson and Reid, 2014).

**Increasing contact time.** Pihlaja et al. (2018) found that the frequency and duration of practitioner–participant contact is an important factor that may affect the therapeutic alliance in internet cognitive behavioural therapy programmes. Although the evidence is not always consistent, it points towards an association between increased contact time and a stronger alliance, possibly due to enhanced emotional support.

**Adapting practitioners' behaviour and communication style.** For example (Bischoff et al., 2004; Manchandra and McLaren, 1998; Mallen et al., 2005):

- Providing more deliberate and overt non-verbal responses, by purposefully exaggerating tone of voice, gestures and mannerisms during video or telephone calls.
- Using emoticons or written expressions of emotional and non-verbal reactions during email or chat therapy.
- Actively paying more attention to social cues and signs of emotionality, conveyed through facial expression, tone of voice or body language.
- Asking more questions than they normally would, to avoid misunderstandings and ensure they have interpreted the participants' experience correctly.

**Being aware of the power dynamics** that are associated with the meeting or event. video/online connection can reduce formality and make people feel at ease, or it could make people feel that professional boundaries are blurred (PSW Network and Social Work England 2020).

## 4 Findings from a study of current practice in the Opening Closed Doors Programme during the Covid pandemic

### 4.1 Methodology for exploring staff and participant experience of remote and digital styles of delivery during the Covid pandemic

Telephone interviews were carried out in September with 11 people who were participating in the Opening Closed Doors Programme. Most (9) were from the IWS cohort, and 2 were young people. Most (8) had joined the Programme recently, either

just before lockdown or during lockdown. A few (3) were coming to an end of the intervention / support. Questions were focused on how they had experienced remote and digital styles of delivery, what was good/helpful about the way the support was delivered, what was less good/ unhelpful and if there was anything that they thought would be worth keeping in the future.

An online focus group was carried out in early September with 7 staff members present representing all the interventions (IWS, DAPP and children and young people). Questions focused on presenting needs, what they had been doing differently, what they'd noticed about how people had responded, what had been working well / less well, when they planned to 'return to normal' and if there was anything about the new ways of working that they would keep going forward.

## 4.2 Limitations of the study

This was a small scale study with the aim of exploring what difference the new ways of working during lockdown had made to staff and service users to help inform the ongoing development of the Programme. It was a challenging time to be asking service users to participate in interviews when many were struggling with personal challenges including the impact of the pandemic. We are grateful to those that agreed to speak to us, and although it was a relatively small number, their responses, together with feedback from staff, have provided some helpful insights to add to the growing body of knowledge about 'what works' in the use of remote and digital methods of service delivery.

## 4.3 Key findings: benefits of remote and digital ways of working

### Accessibility and flexibility of delivery

In response to the question 'what did you find helpful?' almost all interviewees highlighted ease of access and flexibility of delivery. For example, some parents commented that using phone and online mediums had been much easier. "*Less stress just using phone, more convenient – not having to travel*". "*Phone's more convenient and easier*". Information from our participant interviews suggests that telephone contact had been the most used method in this period, although some did mention that they had also experienced online contact.

Others appreciated the use of texting as an informal way of keeping in touch and being flexible about timings. For example: "*He checked in when is the best time for me. He can do it when kids are in school*". Another said: "*He texts me on the morning of our session to check I'm feeling OK. That's nice. He's making sure I'm feeling relaxed. It's not pushed on me*".

Another interviewee felt able to text if they were feeling low and the worker would ring them then and there; at other times they would arrange appointments in advance at times to suit. Another parent preferred remote contact because they found it easier to speak over the phone and felt that maybe face to face would have upset them more and another felt it had been good as they could mute the mike if their children were being noisy.

Another advantage expressed by a parent was that they found zoom calls and regular contacts easier to fit in than going to meetings, particularly with a new baby. Another said that group sessions didn't fit very well with work.

Frequency of contact was also mentioned as being important. One parent said she had only just started and had one session so far via video. However, the key worker had kept in touch since June/July via text every couple of weeks. Another said they found support flexible and responsive, and appreciated the frequent checking that everything was alright from the worker. A parent with a new baby appreciated the flexibility of one to one sessions: *"She is going to try to condense things to get it done quicker. If the baby is good we can do more things in one session."*

There was also evidence that staff were prepared to be flexible and accommodate people's wishes if they didn't want to engage in remote support or if they preferred to do one to one rather than a group. For example, one parent said: - *"they wanted me to do a group, on-line, but I am no good with other people or computers. So today she came to my house. We sat outside, just me and her, two metres apart. This was our first session.' I liked her coming to my house one to one. The times are good for me"*.

Another said: *"I suffer with anxiety and depression. I wasn't very confident. He said better to do a group but I'm not one to talk and open up so I asked for one to one. It's all been over the phone. No face to face contact. We might do a video call to put a name to a face. I don't mind either way."*

### **Engagement and building relationships**

Staff in the focus group were very positive about the new ways of working and felt that engagement during this period had been really good, and that fewer people were dropping out. This was particularly felt to be the case with perpetrators: *"We've had almost 100% engagement in DAPP during Covid one to one work"*. (DAPP worker). The worker felt that early in the lockdown period it had been the sole source of support when perpetrators had been feeling very isolated and the DAPP worker had been *"the only person they could confide in"*.

Others had found that people were sharing more over the phone than they would do face-to-face and put this down to the "disinhibition effect" of using a more impersonal / anonymous style of communication. One parent said that she felt more comfortable and confident speaking over the telephone and hence could get more out of a telephone interaction.

Staff told us that ways of working had evolved and the style of delivery had become more therapeutic/counselling based, more individualised and working with emerging needs, for example help with getting into a refuge and providing consistent support. More time was being spent on relationship building and *"getting people to a place where they are ready to engage"*. Other workers agreed that this was beneficial: *"people are more ready to do the work now. There is better retention"*. One of the workers on the DAPP programme felt this approach had enabled him to be more creative, for example in the way you ask questions, *"getting people onside"* first and building a readiness to change. None of the staff reported finding it more difficult to build trusting relationships through remote and digital platforms (although it is interesting to note that at least one participant had found this to be problematic).

### **Innovations linked to remote and digital working**

Staff told us that as they were using email more to communicate with families, for example, they had started sending materials out the week before a session to be read

beforehand. They noticed that as a result, participants came better prepared and were more engaged in the session. This was also mentioned as helpful in interviews with participants, for example, three parents mentioned that they liked receiving materials by email in advance: *'I like getting them ahead of the session so I can read them. I always have them on my phone then. I've always got it to refer to'*.

Some examples were given by staff who had generated new and creative ways to engage with children online, adapting resources and using stories and props to make it fun and that this was very well received by the children and helped to get important messages across.

Another worker observed that families were now more aware of access to other online resources and information to support wellbeing and this has *"opened other doors"*.

There was general agreement that new ways of working were enabling staff to explore their practice and develop new skills, in particular around using counselling and therapeutic approaches.

#### **4.4 Key findings: challenges of remote and digital ways of working and how they have been addressed**

##### **One size doesn't always fit all**

Although some participants were very positive about using telephone and online mediums, others found digital and remote methods more problematic, for example one parent had tried video calls but it *'kept cutting out'*. One parent who had had support both pre and post Covid, stated that she had preferred face to face, they felt remote support was not the same as having it in person and this had also made it harder for them to relate to their new worker who they had never met in person. They felt that video support might have been more helpful as they could *'see her face'*.

Another parent woman appreciated that the initial contact had been face to face: *"She came to the front door (during Covid-19) and brought a plastic box of cake mix, toys for the kids, bubble bath for me, biscuits"*.

##### **Service users missing out on peer support and challenge**

Whilst the change from delivering groupwork to one to one sessions was seen to be positive in terms of responding to individual need and relationship building, one worker said she was *"missing the group dynamic and peer support/challenge"*. One of the young people interviewed said it had been very helpful getting to know the other young people in the group who had been through the same experience as her. She had found this supportive and had developed good friends through the group which she missed during the lockdown.

##### **The potential for heightened risks**

Staff were very conscious that remote ways of working and providing support to family members in the home environment, particularly if the perpetrator is there too, can pose risks. Risk assessments were a key part of the preparatory work - identifying what scenarios might arise and agreeing protocols for managing them. This has included developing signals/code words, doing one to one follow ups after sessions, escalating concerns to managers, and calling the police.

Staff felt it was much harder to safeguard children, as they were not able to observe children in the same way. They had noted that as a team they were making fewer multi agency referrals. One of the workers spoke about being unable to deliver some sessions with children due to them all being at home and dad preventing engagement. On their first day back at school, one of the children raised some issues, which had the worker been able to speak to them earlier, might have been followed up sooner.

The young person who had felt positive about attending a group in person before the lockdown also made the point that she hadn't felt able to speak as freely on the phone at home due to the perpetrator being around and this was a disadvantage of home based support.

Another worry was that telephone contact prevented workers from observing body language and non-verbal cues which might mean that 'disguised compliance' was easier to miss. An example of this happening in practice was of a serious incident occurring soon after a seemingly positive DAPP one to one telephone session.

### **Workforce wellbeing**

The experience for staff of working from home appeared to be a mixed one. Whilst it was felt that everyone had adapted very well, people missed being part of a team and having informal chats and exchange of ideas which can lead to innovations in practice, as well as the opportunity to debrief with colleagues after tough sessions. Team interaction was now much more structured and had to be planned in advance. It was acknowledged that not being able to meet the rest of the team face to face and get to know them had been particularly hard for new starters.

One worker said she found it challenging as there was "*no break between home and office*", which resulted in "*bringing trauma into your personal space*", a concern which was highlighted by Women's Aid (2020) as having a negative impact on mental health.

## **4.5 Forward thinking**

Staff told researchers that they understood that the changes introduced because of Covid were likely to stay in place for some time. The organisation was described as taking a cautious approach. For example, home visits would not be carried out unless deemed essential, and groupwork would be carried out online. They anticipated that there might be some potential to undertake some face to face meetings with children and young people in school but this was by no means certain.

Both staff and service users expressed the view that, 'if and when we return to normal', there should be a more flexible approach with a number of different options for engaging in the programme to include phone, online, social media as well as more traditional face to face methods. This flexibility could also extend to staff, for example having the option to work from home or from an office. Staff also wanted to retain the increased focus on engaging the client in a therapeutic alliance.

## 5 Recommendations

These research findings suggest that both participants and staff in the Opening Closed Doors Programme have adapted quickly and well to the new circumstances. To ensure that this continues, evaluators recommend the following:

### **Broadening out digital/remote methods**

In regards to the 'new style' delivery, a comparison of Opening Closed Door's current digital/remote methods against Berger's (2017) different approaches suggests that the focus is on *one to one synchronous communication* via telephone, text and online platforms providing counselling/therapeutic style support, blended with materials and content from their group based programmes. *Group based synchronous learning* is also now starting with the first IWS online course up and running.

It may be of interest for the service to consider whether they could usefully supplement their current methods with the addition of online 'self-help' and interactive content including apps. A systematic review recently carried out in the United States (Emezue 2020) suggests there is "*growing evidence of the acceptability and feasibility of trauma-informed digital or digitally delivered interventions that prevent violence, increase the safety and decision-making of persons in an abusive relationship, and ultimately link them to trusted support*". Apps that were mentioned in the study include the MyPlan safety decision app, an interactive mobile application to respond to teen dating violence; an internet safety decision aid for abused women; and a web-based safety decision aid for women experiencing intimate partner violence.

### **Prioritising human contact**

At the same time as acknowledging that offline / self-help style information and resources like apps can have many benefits, it is also important to bear in mind a key finding from research that:

*"Virtual and digital services appear to be more successful when the provision of resources and information is supplemented with additional support from practitioners or where the practitioner communicates with participants in real time"* (Martin et al 2020, p36)

In other words, a crucial component can be the 'human element'. This would suggest that one of the most important elements of digital and virtual methods to get right is the quality of the practitioner-participant relationship. A further consideration is whether there is any difference between telephone and online face to face contact. Information from our participant interviews suggests that telephone contact has been the most used method in this period, although some did mention that they had also experienced online contact. It may be worth exploring further what the barriers might be to increasing online face to face contact as the Women's Aid (2020) findings suggest this offers more potential:

*"Providers also suggested to us that, where possible, videoconferencing should be preferred over phone calls, as being able to see each other allows for better participation, supports the relationship and builds trust"* (Martin et al 2020, p40)

It is clear that the service users in this interim study also appreciated greater frequency of contact and the option of a face to face meeting, at least at the outset.

### **Staff training**

Staff were positive about the opportunities they have had during this time to explore their practice and develop new skills, in particular around using counselling and therapeutic approaches. Although research indicates that it may be possible to build an effective therapeutic alliance 'virtually', there are also challenges in doing so and there is no evidence yet of the efficacy of these methods compared with more traditional ones. Staff also raised important concerns about the safeguarding risks of not having the same opportunities to observe children and other adult survivors that they would normally have, through in person visits and sessions.

It is recommended therefore that Barnardo's provide training and guidance that will enable staff to optimise their skills and competences, to enhance observation and relational skills to support relationship-based practice and support safeguarding online. Helpful resources include those produced by the Principal Children and Families Social Worker Network (PSW) and Social Work England, 2020; the British Psychological Society (2020); and Welsh Government (2020).

### **Adapt carefully**

One of the strengths of the Opening Closed Doors Programme that was identified in the Year One Evaluation (Institute of Public Care, 2020b) is that it uses interventions that are tried and tested and have been proven to work. However, these interventions were designed for 'in person' delivery and in common with many other health and social care programmes which are now being delivered remotely, there is not yet any evidence of whether they work as well in these new conditions.

*"It shouldn't be assumed that interventions will work equally well when delivered through virtual methods. Adaptation of existing interventions needs careful thought and should include a focus on identifying the core components that must be maintained. Providers should also work with experts in digital delivery to ensure content is appropriate and engaging for the target cohort". (Martin J, et al 2020).*

The final part of this quotation may well be worth following up, especially if Barnardo's wish to continue to offer these options when life returns to 'normal'.

### **Workforce wellbeing**

Staff highlighted that there are some challenges to working from home and as this is set to continue for at least the next six months, it is important for Barnardo's to consider what they can do to support their employees for example with using new technologies, putting boundaries in place to separate work from homelife and how to manage the potential negative impacts on their mental health of dealing with their clients trauma and stress on a daily basis. These might include a review of caseloads, higher levels of clinical supervision, more peer to peer time for debriefing and access to activities that promote wellbeing.

## 6 References

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