



BOUNCE BACK 4 KIDS: EVALUATION PROTOCOL

Intervention developer	PACT (Parents and Children Together)
Delivery organisations	PACT (Parents and Children Together)
Evaluator	IFF Research
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Type of trial	Pilot study
Age or status of participants	Children (aged 3–11) and their non-perpetrating parents who have experienced domestic abuse, and where the parent is no longer in a relationship with the perpetrating partner and not receiving other domestic abuse support.
Number of participating Local Authorities	Three delivery sites in Reading, West Berkshire, and Vale of the White Horse (Oxfordshire).
Number of children and families	40 parents and 40 children in the intervention/treatment group, and 32 parents and 32 children in the waitlist treatment group.
Primary outcome(s)	Parents' self-efficacy as measured with the Tool of Parental Self Efficacy (TOPSE)



Secondary outcome(s)

1. Children’s behavioural issues at home measured with the Brief Assessment Checklist for Children (BAC-C)
2. Parent–child relationship and bonding measured with the closeness scale from the Child Parent Relationship Scale (CPRS)

Summary

Bounce Back for Kids (BB4K) is a therapeutically informed group recovery programme for children aged 3–11 and their non-perpetrating parents living in Reading, West Berkshire, and Vale of the White Horse (Oxfordshire) who have experienced domestic abuse, where the parent is not living with or in a relationship with the perpetrating partner and not receiving other domestic abuse support. The model (which is explained in further detail in the ‘Intervention and theory of change’ section) is designed to improve the safety, wellbeing and stability of children and families and reduce offending. BB4K has been running since 2010 but has not yet been evaluated.

Foundations commissioned the evaluation (with funding provided by the Evaluation Task Force) as part of its commitment to strengthen the evidence base about effective approaches that tackle domestic abuse. Foundations is dedicated to raising the standards and volume of good quality research in the sector and is committed to providing an evidence base for social workers, leaders in the sector, and policymakers to support children and their families.

This pilot evaluation seeks to evaluate delivery of the BB4K in Reading, West Berkshire, and Vale of the White Horse (Oxfordshire). This is a pilot evaluation which will cover delivery from May 2024 to May 2025, when it is anticipated that Parents and Children Together (PACT) will be able to recruit 40 parents and 40 children in the intervention/treatment group, and 32 parents and 32 children in the control/waitlist treatment group.

The evaluation will contain an implementation and process evaluation (IPE), impact evaluation (in the form of a waitlist randomised control trial), and a cost evaluation.

The purpose of the impact evaluation is to assess evidence of promise and to explore the viability of a full-scale impact evaluation. The pilot will analyse and examine impact on a range of short-term or medium-term outcomes. These questions will be explored via the delivery of a pilot randomised control trial (RCT). Forty children and their non-perpetrator parents will receive the intervention immediately (i.e. right after randomisation), while 32 children–parent pairs will be allocated to the waitlist treatment group and will receive the BB4K services with delay.

The purpose of the implementation and process evaluation is to assess delivery during the rollout of BB4K across the delivery sites. The aim of this is to help understand and explain any identified treatment effects (or lack thereof) in the impact evaluation, to identify elements of successful delivery, and to improve the understanding of the model.

The overall aim of the cost evaluation is to understand the additional costs and, where possible, benefits of the programme compared to if it was not delivered.



Contents

Summary.....	2
Background and problem statement	4
Intervention and theory of change.....	6
Impact evaluation	13
Implementation and process evaluation	27
Evaluation experiments	41
Ethics & participation	44
Registration.....	46
Data protection	47
Personnel	49
Risks.....	51
Timeline	54



Background and problem statement

It is well established that domestic abuse is harmful to children, and this is reflected in Section 3(2) of the Domestic Abuse Act 2021, which acknowledges children as victims of domestic abuse in their own right. Evidence shows that domestic abuse is a pervasive problem in the UK, estimated to affect 1 in 5 children, and is the most common reason for referrals to children's social care, and the most common factor in 'Children in Need' assessments and when children are removed.¹ Research shows that experiencing domestic abuse can have a wide-ranging devastating impact that can last into adulthood. Children who have experienced domestic abuse are more likely to have lower levels of emotional wellbeing, problems with behavioural, social, and physical development, to misuse drugs or alcohol, and to experience domestic abuse in adult relationships.^{2,3}

The evidence on which programmes improve outcomes for children in families experiencing domestic abuse is limited. Previous feasibility work undertaken by Foundations,⁴ alongside the Oxford Rapid Review,⁵ show that there are over 100 domestic abuse programmes operating across the UK, but only a small number have been evaluated through robust impact evaluations, making it challenging for decision-makers to plan for services that will provide support to every child and adult experiencing domestic abuse. Foundations is committed to developing this evidence base through evaluating promising practices. The aim is to generate actionable evidence needed to improve services for vulnerable families so that more children can live safely at home and have happier, and healthier lives.

As part of this commitment to improve the evidence base on 'what works' for children who are exposed to domestic abuse, Foundations commissioned an evaluation of Bounce Back for Kids (BB4K). The programme was selected as it is representative of wider therapeutic interventions for domestic abuse across the UK, and therefore, evaluation findings could have substantial sector interest. The pilot study will also contribute to an evidence base on implementing and evaluating groupwork therapeutic programmes, and a better understanding of what makes it more difficult or

¹ See Crime Survey England and Wales. (2022). *Domestic abuse prevalence and trends, England and Wales*. <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022>

² Co-ordinated Action Against Domestic Abuse [Caada]. (2014). *In Plain Sight: Effective help for children exposed to domestic abuse: 2nd national policy report*. <https://safelives.org.uk/research-policy-library/in-plain-sight/>

³ Howard, L. M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R. & Feder, G. (2010). Domestic violence and severe psychiatric disorders: Prevalence and interventions. *Psychological Medicine*. 40(6), 881–893. <https://doi.org/10.1017/S0033291709991589>

⁴ See <https://foundations.org.uk/wp-content/uploads/2024/02/domestic-abuse-programmes-for-children-and-families-programme-promise-and-evaluation-feasibility.pdf>

⁵ See <https://foundations.org.uk/our-work/publications/improving-outcomes-for-children-with-child-protection-concerns/>



easier for parents and children who have experienced domestic abuse to participate in these programmes.



Intervention and theory of change

The focus of the section is on the BB4K's intervention and theory of change (ToC). The information presented was synthesised from discussions with the Parents and Children Together (PACT) team concerning current delivery of practice. More information on the intervention can be found in the [Intervention Protocol](#).

Overview

BB4K offers an alternative to individual and separate support services for children and their parents recovering from domestic abuse. It uses a trauma and therapeutically informed group approach that simultaneously supports both children (aged 3–11) and their non-perpetrating parents who have experienced domestic abuse. Other defining features of BB4K include consistency in Support Worker across sessions, high staff-to-service user ratio in group settings, use of a play therapist in the group with children aged 3–5 years old, and joint child/parent activities alongside separate child and parent group sessions.

Aim

The primary aim of BB4K is to improve outcomes for children and their non-perpetrating parent, helping them to recover from the impact of domestic abuse. BB4K aims to equip children and parents with the knowledge, confidence, and tools needed to have relationships they need to keep safe.

Delivery organisation

BB4K was started in 2010 by Parents and Children Together (PACT), an adoption charity and family support provider helping hundreds of families every year through outstanding adoption and adoption support services and community projects across London and the south of England. Established in 1911, PACT is now one of the UK's leading charities in its field and is dedicated to the placement of children with secure and loving families, continued support through therapeutic services, supporting and empowering women facing multiple disadvantages, and the recovery of children affected by domestic abuse. PACT has experience and insight into local needs for recovery support services across Berkshire and Oxfordshire.

Target population

The programme targets children (aged 3–11) and their non-perpetrating parents who have experienced domestic abuse, and where the parent is no longer in a relationship with the perpetrating partner and not receiving other domestic abuse support. The eligibility criteria are further discussed in the 'Participants' [subsection](#).

For this pilot evaluation, dependent on PACT's recruitment, 72 parent–child pairs (2 groups aged 3–5, and 7 groups aged 6–11) will be included in the evaluation. This will include: 40 parents and 40 children in the intervention/treatment group, and 32 parents and 32 children in the waitlist



treatment group. If there is more than one child between 3 and 11 years old in the family, then the parent can select a child that can benefit the most from the group element. PACT will offer one-to-one support for the other children in the family.

In this pilot evaluation BB4K will be delivered to families who live in Reading and West Berkshire and Vale of the White Horse in Oxfordshire. PACT have previously delivered BB4K in Reading and West Berkshire, while Vale of the White Horse is a new location and has been chosen as PACT have received a number of referrals from operational partners in this area.

Theory of change

[View the theory of change here.](#)

The theory of change (ToC) is a key output of the discussions with PACT and Foundations during the evaluation set-up stage and ToC workshop. The ToC sets out the mandatory inputs and activities (i.e. **Referral and triage process; groups sessions; staff training; and offboarding**) for successful delivery. The key inputs and activities are discussed in more detail in the sections below. The referral and triage process is essential to ensure parents and children have access to the appropriate support. The training enables staff to successfully provide support and deliver the weekly sessions. The group element of the sessions is considered an important mechanism as it provides adults and children with a supportive group environment where they can experience connection with other families with similar experiences. This helps to reduce loneliness for both the parent and child, and in turn can increase the parent's agency and self-efficacy. As can be seen in the stated ToC, BB4K aims to improve the child's and the parent's abilities to identify healthy and unhealthy behaviours, to emotionally regulate, and to have a clearer understanding of each other's responsibilities in the short term. As a result, it is anticipated that parents and children can avoid unhealthy behaviours and will seek support when needed. The ToC considers those improvements as essential elements for the medium-term outcomes (i.e. parent better able to understand and advocate for child's needs; healthier parent-child relationship; improved parent/child communication; increased parent DA reporting; and reduced child behavioural issues) and long-term outcomes (i.e. reduced parental stress; reduced repeat victimisation; repaired attachment patterns between parent and child; and improved family functioning) to be realised.

It is important to note that the evaluation is designed to assess impact in a robust way for three outcomes (highlighted in green in the ToC linked above). The outcomes were selected jointly with PACT based on their centrality to the ToC. When deciding, the evaluator also considered the practical and financial limitations placed on this study.

Referral and triage

BB4K accepts referrals into the service from local authorities (primarily children's services, adult social care, and housing), schools, community partners, counselling services and other charities. BB4K also accepts self-referrals from parents.



The first step for anyone making a referral is to complete the eligibility checker on the PACT website.⁶ This checks key information to ensure any families referred meet the project eligibility requirements. Where the referral is deemed to be ineligible, PACT contacts the referrer to check their answers and confirm ineligibility.

Where the referral is eligible, the referrer will automatically receive an online referral form to complete. Once completed, a support worker from PACT will call to arrange an initial assessment call with the referred parent at a time convenient for them. During this call they give the parent information about BB4K and the support it can offer. They then complete a short assessment focused on their family situation, their experiences, the challenges they face at home, any other support they are receiving, any accessibility requirements, and their availability to take part in the groups. During this call, the Support Worker also assesses the physical and emotional safety of the family. If the parent or child is not emotionally or physically safe from the abusive relationship the programme is not recommended.

After the initial assessment, the support worker presents the family's case at an internal triage meeting where a decision is made about whether/what type of support is appropriate to offer. Once this decision has been made, the Support Worker makes a secondary call to the family offering the support deemed appropriate at triage. Then, the Support Worker arranges a home visit to build trust between the family and the support worker, encourage engagement with the programme, and help them feel secure in the sessions they will attend.

Format and mode of delivery

Once families are confirmed to receive BB4K, they are invited to join an upcoming group based on the age of their children (children aged 3–5 join the younger group, and families with children aged 6–11 join an older group which is further split to age bandings such as 6–8 or 9–11), their availability, and their location.

All sessions are delivered face-to-face, with the majority in a group setting located in private facilities, community halls, at schools, or in other similar locations. Sessions are delivered during school hours and during the school term, and last up to 90 minutes per week. Groups are always delivered in the same place to ensure they are accessible and predictable for all. They are delivered with the school's cooperation, which enables parents and children to attend without having to consider childcare for other non-referred children.

Transportation is facilitated where necessary and two to three staff members, including a support worker and at least one volunteer/student on placement, attend each group to ensure participants receive the level of support they require. The Play Therapist also attends groups for children aged 3–5.

For a small number of families, a group session might be deemed inappropriate due to a parent or child's special requirements (e.g. language barriers, not ready for a group setting, etc.). In these

⁶ See <https://www.pactcharity.org/bb4k/looking-for-support/bb4k-referral-form/>



cases, a one-to-one programme is delivered instead. These small number of families would be considered to be participants of the trial if they were randomly assigned to the treatment or waitlist treatment.

In cases where more than one child has been referred with the parent, only one child will join the group sessions. The child selected to participate is determined through conversations with the parent about which child would benefit most from groups compared to one-to-one sessions.

Staff training

All new members of staff receive training including observation of a full group. All Support Workers receive intensive inductions including specialist training on domestic abuse, the impact of Adverse Childhood Experiences (ACE's) and trauma, attachment, safeguarding/child protection, children and parent violence and abuse, and GDPR. Most have completed the following teaching or professional qualifications:

- EduCare – Adverse Childhood Experiences Level 2
- EduCare – Domestic Abuse: Children and Young People
- Domestic abuse and the impact of historical trauma and Adverse Childhood Experiences
- Attachment and Trauma training
- West Berks Domestic Abuse Champion training
- Training for delivering Healing Trauma
- SEN training, e.g. Autism Spectrum Disorder Course, Dyslexia Course, etc.
- Keep Them Safe – protecting children from child sexual exploitation.

The content of sessions is discussed at the beginning of every week to ensure staff are familiar and comfortable with the programme they are delivering. All staff also receive an overview of how to work therapeutically with children including details of how to use different techniques delivered by the Play Therapist. This training builds the skills of Support Workers and helps them build children and parents' trust.

BB4K group content and delivery

The BB4K groups consist of 8 or 12 sessions which are up to 90 minutes long each. The number of sessions delivered depends on the delivery method and the age of the children. Families receiving one-to-one support engage in eight sessions. Groups for children aged 6–11 engage in eight sessions. Groups for children aged 3–5 engage in 12 sessions as younger children may need more time to build relationships and a sense of safety.

Session content is designed to be trauma-informed and age-appropriate. The session content for parents and children over 6 years revolves around five key themes (explored below). For the younger age group (aged 3–5) it uses the principles of theraplay (structure, engagement, nurture, and challenge) and child-centered play therapy. They follow the same structure and routine making them predictable and comfortable for the children.

Session contents are explored below alongside the assumptions and mechanisms that lead to outcomes for families.



Theme one: Support networks and reducing isolation

This theme encourages parents and children to recognise their own support networks and links with support in the community. Reducing isolation and building social networks helps to reduce the parent and child's loneliness and build their resilience and confidence. This can in turn lead to improved parental self-efficacy, increased agency and reduced stress. The goal of the session is to remind parents of their own support networks, and resources available to them. This in turn could improve self-confidence and esteem, help them realise they aren't alone, and could empower them to take back control of their lives.

Theme two: Accept they are not to blame for the abuse

This theme challenges internalised guilt caused by experiencing abuse. It aims to help adults and children accept that they were not to blame for what happened to their family and to build new positive coping strategies to deal with negative feelings. Supporting parents to let go of the guilt and move forward with new strategies in place can increase their self-efficacy because it gives them the confidence to know that the child's behaviour is not caused by their parenting decisions but by the abusive behaviour of the perpetrator. It also helps them understand how their child may be feeling so they are better able to understand and advocate for their child's needs which, in turn, helps to build child–parent relationships.

Theme three: Learn about types of abuse and the right to feeling safe in relationships

This theme helps children (aged 6–11) and parents to understand what domestic abuse is and the power and control tactics used by perpetrators. This helps them recognise the abuse they have experienced and to identify healthy and unhealthy/abusive behaviours in others. Alongside the other tools developed during the programme, such as building a support network, this can result in parents and children recognising and avoiding this behaviour in others in the future, leading to healthier relationships and reduced victimisation. It also gives parents and children (aged 6–11) information about how to report abuse and seek help which may contribute to increased future reporting of domestic abuse.

Theme four: Understanding emotions and how to manage them

This theme encourages parents and children (aged 6–11) to identify and understand their emotions such as anger, worry and sadness. For example, it delves into how anger feels and presents itself and when anger becomes a problem. It provides parents and children with coping mechanisms and ways to calm themselves down which helps them to emotionally self-regulate more easily. This can lead to a reduction in child behavioural issues at home, facilitating communication between parents and children. Furthermore, it can lead to children and parents having healthier relationships in the future.



Theme five: ‘Thinking through the eyes of our children’ and rebuilding bonds

This theme focuses on reframing the roles and responsibilities of the parent and the child. It encourages parents to see things from their child’s perspective and to recognise that their child may feel responsible for the abuse or for keeping things in the house calm. Parents are helped to understand what their children may need to feel emotionally and physically safe and how they can re-draw boundaries, routines, and responsibilities to allow this to happen. This can lead to more open communication between the family and could improve the child/parent relationship. In the long term this leads to repaired attachment patterns between the child and their parents and improved family functioning.

More information on the content of each session is provided in the [Intervention Protocol](#).

BB4K offboarding

Throughout BB4K groups, children are reminded of how many sessions they have left. This is important to prepare children for the end of the support to avoid any re-traumatisation from an abrupt ending to the routine.

Family cases are then closed to PACT unless a further need for support is identified. Further support is either delivered by PACT or families are signposted to other community-based support appropriate for their needs.

Adaptation

PACT’s expert delivery staff are adept at coping with a wide range of needs and behaviours and can make small adjustments to incorporate challenging behaviours and addressing different needs (such as ensuring support is delivered in accessible buildings and increasing volunteers to provide group delivery, etc.). In this trial PACT are not able to provide interpreters due to the financial limitations placed on the study.

Staff are able to support all adult victims, irrespective of gender. All women are asked directly if they want to be in mixed gender group and if they're not comfortable they will be accommodated in a different group.

However, if for some reason the needs and risk assessments conclude that PACT is unable to provide a suitable group that meets the needs and circumstances, parents and children will be offered individual (one-to-one) support which follows the same themed modules and would be expected to achieve the same outcomes. This may also be preferable to families living in more rural locations who may struggle with transportation to the venue.

Additional online support

Families in the treatment and waitlist treatment group can access the BOUNCE online platform and PACT will signpost to this as is their standard practice. ‘Bounce’ is a new digital platform co-developed with ex-service users offering a range of tools, age-appropriate games, and e-learning to



support children and parents before, during and after accessing BB4K to embed learnings and sustain outcomes.

Business as usual

In addition to ‘Bounce’, parents and children in the waitlist treatment may access external support provided through schools or other agencies. Engagement with other services will not impact eligibility for BB4K, as long as their involvement in this support ends by the time their BB4K sessions start.

For children these could include:

- Child and Adolescent Mental Health Services (CAMHS): the NHS services that assess and treat young people with emotional, behavioural, or mental health difficulties
- Emotional Literacy Support Assistant (ELSA): sessions in schools typically held once a week across the length of a term and last between half an hour and an hour –a child could be offered one-to-one or group sessions, depending on need
- Play therapy
- Counselling or outreach services from other charities such as No5 Young People’s Counselling Service, a Reading-based young person’s counselling and mental health support service for anyone between the ages 11–25
- SAFE!’s individual support services: an independent charity providing support to children and families around the Thames Valley who have been affected by crime or abuse through one-to-one and group sessions, and available to children age 5–18.

For parents these could include:

- Berkshire Women’s Aid
- Cranstoun: a charity offering housing, health and social care support to adults, children and young people, including domestic abuse support
- A2Dominion: domestic abuse support services for adults in Oxfordshire.

These commissioned services tend to focus on adults in crisis, at medium/high risk, rather than families who are now safe and ready for recovery. They also typically provide individual support services, as opposed to group work that simultaneously supports the parent and child.



Impact evaluation

Research questions

The impact evaluation is designed to assess the following primary research questions:

RQ1: To what extent do parents taking part in BB4K's group sessions have improved self-efficacy measured by the Tool of Parental Self Efficacy (TOPSE) at five months post-randomisation compared to parents who do not receive the intervention? (Primary outcome, short- and medium-term)

As outlined in the ToC, we also expect to see changes in other important, but secondary outcomes, such as reduction in children experiencing behavioural issues at home or improved parent–child relationship and bonding.

The pilot evaluation will address the following secondary research questions:

RQ2: To what extent do children taking part in BB4K's group sessions have reduced behavioural issues at home measured by the Brief Assessment Checklist for Children at five months post-randomisation, compared to children who do not receive the intervention? (Secondary outcome, medium-term)

RQ3: To what extent do parents and children taking part in BB4K's group sessions have improved parent–child relationship and bonding measured by the closeness scale of the Child Parent Relationship Scale at five months post randomisation, compared to parents and children who do not receive the intervention? (Secondary outcome, medium-term)

RQ4: To what extent the BB4K's group sessions lead to improvements in all above areas at five months post randomisation for certain groups of parents and children (including: children in the following age bands: 3–5; 6–8; 9–11; children's gender and ethnicity) taking part in BB4K compared to the same groups of parent and children who do not receive the intervention? (Subgroup analysis)

Design

The impact evaluation of BB4K will be a cohort two-armed, randomised waitlist trial with 72 pairs of children (aged 3–11) and their non-perpetrating parents. The design allows for participants to be exposed to BB4K in cohorts (i.e. Cohort 1 and 2), allowing for staggered recruitment and delivery. Delivery will take place in cohorts for reasons of capacity and recruitment practicalities. In the waitlist design, all participants referred to BB4K will eventually take part in the intervention. Randomising the start date of implementation will allow participants with the later start date to act as a comparison group.



There is only one treatment condition: i.e. children and their non-abusive parent will receive BB4K sessions. In total 40 parent–child pairs referred to BB4K will be assigned to the treatment group. Parents and children recruited in Cohort 1 and assigned to the treatment condition (i.e. 16 parent–child pairs) will receive BB4K sessions between May and July 2024, while those recruited in Cohort 2 and assigned to the treatment arm (i.e. 24 pairs) will receive BB4K sessions between September and December 2024.

A total of 32 parent–child pairs will be assigned to the waitlist treatment. They will be given access to the new digital platform, ‘Bounce’, in addition to the business as usual support they are receiving from other services, before they receive the BB4K support (see ‘Business as usual’ for more information on the additional support offered). For this evaluation, that means that we are assessing the effect of the group sessions rather than the full package of support offered as part of BB4K which includes ‘Bounce’ (but is not required for all BB4K families to use). This has the benefits of offering a support to the waitlist group and may improve retention in the waitlist treatment group.

Given that the delivery of BB4K will take place sequentially in two cohorts, randomisation will occur at two different time points (see ‘Randomisation’ for more information).

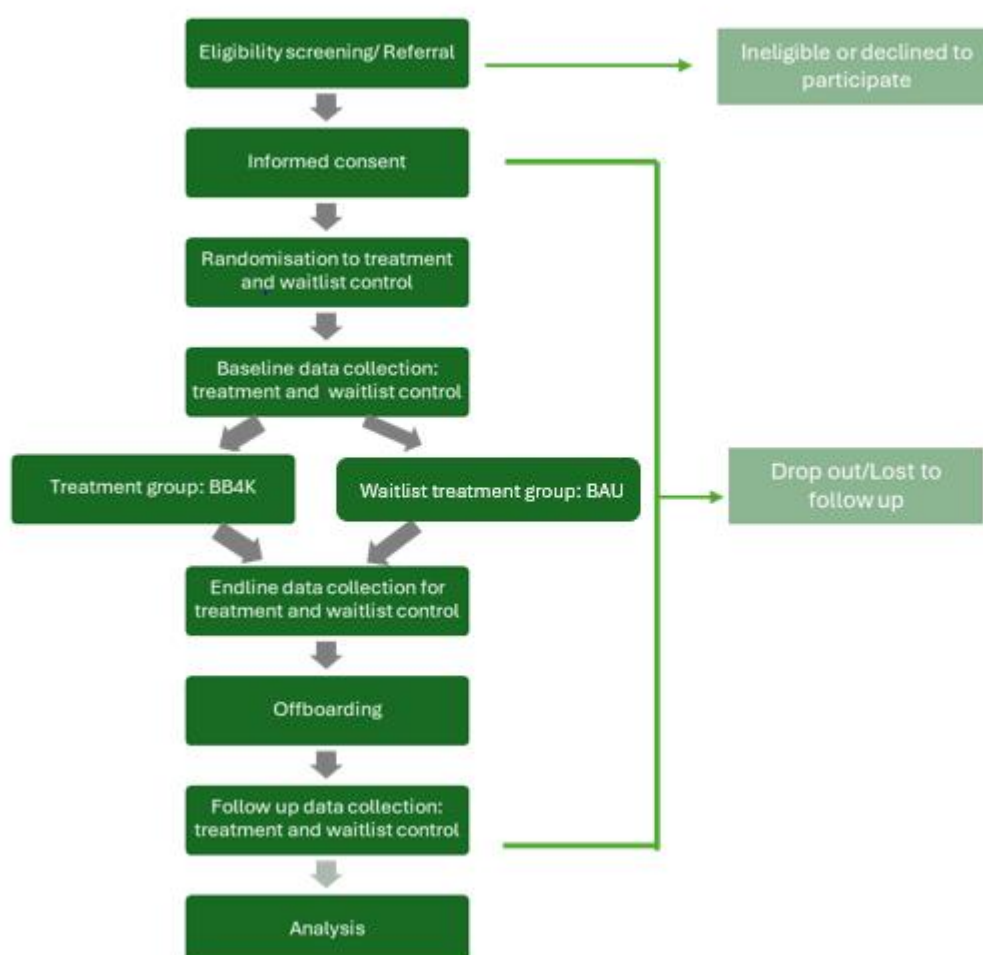
Trial type and number of arms		Two-arm, cohort, randomised waitlist trial
Unit of randomisation		Parent–child pairs (family level)
Block (stratification) variables		Delivery site (age ⁷)
Primary outcome	variable	Parents’ self-efficacy
	measure (instrument, scale)	Tool of Parental Self Efficacy (A multi-dimensional parent self-report of 48 statements within 8 scales measuring parental self-efficacy. The score ranges between 0 and 60.)
	variable(s)	<ol style="list-style-type: none"> 1. Children’s behavioural issues at home 2. Parent–child relationship and bonding

⁷ Relevant for Cohort 2 only, as only children between 6 and 11 will take part in Cohort 1.



Secondary outcome(s)	measure(s) (instrument, scale)	<ol style="list-style-type: none">1. Brief Assessment Checklist for Children (20 items parent self-report screening and monitoring scale. The total score is between 0 and 40)2. Child Parent Relationship Scale – closeness scale (Parent self-report, 10 items, ranging between 10 and 50)
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The diagram below shows the participants' journey through the trial.





Randomisation

As BB4K is a group-based programme, randomisation will be executed in blocks according to children's age and stratified by site. Allocation into treatment or waitlist control will be done at the parent-child level. Randomisation of children-parent pairs will be undertaken after families have been referred to BB4K and informed consent has been provided. Randomised blocks will be used at each delivery site to allocate participants to either treatment or waitlist treatment groups.

Randomisation will occur at two different time points for Cohort 1 and 2, as follows:

Randomisation for Cohort 1 (scheduled for Apr 2024): Once parents and children in Cohort 1 are recruited they will be randomised to either receive BB4K immediately, i.e. between May and July 2024, or to be allocated to the waitlist treatment group who will receive BB4K 8 months after the treatment group, i.e. in January 2025. In total, 32 parent-child pairs will be randomised to two treatment and two waitlist treatment groups. Given that group delivery is organised regionally, with key covariates likely to vary across delivery sites, stratifying by delivery site ensures the treatment and waitlist treatment are balanced across sites. Groups will be blocked on the age of the children with age bandings: 6–8, and 9–11.

Randomisation for Cohort 2 (scheduled for Sep 2024): Parents and children from Cohort 2 will be randomised to the treatment condition, i.e. to receive BB4K immediately in Sep 2024, or to the waitlist treatment condition, who will receive the intervention 5 months after the treatment groups, i.e. in March 2025. Up to 40 parent-child pairs will be recruited in Cohort 2 and this cohort will also include children aged 3–5. There will be up to 16 families with children aged 3–5, and up to 24 families with children aged 6–11. Half of the families with younger children (3–5) will be allocated to the treatment, and the remaining half to the waitlist treatment. Families with children aged 6–11 will be allocated to the treatment and waitlist treatment condition with 2:1 assignment, i.e. 16 parent-child pairs will be allocated to the treatment group, and 8 parent-child pairs will be allocated to the waitlist treatment group. Parent-child pairs will be stratified by region and on whether they are eligible for the younger or older group based on the child's age classification prior to randomisation. This will ensure balance across treatment and waitlist treatment arms across sites and younger/older groups after randomisation.

It is important to note that the transition period for the waitlist treatment group is long, particularly for the waitlist treatment in Cohort 1. The timeline was selected to accommodate PACT's capacity for delivery (maximum two or three groups) and to enable outcomes to emerge (i.e. the timeline is designed to allow two months between endline and follow-up data collection).

The differential waitlist times has the potential to introduce a number of biases that could impact the validity and reliability of the findings. Cohort 1 waitlist participants who have to wait three months longer (8 months compared to Cohort 2's 5 months) to receive the programme may be more likely to drop out of the study. Likewise, longer waiting times might affect participants' expectations or motivation regarding the programme. Additionally, those with a longer waitlist time may experience changes over time, like an improvement or worsening of outcomes, or may be more likely to seek additional support which could confound the effects of the programme.



The study recognises the risk of attrition for the waitlist treatment groups due to the long delay between randomisation and provision of support. This will be addressed by providing parents and children with clear instructions at the outset to maintain motivation to take part in the study, offering other support while waiting for BB4K delivery (see ‘Business as usual’) and monitoring and documenting differences in dropout rates. If necessary, statistical techniques to adjust for potential confounding factors will be considered. The potential influence of these biases will be acknowledged in the analysis and write up of findings.

In preparation for randomisation, we will examine the distribution per location/age. We will work jointly with PACT to understand the target numbers per location.

Randomisation will be conducted by IFF researchers and will include only those parent–child pairs that did not opt out from the evaluation. Once completed the delivery team will be notified of randomisation results, following which they will notify families of their allocation.

The table below summarises the randomisation dates and the number of groups and parent–child pairs randomised in Cohorts 1 and 2.

	Randomisation date	Treatment allocation	Maximum number of parent–child pairs	Number of treatment groups	Number of waitlist treatment groups
Cohort 1	Apr- May 24’	1:1	Up to 32	1 (6-8 years) 1 (9-11 years)	1 (6-8 years) 1 (9-11 years)
Cohort 2	Aug – Sep 24’	3:2	Up to 40	2 (6-11 years) 1 (3-5 years)	1 (6-11 years) 1 (3-5 years)

Baseline equivalence will be examined based on the initial randomisation. A well-conducted randomisation will yield groups that are equivalent at baseline.⁸ Because parent–child pairs will be randomly allocated to the treatment and waitlist treatment conditions, any imbalance at baseline will have occurred by chance.

⁸ See Glennerster, R. & Takavarasha, K. (2013). *Running randomized evaluations: A practical guide*. Princeton University Press.



Participants

Children and their non-perpetrating parent that will be included in the pilot evaluation are those who meet the following criteria:

- Children have witnessed and experienced domestic abuse, and children and parent acknowledge that hurt has happened and are willing to talk about it
- Parent or child has not exclusively experienced sexual abuse
- Children are between 3 and 11 years old
- Non-perpetrating parent and child speak English
- Non-perpetrating parent and child not currently receiving other domestic abuse support
- Children and non-perpetrating parent live in Reading, West Berkshire, or Vale of the White Horse in Oxfordshire
- The perpetrator parent must have left the family home and be out of the relationship for at least a month⁹
- The referral falls within the trial period as defined above
- Referred parents provide consent: they agree that they and their child can participate in the evaluation: are willing to be randomly assigned to treatment or waitlist treatment group, complete questionnaires at three time points and potentially take part in qualitative discussions.

Sample size/MDES calculations

		MDES (Proportion of a Standard Deviation)
MDES		0.79
Baseline/Endline correlations	Child	N/A
	Participant (parent/child)	0.56
	Social Worker	N/A

⁹ If the parent had split from the perpetrator less than a month ago, PACT will need to consider if safe engagement can be enabled. PACT also monitors during delivery if parents reengage with perpetrators: first, at the point of referral and triage, and this is captured in their CMS, Lamplight, and second, support workers document in their post-session notes.



Intracluster correlations (ICCs)	Family	N/A
	Site	0
	Group	0.1
Alpha		0.05
Power		0.8
One-sided or two-sided?		Two-sided
Level of intervention clustering		Treatment groups
Average cluster size		9
Sample size (parent–child pairs)	Intervention	40
	Control	32
	Total	72

The power calculations assume 5:4 allocation to treatment and waitlist treatment groups. In total, 9 groups will participate in the trial, out of which five will be assigned to the treatment, and four will be allocated to the waitlist treatment. This will result in a total of nine clusters of eight parent–child pairs. It was assumed that 72 eligible parent–child pairs would be randomised, with 40 in the treatment, and 32 in the waitlist treatment groups. We further assumed the within-participant correlation to be 0.56 based on a similar study.¹⁰ We assumed that the outcomes would not be related to the delivery site. The intervention is delivered in groups, therefore there is a potential for clustering in the treatment arm (with no such effect in the waitlist treatment). The degree of this

¹⁰ See Caldwell, J. G., Shaver, P. R., Li, C. S. & Minzenberg, M. J. (2011). Childhood maltreatment, adult attachment, and depression as predictors of parental self-efficacy in at-risk mothers. *Journal of Aggression, Maltreatment & Trauma*. 20(6), 595–616. <https://doi.org/10.1080/10926771.2011.595763>



effect is difficult to predict. We assumed a conservative ICC of 0.01. Assuming a desired power of 80%, alpha of 5%, and continuous, normally distributed outcome, the minimum standardised effect size detectable is estimated to be 0.79, suggesting that the study is only powered to detect significant difference of this size. While there is no established minimal clinically important difference on the TOPSE, between 8 and 11.6 depending on the TOPSE scale may indicate a detectable effect size corresponding to 6.5 to 9.28 point difference per scale.¹¹

The power and minimum detectable effect size (MDES) calculations were performed using PowerUp!¹²

Outcome measures

The pilot impact evaluation is designed to focus on a sample of the outcomes outlined in the ToC in order to ensure that data requests are proportionate, and to reduce the risk of chance findings.¹³ All measures were selected in collaboration with PACT, where only those tests found to possess adequate level of reliability and sensitivity were selected for initial review.

This pilot will evaluate one primary outcome (parental self-efficacy) and two secondary outcomes: children's behavioural issues at home and parent-child relationship and bonding. The primary outcome (parental self-efficacy) will be measured by the Tool to Measure Parental Self-efficacy (TOPSE). The Brief Assessment Checklist for Children (BAC-C) questionnaire will be used to measure child-behaviour (secondary outcome), while the closeness scale of the Child-Parent Relationship Scale (CPRS) will be used to assess parent-child relationship and bonding (secondary outcome). We provide rationale and more information on the selected measures below.

Primary outcome: Self-efficacy

To answer research question 1, we will analyse if parents taking part in BB4K's group sessions have improved self-efficacy (primary outcome), compared to parents who do not receive the intervention. Self-efficacy relates to an individual's perception and expectation of how well they think they will cope in a given situation. To measure change in self-efficacy we will use the TOPSE. This is a parent self-report, and it was selected as a primary outcome measure as is already collected by PACT as part of usual practice and was considered most relevant for the programme theory. The questionnaire can be used with all parents and is cost effective to collect. The tool has

¹¹ See *Evaluating parenting programmes using TOPSE - a tool to measure parenting self-efficacy* at <https://uhra.herts.ac.uk/bitstream/handle/2299/1865/902057.pdf?sequence=1> and Bloomfield, L. & Kendall, S. (2012). Parenting self-efficacy, parenting stress and child behaviour before and after a parenting programme. *Primary Health Care Research & Development*. 13(4), 364–372.

¹² See Dong, N. & Maynard, R. (2013). 'PowerUp!: A tool for calculating minimum detectable effect sizes and minimum required sample sizes for experimental and quasi experimental design studies', *Journal of Research on Educational Effectiveness*. 6, 24–67. <https://doi.org/10.1080/19345747.2012.673143>

¹³ For more information see: <https://www.eif.org.uk/resource/10-steps-for-evaluation-success>



been used in parenting programmes applied in different cultural, social, and educational contexts. The questionnaire includes eight domains including: emotion and affection; play and enjoyment; empathy and understanding; control, discipline, and boundaries; external pressures on parenting; self-acceptance; and learning and knowledge. Each six-item domain is then summarised in a score ranging from 0 to 60. The questions are based on the Likert scale of 0 to 10 points, where 0 corresponds to completely disagree and 10 completely agree. Internal reliability coefficients for the subscales ranged from 0.80 to 0.89, and the overall scale reliability was 0.94. The test takes 10–15 minutes to complete.¹⁴

Secondary outcome: Child behaviour

To answer research question 2, we will use the BAC-C questionnaire.¹⁵ The BAC-C is a measure that can be used by parent of children aged 4 to 11 to screen and monitor mental health difficulties for children. Descriptions are given for 20 behaviours and feelings, and parents are asked to assess if the behaviour occurred in the last 4 to 6 months. The test takes 5 minutes to complete. The total raw problem score ranges between 0 and 40, with high scores indicating that more problems are present.

Secondary outcome: Parent–child relationship and bonding

To answer research question 3, we will use the closeness scale from the CPRS questionnaire.¹⁶ This is a parent self-report questionnaire that aims to assess the quality of a parent–child relationship. The pilot will focus on the items of the CPRS that aim to assess closeness by assessing level of warmth, affection, and open communication. There are 10 outcomes that measure positive aspects of the relationship. The total score will range between 10 and 50, with higher scores indicating that a parent feels higher levels of closeness. The questionnaire will take no more than 5 minutes to complete.

Data collection

We will survey participants assigned to the treatment and waitlist treatment group **three times**: at baseline; at endline when the delivery of the programme is completed; and in a follow-up which will take place roughly two months after delivery is completed. The follow-up window is two months because this is hypothesised to provide ample time for outcomes to emerge and allows

¹⁴ Kendall S. & Bloomfield L. (2005). TOPSE: Developing and validating, a tool to measure Parenting Self-Efficacy, *Journal of Advanced Nursing*. 51(2), 174–181.

¹⁵ Tarren-Sweeny, M. (2012). Brief assessment checklists. scoring and interpretation. http://www.childpsych.org.uk/BAC_scoring_and_interpretation.pdf

¹⁶ Pianta, R. C. (1992). *Child-parent relationship scale*. Unpublished measure, University of Virginia, 427.



sufficient time for the follow-up surveys to be completed in time for analysis. The endline survey was added in order to explore early emerging impact.

Given that PACT collects TOPSE (parental self-efficacy) as part of usual practice, they will collect the questionnaire from participating parents and will share the data with IFF, while IFF research will collect data on the secondary outcome measures (i.e. BAC-C and CPRS) from participating parents through parent-administered surveys. This approach has been taken to keep data collection from participants as minimal as possible in line with ethical good practice.

Parents will be given the questionnaire to fill in on their own without PACT present.

The researchers scoring the data will not be blind to intervention allocation. If the parent reveals their allocated treatment group to the researcher, this will be recorded.

The baseline and follow-up surveys will be sent via email and IFF will follow-up with reminder emails and telephone calls. Parents in the treatment group will complete the endline survey in the final session. PACT will extend the last session by 15 minutes to give parents time to complete the survey. Parents will be encouraged to complete the survey on their own device (e.g. their phone), but PACT will provide an alternative if needed (e.g. using a PACT laptop). Parents and children in one of the Cohort 1 waitlist treatment groups will complete the endline survey during an in-person event (for more information on the event please see the [Experiment 1: Testing use of in-person events](#)). For groups not involved in-person experiment events, parents will be sent the surveys via email by IFF to complete.

The study acknowledges that the different approaches to outcome measure deployment between the treatment group and the waitlist treatment group has the potential to introduce different biases. Though PACT may not be present, the treatment group's TOPSE being organised by PACT for the baseline and endline still may influence responses, for example by increasing the likelihood of socially desirable answers. Conversely, the waitlist treatment group receiving all measures via email may increase the potential of experiencing technical issues filling in the survey or not being able to ask for clarity on questions as they will not be in regular contact with PACT.

To limit the effect of these factors, anonymity and confidentiality are emphasised in communication with participants, and clear standardised instructions are provided. Likewise, feedback on the experience of using the surveys will be collected as part of the study and a review of selected outcome measures will occur between Cohort 1 and Cohort 2 (for details, see the following section).

Cohort 1 parent–child pairs will complete the baseline survey between April and May 2024, the endline between July and August 2024, and the follow-up between September and October 2024. Cohort 2 parent–child pairs will complete the baseline survey in September 2024, the endline between December 2024 and January 2025, and the follow-up survey between February and March 2025.



	Cohort 1		Cohort 2	
	Treatment (2 groups)	Waitlist treatment (2 groups)	Treatment (3 groups)	Waitlist treatment (2 groups)
Baseline survey	Apr–May 24	Apr–May 24	Sep 24	Sep 24
Delivery	May–Jul 24 (2 groups)	Jan–Mar 25 (2 groups)	Sep–Dec 24 (3 groups)	Mar–May 25 (2 groups)
Endline survey	Jul–Aug 24	Jul–Aug 24	Dec 24–Jan 25	Dec 24–Jan 25
Follow-up survey	Sep–Oct 24	Sep–Oct 24	Feb–Mar 25	Feb–Mar 25

Review of outcome measures before they are used with Cohort 2

It is important to note that measuring outcomes for children and young people who have experienced domestic abuse can be a challenging task. While the selected measures have been used with a general population, these are not validated specifically for this group. Therefore, we will review the suitability of using the secondary outcome measures with Cohort 1. As part of this, we will review the ease of administration of the self-report surveys, including take up and time needed for administration with Cohort 1. We will also assess whether the scores are normally distributed.

Following the review, a decision will be made on whether we will employ the same outcome measures with Cohort 2.

Analysis plan

The Statistical Analysis Guidance produced by What Works for Children’s Social Care is still applicable for the work of Foundations.¹⁷

Primary analysis

The pilot is designed as a cohort two-armed, randomised waitlist trial.

¹⁷ See <https://whatworks-csc.org.uk/wp-content/uploads/WWCSC-RCT-Statistical-Analysis-Guidance-V1.2.pdf>



The primary outcome is the TOPSE score at follow-up,¹⁸ controlling for baseline TOPSE score. We will estimate the mean difference in TOPSE scores between participating families in BB4K and the waitlist treatment group participants. The primary analysis will use a mixed effects model allowing for different outcome variance between the treatment group and waitlist treatment group arms, and heteroscedastic individual-level errors. The model will control for delivery site, child age,¹⁹ and baseline TOPSE score via fixed effects. The between-cluster variation in the treatment group groups will be modelled as a random effect. The model is not powered to investigate differences in treatment effects between sites.

The analysis model will be:

$$Y_{ijk} = \beta_0 + \sum_{k=1}^3 \beta_k s_k + \gamma Y_{0ijk} + \delta X_{ijk} + \theta t_{ijk} + t_{ijk} u_{jk} + (1 - t_{ijk}) r_{ijk} + t_{ijk} \varepsilon_{ijk}$$

- Y_{ijk} is the outcome at follow up for parent i in treatment group j and sites k
- There are three sites $k= 1,2,3$
- There are $j=9$ clusters corresponding to 5 treatment group and 4 waitlist treatment groups
- Sites $k=1,2,3$
- β_k represents difference in outcomes between sites
- θ is the treatment effect.

In line with Foundation's Statistical Guidance, the analyses will follow an intention-to-treat (ITT) approach. The analysis will include all randomised children and parents in the groups to which they were randomly assigned, regardless of the treatment actually received, withdrawal from BB4K post-randomisation, or deviations in programme implementation. This principle is key in ensuring an unbiased analysis of intervention effects. The difference between the treatment and waitlist treatment groups at endline will be expressed as a standardised effect size using Hedges' g with 95% confidence intervals. The primary analysis will also include detailed descriptive analysis: histograms, means, quartiles, and standard deviations, for all measures, groups, and time points. All analysis will be scripted to allow for transparency and replication and will be uploaded to GitHub.

If there is less than 5% missingness overall, we will undertake a complete case analysis as the primary analysis. However, it can be problematic to apply the intention-to-treat principle if parents are not able to complete the outcome surveys. To deal with missing data we will complete the following analyses. First, we will report on attrition from analysis and attrition from BB4K including reasons. Second, we will explore the extent of missingness, and then we will assess the pattern of missingness. To assess whether there were systematic differences between those who did not complete the outcome surveys and those who did, we will model missingness through a logistic

¹⁸ The follow-up measure is used instead of the endline measure to allow for ample time for outcomes to materialise.

¹⁹ As we stratify (block) by region and age.



regression model at follow-up as a function of key covariates, including treatment, age of child, and region to assess if any covariates are associated with missing data.

For each outcome measure, we will address any item non-response by using a mean of the completed items.

If values on covariates are missing and the overall percentage of the missing covariate is over 5% and smaller than 40%, we will use multiple imputation of missing covariates.

Secondary analysis

To assess impact for the secondary outcomes (i.e. child behaviour and parent–child relationship bonding) we will employ the same principles as the primary outcome analysis.

Early impact analysis using the endline survey

To explore the timing of when outcomes can be expected to materialise, and to capitalise on existing contact with treatment group participants still being in regular contact with the programme (assuming this will support treatment group response rates as low response rate to the surveys is a key risk to the evaluation), an endline survey will be deployed once the treatment groups complete the BB4K programme.

Those in the treatment group will complete the endline survey at the end of the final BB4K session. The waitlist treatment group will be sent the endline survey to complete via email.

Early impacts will be assessed using the same analysis strategy outlined for the primary outcome analysis.

Subgroup analysis

The pilot evaluation of BB4K is not powered to detect significant differences between sub-groups, however there is still benefit from conducting subgroup analysis. Even with low statistical power, subgroup analysis can act as exploratory analysis to generate hypotheses or insight that could be explored in a full-scale trial. Additionally, subgroup analysis will provide valuable descriptive information about the characteristics of different subgroups to give us a better view of the diversity of the BB4K population.

Therefore, subgroups based on age (i.e. three categories based on the child group age bands of age: 3–5; 6–8 and 9–11 years old) gender (i.e. two categories girls vs boys) and ethnicity (with the exact ethnicity categories to be confirmed after recruitment is completed).

The effect of the programme on these subgroups will be explored by including an interaction term with the treatment variable. As previously discussed, these analyses are exploratory and underpowered meaning they need to be interpreted with caveats. Therefore, we will not report significance tests.



Analysis of harms

The trial is evaluating a therapeutically informed intervention that has been piloted and developed over many years. However, we cannot assume that there will not be any unexpected adverse events. We will monitor and record any reports of harm during the trial. For example, data from qualitative interviews will be used to consider a range of experiences with the intervention, including potentially negative experiences. All adverse events will be monitored and recorded by the research team, and discussed with PACT and Foundations.

Contextual factors analysis

This study is not powered for quantitative contextual analysis. We intend to use information from the qualitative interviews to assess number of contextual factors relevant for engagement and implementation (e.g. referral source, context across delivery sites, trust in support worker).



Implementation and process evaluation

Aims

The pilot includes a robust implementation and process evaluation (IPE) to explore how BB4K has been implemented, whether that was as intended, how it is working, and the reasons it has/has not worked. In line with the ToC, we will also look at mechanisms of change and aim to understand the circumstances that best supported implementation and the reasons for this (i.e. the implementation determinants), and the circumstances that best supported parent and child outcomes and the reasons for this.

Research questions

The table below summarises the IPE research questions and approach to address each:

IPE research question	Approach
RQ1: Does the intervention work as intended?	
<p>RQ1a. What is the proportion of families that attend all scheduled group sessions, and how does attendance vary by family characteristics?</p> <p>Explore whether referral, participation and drop-out trends vary by family characteristics/circumstances, where data is available:</p> <p>Demographics: gender sexual orientation, ethnicity, disability, first language</p> <p>Circumstances: whether child is on CP or CIN plan; housing situation (temporary or permanent housing); abuse type.</p> <p>We will also see whether referral source influences profile of families referred to and taking up BB4K.</p>	<p>Management Information (MI) analysis</p>
<p>RQ1b. To what extent is the BB4K theory of change validated? (evidence of outcome pathways, including input, activities, outputs and mechanisms, as detailed in the BB4K theory of change)</p>	<p>MI analysis, qualitative research with BB4K managers, practitioners, volunteers, and parents and children</p>
RQ2: Does the intervention work differently in certain conditions?	



<p>2a. Do perceived outcomes (and experiences) vary by the three sites, and if so, reasons?</p>	<p>Qualitative research with BB4K managers, practitioners, and parents and children</p>
<p>2b. Do perceived outcomes (and experiences) vary by characteristics of families (child age group, type of abuse, children’s social care status, housing situation, and duration taking part in intervention), and if so, reasons?</p> <p>Exploring differences in programme experience by family characteristics and circumstances (See RQ1A); exploring experiences of overcoming access and participation barriers with practitioners and families</p>	<p>Qualitative research with BB4K managers, practitioners, parents, and children</p>
<p>RQ3: To what extent was the intervention implemented as intended?</p>	
<p>3a. Fidelity: To what extent was BB4K delivered as intended?</p> <p>To include qualitative exploration of a mechanism for change: ‘parents primed for child sessions by having their session on same day as child, and knowing what will be covered in child sessions’</p>	<p>MI analysis, qualitative research with BB4K managers, practitioners, referrers, parents, and children</p>
<p>3b. Feasibility: What were the barriers and enablers to implementing BB4K, and how were barriers addressed?</p> <p>To include qualitative exploration of two mechanisms for change: ‘child and parents trust their support worker and feel safe and secure in sessions’, and ‘experience connection with other families with experience of DA/ peer support’</p>	<p>Qualitative research with BB4K managers, practitioners, referrers, parents, and children</p>
<p>3c. Dosage: How much 1) group work, 2) one-to-one work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?</p>	<p>MI analysis</p>
<p>3d. Quality/responsiveness/acceptability: How acceptable do children and parents find BB4K? (content, number/duration of sessions, group size, ratio of worker/family, format of materials)</p> <p>Exploring differences in programme experience by family characteristics and circumstances (See RQ1A)</p>	<p>Qualitative research with practitioners, referrers, parents, and children</p>



<p>3e. Adaptations: What adaptations have been made to make BB4K more acceptable to families and referring organisations?</p> <p>Exploring families' access needs with BB4K staff and steps they made to meet these, perceptions of appropriateness of those steps.</p>	<p>Qualitative research with BB4K managers, practitioners, referrers, parents, and children</p>
<p>RQ4: Can the intervention be improved?</p>	
<p>4a. What (if any) changes are recommended to the design, procedures or delivery approach of the BB4K programme before the intervention is rolled out more widely or scaled up?</p> <p>BB4K staff and children and parents' ideas for improving access and engagement to BB4K in the future.</p>	<p>Qualitative research with BB4K managers, practitioners, referrers, parents, and children</p>

Design and methods

Scoping activities

To help inform the evaluation design, immediately following the set-up meeting, we:

- Reviewed 17 documents related to the design and delivery of BB4K to inform the evaluation design. This included data protection and ethics, the content of BB4K groups, referral and assessment procedures, and existing parent and child evaluation forms.
- Reviewed data collected and stored about the families referred and supported by BB4K, including outcome and cost data. This review included what exists, the quality/completeness of data, its format and data access requirements. This informed any refinements to the evaluation design required to add the most value, including any additional information to be collected, and data protection and sharing plans. This was also essential for avoiding duplicating data collection. Undertook six individual or paired scoping interviews. To understand the aims, scope and intended outcomes of BB4K, and available data for evaluation, we spoke with eight individuals with knowledge of BB4K, including the Head of Communities, Manager, Service Lead, Play Therapist, Administrator, Database Office, Accountant and a parent who had completed BB4K.

All of PACT's data is stored on Lamplight, an online CRM system. Data is stored at an individual level for both parents and children and the records of family members are linked once they've been created. Weekly and quarterly reports are produced using Lamplight data that show attendance and outcome data for the whole of BB4K.

The table below details the MI collected and how it will be used in the evaluation.



IPE research question	Approach
RQ1: Does the intervention work as intended?	
<p>RQ1a. What is the proportion of families that attend all scheduled group sessions, and how does attendance vary by family characteristics?</p> <p>Explore whether referral, participation and drop-out trends vary by family characteristics/circumstances, where data is available:</p> <p>We will also see whether referral source influences profile of families referred to and taking up BB4K.</p>	<p>MI analysis – Demographics: sex, sexual orientation, ethnicity, disability, first language</p> <p>Circumstances: whether child is on CP or CIN plan; housing situation (temporary or permanent housing); abuse type</p> <p>Referral source</p>
RQ1b. To what extent is the BB4K theory of change validated? (evidence of outcome pathways, including input, activities, outputs and mechanisms, as detailed in the BB4K theory of change)	MI analysis
RQ3: To what extent was the intervention implemented as intended?	
<p>3a. Fidelity: To what extent was BB4K delivered as intended?</p> <p>To include qualitative exploration of a mechanism for change: ‘parents primed for child sessions by having their session on same day as child, and knowing what will be covered in child sessions’</p>	<p>MI analysis – whether actively experiencing DA, whether receiving any other support at point of assessment (and organisation providing it), whether completed: assessment call, triage meeting, secondary call, home visit, signposted to other services; whether post-session parent reflections completed; whether end-assessment process for offboarding completed</p>



<p>3c. Dosage: How much 1) group work, 2) one-to-one work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?</p>	<p>MI analysis – attendance at each session; whether used BOUNCE and length of time spent on all BOUNCE courses, whether received one-to-one support and reasons, drop-out rate and reasons</p>
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Qualitative research

The mainstage IPE will explore the perspectives of all stakeholders across two fieldwork waves, including BB4K managers, practitioners, referrers, parents, and children. The table below summarises the planned IPE qualitative fieldwork. A two-wave approach will enable us to capture insight at the start of the delivery period and again at the end, so we can see change over time and capture both initial perceptions, experiences, and views on outcomes.

Parents will receive a £40 voucher for their/their child’s participation. Staff, including referrers, will not receive an incentive. All discussions will be audio recorded with the consent of participants. Where consent is not given, discussions will not be recorded, and instead detailed notes will be written after discussions.

	Wave 1	Wave 2
<p>Senior leadership (Head of Communities, Service Lead, Manager)</p>	<p>x3 senior staff, via x1 online mini group, 75 mins, August 2024</p>	<p>x3 senior staff, via x1 online mini group, 75 mins Dec 2024</p>
<p>Practitioners (Support Workers, Play Therapist)</p>	<p>x4 practitioners, via x1 online mini group, 90 mins, August 2024</p>	<p>N/A</p>
<p>Referrers (e.g. LA (children’s services, adult social care, and housing), schools, community partners, counselling services and other charities)</p>	<p>N/A</p>	<p>x3 via online interviews, 45 mins, Dec 2024</p>
<p>Parents – Treatment</p>	<p>x8, via x1 in-person focus groups, 1 hour, July 2024</p>	<p>x8, via x1 in-person focus groups, 1 hour, Nov 2024</p>



Children – Treatment	x8, via x1 in-person focus groups, 1 hour, July 2024	x8, via x1 in-person focus groups, 1 hour, Nov 2024
Parents – Waitlist treatment	x2, via online interviews, 45 mins, July 2024	x2, via online interviews, 45 mins, July 2024
Total	25	24

Focus groups with children and parents were chosen over one-to-one interviews to make it easier for families to engage (hosted right after scheduled BB4K session), safeguarding (hosted in a safe and familiar space and with their PACT practitioner in the building) and data protection reasons (does not require the sharing of parent/child name, contact details with IFF). The use of focus groups also aligns with the IPE research questions (pilot evaluation requiring identification of improvements, no need for in-depth individual family journey exploration), and evaluation efficiencies (ability to capture more family views across the three delivery sites compared with one-to-one discussions).

BB4K managers

Recruitment

Sampling is not required, because we are speaking to all leadership staff. To secure a convenient time for participants, our in-house specialist recruiter will reach out to participants one month ahead of fieldwork. To mitigate cancellations, at this time they will also agree a back-up time and will send a reminder two days before the scheduled appointment.

Fieldwork

We are planning to cover the following topics:

- **Implementation approach and experience:** during the interview we will use the ToC as a guide to understand how the intervention has been implemented and delivered; explore where delivery has changed from planned and the reasons for this (e.g. workforce, local context, and required adaptations), explore the level of consistency or variation in support delivered and reasons for this (e.g. workforce availability/capability, family characteristics/needs; this includes EDIE); explore views on what has worked well/less well and why, challenges/barriers and mitigations to involvement, and areas for improvement (for all, including EDIE).
- **Perceived outcomes:** whether/what outcomes emerging (including any unintended consequences), whether outcomes achieved at expected timescales, including mechanisms driving achievement of these outcomes, evidence for any outcomes achieved, reasons for



any outcomes not being achieved, any impact of their local contexts and external factors, and ways to strengthen outcomes in the future.

- **Reflections on delivery and lessons learned for moving into the future (including scaling up):** areas that worked well and why in their local context – including what they intend to keep, and what might have worked better and why; the characteristics and circumstances of families that BB4K works best for.

We plan to cover similar topic areas at initial and follow-up interviews, as we will be able to discuss views based on different cohorts. This will also help us to identify any changes over time.

Practitioners

Recruitment

PACT employs eight Support Workers and one Play Therapist, and we will invite three Support Workers and the Play Therapist to take part in a mini group discussion. To sample practitioners, we will ask PACT for the following information for each Support Worker: length of time in role, site they work in, age group they support, and whether they have provided one-to-one support. We will invite three support workers that reflect the range of sampling characteristics to participate in the interviews. In the event they do not all agree to take part, we will then invite the next relevant Support Worker based on their characteristics. To secure a convenient time for participants, we will first speak with the Service Manager to identify days of the week/times of day when practitioners are most likely available. For example, whether we can extend a regularly scheduled meeting to include this discussion. If that is not possible, our in-house specialist recruiter will reach out to participants one month ahead of fieldwork. To mitigate cancellations, at this time they will also agree a back-up time and send a reminder two days before the scheduled appointment.

Fieldwork

Interviewing a smaller group of four practitioners instead of a group of all nine practitioners ensures in-depth discussion given the complexity of the intervention. Interviewing larger groups creates risks that qualitative data would not capture the level of detail required to thoroughly test the ToC and explore factors influencing implementation success and emerging outcomes. We intend to conduct these online; however, if practitioners have availability while researchers are on-site to interview parents and children, we will conduct these discussions in-person.

We are planning to cover the following topics:

- **BB4K awareness and understanding** programme focus, eligibility criteria; sources of knowledge; any confusion with programme
- **Overall:** whether BB4K is working well and for what groups of families; key successes and challenges related to implementation
- **Referral and triage:** whether practitioners are able to identify and prepare families for support; experiences of assessment and consent forms and meetings with families and associated mechanisms; working well/less well



- **Delivery experiences:** whether service is being delivered as intended, adaptations and reasons (for staff, volunteers, families), working well/less well, for each of group, one-to-one and optional support
- **Perceived outcomes:** intended/unintended, evidence on outcomes, BB4K features enabling/preventing outcomes, variation by family characteristics (see RQ table for details)
- **Suggestions for improvement** – achieving/sustaining outcomes; scaling BB4K: referral and triage, group/one-to-one delivery, accessibility, and quality.

Referrers

Recruitment

BB4K referral sources include LAs (children’s services, adult social care, and housing), schools, community partners, counselling services, and other charities. We will know the volume and sources of referrals made to BB4K from the management information. Using that, we will identify the most and least common referral sources, then we will ask PACT to contact those sources with an email we draft to explain the research and invite them to participate in interviews. Once a referrer has expressed willingness, IFF’s recruiter will follow up by email to arrange a short call to share information on the interview, answer questions, confirm eligibility (e.g. organisation has referred to the programme) and schedule a time for a telephone discussion. Where multiple people from a referral organisation have been referred and would like to take part, we can accommodate paired discussions.

Fieldwork

Initial thinking on topic coverage:

- **Context:** organisational overview; referrer role and responsibilities; overview of involvement with BB4K; when/how they heard about BB4K; first impressions and expectations of it for their organisation/people they support; support needs of families experiencing DA in local area.
- **Referral process:** understanding of eligibility criteria and how to refer. Views on: how the referral pathway works from their perspective, what is working well/less well; the ease/appropriateness of the online referral form and of administrator checking their information; any suggestions for improving the referral process; whether the right families are being identified and supported by BB4K; any families they referred that were not eligible; value of the intervention within the wider support available for families in their area.
- **Experience of engaging with BB4K:** relationship with BB4K team (e.g. partnership meetings); whether/how they want to hear from BB4K to maintain engagement; what has worked well/not well and what could be improved.
- **Lessons learned for moving into the future:** areas that worked well and why in their local context – including what they intend to keep, and what might have worked better and why.



Parents and children – Treatment

Recruitment

BB4K is being delivered to five groups: two in Cohort 1 and three in Cohort 2. We will invite one treatment group family to take part in a group discussion – both parents and children – after their final BB4K group session. We will support PACT Support Workers to introduce the research to families in session 5 or 6 so parents can plan to stay after their group on their final day. To maximise family participation, we will produce an informative animation introducing the research, what taking part involves and reassurances about participation. An animation helps to communicate the research to younger children, or to people who prefer watching/hearing information over reading. Paper information leaflets will also be used for all audiences. We will incentivise parents and children, with £40 per family. We will offer Love2Shop or Amazon vouchers; parents can choose.

Fieldwork

The discussions will be in-person after the final BB4K session to ensure the discussion takes place in an accessible, familiar, safe space (i.e. where the intervention has taken place) and we can be confident they are already available, because they were in the BB4K session. This should not only help parents and children feel more comfortable talking with us, but also help us structure the conversations with young children (e.g. ‘what did you like about the things you have been doing *here?*’). Parents and children will also have the support of their peers during the discussion and the BB4K delivery team will be on hand if needed. To further support family inclusion in qualitative fieldwork we will use semi-structured topic guides and supporting stimulus adapted for the needs of the groups.

Initial discussion coverage for parents:

- **Warm up:** name, how they spend their time
- **Overall experiences:** satisfaction, likes/dislikes
- **Group experiences and perceived outcomes:** working through the group themes, exploring experiences of content, facilitation, pace, and whether/how they benefited from each of these (e.g. outcomes) and factors enabling that (e.g. mechanisms); to include experiences of joint child/parent activities and weekly progress reflection and emotional literacy
- **Experiences of optional features:** between-session takeaway literature and Bounce experiences: awareness, impressions, whether/who used it, including reasons and briefly discuss whether/how benefited from it
- **Referral experiences:** whether aware of BB4K before, how they learned about it and first impressions, what worked well/less well about referral and triage process, ease/comfort of process
- **Whether offered Bounce** and experiences of using it (if relevant), whether/how benefited from it



- Suggestions for improvement.

Initial discussion coverage for children:

We want to explore experiences of being involved with BB4K, and assess perceptions of any impacts on children. However, these concepts can be difficult for children to articulate, and we will therefore need to use more indirect ways of questioning. Different approaches/tailored questions will be needed depending on the age of the participants, as there will be significant differences between the way that a 10-year-old might understand the concept/be able to express themselves compared to a 6-year-old. The table below shows our tailored and tried/tested approaches to collecting data from different age groups.

Approaches to collecting qualitative data	
3–5-year-olds	<ul style="list-style-type: none">• We do not feel that collecting qualitative data with 3–5-year-olds would be appropriate given the nature of their needs and support required. We will instead capture views on experiences and outcomes for this group via parents.
6–8-year-olds	<ul style="list-style-type: none">• Use activity-based approaches, including asking them to draw or select ‘emoticons’ (smiley, sad, angry, etc.) from an emotions board and asking them to assign a face to how they are feeling and how they felt about intervention activities.• Using social stories (i.e. a simple story that describes a social situation and the appropriate way to act in that situation) can work well with this age group. We would write a short social story about the intervention and get the children’s views on the story.
9–11-year-olds	<ul style="list-style-type: none">• With this older age group, there is more scope to ask questions specifically relevant to the intervention.• Visual exercises can work well with this age group and effectively break up time. We would suggest a card sorting activity, where the children match different starts and ends of sentences depending on how they feel.• We will also use projection techniques (e.g. ‘if you were telling a friend about the session what would you tell them?’ or ‘if you were the teacher/project leader for a day, what would you do?’).

The approach includes families with experience of group intervention and excludes discussion with families only with experience of one-to-one support. Resources and reprioritisation meant it is not possible to conduct qualitative work one-to-one with families. Instead, BB4K staff discussions will



discuss the one-to-one provision, and MI analysis will assess the number and characteristics of families that received one-to-one support.

Parents in the waitlist treatment group

Recruitment

All parents in the waitlist treatment group can provide their consent to be contacted for an interview in the endline survey. IFF's recruiter will contact those who have consented to be contacted to introduce the research, answer questions, confirm eligibility (e.g. has not yet received BB4K) and ask whether they used Bounce (we aim to include at least one parent who used Bounce) and schedule the interview.

Fieldwork

Initial thoughts on topic coverage:

- **Warm up:** name, how they spend their time, their local area
- **Referral experiences:** whether aware of BB4K before, how they learned about it and first impressions, expectations, what worked well/less well about referral and triage process, outcome of triage process and how that was communicated, ease/comfort of process
- Whether took part in BB4K
- Whether accessed any other (non-BB4K) support since BB4k referral – reasons and how it compares to BB4k
- Whether offered Bounce and experiences of using it (if relevant), whether/how benefited from it
- Suggestions for improvement.

Management information (MI) analysis

We will analyse information relating to the implementation and delivery of the programme from the management information (MI) collected by PACT at two time points: early intervention delivery and towards the end of delivery which allows for tracking over time. This will help provide quantitative evidence on the adoption, fidelity and integration of the intervention and provide the contextual basis for the qualitative IPE activity. The table below details the data we will analyse and the research question it relates to.

Some of this data is already collected by PACT through their existing procedures and systems, and some involves additional data collection by PACT.



IPE research question	Data
RQ1: Does the intervention work as intended?	
RQ1a. What is the proportion of families that attend all scheduled group sessions, and how does attendance vary by family characteristics?	<p>Number, source, and profile of referred families (age, location, gender, ethnicity, special needs/disability information, any court orders in place, number of children, other services accessed, and identified family risks).</p> <p>Number, source and profile of referred families confirmed as eligible.</p> <p>Number, source and profile of eligible referred families who complete the programme.</p> <p>Number of families in treatment and control group.</p>
RQ3: To what extent was the intervention implemented as intended?	
3a. Fidelity: To what extent was BB4K delivered as intended?	<p>Number of the following and how this compared to intended: assessment calls completed, triage meeting completed, secondary call completed, home visit completed, groups for age 3–5 and groups for age 6–11 completed, post-session parent reflections completed, end-assessment completed.</p> <p>Waiting time between referral and accessing support.</p>
3c. Dosage: How much 1) group work, 2) one-to-one work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?	<p>Attendance and drop-out of families for each of group work and one-to-one work offered to individuals where group work not deemed appropriate.</p> <p>Reasons for drop-out (where PACT can collect this before drop-out) for each of group work and one-to-one work.</p> <p>Treatment and comparison group engagement with the Bounce digital platform: module completion, length of time spent accessing content.</p>



Analysis

Qualitative analysis

Throughout the interview, researchers will continually weigh up the implications of what the participants said and devise relevant follow-up questions (where useful to draw out additional insight). Through this process of active listening and ‘weighing up’ feedback, the researcher will ensure they are clear on the implications of the discussion on the IPE questions.

Where given permission, researchers record the interviews on video-conferencing software on Microsoft Teams or via a digital recording device. Researchers will use the recording and interview summary to assess the implications of the discussion against the IPE questions. This involves triangulating feedback from different sections of the interview, including non-verbal cues observed.

Qualitative data will be analysed thematically. Researchers will organise and code this data in a bespoke Excel-based analysis framework. The framework will be structured around thematic headings relating to the theory of change and research objectives. Individual interviews can then be compared to determine the commonality of experiences. Interviewers will write-up their discussion into this framework, including verbatim quotes, and their impressions/observations. The framework contains coded ‘classification’ variables, to allow the qualitative data to be ordered/‘cut’ in different ways to explore any subgroup differences. For example, BB4K cohort, site, and child age. The framework is piloted with the first couple of interviews then revised to ensure it is fit for purpose. A senior researcher will check the framework coding of at least one interview per researcher, providing feedback to improve specificity and clarity.

Researchers will then process the findings through abstraction and interpretation. Researchers devise a more analytic set of building blocks to categorise and classify the data. The first stage is ‘description’, identifying the range of things said about a particular theme; how this varies; and the different types of responses that could be identified. Variation is measured against the sampling characteristics. Other unexpected or emerging patterns are also noted.

Next, researchers undertake ‘mapping linkage, ’exploring the ways that different parts of the data are connected. This is followed by ‘explanation’: identifying the reasons why the data fell out in the way that it did. During this stage, researchers look for both explicit accounts (reasons given directly by participants) and implicit accounts (where researchers infer an underlying logic based on participant views, context of the wider legal system, power dynamics).

Management information analysis

Upon receipt from PACT, a researcher will conduct an initial check of the data received against our IPE MI plan and follow up with PACT to fill data gaps and clarify any discrepancies. After we are confident we have the correct data, our data services team processes the data (e.g. ensures consistent formatting; reorganises it for evaluation purpose) and creates an SPSS file and tables for descriptive analysis using a data specification the research team develops. The process is repeated at Wave 2 (the final analysis wave) and tables are created that show change between waves 1 and 2.



Triangulation

We will take a systematic approach to the analysis of all strands of data collection (impact and IPE) to generate insight that covers both the breadth of all participating families and the depth of experiences and impacts for different types of families (different Cohorts or younger/older age groups). To incorporate the information from all strands of data collection we will design an analysis framework. The framework will be structured around the research questions. It will be set up to allow us to identify differences across parents and children and stakeholder groups. We will organise an internal analysis workshop to triangulate the evidence gathered into a coherent set of findings; to explore possible convergence and divergence of trends and themes and anticipate their plausible outcomes; and draft recommendations for the programme.



Evaluation experiments

We will conduct two experiments to answer RQ4 of the implementation and process evaluation, focusing on strategies to boost response rates to the endline and follow-up surveys. The experiments will be conducted 5 months after randomisation. At this point, waitlist treatment groups have not yet taken part in BB4K. These experiments include:

1. Testing use of in-person events for survey completion
2. Testing use of £10 incentives on endline survey response.

Experiment 1: Testing use of in-person events for survey completion

Experiment 1 involves testing the use of in-person events on follow-up survey completion with Cohort 1 only. Cohort 1 has two treatment groups and two waitlist treatment groups (32 families total). One treatment group and one waitlist treatment group will take part in the celebration events (16 families) and the other treatment and waitlist treatment groups will not (16 families).

Treatment group celebration event: PACT will host an in-person event with one of the Cohort 1 treatment groups (selected by IFF using a random number generator) during the follow-up survey collection period at the end of September 2024. All parents and children who took part in the group will be invited via email to attend the ‘coffee morning’ celebration event and come back together a few months after their last session to reconnect and reflect on their successes.

Waitlist treatment group introduction event: PACT will host an in-person event with one of the Cohort 1 waitlist treatment groups during the endline survey collection period at the end of September 2024. IFF will randomly select the groups using a random number generator. All parents and children from one of the waitlist treatment groups, will be invited via email to attend the ‘coffee morning’ introductory event and come together to meet for the first time and learn more about what BB4K will entail.

PACT will host both events at the same location where the groups sessions are held. Events will be hosted during school hours to ensure accessibility, familiarity, and available childcare. Children will not be required to attend but parents may wish to bring along those under school age. PACT will provide tea, coffee, and cakes to encourage families to attend.

IFF will issue the follow-up survey to both groups a week before the event. During the events two researchers from IFF Research will speak to the groups about the importance of their involvement in the evaluation. They will bring laptops and offer to help parents complete the survey in-person during the event. Parents who do not attend the event and do not complete the survey following the email invite and two reminders, will receive a phone call from an IFF telephone interviewer, asking the parent to complete the survey over the phone.

For groups in Cohort 2 – not involved in this experiment – surveys will be administered by email at the time indicated in the project timetable.



Reporting results: The interim and final reports will discuss the results of Experiment 1, specifically, the effectiveness of the celebration groups by comparing response rates in the treatment group participating in the experiment to response rates in the treatment group not participating in the experiment, and similarly for the waitlist treatment groups.

Experiment 2: Testing use of incentives

Experiment 2 tests the use of incentives on endline survey completion with Cohort 2 only, in January 2025. Cohort 2 has three treatment groups and two waitlist treatment groups (40 families total). We will explore the effect of offering £10 incentives for endline survey completion with two treatment and two waitlist treatment groups in Cohort 2 (32 families). IFF will randomly select the groups using a random number generator.

Those groups selected will be notified of the opportunity to receive the incentive when they're invited via email to complete the survey. At the end of the survey, they will be able to select from a £10 Amazon voucher or a £10 Love2Shop voucher and asked to provide an email address to receive the voucher. Those selected for the incentive who do not respond to the email prompts will be notified of the incentive when they receive a phone call asking them to complete the survey.

Reporting results: The final report will discuss the results of Experiment 2, specifically, the effectiveness of the incentives by comparing response rates in the treatment group participating in the experiment to response rates in the treatment group not participating in the experiment, and similarly for the waitlist treatment groups.

Cost evaluation

The overall aim of the cost evaluation is to understand the additional costs and, where possible, benefits of the programme compared to if it was not delivered. Our proposed approach is to calculate **the overall cost for BB4K delivery, and the unit cost per family and per each of the three sites.**

Costs will be based on the resources needed to roll out BB4K in comparison to 'business as usual'. In line with the WWCS cost analysis guidance, we will split costs into prerequisites (e.g. access to facilities to deliver, overheads), start-up (e.g. the purchase of equipment, training staff cost, salaries) and recurring delivery costs (e.g. non-durable materials, costs for new staff).

Outside the cost evaluation we will present separately costs of parents' time, children's time, and volunteers' time

As a first step we will calculate the overall costs at BB4K level. We will ask PACT to provide information on the following cost categories:

- Staff costs: including salaries, National Insurance Contributions, pensions for all workers including temporary and contract workers; if staff don't spend all of their time on BB4K, we will ask PACT to confirm the time allocated for the year to BB4K
- Volunteer time, if any



- Facilitation costs, these include all of the costs for delivering the service including paying for specialist staff, travel budgets, venue hire, etc.
- Overhead costs – we will ask PACT to provide overhead costs per department (e.g. Finance) and an estimate of each team’s time allocated to BB4K management for the financial year.

To collect cost data, we will create a simple, clear, online tool, and accompanying guidance, for PACT to input these costs at two time points: after set-up and before delivery starts, to show costs over time and to ensure cost data is being collected and the tool works for PACT, and at the end of delivery, in aggregate form.

The evaluation will also provide useful insight on the benefits expected from the pilot for future economic evaluation. This will take the form of a summary table indicating potential savings to society rather than accurate monetary estimation. We will draw on the evidence from the impact evaluation and IPE to derive the expected benefits from the pilot. In the absence of accurate impact estimation (given that this is a pilot) it is not possible to undertake monetary estimations to the likely additional level of costs avoided or benefits derived from the BB4K.



Ethics & participation

Ethical approval

Ethical approval was obtained from Foundation's Research Ethics Panel in April 2024.

Obtaining consent

Establishing whether individuals have the capacity to give informed consent can be difficult for some vulnerable people. We will use consent forms that are clear and concise, and make sure the process of ensuring consent continues throughout the participant's interaction with us (i.e. does not end after recruitment). In line with the Mental Capacity Act (2005) and Code of Conduct (2007), we assume that people have capacity to consent, unless established otherwise.

Participants will be informed of the purpose of the research and will be provided with full and complete information about it, in Participant Information Sheets (tailored to be age appropriate, young people will also receive an **animated video** explanation). Participants will be encouraged to ask any prior questions by email or telephone to enable them to give informed consent. The privacy notices will contain an informed consent and data protection statement for respondents. This will inform respondents that participation is entirely voluntary. Participants will have the opportunity to withdraw consent at any time.

For young people under age 16, appropriate consent will be sought from parents/carers (as well as asking consent directly of young people at the start of the discussion). We will send a parental consent form designed by us to recruited parents, to complete and return if their child wants to take part. We will develop a concise, visual information leaflet and animated video covering the same information about the project to give to young people, to help them understand what the research is about and what taking part involves. We will also reiterate to all young people that the research is entirely voluntary, so they do not need to take part and they will not 'get into trouble' with anyone if they decide not to – before, during or after the discussion.

Safeguarding and mitigating distress

While we understand BB4K can be delivered to mixed gender groups, we have assumed all adult qualitative discussions would be carried out by an interviewer of the same gender, unless PACT advises otherwise based on the needs of parents. Interviewers for mixed gender groups will be selected based on advice from PACT on group preferences.

The interview protocol includes guidance for ensuring a safe space for interviews to take place, guidelines for conduct where a participant becomes upset or distressed and will include support materials for respondents should they raise issues requiring assistance. An information sheet including signposting to specialists, local support will be provided to all participants. We will regularly revisit protocols and discuss issues arising in our project meetings with you and PACT.



All those conducting interviews will receive refresher training with the fieldwork briefing on safeguarding and ethics in research relating to DA and will be thoroughly briefed on this specific project. Everyone on the team will be DBS checked and will be selected for their experience conducting interviews with vulnerable groups. Regular team meetings and open lines of communication will enable researchers to raise concerns directly with project directors.

Handling disclosures

The ethics protocol includes content on handling disclosures relating to DA. This will enable an interviewer to identify when an individual taking part in the research might be at risk of harm, and the next steps for the interviewer. It includes lines to take when a participant discloses harm, FAQs and contact details for support. We will inform Foundations of all cases of disclosure and how we responded. This will be reported anonymously unless prior consent is gained from the participant. Any legal information that is disclosed will be treated as confidential by the research team.

Adults may disclose current harm, abuse, or crimes. Information sheets and consent forms will clearly state that if participants disclose this, we will have to report it to relevant authorities. **Children**, especially very young children (this intervention's age range is 3 to 11) may disclose their experience of abuse and neglect in many different ways, which can be complex and fragmented, and not always direct or verbal. We will follow NSPCC's evidence-based approach to responding to a child disclosing abuse. In short, the interviewer will give their full attention; keep body language open; encourage and show reassurance through phrases like "you've shown such courage"; recognise and respond to their body language and show empathy; show we understand and are interested in what they are saying. When the time is appropriate, the interviewer will ask if there is a trusted adult we can contact, how to contact them and how involved the child wants to be.

Interviewer safety and wellbeing

Due to the sensitive subject matter, these interviews may impact interviewers as well as participants. The ethics training mentioned above will include detailed coverage of this, including guidelines if a participant becomes abusive or aggressive.

Interviewers will have a guide to staying safe while conducting face to face interviews. If staff find themselves upset by the nature of a call or interview, we train and encourage staff to do what they need to do to feel better. This might be taking a break and reaching out to the project director, a friend, or a colleague to talk about what they heard and how that made them feel. Staff are reminded and encouraged to reach out for support, not time-limited to the day of the interview. At the start of each project, staff are also signposted to a 24-hour, confidential counselling service available free to all staff. We also have detailed safeguarding plans for in-person fieldwork.



Registration

The trial protocol will be registered with the OSF in May 2024.



Data protection

Data security

IFF takes all reasonable steps to ensure the safety and confidentiality of respondents' data, and of management and administrative data. IFF is registered with the Information Commissioner's Office under registration number Z5571698. IFF is accredited to ISO27001:2013, the international standard for information security, and certified under CyberEssentials Plus. Our server is located in a secure location in the UK, and we will create a secure folder exclusively for the use of this project.

Data transfers

Any transfers of data (including but not limited to transfers between PACT and IFF, between IFF and partners, and between IFF and Foundations) will be in accordance with the Data Sharing Agreements (DSAs). A secure transfer method will be used for transfer of any personal or individual pseudonymised data, including of final data for storage in the Foundations research archive. IFF uses FileXchange, an encrypted email and file transfer platform based on AES-256 encryption, but we would be happy to use an alternative system subject to checks on its security level.

Control of data

This research study involves processing individuals' personal data, including data classed as sensitive. Personal information taken from participants will include participants' names, children's ages and parents' and children's protected characteristics, if any. We will produce privacy notices for those elements of the research involving personal data. These notices will be distributed to all research participants.

For the purpose of this project, the relevant condition(s) that we are meeting under Article 6 of the Data Protection Act 2018 in that this processing of personal information is carried out under our legitimate interests for research purposes.

Special category personal data (e.g. age, gender, ethnicity) is being processed for research and statistical purposes in accordance with the conditions of the UK Data Protection Act 2018 Schedule 1 Part 1.²⁰

In line with GDPR, personal information will be securely stored, and will only be used for the purpose for which it has been collected, before being destroyed when no longer required.

²⁰ See <https://www.legislation.gov.uk/ukpga/2018/12/schedule/1/part/1>



Interview recordings and transcripts

All recordings and interview notes made will be password encrypted, and stored only in secure locations, accessible only to the interviewing and analysis team for this project and kept for no longer than necessary for the purposes of the research. All recordings will be made only with explicit permission from respondents both on consent forms and verbally during the interview, in line with GDPR requirements.

Publication of data

No identifiable data will be published regarding project participants; names and identifiers will be removed, and any piece of information which might identify an individual (including, for example, descriptions of individual situations, locations or personal stories which might be disclosive) will be checked for and removed prior to publication. For all research participants, all personal data will be destroyed when no longer required, in line with GDPR requirements.

Future use of data

After deletion of personal or identifying data at the conclusion of the project, pseudonymised datasets can be retained on our servers for future analysis as required by Foundations. We will pseudonymise by removing all identifying data (names, contact details, any unique IDs used beyond the project), and manually scanning any text-based data held for statements which could identify an individual or household. These will also be made available in a format suitable for storage in Foundations' own data archive and transferred securely for that purpose. We will also include data protection and data security risks in our project risk register.



Personnel

Delivery team

Kathryn Warner, Head of Communities, PACT

Luke Pepperell, BB4K Manager, PACT

Panda Phelan, BB4K Service Lead, PACT

Rachael Grenz, BB4K Administrator, PACT

Giulia Savini, Database Officer, PACT

Colin Stevens, Assistant Management Accountant, PACT

Stephs Ollis, Play Therapist, Contractor to PACT

Evaluation team

Kesley Beninger, Research Director (Co-Principal Investigator). **Responsibilities:** Co-PI, contract responsibility, design and quality assurance.

Sashka Dimova, Research Director (Co-Principal Investigator). **Responsibilities:** Co-PI, lead trial protocol, impact and value for money design, analysis and reporting.

Sophie Elliott, Associate Director. **Responsibilities:** Safeguarding and ethics lead, conducting qualitative discussions with children and parents, and contributing to analysis and outputs.

Caitlin Webb, Research Manager. **Responsibilities:** Trial project manager, contributing to IPE activities, and conducting qualitative discussions with staff, contributing to analysis and outputs.

San Singh, Research Manager. **Responsibilities:** IPE Project Manager, conducting qualitative discussions with children and parents, contributing to analysis and outputs.

Sophie Johnston, Research Manager. **Responsibilities:** Questionnaire administration, Project Manager, quality assurance completion/compliance, conducting qualitative discussions and contributing to analysis and outputs.

Georgia Mealing, Senior Research Executive. **Responsibilities:** contributing to questionnaire administration, and conducting qualitative discussions with staff, contributing to analysis and outputs

Hanna Hernandez, Research Executive. **Responsibilities:** Daily project support, monitor MI/cost data, contribute to analysis and outputs.

Ella Hewavisenti, Research Executive. **Responsibilities:** Qualitative discussions, contributing to analysis and outputs.



Professor Jane Callaghan, Director of Centre for Child Wellbeing and Protection, University of Stirling. **Responsibilities:** Advisory, contributing to ToC, trial protocol and questionnaire development, analysis and review interim and final report.



Risks

The anticipated risks to the successful completion of this pilot evaluation that may arise and the steps that will be taken to mitigate against these are as follows:

Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Risks relating to low response rates/engagement			
Difficulties engaging parents and children in qualitative research	Medium/high	High – would affect our ability to report findings on time. Importance of capturing the voice of parents and young people.	Activate recruitment plans immediately upon confirming sampling approach. Provide choice for parents about how to engage (i.e. group-based discussion or one-to-one). Assign large, specialist fieldwork team to schedule interviews. Build in sufficient lead-in times for recruitment. Work closely with PACT and provide them with support they need (e.g. information about the study, etc.). Information will include a convincing rationale for participation and reassurances on confidentiality and how the information will be used. Information will take different formats (e.g. short animation, leaflet) to ensure accessibility. Offer an incentive for taking part.
Difficulties engaging/retaining parents especially in waitlist treatment	Medium/high	There's a risk of attrition especially for the waitlist treatment group due to long delay between randomisation and provision of support	This will be addressed by setting out the requirements for pilot at the outset providing parents and children with clear instructions on what needs to be done and by when. This can be further mitigated by continued communication. Attrition to be monitored and reported according to statistical guidelines.
Low response rates to outcome assessment	Medium/high	There's a risk that parents will not complete all outcome assessments	We selected outcome measures that are relatively easy and quick to fill in; we will provide sufficient data collection window will be given with real-time monitoring.



Risks relating to ethical issues, accessibility, safeguarding, and data protection			
Distress caused to parents/children through the evaluation	Medium	Medium/High – this would be ethically concerning as we aim to provide a positive interview experience and avoid harm. Key consideration for delivery of the evaluation.	Detailed safeguarding plan ensures that participants provide informed consent. Evaluation delivered in line with MRS and GSR ethical guidelines, and in line with Foundations ethical standards. The research team is trained in how to respond to distress and have experience in undertaking similar qualitative research. All staff have enhanced DBS checks and will receive specific training and support. Researchers will offer breaks or end the interview early if participants express strong emotions during the discussion. Design will be approved by the Foundations ethics committee.
Safety and wellbeing of IFF staff	Low	High – this would be ethically concerning. Key consideration for delivery of the evaluation.	Committed to safeguarding and promoting the wellbeing of our team. Wellbeing committee runs regular activities to promote, and we have a team of seven mental health first aiders. Brief interviews on how we will ensure interviewer safety and wellbeing.
Data security breach, leads to sensitive information being released/shared	Low	Very High – for this specific audience, disclosure of personal data is a particular concern due to the risk of re-victimisation. Even a perceived risk of this may lead to distress and worry for participants.	Stringent data security measures are in place and IFF holds ISO 27001:2013 and CyberEssentials Plus accreditations. All sensitive files are held on secure servers with access restricted to the core research team. Any transfer of sensitive data will be encrypted. We would minimise the data we held and encrypt files containing contact details even within our secure server, to further reduce any risk in the event of a breach.
Risks relating to quality			



Unmanageable burden on BB4K staff around evaluation	Low/Medium	High – would affect our ability to report findings on time and our ability to answer evaluation questions.	Clear strategy and ongoing communication with BB4K. Assessment of existing data to avoid duplication of data collection. Commitment to working flexibly and collaboratively with the BB4K team to minimise burden.
Outcome measures are not optimal	Low/Medium	Outcome measures do not align with the theory, are difficult to administer, or measure a change that cannot be realised within the timeline.	Our experienced team will ensure that outcome measures are fit for purpose. This includes expert assessment and consultations with PACT to allow us to select the most robust instruments.



Timeline

Dates	Activity	Staff responsible/ Leading
January to April 2024	Onboarding and set-up (including evaluation protocol, ethics and data protection)	IFF Research
April to May 2024	Cohort 1 delivery set-up, randomisation and baseline survey (2 research/treatment groups and 2 non-research/waitlist treatment groups)	IFF Research/PACT
May to July 2024	Cohort 1 group delivery (2 groups of aged 6-11s) – 8 sessions over 10 weeks	PACT
July 2024	Cohort 1 endline survey	IFF Research
June to August 2024	Implementation and process evaluation Wave 1	IFF Research
September to October 2024	Cohort 1 follow-up survey	IFF Research
January to March 2025	Cohort 1 waitlist treatment group delivery	PACT
August to September 2024	Cohort 2 delivery set-up, randomisation and baseline survey (3 research/treatment groups and 2 non-research/waitlist treatment groups)	IFF Research/PACT
August 2024	Cost evaluation data collection Wave 1	IFF Research
September to December 2024	Cohort 2 group delivery (2 groups of aged 5–11s; 1 group age 3–5)	PACT



December 2024	Cohort 2 endline survey	IFF Research
November 2024	Mid-point grant progress report	IFF Research
December 2024 to January 2025	Implementation and process evaluation Wave 2	IFF Research
January to March 2025	Interim report	IFF Research
March 2025	Cohort 2 follow-up survey	IFF Research
April 2025	Cost evaluation data collection Wave 2	IFF Research
May to September 2025	Final reporting	IFF Research