November 2025 | **Report**

A pilot randomised controlled trial

BOUNCE BACK 4 KIDS

Foundations
What Works Centre for Children & Families

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Authors

Caitlin Webb, Millie Morgan, Sophie Johnston, Lori Tyson, Sashka Dimova, Kelsey Beninger, all from IFF Research.

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About Foundations, the national What Works Centre for Children & Families

Foundations, the national What Works Centre for Children & Families, believes all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home with the foundations they need to reach their full potential.

About IFF Research

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GLOSSARY OF TERMS / ABBREVIATIONS & ACRONYMS

Abbreviation / acronym / terms	Description
Accessibility fund	The accessibility fund was a £1,200 grant provided by Foundations which PACT could use to help families access the programme who otherwise would not have been able to. For example, taxis for families who did not have a car to get to sessions.
BAC-C	The Brief Assessment Checklist for Children (BAC-C) is a measure that can be used by parents 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 four to six months. The test takes around five minutes to complete. The total raw problem score ranges between 0 and 40, with high scores indicating that more problems are present. Further details on this outcome measure can be found here: https://www.corc.uk.net/outcome-measures-guidance/directory-of-outcome-measures/brief-assessment-checklist-for-adolescents-bac-a-bac-c/
BB4K	Bounce Back 4 Kids (BB4K) is a therapeutically informed group recovery programme for children aged 3 to 11 and their non-perpetrating parents who have experienced domestic abuse.
Bounce platform	The Bounce platform is an online resource for families referred to BB4K, giving them secure access to a range of materials and activities related to the programme content they can use at home.
CIN	A Children in Need plan (CIN) is a support plan for a child who needs extra help (e.g. with health or development) but is not at immediate risk of harm.

CP	A Child Protection plan (CP) is a plan for a child who is at risk of significant harm. It outlines actions to keep the child safe and promote their welfare.
CPRS	Child Parent Relationship Scale (CPRS) is a parent self-report questionnaire that aims to assess the quality of a parent–child relationship. Further details on this outcome measure can be found here: https://www.bristol.ac.uk/media-library/sites/sps/documents/c-change/cprs.pdf
DA	Domestic abuse
Dyads	A dyad refers to a pair of individuals who are linked in some way and studied together as a unit – in this case, it refers to the parent and child.
Fidelity	The degree to which the intervention is delivered as intended.
Heart to Heart	An additional programme which can be offered to families to focus more on the parent–child attachment relationship. Practitioners attend training developed by children's charity Clear Sky to enable them to run the groups. This is a group programme for children, teens and their parents to attend together across the age ranges of 5–9 years and 10–15 years.
IPE	Implementation and process evaluation
MI	Management information
PACT	Parents and Children Together (PACT) is a charity organisation that specialises in supporting families through adoption and community projects. They developed and deliver BB4K.

Programme dosage	The amount of the intervention a participant receives, measured by factors such as the number, length, and frequency of sessions attended.
RCT	Randomised control trial (RCT) is the methodology used in the evaluation. The sample was randomised so 40 children, and their non-perpetrating parents received the intervention immediately, while 32 children-parent pairs were allocated to the waitlist and received the BB4k services at a later date.
ToC	A theory of change is a detailed framework that explains how and why a desired change is expected to occur in a specific context. It outlines the intended long-term impacts and outcomes of a programme, and how those impacts and outcomes are intended to be brought about by inputs, activities and outputs, the causal mechanism between these, including assumptions and contextual factors.
TOPSE	Tool of parental self-efficacy (TOPSE). A parental self-report measure based on the Likert scale of 0–10 points where 0 corresponds to completely disagree and 10 completely agree. The questionnaire covers 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. Further details on this outcome measure can be found here: https://www.topse.org.uk/site/wp-content/uploads/2019/01/Guide-to-using-TOPSEscoring-template.pdf
Treatment group	The treatment group refers to the participants who receive the intervention immediately. This group is compared to a control group (waitlist control group) to assess the impact or effectiveness of the intervention.
Waitlist control group	A waitlist control group is a group of participants who do not receive the intervention immediately but are scheduled to receive it after the initial evaluation period. This allows researchers to compare outcomes between those who received the treatment and those who are still waiting,

	while ensuring all participants eventually benefit from the intervention.

EXECUTIVE SUMMARY

Introduction

Domestic abuse significantly harms children, a fact recognised in section 3(2) of the Domestic Abuse Act 2021, which identifies children as victims in their own right. Around one in five children in the UK are affected, making domestic abuse the leading cause for referrals to children's social care and a key factor in 'Children in Need' assessments and child removals.[1] The long-term effects can include emotional distress, developmental challenges, substance misuse, and future experiences of abuse. Interventions that support children's recovery therefore have potential for reducing harm.

Bounce Back 4 Kids (BB4K) is a trauma and therapeutically informed group approach that simultaneously supports both children (aged 3 to 11) and their non-perpetrating parents who have experienced domestic abuse. The delivery organisation, Parents and Children Together (PACT), does this through eight weekly themed sessions (or 12 sessions for children aged 3 to 5), lasting 90 minutes and delivered in-person. The programme aimed at improving parental self-efficacy, the child's behaviour at home and parent–child closeness.

BB4K has not been evaluated before. The aim of this pilot study is to therefore rigorously examine the child and parent benefits of BB4K.

Evaluation objectives and design

IFF Research evaluated the implementation, outcomes and costs of the BB4K programme delivered by facilitators and volunteers from PACT to children and their non-perpetrating parent who have experienced domestic abuse.

Objectives

The overall aims were:

- To evaluate the effectiveness of BB4K compared with business as usual (the waitlist control group)
- To assess the process of implementing BB4K and the factors involved in successful delivery and benefits to families
- To assess the costs of BB4K.

[1] See: Office for National Statistics (2022) *Domestic abuse prevalence and trends, England and Wales.* https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2022

Design

This was a waitlist randomised control trial delivered in three local authorities in England. This means half of eligible referred families were randomised to either receive BB4K when it was next delivered, or to be put on a waitlist and to receive BB4K at a later date.

PACT trained practitioners and volunteers to deliver the programme across two cohorts. Cohort 1 included two groups (8 parents and 8 children per group) held at different sites. Cohort 1 received the intervention between May–July 2024, with waitlist participants receiving the intervention from January 2025. Cohort 2 included three groups (8 parents and 8 children per group), and began in September 2024, with waitlist participants receiving the intervention from March 2025.

The primary outcome measured was parental self-efficacy, measured using the Tool of Parental Self-Efficacy (TOPSE) questionnaire. The secondary outcomes measured were child behaviour at home, measured using the Brief Assessment Checklist for Children (BAC-C), and parent–child closeness, measured using the Child Parent Relationship Scale (CPRS). The pilot study also examined various aspects of the implementation of the intervention, including fidelity, acceptability, scalability, and the cost of delivery.

To assess impact, questionnaires were administered to eligible parents referred to BB4K, during the assessment stage, and during or immediately after the final session. Questionnaires were either administered online or through a telephone-assisted interview administered by an IFF interviewer. For the implementation process evaluation, focus groups and semi-structured interviews with referrers, delivery practitioners and managers, and parents were conducted. To capture the views of children, a focus group and session observation were conducted. Management information collected by PACT and analysed by the evaluation were used for both evaluations. Cost data for the delivery of BB4K was collected from PACT's Finance and Fundraising Teams after the delivery of each cohort, through a simple form.

Sample recruitment and selection criteria

Participants were identified and referred to the pilot study by PACT's referral partners. Parents and their child (3 to 11 years old) were eligible to participate if they had experienced domestic abuse, both spoke English, were not currently receiving support for ongoing domestic abuse and the perpetrator had left the family home.

Out of 120 eligible referrals, 75 parent–child pairs were randomly allocated to either the treatment or waitlist control group (including three families identified as needing one-to-one support). Of these 75 pairs, 31 families either did not respond to contact or declined support. A further 21 families were randomly drawn from the remaining eligible referrals to replace them. In total, 65 parent–child pairs were recruited to take part in the pilot study (35 to the treatment group and 30 to the waitlist control group).

Evaluation limitations

This trial had several important limitations that should be considered when interpreting the findings. First, the pilot study was not designed to be sufficiently powered to detect small or

moderate effects with statistical confidence, limiting the strength of the conclusions that can be drawn. Second, the evaluation lacked longer-term follow-up, meaning it was not possible to assess the sustained impact of the intervention over time. Third, the tools used to measure parenting confidence, child behaviour, and parent–child closeness were not designed for families affected by domestic abuse. It's possible that our audience may interpret concepts in the outcome measures differently than the audiences that the scales have been validated for, increasing the risk of systematic error and measurement bias.

The findings may not apply to everyone because the group of parents in the study was limited in its diversity: parents involved were exclusively women, mainly White and referred through a small number of agencies from within a single region in the South East of England. The findings are not meant to reflect or apply to the wider population, including men, individuals from different ethnic backgrounds, or those accessing services through other pathways or in other geographic areas.

Finally, external validity (whether the results apply to people, settings, or situations outside of the sample) was constrained by contextual factors related to the referral process. Not all parents were ready or willing to engage with the intervention at the point of referral, and the role of referral partners in identifying and referring participants may have influenced who ultimately took part. These factors may limit the applicability of the results to real-world service settings.

Despite these limitations, the findings still provide valuable early evidence for a promising intervention.

Key findings

No statistically significant differences in the primary or secondary outcomes were observed between treatment and waitlist control groups between baseline and endline. The sample of 46 parents who had completed both baseline and endline, although consistent with similar studies (e.g. Romano et al., 2021), was still too small to detect moderate effects. Nevertheless, the study found that families in the treatment group showed improvements in parental self-efficacy (the primary outcome measured by TOPSE) and child behaviour at home (a secondary outcome measured by BAC-C) when baseline scores were controlled.

Furthermore, while endline differences were not statistically significant, midline results did show a moderate, statistically significant improvement in parental self-efficacy, and qualitative findings consistently supported positive experiences. One possible explanation for this pattern is that BB4K had a short-term positive effect on parents' confidence, which diminished over time without further support. Another possible reason is related to the study method — the smaller number of participants at the end and the fact that some types of participants were more likely to drop out may have made it harder to see effects that were actually still there.

No changes were observed in parent–child relationship (measured by CPRS), a key secondary outcome. Evidence collected through the IPE from parents supported this, indicating a desire for more emphasis on bonding and joint parent–child activities. The programme offered only a small number of joint sessions—just one for older children and weekly for younger ones—which

may not have been enough to make a real difference in this area. This contrasts with other studies that have found that interventions with more joint sessions tend to be more effective (Anderson & Van Ee, 2018). Future improvements to BB4K should look at adding more joint parent–child sessions, while still keeping the advantages of having separate sessions.

The programme was carried out as planned, with only small changes to suit each family's needs. Most parents thought the programme was helpful, though some suggested having more sessions and more focus on building relationships. Overall, attendance was high, with 60% attending all of the sessions.

One of the most effective ways in which the programme brought about change was through the onboarding and triage process – where families are welcomed, and practitioners gather key information about their situation and assess their support needs. The home visit before the first session was particularly important: this early contact helped establish trust, significantly improving engagement, especially for children who might otherwise not have attended. Peer support emerged as another critical mechanism. Parents consistently cited group discussions as the most valuable aspect of the programme, highlighting the importance of shared experience, validation, and connection. Practitioners noted that these connections often continued informally after the programme via WhatsApp groups or social meetups.

The findings from the interviews and group discussions support what other studies have found (Anderson & Van Ee, 2018) – that peer support is a key part of trauma-informed programmes. Even though strong results were not identified via the outcome measure, the way participants described their experiences – along with what other research says – adds confidence that BB4K's core approach is working.

The BB4K evaluation contributes valuable UK-based evidence to an area with historically limited research. BB4K provides a clear, structured programme, unlike the mixed approaches seen in past reviews (Austin et al., 2017) and the evaluation shows encouraging results similar to those found in international studies. However, important limitations remain. The sample lacked diversity (78% White), raising concerns about inclusion. PACT should focus on improving the number and types of referral pathways and overcoming access barriers for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours. Future versions should focus on being more culturally and language-friendly and provide more flexible scheduling to make sure families who need it most can take part.

Recommendations and next steps

- **Strengthening evaluation design and reach**
  Future evaluations should prioritise recruiting more diverse families by partnering with public services and community organisations, and addressing access barriers like language, childcare, and scheduling.

- **Validation of outcome measures**
  Current tools like TOPSE, BAC-C, and CPRS need further validation for use specifically with families affected by domestic abuse and, for CPRS, for use in UK contexts.
- **Theory of change validation**
  Future research should examine whether BB4K content addresses gender norms implicitly and whether making this mechanism more explicit could improve outcomes.
- **Codesign and stakeholder involvement**
  Evaluations should embed codesign with parents, children, and delivery staff from the outset to ensure the programme remains relevant and user-informed.
- **Increasing the follow-up period**
  Longer-term follow-up on outcomes (e.g. 6, 12, and 18 months) is needed to capture delayed or sustained impacts that short-term evaluations may miss.
- **Capturing the child's voice**
  Future studies should explore ethical, age-appropriate methods for better capturing children's perspectives, especially for those aged 3 to 11.
- **Importance of a 6-month lead time for setup**
  A six-month setup period would support better planning, staff training, and engagement with both treatment and waitlist groups, improving overall implementation.
- **Additional resource for evaluation administration**
  Future evaluations should allocate a dedicated staff role to manage administrative tasks and communication, maintain regular contact with the waitlist group, and thereby reducing the burden on delivery partners and supporting better participant engagement.

INTRODUCTION

Background

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.[2] Evidence shows that domestic abuse is a pervasive problem in the UK: it is estimated to affect one in five 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 from the care of their parents or carers (Office for National Statistics, 2022). 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 (CAADA, 2014; Howard et al., 2010).

The evidence on which programmes improve outcomes for children in families experiencing domestic abuse is limited. Previous feasibility work by Foundations, alongside the Oxford Rapid Review (Foundations, 2023a), shows over 100 domestic abuse programmes operate across the UK. However, only a small number have undergone robust impact evaluations, making it challenging for decision-makers to plan for services that support every child and adult experiencing domestic abuse (Foundations, 2023a; Foundations, 2023b). 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.

Previous evaluations

There have been no previous evaluations of Bounce Back 4 Kids (BB4K), but evaluations of similar programmes do exist. Holt et al. (2015, pp. 8–33) evaluated groupwork interventions for women and children affected by domestic abuse, finding them to be effective but potentially exclusionary due to practical and cultural barriers. Similarly, the NSPCC evaluated the Domestic Abuse Recovering Together (DART) programme (Smith et al., 2015), a 10-week intervention designed to rebuild the mother–child relationship following domestic abuse and support wider recovery. This evaluation provides a useful comparison, offering methodological insights through its quasi-experimental design and emphasis on real-world implementation of group-based interventions.

[2] See: https://www.legislation.gov.uk/ukpga/2021/17/section/3

Evaluation rationale

While early reviews identified the need for rigorous evaluation of interventions addressing both mothers and children (Rizo et al., 2011), and recent reviews continue to find limited evidence particularly in UK contexts (Austin et al,. 2019), few programmes have undergone randomised evaluation. To address this gap, and as part of their commitment to improve the evidence base on 'what works' for children who are exposed to domestic abuse, Foundations commissioned this pilot RCT of BB4K.

The programme was selected because 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 also aimed to contribute to an evidence base on implementing and evaluating groupwork therapeutic programmes, and a better understanding of what makes it more difficult or easier for parents and children who have experienced domestic abuse to participate in these programmes.

Evaluation design, aims, and objectives

The evaluation assessed the impact of BB4K using a two-armed, randomised waitlist-controlled cohort trial[3] with 65 parent–child pairs. Participants were randomised post-consent into treatment or waitlist control groups, stratified by site and child age. Cohort 1 received the intervention between May to July 2024, with waitlist participants receiving the intervention from January 2025. Cohort 2 began in September 2024, with waitlist participants receiving the intervention from March 2025.

The primary outcome measured was parental self-efficacy, measured using the TOPSE questionnaire. The secondary outcomes measured were child behaviour at home, measured using the BAC-C, and parent–child closeness, measured using CPRS.

Ethical approval was obtained from Foundation's Research Ethics Panel in April 2024. All families living within the study's sites (Reading, West Berkshire, and Vale of the White Horse) on PACT's existing waiting list were informed of the evaluation by email and were given the option to opt out of being randomised as part of the trial. Ahead of qualitative research exercises, participants were informed of the purpose of the research and were provided with full and complete information about it, in Participant Information Sheets. These information sheets were circulated to families ahead of interviews and focus groups and consent forms were signed by parents on behalf of themselves and their children by IFF researchers immediately before.

The evaluation posed a moderate risk of distress to participants, so a robust safeguarding plan was implemented, with ethical oversight, trained staff, and flexible interview protocols.

[3] A randomised waitlist-controlled cohort trial is a type of study where families are randomly assigned to either start the programme straight away or join a 'waitlist' and receive it later. This allows researchers to compare outcomes between those who have already received the programme and those still waiting, helping to show whether changes are likely due to the programme rather than other factors.

Stringent data security measures, including encryption and restricted access, were enforced to prevent breaches and protect sensitive information.

The implementation and process evaluation (IPE) of the BB4K intervention examined whether the programme was delivered as intended, under what conditions it worked best, and how it could be improved. Using management information (MI) and qualitative research across two waves (2024–2025), the evaluation involved BB4K managers, practitioners, referrers, parents, and children.

MI analysis assessed referral patterns, programme dosage, fidelity, and family characteristics, while qualitative research explored participant experiences, perceived outcomes, and implementation lessons. Qualitative research with parents covered referral experiences, overall programme satisfaction, group session content, use of optional features (e.g. Bounce platform), and outcomes. Qualitative discussions with children in the first wave included age-appropriate methods such as emoticon boards and storytelling to understand engagement and impact. Observation of a child's group session replaced the focus group for younger cohorts due to opportunities to improve capturing the voice of these younger children identified in Wave 1.

Interviews were analysed thematically using a framework aligned with the BB4K theory of change. We compared data across sources to identify trends, subgroup differences, and areas for refinement.

MI data was collected at two timepoints to assess change over time, with descriptive analysis comparing Wave 1 and 2 results. A key protocol deviation was the shift from child focus groups to observations, which improved data quality for younger children.

INTERVENTION

BB4K is a group recovery programme for children aged 3 to 11 and their non-perpetrating parents who have experienced domestic abuse. It 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 to help families recover from the impact of domestic abuse.

The programme targets children (aged 3 to 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 support for ongoing domestic abuse. It is available to families who live in Reading, Wokingham, West Berkshire, South Oxfordshire, Oxford City, and Vale of the White Horse. Further eligibility criteria can be found in the intervention protocol (Foundations, 2024). The primary aim of BB4K is to equip children and parents with the knowledge, confidence, and tools needed to have the relationships they need to keep safe.

The intervention is delivered by PACT, an organisation that specialises in supporting families through adoption and community projects, as summarised in Table 1 below. Appendix A presents the full BB4K theory of change (ToC) and a discussion of the elements it encompasses. It was developed in collaboration with PACT and Foundations during the evaluation setup stage. More information on the intervention can be found in the intervention protocol (Foundations, 2024).

Table 1. Description of the BB4K Programme using the template for intervention description and replication (TIDieR checklist; Hoffman et al., 2014)

Item Number	Item
Name	
1	Bounce Back 4 Kids (BB4K)
Why	
2	Group recovery programmes that support both children and their non-abusive parents or carers may be effective in reducing the harm experienced by children who have experienced domestic abuse.

Item Number	Item
What	
3	BB4K is a therapeutically informed group recovery programme for children aged 3 to 11 and their non-perpetrating parents who have experienced domestic abuse. Children aged 3 to 5 receive 12 weekly sessions (up to 1.5 hours) while children aged 6 to 11 receive eight sessions. Support workers follow session plans with clear learning objectives that follow the same structure to create a safe, predictable space for children to share experiences of the hurting that has happened in their families. Support Workers use bespoke age appropriate BB4K materials and therapeutic activities (music, drama, puppets, group games, arts and crafts), with regular breaks for discussions and refreshments. Where possible, activities are kept the same between the different age groups. On occasion they may be varied to meet the needs of a particular age cohort. For younger children (3 to 5s) the programme includes a Play Therapist for the children's elements to better understand the behaviour and non-verbal communication displayed. Each parents' session takes place simultaneously to the children's session. The staff use trauma-informed activities and therapeutically informed techniques to simultaneously support parent and child to express their feelings and experiences, learn they aren't to blame, and understand the impact of trauma. Parents are given a resource pack with information materials to support their journey and have access to the Bounce platform with further resources.
Who provided	
4	Parents and Children Together (PACT) is an organisation that specialises in supporting families through adoption and community projects. To facilitate delivery of the whole BB4K programme, PACT employs two Service Leads, one Manager, eight Support Workers, one Administrator, and one Play Therapist (as a contractor). PACT also offers student placements and recruits volunteers who support by attending groups and assisting with administration, setup and preparatory work. Each session is facilitated by two to three staff members, including a Support Worker and at least one volunteer or student on placement. All Support Workers and Play Therapists receive intensive inductions observation of facilitating a full group and the following training: • EduCare – Adverse Childhood Experiences Level 2 • EduCare – Domestic Abuse: Children and Young People • West Berks Domestic Abuse Champion training

Item Number	Item
	• Training for delivering Healing Trauma (non-mandatory training) • SEN training, e.g. Autism Spectrum Disorder Course, Dyslexia Course, etc. • Keep Them Safe – Protecting children from child sexual exploitation. All full-time frontline staff receive monthly supervision sessions with the BB4K Service Lead. The BB4K Manager also conducts monthly supervision for all Service Leads as well as staff in back-office roles. Additionally, all staff are offered group clinical supervision. For part-time staff, supervision sessions are scheduled less frequently, approximately every six weeks.
How	
5	Each BB4K group supports up to eight adults and eight children and includes eight weekly themed sessions (12 shorter sessions for 3 to 5s, due to their shorter attention spans), lasting 90 minutes. Sessions are delivered in person in a community venue, and each parents' session takes place simultaneously with the children's session. BB4K for children aged 3 to 5 years old involves joint parent and child sessions in the final portion of each session. The group starts together, separates and then returns to do joint work in each session, finishing every week with parent and child dyad work. BB4K for children aged 6 to 11 involves one joint parent and child session during the final group session.
Where	
6	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 across Reading, West Berkshire, and Vale of the White Horse. The programme had previously been delivered in the first two locations, enabling swift implementation due to established buy-in from local authorities and other referral partners, the identification of suitable venues, and accessibility for existing trained staff and volunteers. For the purpose of demonstrating scalability, a third delivery location, Vale of the White Horse in Oxfordshire, was included. This area was chosen because a number of referrals had been received from operational partners in the area. There was no attrition of sites during the evaluation.
When and how much	

Item Number	Item
7	Groups are always delivered during school hours, during the school term and in the same place to ensure they are easy to plan for and predictable for all. In addition to the 8- or 12-week weekly programme, families are encouraged to put into practice what they have learned during the sessions and use the private WhatsApp group to share advice and encouragement with other service users.
Tailoring	
8	Once a family has been accepted onto the programme, a Support Worker arranges a home visit to build trust between the family and BB4K staff, encourage engagement with the programme, and help them feel secure in the sessions they will attend. Parents are able to communicate with BB4K staff via WhatsApp messages between sessions and further support can be offered for families struggling to attend the sessions (e.g. an Accessibility Fund can be used to cover transport costs to the venue). Staff are able to support all adult domestic abuse survivors, irrespective of gender. Everyone is asked directly if they would feel comfortable being in a mixed gender group and if not, they will be accommodated in a different group. In this pilot, one male parent was referred. 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.
Modifications	
9	For the purpose of demonstrating some amount of scalability, a third delivery location, Vale of the White Horse in Oxfordshire, was included. This area was chosen because of the number of referrals that had been received from operational partners in the area.
How well	

Item Number	Item
10	Practitioners' fidelity to the BB4K programme was measured by the number of assessment calls, triage meetings, home visits, groups sessions, post-session parent reflections, and end-assessments that were completed compared to the BB4K model. Adherence was monitored by the BB4K Manager who regularly attended group delivery and training, and scrutinised participant feedback, group outcomes/quarterly service reports, and waiting list demographics. They held regular supervision with the BB4K Service lead (who undertook regular supervision with all the BB4K Support Workers).

Participating sites, settings, and individuals

There were no significant changes made to PACT's business as usual approach to recruitment and referrals for the purpose of this pilot study. As outlined in the intervention protocol (Foundations, 2024), 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 accept self-referrals from parents. Referrals are submitted through a form on the PACT website which includes an in-built eligibility criteria checker. Children and their non-perpetrating parents were eligible to take part if they met 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 ages 3 and 11 years old
- Non-perpetrating parent and child speak English fluently
- Non-perpetrating parent and child not currently receiving other support for ongoing domestic abuse
- 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.[4]

The only additional eligibility criteria added for the purpose of this pilot study was that the family were available to participate in a group during the trial period and consented to them and their child participating in the evaluation. Ahead of randomisation all parents were made aware

[4] If the parent had split from the perpetrator recently, PACT will need to consider if safe engagement can be enabled. PACT also monitors during delivery if parents re-engage with perpetrators: first, at the point of referral and triage, and this is captured in their CMS, Lamp Light; and second, Support Workers document in their post-session notes.

of the evaluation and given the opportunity to opt out. Those who did not opt out went on to receive BB4K's onboarding processes.

Sites

BB4K groups were delivered in three sites: Reading, West Berkshire, and Vale of the White Horse in Oxfordshire. One group was aimed at children aged 3 to 5 years and, due to the limited number of referrals for this age group, this group was recruited across all three sites and participants were supported to be able to access the group (via the accessibility fund) which took place in Reading. Table 2 shows final family recruitment numbers in each of these three sites. As shown, recruitment did not vary much between sites with all sites achieving recruitment of around 85% of the target.

The programme had previously been delivered in the first two locations, enabling swift implementation due to established buy-in from local authorities and other referral partners, the identification of suitable venues, and accessibility for existing trained staff and volunteers. For the purpose of demonstrating a degree of scalability, a third delivery location, Vale of the White Horse in Oxfordshire, was included. This area was chosen because of the number of referrals that had been received from operational partners in the area. There was no attrition of sites during the evaluation.

Table 2. Recruitment by site and cohort

Site	Cohort 1		Cohort 2		Total	
	Target	Achieved	Target	Achieved	Target	Achieved
Reading	16	14	8	6	24	20
West Berkshire	16	12	16	15	32	27
Vale of the White Horse	N/A	N/A	8	7	8	7
All (3–5s group)	N/A	N/A	8	11	8	11
Total	**32**	**26**	**40**	**39**	**72**	**65**

Settings

BB4K was delivered in a group setting. Group sessions took place in an in-person delivery setting which was easily accessible and close to families and deemed suitable by Support Workers. Examples included schools, community centres, and PACT-owned venues (such as family therapy rooms). There was no attrition of settings during the evaluation.

As well as group settings, one-to-one support was offered for families who were not available at group times, or where there were additional support requirements that could not be facilitated in a group setting (such as behavioural challenges or learning difficulties). In Cohort 1, three families received one-to-one support and in Cohort 2, five families received one-to-one support.

Individuals

Participants were identified and referred to the pilot study by PACT's referral partners. Parents and their child (3 to 11 years old) were eligible to participate if they had experienced domestic abuse, both spoke English, were not currently receiving support for ongoing domestic abuse, and the perpetrator had left the family home.

Out of 120 eligible referrals, 75 parent–child pairs were randomly allocated to either the treatment or waitlist control group (including three families identified as needing one-to-one support). Of them, 31 families either did not respond to contact or declined support. A further 31 families were randomly drawn from the remaining eligible referrals to replace them but only 21 of these agreed to take part. Therefore, in total, 65 parent–child pairs were recruited to take part in the pilot study (35 to the treatment group and 30 to the waitlist control group).

Table 3 shows the actual number of referrals, take-ups (those that agreed to take part in the evaluation and completed baseline), and outcome data collected compared to projected expectations produced as part of the intervention protocol drafted prior to this pilot study. As shown:

- Fewer referrals to the programme than expected (120 families vs 200 families)
- Slightly fewer families who took up the programme went on to complete it than expected (92% vs 95%)
- Slightly more outcome data from families completing the intervention than expected (77% vs 75%).

For further information about how these projected figures were estimated, please see the intervention protocol (Foundations, 2024).

Table 3. Trial flow

	Projected	Actual
(1) Estimated size of the eligible population	Over 100,000 families across the Thames Valley	Over 100,000 families across the Thames Valley
→ (2) Of those, estimated number of people with protected characteristics[5]	Over 70,000 (70% of (1))	Over 70,000 (70% of (1))
(3) Estimated number of referrals	200 families (0.2% of (1))	120 families (0.12% of (1))
→ (4) Of those, estimated number of people with protected characteristics	140 families (70% of (3))	44 families (based on adults characteristics) (37% of (3))
(5) Estimated number of take-ups	79 families (79% of (3))	65 families (54% of (3))
→ (6) Of those, estimated number of people with protected characteristics	55 families (70% of (5))	20 families (based on adults characteristics) (31% of (5))
(7) Estimated number of people completing the intervention	75 families (95% of (5))	60 families[6]

[5] Actual figures were defined as anyone who is not-heterosexual, not White-English, anyone with a disability or does not have English as a primary language. Projected figures were based on ONS data which suggests that 70% of the population fall into this category. For ONS protected characteristics statistics see: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/adhocs/11398protectedcharacteristicspopulationsuk2018

[6] This is the number of families who took up the intervention, minus the number of families who dropped out after the intervention had started.

	Projected	Actual
(8) Of those, estimated number of people with protected characteristics	53 families (70% of (7))	19 families (based on adults characteristics) (32% of (7))
(9) Estimated number of people for whom we have outcome data	56 families (75% of (7))	46 families (77% of (7))
(10) Of those, estimated number of people with protected characteristics	40 families (70% of (9))	16 families (based on adults characteristics) (35% of (9))

Table 4 shows a breakdown of participation and attrition from the programme and evaluation. As shown, five families assigned to the treatment group ended up dropping out during the BB4K programme, and therefore did not continue to participate in the evaluation. In all cases this was due to either parent or child's poor mental or physical health. Overall, we saw different levels of attrition from the treatment group compared to the waitlist control group (20% vs 40%). Across treatment and waitlist control groups we saw around 30% attrition, resulting in collection of outcome data for 46 families (71% of those originally recruited to the evaluation). Please see Appendix C for a breakdown of attrition by cohort.

Table 4. Attrition

	Treatment group	Waitlist control group	Total
Recruitment target	40	32	72
Initial achieved recruitment*	35 (88% of target)	30 (94% of target)	65 (90% of target)
Attrition from the BB4K programme	5 (14% of recruited)	N/A	5 (8% of recruited)
Attrition from the evaluation	2 (6% of recruited)	12 (40% of recruited)	14 (22% of recruited)

Final number completing baseline and endline	28 (80% of recruited)	18 (60% of recruited)	46 (71% of recruited)
*Defined as those who consented to take part in the evaluation and completed the baseline survey.			

Descriptive statistics

Table 5 presents the demographic characteristics of families recruited to the evaluation (except two treatment group dyads who were excluded from the evaluation after recruitment). Parents were mostly female (98%), White (78%), heterosexual (81%), and who had English as a primary language (90%). Only 11% were identified as having a disability. The sample of children was more diverse. Just over half (57%) of children were male and most (57%) were from a Black or minoritised ethnic group. Most (90%) spoke English as their primary language and 13% were identified as having a disability.

When compared with Reading local authority census data, the sample underrepresented both ethnic and language diversity. While 46.5% of Reading's population belong to Black or minoritised ethnic group (Reading Borough Council, 2021), only 22% of our sample did. Similarly, although 81.8% of Reading residents speak English as their primary language (Office for National Statistics, 2025), 90% of the sample reported English as their primary language.

Table 5. Participant characteristics

	Treatment group	Waitlist control group	Total
Parent Gender: n (%)			
Female	31 (97%)	30 (100%)	61 (98%)
Male	1 (3%)	0 (0%)	1 (2%)
Parent ethnicity: n (%)			
White	27 (82%)	22 (73%)	49 (78%)

	Treatment group	Waitlist control group	Total
Black or minoritised ethnic group	6 (18%)	8 (27%)	14 (22%)
Parent sexual orientation: n (%)			
Heterosexual	30 (91%)	21 (70%)	51 (81%)
Bisexual	0 (0%)	1 (3%)	1 (2%)
Not stated	3 (9%)	8 (27%)	11 (17%)
Parent disability: n (%)			
Has a disability	6 (18%)	1 (3%)	7 (11%)
Does not have a disability	21 (64%)	24 (80%)	45 (71%)
Unknown	6 (18%)	5 (17%)	11 (17%)
Parent primary language: n (%)			
English	31 (94%)	26 (87%)	57 (90%)
Other	2 (6%)	4 (13%)	6 (10%)
Child gender: n (%)			
Female	14 (42%)	11 (37%)	25 (40%)
Male	18 (55%)	18 (60%)	36 (57%)

	Treatment group	Waitlist control group	Total
Prefer not to say	1 (3%)	0 (0%)	1 (2%)
Child age: n (%)			
3–5s	5 (15%)	6 (21%)	11 (18%)
6–8s	12 (35%)	14 (48%)	26 (41%)
9–11s	17 (50%)	9 (31%)	26 (41%)
Child ethnicity: n (%)			
White	14 (42%)	11 (37%)	25 (40%)
Black or minoritised ethnic group	18 (55%)	18 (60%)	36 (57%)
Unknown	1 (3%)	0 (0%)	1 (2%)
Child disability: n (%)			
Has a disability	4 (12%)	4 (13%)	8 (13%)
Does not have a disability	20 (61%)	22 (73%)	42 (67%)
Unknown	9 (27%)	3 (10%)	12 (19%)
Child primary language: n (%)			
English	32 (96%)	25 (83%)	57 (90%)

	Treatment group	Waitlist control group	Total
Other	1 (3%)	4 (13%)	5 (8%)
Social care status: n (%)			
Child Protection plan	3 (9%)	4 (13%)	7 (11%)
Child in Need plan	2 (6%)	6 (20%)	8 (13%)
None	5 (15%)	8 (27%)	13 (21%)
Not applicable	22 (67%)	11 (37%)	33 (52%)
Unknown	1 (3%)	0 (0%)	1 (2%)
Housing situation: n (%)			
Permanent	31 (94%)	21 (70%)	52 (83%)
Temporary	2 (6%)	5 (17%)	7 (11%)
Police involvement at referral: n (%)			
Police involved	5 (15%)	2 (7%)	7 (11%)
No police involvement	28 (85%)	27 (90%)	55 (87%)

Implications for the evaluation

The evaluation aimed to recruit 72 families, and 65 were randomised. There was a higher level of participant drop-out than expected (30%). As a result, the smaller final sample makes it more challenging to detect any real effects of the intervention with statistical confidence.

The final sample lacks significant representation of certain groups, including men, Black or minoritised ethnic groups, non-heterosexual relationships, those who speak English as an additional language, or those in temporary or unsupported accommodation. Therefore, it is unlikely that the sample is representative of the population of families experiencing domestic abuse, which impacts the findings generalisability. Furthermore, with such small sizes of minoritised ethnic groups, it will not be possible to draw any reliable conclusions about differences in experience or impact of the programme by different groups.

IMPACT EVALUATION

Evaluation questions

The overall objective of the Impact Evaluation was to assess the effectiveness of BB4K compared with usual support. The research questions were:

Impact evaluation Q1: 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, medium-term)

Impact evaluation Q2: 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 (BAC-C) at five months post-randomisation, compared to children who do not receive the intervention? (Secondary outcome, medium-term)

Impact evaluation Q3: 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 (CPRS) at five months post-randomisation, compared to parents and children who do not receive the intervention? (Secondary outcome, medium-term)

Impact evaluation Q4: To what extent do 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)

Evaluation method

The impact evaluation used a two-armed randomised waitlist control cohort trial to assess the effectiveness of BB4K. Three local authority sites in England participated in the trial: Reading, West Berkshire and Vale of the White Horse. Randomisation was stratified by site and child age group. The analysis followed the intention-to-treat (ITT) principle, including all randomised participants in the groups to which they were assigned, regardless of attendance, drop-out, or variations in implementation. This approach is essential for reducing bias and maintaining the validity of comparisons between groups.

Delivery took place in two staggered cohorts. Treatment group participants in Cohort 1 received BB4K between May and July 2024. The corresponding waitlist control group participants began BB4K in January 2025. Treatment group participants from Cohort 2 began receiving BB4K in September 2024, while the waitlist control group participants began BB4K in March 2025.

The primary outcome was parental self-efficacy, measured by TOPSE. Secondary outcomes included child behavioural difficulties, measured by BAC-C, and parent–child closeness,

measured by CPRS closeness subscale. Group differences at endline were assessed using a linear mixed-effects model, adjusted for baseline values, age groups, and site, and summarised using Hedges' g standardised effect sizes, with 95% confidence intervals to reflect uncertainty.

The impact evaluation was a pilot study, which means it was mainly designed to test whether a larger study would be possible in the future, not to provide final proof that the programme works or not. Because of this, the study's sample was not big enough to detect small or moderate changes in outcomes for families. So, if some results do not show a clear difference, we cannot tell at this stage whether this is because BB4K had no effect or because the study lacked the statistical power to detect an effect. Therefore, the findings should be interpreted with caution. While the results can offer useful early insights, they do not provide conclusive evidence about how effective or ineffective the programme is.

Deviations from the protocol

Subgroup analyses were planned based on child age, gender, and ethnicity. However, due to the very small number of participants in all ethnicity categories, we did not conduct subgroup analysis by ethnicity. This decision was made to preserve participant confidentiality and to avoid producing unreliable or misleading estimates based on insufficient data.

Findings

A total of 63 participants, out of 65 who consented to participate in the evaluation, provided usable outcome data at baseline (34 who received BB4K treatment, 29 in the waitlist control group). Of these, 46 provided outcome data at follow-up (28 who received BB4K treatment, 18 in the waitlist control group). The intention-to-treat primary outcome analysis is based on these 46 participants. Results are organised by evaluation questions. This means the analysis approach was based on the treatment assignment as randomised rather than the actual treatment received.

Primary outcome: Parental self-efficacy (Impact Evaluation Q1)

To address Q1, we used the Tool of Parental Self Efficacy (TOPSE).[7] This outcome examined whether participation in BB4K's group sessions improves parents' confidence and competence in their parenting role, relative to those in the waitlist control group who had not received BB4K at the time of follow-up (five months post-randomisation). A higher TOPSE score indicates greater parental self-efficacy.

[7] TOPSE is a parental self-report measure based on the Likert scale of 0–10 points where 0 corresponds to completely disagree and 10 completely agree. The questionnaire covers 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.

Descriptive data indicates that parental self-efficacy of parents receiving BB4K increased between the start of the programme and after the programme had finished; however, a lack of statistical significance compared to the waitlist control group means that we cannot conclude that this change was caused by the programme. As shown in Table 6, the waitlist control group had higher average scores at baseline (373) compared to the treatment group (354), suggesting slightly greater initial confidence in parenting among families assigned in the waitlist control group. This baseline difference is reflected in the distribution of TOPSE scores presented in Appendix B. By endline, the treatment group's mean score increased by over 30 points to 386, while the waitlist control group showed a small decrease to 369. This pattern suggests a potential positive impact of BB4K on parental self-efficacy, but variability remained high in both groups. Furthermore, while the direction of change is promising, the lack of statistical significance and small sample size means that we cannot be confident that the change is due to the intervention.

Table 6. TOPSE descriptives, 5 months post-randomisation compared to baseline, by treatment group

	Baseline: Treatment group	Baseline: Waitlist control group	Endline: Treatment group	Endline : Waitlist control group
Mean	354	373	386	369
SD	71	63.7	69.6	43.4
Minimum	144	257	147	275
Maximum	480	470	473	436
N	28	18	28	18

A mixed-effect regression model was used to assess the treatment effect of BB4K participation on the endline TOPSE score. The model controlled for baseline TOPSE score, child age group, and accounted for cluster-level variation using a random intercept. Residual variances were allowed to differ by treatment group. The estimates of the model are presented in Table 7.

Table 7. Estimates from a partially clustered mixed effects model of TOPSE score at endline (n=46)

	Coef	SE	95 % C.I.		t	df	p-value
Intercept	140.146	32.202	74.955	205.336	4.352	38	0.001
Treatment	25.167	11.023	-114.892	165.226	2.283	1	0.263
TOPSE Baseline	0.659	0.084	0.488	0.829	7.828	38	0.000
Age 6–8	-26.077	15.854	-58.172	6.017	-1.645	38	0.1083
Age 9–11	-17.003	15.876	-49.142	14.115	-1.071	38	0.291
Site: Vale of the White Horse	21.143	24.008	-283.907	326.193	0.881	1	0.540
Site: West Berkshire	3.009	11.921	-21.125	27.142	0.252	38	0.802
Random effects	**Residual variance**	**ICC**					
Treatment	434.076	0.000					
Waitlist control	1746.289	0.000					

Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval; df: degrees of freedom; ICC: intraclass correlation coefficient.

The data does not provide evidence that participation in the BB4K programme has an effect on parental self-efficacy at endline. The treatment effect estimate was 25.167 (95% CI: -114.892,

165.226), favouring the treatment group.[8] This corresponds to a moderate standardised effect size (Hedge's g = 0.613, 95% CI: 0.156, 1.071). However, the confidence intervals cross zero, and t-test of the null hypothesis of no effect (p = 0.26) indicates that there is no significant difference between the two groups at the 5% significance level. This means we cannot conclude with confidence that BB4K had a statistically significant effect on parental self-efficacy based on this data.

The intraclass correlation coefficient (ICC) is a statistic that helps us measure how much of the variation in outcomes (TOPSE scores) is explained by group-level differences that may arise due to some parents attending the same group. The ICC for this random effects model was close to zero (ICC ≈ 0), indicating that there was little influence of the particular BB4K group attended on TOPSE scores. This suggests that individual-level factors (e.g. TOPSE scores at baseline) are far more influential in explaining the outcome than the group-level treatment effect. However, it is important to note that this was a small pilot study with limited number of groups, and the ICC is unstable, and the group-level effects may be under- or overestimated.

Residual variance remained high, and the variance function indicated greater variability in the waitlist control group. This suggests that among waitlist control participants, changes in parental self-efficacy were more varied, while outcomes among treatment participants were more consistent.

Early impact analysis (midline results)

To assess impact at midline we used the same linear mixed-effects model as in the primary analysis. The only difference was the timing of outcome measurement. The midline questionnaire was completed by parents immediately after the BB4K programme ended for the treatment group, and while the waitlist control group had not yet received BB4K and were still on the waitlist.

The data suggests that immediately after finishing the BB4K programme, parents who had received the programme had greater parental self-efficacy compared to those on the waitlist. At midline, the estimated TOPSE score was 23.908 points higher in the treatment group compared to the waitlist control group (95% CI: 2.76, 45.05; p = 0.027), after adjusting for covariates. This corresponds to a standardised effect size of 0.833 (95% CI: 0.118, 1.548), indicating a moderate positive effect in favour of the treatment group. The confidence interval does not include zero, providing statistically significant evidence of a treatment effect on parental self-efficacy at midline. These findings suggest that, by the midline timepoint, parents in the BB4K intervention group had higher levels of parental self-efficacy than those in the waitlist control group.

[8] TOPSE consists of 48 items, each rated on a scale from 0 to 10, giving a maximum score of 480. A 25-point difference is roughly equivalent to an average increase of about half a point per item.

Secondary outcome: Child behaviour (Impact Evaluation Q2)

To answer Q2, we used the Brief Assessment Checklist for Children (BAC-C), a parent-report tool designed to monitor general behavioural and emotional difficulties in children. This outcome addresses whether children who were assigned to the treatment group improved behaviour, relative to those in the waitlist control group at five months post-randomisation. A higher BAC-C score indicates greater child behavioural difficulties – therefore a lower score would indicate an improvement in behaviour.

Results indicate a potential small improvement in child behaviour among families that took part in the BB4K programme; however, a lack of statistical significance and small sample size means that we can't conclude with confidence that this change was due to the intervention. As shown in Table 8, both groups showed similar BAC-C scores at baseline, with mean scores of 15.6 (treatment group receiving BB4K) and 14.9 (waitlist control group) indicating comparable levels of parent-reported concerns prior to BB4K delivery. This pattern was reflected in the score distribution of BAC-C scores (see Appendix B). By endline, the treatment group's average score had decreased by about 2 points to 13.5, while the waitlist control group's scores remained the same at approximately 14.6, suggesting a small potential improvement associated with the treatment despite high variability in both groups. As with TOPSE scores, while the direction of change is promising, the lack of statistical significance and small sample size means that we cannot be confident that the change is due to the intervention.

Table 8. BAC-C descriptives, 5 months post-randomisation compared to baseline, by treatment group

	Baseline: Treatment group	Baseline: Waitlist control group	Endline: Treatment group	Endline: Waitlist control group
Mean	15.6	14.9	13.5	14.6
SD	7.03	8.55	7.16	8.82
Minimum	2	1	1	2
Maximum	30	34	29	33
N	28	18	28	18

To estimate the treatment effect of BB4K on child behaviour at five months post-randomisation, we used a linear mixed effect regression consistent with the model used for the primary outcome analysis. The estimates of the model are presented in Table 9.

Table 9. Estimates from a partially clustered mixed effects model of BAC-C score at endline (n=46)

	Coef	SE	95 % C.I.		t	df	p- value
Intercept	-0.828	2.247	-5.377	3.72	-0.368	38	0.715
Treatment	-1.902	1.603	-22.264	18.461	-1.187	1	0.446
BAC-C Baseline	0.823	0.090	0.640	1.006	9.121	38	0.000
Age 6–8	2.824	2.065	-1.357	7.006	1.367	38	0.180
Age 9–11	3.109	2.063	-1.067	7.284	1.507	38	0.140
Site: Vale of the White Horse	0.769	2.981	-37.106	38.643	0.257	1	0.839
Site: West Berkshire	1.770	1.653	-1.577	5.117	1.070	38	0.291
Random effects	**Residual variance**	**ICC**					
Treatment	14.238	0.030					
Waitlist control	23.368	0.019					

Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval; df: degrees of freedom; ICC: intraclass correlation coefficient.

Results indicate that there was no meaningful or statistically significant difference in parent-reported child behaviour at endline, between families who had received the programme and those on the waitlist. The treatment effect estimate was -1.902 (95% CI: -22.264, 18.461) indicating that after adjusting for baseline BAC-C scores, age group, and delivery site location, children in the treatment group had slightly lower BAC-C scores at endline compared to those in the waitlist control group as reported by their parents.[9] The difference between the treatment and waitlist control group was not statistically significant (p = 0.45), indicating that it cannot be concluded with confidence that BB4K improved child behavioural outcomes. The difference corresponds to a standardised effect size of -0.389 (95% CI: -1.031, 0.253) indicating that there was no meaningful difference in BAC-C scores between the treatment and waitlist control group.

The ICC for the random effects model is relatively small, with ICC estimates ranging from 0.019 to 0.030, depending on the group-specific residual variance. This implies that only 2–3% of the variance in endline BAC-C scores can be attributed to differences between groups (i.e. group-level effects), while the majority of the variance is explained by individual-level factors.

Early impact analysis (midline results)

Immediately after finishing the BB4K programme, child behaviour was moderately better among children who had received the intervention, compared to those on the waitlist; however, these results did not reach the level of statistical significance with the pilot sample size, and therefore we cannot conclude that the intervention has an impact on child behavioural outcomes at this timepoint. At midline, the estimated BAC-C score was 1.598 points lower in the treatment group compared to the waitlist control group (95% CI: −4.27, 1.07; p = 0.235), after adjusting for baseline scores, age groups, and site location. This corresponds to a standardised effect size of −0.612 (95% CI: -1.608, 0.384), suggesting a moderate but statistically non-significant effect in favour of the treatment group. The confidence interval includes zero, indicating no reliable evidence of an early treatment effect on child behavioural outcomes.

Secondary outcome: Parent–child relationship and bonding (Impact Evaluation Q3)

To answer Q3, we used the closeness scale from the Child-Parent Relationship Scale (CPRS), a parent self-report measure of perceived closeness in the parent–child relationship. A higher CPRS average indicates a closer bond between child and parent.

Both parents who had received the BB4K programme and those on the waitlist reported high levels of parent closeness, at both baseline and endline, with a slight improvement between timepoints. At baseline, both treatment and waitlist control groups reported equally high closeness scores (mean = 4.2). The distribution of baseline scores is shown in Appendix B. By

[9] BAC-C consists of 20 items, each rated on a scale from 0 to 2, giving a maximum score of 40. A 2-point difference is roughly equivalent to an average decrease of about 0.1 points per item.

endline, both groups showed slight increases. The average score for the treatment group was 4.4, and for the waitlist control was 4.3, suggesting high levels of closeness (see Table 10).

Table 9. CPR closeness scale descriptives, 5 months post-randomisation compared to baseline, by treatment group

	Baseline: Treatment group	Baseline: Waitlist control group	Endline: Treatment group	Endline: Waitlist control group
Mean	4.29	4.19	4.36	4.31
SD	0.363	0.573	0.424	0.289
Minimum	3.5	2.7	3.3	3.8
Maximum	4.9	4.8	5	4.9
N	28	18	28	18

To estimate the treatment effect, we used a linear mixed-effects model, consistent with the analysis.

Table 10. Estimates from a partially clustered mixed effects model of CPRS closeness score at endline (n=46)

	Coef	SE	95 % C.I.		t	df	p-value
Intercept	3.172	0.475	2.209	4.135	6.671	38	0.000
Treatment	-0.002	0.114	-1.454	1.449	-0.017	1	0.989
CPRS Baseline	0.286	0.117	0.049	0.522	2.443	38	0.019
Age 6–8	-0.081	0.177	-0.438	0.277	-0.458	38	0.649

	Coef	SE	95 % C.I.		t	df	p-value
Age 9–11	-0.093	0.173	-0.444	0.257	-0.538	38	0.594
Site: Vale of the White Horse	0.164	0.237	-2.848	3.175	0.690	1	0.616
Site: West Berkshire	0.036	0.127	-0.221	0.292	0.282	38	0.780
Random effects	**Residual variance**	**ICC**					
Treatment	0.090	0.000					
Waitlist control	0.164	0.000					
Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval; df: degrees of freedom; ICC: intraclass correlation coefficient.							

The data does not indicate any meaningful or statistically significant impact of attending BB4K on perceived child–parent closeness. The estimated treatment effect at endline was –0.002 points (95% CI: –1.454, 1.499; p = 0.989), indicating no meaningful difference in CPRS closeness scores between the treatment and waitlist control group at five months post-randomisation. This corresponds to a standardised effect size of –0.005 (95% CI: –0.551, 0.542). The wide confidence interval and lack of statistical significance suggest that the observed estimate does not provide reliable evidence of a true effect of BB4K.

The residual variance was lower in the treatment group than in the waitlist group, suggesting that scores were more consistent within the treatment group. The ICCs were close to zero for both groups, indicating that very little of the variance was attributable to group-level factors; most of the variability occurred at the individual level.

Early impact analysis (midline results)

Immediately after finishing the BB4K programme, the child–parent relationship was moderately stronger among families who had received the intervention, compared to those on the waitlist; however, these results did not reach the level of statistical significance with the pilot

sample size, and therefore we cannot conclude that the intervention has an impact on child–parent relationship at this timepoint. At midline, the estimated CPRS closeness scale was 0.140 points higher in the treatment group compared to the waitlist control group (95% CI: -0.05, 0.33; p = 0.15), adjusting for baseline closeness scores and covariates. This corresponds to a standardised effect size of 0.459 (95% CI: -0.153, 1.071), indicating a small to moderate but statistically non-significant improvement in parent–child closeness following the BB4K intervention. The confidence interval includes zero, suggesting no conclusive evidence of early treatment impact on this outcome.

Subgroup analysis (Impact Evaluation Q4)

A subgroup analysis was conducted to explore whether the effect of BB4K on parental self-efficacy (TOPSE) varied by child's age group or child's gender. The analysis followed the same mixed-effects model as the primary outcome, including an interaction term between treatment group and child age or gender. The subgroup analysis was exploratory only and would not report statistical significance levels for the results. It was undertaken for the primary outcome measure only.

Due to very small numbers, we did not investigate the effect of ethnicity, and no conclusions should be drawn about subgroup differences by gender or age due to the small sample sizes.

Age groups

This subgroup analysis examined whether the effect of BB4K on parental self-efficacy varied by child age, comparing parent of children aged 6 to 8 (treatment group n=10, waitlist group n=9), and 9 to 11 (treatment group n=13, waitlist group n=6) years to those with children aged 3 to 5 (reference group; treatment group n=5, waitlist group n=3). Results are shown in Table 12.

Overall, the findings suggest that the effect of BB4K on parental self-efficacy did not differ by child age group. Among the 6 to 8 age-group, a relatively larger estimated effect of BB4K was observed, but this result was not statistically significant, and therefore we cannot draw conclusions based on the current pilot; however, these findings may warrant further investigation in future research with larger samples.

Compared to the reference group (children aged 3 to 5), the interaction term for the 6 to 8 age group was 38.661 (SE = 30.795; 95% CI:–23.793, 101.116). The corresponding effect size was moderate to large (0.89, 95% CI: –0.501, 2.287). While the point estimate suggests a potentially meaningful difference (higher parental self-efficacy in the 6 to 8 age group compared to those aged 3 to 5), the wide confidence interval that crosses zero indicates no statistically significant difference in effect compared to the 3 to 5 group.

For the 9 to 11 age group, the interaction coefficient was 11.15 (SE = 33.23; 95% CI: –56.230, 78.538). The corresponding effect size was small and also not significant, as the confidence intervals include 0 (0.26, 95% CI: –1.246, 1.762).

Table 11. Subgroup analysis: Child age group (n=46)

	Coef	SE	95 % C.I.		df
Intercept	137.659	32.889	70.957	204.360	36
Treatment	4.232	24.031	-301.111	309.574	1
TOPSE Baseline	0.690	0.087	0.513	0.866	36
Age 6–8	-45.697	22.622	-91.576	0.181	36
Age 9–11	-26.252	20.059	-66.934	14.430	36
Treatment x Age 6–8	38.661	101.116	-23.793	101.116	36
Treatment x Age 9–11	11.154	78.538	-56.230	78.538	36
Site: Vale of the White Horse	22.431	343.588	-298.727	343.588	1
Site: West Berkshire	13.239	49.175	-22.698	49.175	36
Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval; df: degrees of freedom.					

Child's gender

This subgroup analysis explored whether the treatment effect on parental self-efficacy differed by child's gender. Specifically, we tested for an interaction between treatment assignment and whether the child was a girl (treatment group n=13, waitlist group n=4). The group of families where the child was a boy (treatment group n=14, waitlist group n=14) was a reference group. Results are shown in Table 13.

The findings suggest that child gender did not meaningfully moderate the impact of BB4K on parental self-efficacy scores at five months post-randomisation. Compared to the reference group (boys), the interaction term for Treatment × Girls was –14.365 (SE = 30.250; 95% CI: –

75.716, 46.986), indicating that parents of girls in the treatment group had lower endline parenting self-efficacy scores compared to parents of boys. However, there's no strong evidence that this effect was different for boys and girls as the confidence intervals are wide. Similar, the corresponding standardised effect size was negative but not significant (Hedges' g = –0.288; 95% CI: –1.475, 0.9), with a wide confidence interval reflecting high uncertainty around the estimate.

Table 12. Subgroup analysis: Child's gender (n=46)

	Coef	SE	95 % C.I.		df
Intercept	138.773	30.226	77.472	200.074	36
Treatment	34.818	10.239	14.053	55.582	2
TOPSE Baseline	0.622	0.074	0.472	0.770	36
Treatment x Girls	-14.365	30.250	-75.716	46.986	36
Site: Vale of the White Horse	15.765	21.335	-27.504	59.035	36
Site: West Berkshire	-1.639	9.954	-21.827	18.549	36
Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval; df: degrees of freedom.					

Missing analysis (Impact Evaluation Q1)

To examine whether missing endline data on TOPSE were systematically related to participant characteristics, a logistic regression model was fitted predicting missingness at follow-up TOPSE scores as a function of treatment group, age groups, and site location.

As shown by Table 14, the model revealed a significant association between treatment group and missingness. Participants in the treatment group were significantly less likely to have missing endline TOPSE data compared to those in the waitlist control group. The associated odd ratio of 0.212 (95% CI:0.04, 0.81, p = 0.034) suggests substantially lower odds of missing data in the treatment in comparison to the waitlist control group. There were no statistically significant

differences in missingness across age groups or site locations. However, participants from the Vale of the White Horse site showed a weak, non-significant trend toward increased missingness relative to participants in the Reading site.

These findings suggest that missing data may not be missing at random but are related to treatment assignment, with participants in the waitlist control group more likely to have missing endline TOPSE data. This differential missingness could introduce bias in the estimated treatment effects. Specifically, if participants who dropped out from the waitlist control group had systematically different TOPSE scores than those who remained, the comparison between groups might be skewed. For example, if those with poorer TOPSE outcomes were more likely to drop out, the observed group differences could underestimate the true treatment effect. Conversely, if participants with better outcomes dropped out, the treatment effect might be overestimated. Therefore, results should be interpreted with caution, acknowledging this limitation.

Table 13. Logistic regression model assessing predictors of missing TOPSE scores at endline

	Coef	St. Error	Odd ratio	95% CI		z-value	p-value
Intercept	-0415	0.739	0.660	0.134	2.721	-0.562	0.574
Treatment	-1.550	0.730	0.212	0.043	0.808	-2.125	0.034
Age 6–8	0.048	0.946	1.050	0.160	7.207	0.051	0.959
Age 9–11	0.081	0.939	1.084	0.175	7.492	0.086	0.931
Site: Vale of the White Horse	1.606	1.079	4.983	0.598	45.469	1.489	0.137
Site: West Berkshire	-0.340	0.745	0.712	0.160	3.147	-0.457	0.648
Notes: Coef: regression coefficient; SE: standard error; CI: confidence interval.							

Discussion

The pilot study aimed to test whether BB4K might help parents feel more confident in their parenting and improve children's behaviour and strengthen parent–child bond. While the results suggest some promising trends, they should be interpreted with caution, as the study involved a small number of families.

The results suggest that BB4K may boost parents' self-efficacy in their parenting especially immediately after completing the programme. This improvement was statistically significant at midline, indicating a potential short-term effect. However, five months after the programme this improvement was no longer statistically significant, though the scores were still higher than at the start. This may reflect diminished benefits over time, or could be due to the small size of the study or the higher rate of missing data in the waitlist control group, which limits our ability to detect differences.

Parents in the BB4K group reported slightly fewer behaviour problems in their children by the end of the study. While this trend is positive, the change was not statistically significant, and we cannot say with confidence that it was caused by the programme. A similar trend was observed at midline. This consistency across timepoints may reflect stability in parent-reported child behaviour, or it may suggest that any true impact of the programme on behaviour requires a longer period to emerge or may not be well captured by the BAC-C measure. Again, the small sample size may have made it hard to detect a real impact.

The treatment and waitlist control group reported high levels of closeness with their children from the beginning. At midline, there was a small, non-significant improvement in closeness in the treatment group compared to the waitlist group. In contrast, the endline estimate showed that there was no difference in closeness between the treatment and waitlist control group. The lack of statistically significant change may be because many parents already reported strong bonds with their children, meaning that the outcome measure may not have been sufficiently sensitive to detect changes, or because the sample size was too small to pick up on more subtle improvements.

When comparing results by child age or gender, no clear differences were found. However, the study was too small to draw conclusions – the largest two subgroups were only made up of n=14 each (waitlist group boys, and treatment group boys). There was some indication that parents of children aged between 6 and 8 may have benefited more in comparison to parent of children aged between 3 and 5, but larger studies are needed to explore this further.

Limitations

There are several limitations of the impact evaluation which must be considered when interpreting results.

Small number of families: This is a pilot study including a small number of families. As a result, the study was not large enough to detect real changes caused by the programme. A study with a larger sample of families is needed to confirm these findings.

Missing data: Analysis of missing responses revealed that endline outcome measures were more likely to be missing from parents on the waitlist control group. While we cannot determine whether those with missing data would have had better or worse outcomes than those who responded, this could affect the reliability of the results.

Suitability of the outcome measures: The tools used to measure parenting confidence, child behaviour, and parent–child closeness were not designed for families affected by domestic abuse. Some of the concepts may not fully match the experiences of these families, which could affect how accurate or meaningful the results are. It is also important to note that the CPRS also originates from the US and has not been validated for UK families. It's possible that our audience may interpret concepts in the outcome measures differently than the audiences that the scales have been validated for, increasing the risk of systematic error and measurement bias.

Ceiling effect of the closeness score: Many parents reported very high levels of closeness with their children at the start of the programme, measured using the CPRS questionnaire, which left little room to show improvement after the programme. This could mean that the CPRS questionnaire used may not be sensitive enough to detect small but important changes in the parent–child relationship. This could be influenced by the fact that the tool is not validated for use in UK families who have experienced domestic abuse. Furthermore, the scale is self-reported, so parents could have inflated their answers for social desirability.

Subgroup analysis by ethnicity: Finally, due to lack of diversity in the pilot sample, we could not conduct subgroup analysis by ethnicity. This also means that we cannot conclude that results are generalisable to the wider population, as the pilot study has not been conducted with a representative sample of families from ethnic minority backgrounds. Future studies should aim to recruit diverse families, to maximise likelihood of results being representative and generalisable to diverse populations.

IMPLEMENTATION AND PROCESS EVALUATION

Evaluation questions

The implementation and process evaluation (IPE) aimed to assess the process of implementing BB4K and the factors involved in successful delivery and benefits to families. The research questions were:

IPE Evaluation Q1: Does the intervention work as intended?

- **1a.** What is the proportion of families that attend all scheduled group sessions, and how does attendance vary by family characteristics?
- **1b.** 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)

IPE Evaluation Q2: Does the intervention work differently in certain conditions?

- **2a.** Do perceived outcomes (and experiences) vary by the three sites, and if so, reasons?
- **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?

IPE Evaluation Q3: To what extent was the intervention implemented as intended?

- **3a. Fidelity:** To what extent was BB4K delivered as intended?
- **3b. Feasibility:** What were the barriers and enablers to implementing BB4K, and how were barriers addressed?
- **3c. Dosage:** How much 1) group work, 2) support work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?
- **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)
- **3e. Adaptations:** What adaptations have been made to make BB4K more acceptable to families and referring organisations?

IPE Evaluation Q4: Can the intervention be improved?

- **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?

Evaluation method

To answer the above evaluation questions, the evaluation used qualitative research with BB4K managers, practitioners, referrers, parents and children, and management information (MI). The use of diverse methods, such as focus groups, depth interviews, and management information (MI) analysis, allowed for triangulation of data. The strategy also incorporated innovative and sensitive techniques, such as activity-based methods for children and projection techniques for parents, to gather meaningful insights while mitigating risks of retraumatisation.

We took a phased approach to fieldwork, with two waves of data collection aligning with the two cohorts design of the impact evaluation to capture insights at different stages of delivery. By aligning data collection with the intervention's theory of change (ToC) and focusing on key implementation dimensions (e.g. adoption, fidelity, feasibility), the design ensured that findings were directly relevant to understanding and improving BB4K's delivery and outcomes. More information on the evaluation method can be found in Appendix D.

Qualitative research with PACT staff

IFF researchers conducted online group discussions with BB4K senior staff and practitioners to gather insights into their programme implementation and delivery experiences. In Waves 1 and 2, we engaged with four senior staff members for approximately 75 minutes each session. Discussions centred on their implementation approach, perceived outcomes, delivery reflections, and lessons learned for future scaling up.

Additionally, we held online group discussions with BB4K practitioners, involving five participants in Wave 1 and three in Wave 2, each lasting around 90 minutes. Key themes discussed included awareness and understanding of BB4K, successes and challenges, reflections on the referral and triage process, delivery, perceived outcomes, and suggestions for improvement.

Qualitative research with parents

We conducted face-to-face focus groups with parents in the treatment group, each session lasting about an hour. These groups included five parents in Wave 1 and four parents in Wave 2. Discussions explored their overall experience with BB4K, referral experiences, group setup experiences, use of optional features like the Bounce platform, and perceived outcomes.

We also carried out online interviews with four parents in the waitlist control group: two in each wave, lasting up to 45 minutes. These interviews focused on their referral experiences, engagement with support services, and suggestions for improvement.

Qualitative research with children

Fieldwork with children in the treatment group aimed to explore their experiences of being involved with BB4K and assessed any impacts on children. In Wave 1, we conducted a focus group with five children (aged 6 to 11 years) lasting one hour, although we found these concepts were difficult for the children to articulate and therefore, we adapted our approach for Wave 2 to consist of an observation of the final BB4K session of four children (aged 3 to 5 years).

Qualitative research with referrers

In Wave 2, we completed online interviews with three referrers from a variety of backgrounds (e.g. schools, family charity, and family support worker), each interview lasting up to 45 minutes. Discussions included the context of their role and organisation, their experience of the referral process and engaging with BB4K and lessons learned.

Analysis

During interviews, researchers used active listening to develop relevant follow-up questions and understand the implications for IPE questions. With consent, interviews were recorded, synthesised data and analysed by triangulating feedback, including non-verbal cues. We took a deductive approach by thematically analysing the synthesised data using a custom Excel framework based on the theory of change and research objectives. Inductive codes were created during analysis where unexpected themes arose. Interviews were summarised with verbatim quotes and reflections, allowing for comparison of experiences and exploration of subgroup differences by cohort, site, and child's age. Further analysis involved three stages:

1. Description: identifying response variations and unexpected patterns
2. Mapping linkage: exploring data connections
3. Explanation: identifying reasons for data through participant accounts and inferred logic.

Management information (MI) analysis

We analysed information relating to the implementation and delivery of the programme from the management information (MI) collected by PACT at two timepoints: early and late intervention delivery. This helped to provide quantitative evidence on the adoption, fidelity and integration of the intervention and provide the contextual basis for the qualitative research. More information on the data analysed and the research question it relates to can be found in the evaluation protocol (Foundations, 2024).

We conducted initial checks of the data received from PACT against our analysis plan and followed up with PACT to fill data gaps and clarify any discrepancies. Once we were confident that we had the correct data, a data services team processed the data and created an SPPS file and tables for descriptive analysis. The process was repeated at Wave 2 and tables were created that show change between Waves 1 and 2.

Triangulation

We took a systematic approach to the analysis of all strands of data collection to generate insight that covers both the breadth of all participating families and the depth of experiences and impacts for different types of families. To incorporate the information from all strands of data collection we designed an analysis framework that was set up to allow us to identify differences across parents and children and stakeholder groups. We conducted internal analysis workshops to triangulate the evidence gathered into a coherent set of findings, explore possible convergence and divergence of trends and themes and anticipate their plausible outcomes and draft recommendations for the programme.

Deviations from the protocol

The main change to the protocol was replacing the children's focus group with an observation of their final BB4K session. This shift helped us better understand the children's experiences. In Wave 1, the older children found the focus group challenging due to the time gap, session fatigue, and disruptions. Observing the final BB4K session during Wave 2 instead allowed researchers to gather meaningful data by directly witnessing group interactions. We observed the setting environment, session delivery and accessibility of the group, including any planned or unplanned adaptations made. This helped us to understand whether the group was delivered as intended, observe factors influencing child engagement, and capture mechanisms for change within the group.

Findings

1: Does the intervention work as intended?

What did we expect?

The BB4K ToC suggests the referral and triage process is essential to ensure parents and children have access to the appropriate support needed to access and maintain engagement in BB4K. The training enables staff to successfully provide support and deliver the weekly sessions. The group element of the sessions is considered an important mechanism for achieving outcomes because it provides adults and children with a supportive group environment where they can experience connection with other families with similar experiences. This is believed to help reduce loneliness for both the parent and child, and in turn can increase the parent's agency and self-efficacy.

Together, the BB4K group session content, facilitated group discussion and reflection exercises aim 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 and long-term outcomes to be realised.

What did we find?

1a. What is the proportion of families that attend all scheduled group sessions, and how does attendance vary by family characteristics?

Attendance was recorded by BB4K practitioners at each group session. As shown in Table 15, over half (60%) of families attended all scheduled group sessions. Discussions with practitioners and parents highlighted that there were some instances where families had to miss sessions on an ad hoc basis (such as sickness or issues with childcare in the case of multi-child families) but in those instances practitioners offered one-to-one sessions with the families to make up for any missed sessions. We did not collect information about whether these sessions happened. Parents with younger children who are not yet in school, and parents who work during the day also faced challenges with consistent attendance. PACT intended to offer childcare during sessions but practitioners struggled to find resource for the sessions. Nurseries and childcare providers were unable to offer limited half-day sessions and the range in ages for other siblings was too wide.

> "We planned to [offer childcare initially]. We budgeted for it and then we couldn't find anyone in the entire South Oxfordshire that would provide childcare. And initially, when they said they would, we then contacted them and they said, 'oh no actually I don't think that we can'." –Manager

Other, less common, reasons for families missing a session were due to scheduling conflicts, for their child's sport day or a school play.

Table 14. Attendance and drop-out rates by group

	Cohort 1: West Berkshire	Cohort 1: Reading	Cohort 2: West Berkshire	Cohort 2: Vale of the White Horse	Cohort 2: 3–5s	All groups
Allocated to BB4K programme: N(%)	8 (100%)	8 (100%)	7 (100%)	7 (100%)	5 (100%)	35 (100%)
Withdrew from BB4K programme: N(%)	2 (25%)	0 (0%)	1 (14%)	2 (28.5%)	0 (0%)	5 (14%)

	Cohort 1: West Berkshire	Cohort 1: Reading	Cohort 2: West Berkshire	Cohort 2: Vale of the White Horse	Cohort 2: 3–5s	All groups
Received one-to-one support: N(%)	1 (12.5%)	2 (25%)	0 (0%)	2 (28.5%)	0 (0%)	5 (14%)
No. group sessions attended per participant: Mean (range)	5.71 out of 8 (1–8)	6.88 out of 8 (2–8)	6.71 out of 8 (0–8)	7 out of 8 (3–8)	11.8 out of 12 (11–12)	6.59* (0–8)
Attended all scheduled group sessions: N(%)	3 (37.5%)	4 (50%)	5 (71%)	5 (71%)	4 (80%)	21 (60%)
*Excludes children aged 3 to 5, for whom the programme consists of 12 sessions as opposed to eight.						

According to MI data, a common characteristic of families with lower attendance was the parent or child having a disability or a physical or mental health condition. In some cases, this made it hard for families to attend, leading to one-on-one support instead of group sessions, or families leaving the programme to focus on their health. In interviews, practitioners also expressed that some parents and children struggled to attend sessions if they were neurodivergent or had multiple needs, such as ADHD and autism, making it difficult to cope with group settings.

There was no evidence to suggest that attendance varies by parent or child gender, parent sexual orientation, ethnicity, primary language, the Child Protection plan/Children in Need plan (CP/CIN), housing situation, or referral source. However, the proportion of minoritised parents or children taking part in the programme was very small (see Table 15). Therefore, any differences in attendance for these groups would not have been detected.

Since the proportion of parents who dropped out of the programme or who received one-to-one support was so small, it was also not possible to determine whether drop-out trends and received one-to-one support varied by family characteristics (beyond disability requirements mentioned above).

1b. To what extent is the BB4K theory of change validated?

The ToC detailed three key outcomes of BB4K: increased parental self-efficacy, reduced child behavioural issues, and improved parent–child relationship. As well as measuring these in the impact evaluation, there was qualitative evidence of each of these outcomes and the causal pathways between them.

Parental self-efficacy

The impact evaluation found that families in the treatment group showed improvements in parental self-efficacy (as measured by TOPSE) when baseline scores were controlled.[10] This was supported by the data collected via interviews with both practitioners and parents. According to practitioners, as the programme progressed, parents were more able to reflect on difficult situations that they had dealt with positively compared to when they first started the sessions and had increased confidence in doing so. Parents also reflected that the programme helped to build their self-esteem and their confidence.

> "It helped me build confidence in myself … every week, coming here trying to express myself, has helped me." –Parent

For parents in Cohort 2, we added a question to the outcome measurement survey at midline and endline, asking them to reflect on whether their confidence had increased over the past few months: 100% of parents receiving the intervention said they felt their confidence had increased since starting BB4K, while only 36% of parents on the waitlist said they felt their confidence had increased (based on 30 responses to the midline survey). This was mostly sustained after the programme had ended, with 87% of parents who had completed BB4K saying they felt more confident at endline, compared to 40% of parents on the waitlist (based on 25 responses to the endline survey).[11]

The ToC assumed the causal pathway to increased self-efficacy was through the group session theme of 'accepting they are not to blame for abuse'. However, there was little evidence to indicate that this theme in particular had led to increased self-efficacy. Instead, parents attributed their increased confidence to the supportive closed group environment of the sessions. The mechanism of experiencing connection with other families with experience of domestic abuse meant they were able to reflect with others on shared experiences and build their confidence in how to deal with their emotions in the future.

> "They seemed to really value a place to look back, reflect on how far they've come … the thing that was reflected the most was how important it was to be in a group

[10] While endline differences were not statistically significant due to small base sizes, midline results did show a moderate, statistically significant improvement in parental self-efficacy.

[11] Please note that the question about self-reported confidence was only added to the survey for Cohort 2, hence why base sizes are lower.

setting and to see that they weren't on their own and they learned from each other, and they supported each other." –Practitioner

Child behavioural issues

The impact evaluation found that families in the treatment group showed improvements in child behaviour at home (as measured by BAC-C).[12] The ToC assumed this outcome would be achieved through the session theme of 'understanding emotions and how to manage them' which would help both the child and parent be better able to emotionally regulate, thus in turn improving child behaviour. This was validated through the IPE with practitioners telling us they noticed children becoming better able to communicate their emotions which led to children finding it easier to interact with others and show understanding and empathy. In the focus group with children, children also said they were better able to talk about 'big feelings'.

In interviews, some parents expressed that their children were much calmer, emotionally regulated, and able to express their feelings as a result of attending the programme. Some also mentioned they felt their children had more respect for them as parents and were better able to understand their boundaries.

"Now she can say how she is feeling, she doesn't need to shout to make me understand. I think it's positive for her." –Parent

Practitioners attributed this outcome to the inclusive and positive environment that they created for children.

"It's the total acceptance of the child where they are when they arrive, and that we don't judge the children. We don't use language that's negative, it's always positive. So, with their increase in self-esteem and the relationship building, you notice the behaviours, you notice the language change, you notice how they work with each other in the groups." –Play Therapist

There was one parent, however, who felt their child's behaviour had not improved and had, in fact, worsened slightly since dealing with the complex feelings the programme had brought up for them. Previous studies have shown that it can be common for mental wellbeing and behaviour to decline at first when DA survivors engage in support programmes before improving (Callaghan et al., 2018). Due to the timescales of this pilot study, it is not possible to tell whether in this case, child behaviour improved in the long term, or whether the child's behaviour remained poorer after the programme. This highlights the need for future studies that monitor longer-term outcomes.

Improved parent–child relationships

While the impact evaluation found no evidence that BB4K affected parent–child relationships, the IPE did find some evidence to validate the ToC for this outcome. Some parents told us they

[12] These findings are not statistically significant due to the small base sizes.

had an improved bond with their child since taking part in BB4K. Practitioners told us that they had observed improvements in relationships through the way children began to greet their parents at the end of each session as the group went on. Furthermore, during the focus group with parents, some said they had observed relationships between other parents and their children improving.

> "Seeing [another parent] and [her child] together now, it makes my heart melt." –Parent

The ToC assumed this outcome would be reached through better emotional regulation and communication of boundaries. One parent validated this and attributed the outcome to the programme allowing them to recognise and process what they had been through, which helped them understand their own reactions and better emotionally regulate while parenting.

> "Once you know about something you can start dealing with it in your mind, 'cause you can make sense of it. It's not just the group, it's like when you go away and you can process it, it calms you down … it helps you to be a better parent." – Parent

However, practitioners attributed improvements in relationships to the learning parents did around how DA can affect children's ability to emotionally regulate. They told us that parents seemed better able to reflect on why their children were displaying difficult behaviours which helped them meet their needs and build stronger bonds.

> "It just helps them to think 'he's really angry today, what is he actually feeling underneath', and get them to think more about it and reflect lots on his behaviour and try and understand where he's coming from so that she could build that connection with him." –Practitioner

Despite these positive findings, parents told us they would have liked the programme to have focused more directly on improving the parent–child relationship.

Other outcomes

There was also evidence that the programme reduced loneliness and isolation, improved ability to emotionally regulate, and identify healthy and unhealthy behaviour in others. Key mechanisms for these outcomes were the group format of the sessions, the 'no judgement' environment and the trust and bond they built with other parents and the practitioners.

> "I think sometimes you feel like you're alone with things. Like, 'why can't I move on' and then someone comes up and puts [the same things I'm thinking] on the board and you understand it's normal to feel like that and it's really nice." – Parent

There was no evidence collected to suggest that BB4K impacted school engagement, behaviour, or attendance.

2: Does the intervention work differently in certain conditions?

What did we expect?

The only planned adaptation to the programme for the purposes of this pilot study was the inclusion of a new site, Vale of the White Horse. The site is nearby existing locations and they already had existing relationships with referral partners. PACT staff were responsible for delivering the programme in this new site which is well established with clear documentation, session plans, and robust staff training and quality assurance processes in place. For these reasons, we did not expect the intervention to be delivered differently in the different sites.

The BB4K programme is designed to be inclusive for all those who meet the eligibility criteria. PACT's delivery staff are trained to cope with a wide range of needs and behaviours and can make small adjustments to accommodate different needs such as providing interpreters, signers, accessible buildings and increasing volunteers. Despite this, there were a few barriers to delivery identified through the ToC development process including a participant's lack of English language skills and cultural barriers making it more difficult for families to engage with the programme. For this reason, we expected that the outcomes from the programme may vary depending on these characteristics.

Furthermore, enablers for the programme included the group-based element participants' willingness to embed the learning. For this reason, we also expected to see some variation in outcomes for those who we're unable to take part in group sessions (and instead received the programme via one-to-one support) and those who did not attend all sessions.

What did we find?

2a. Do perceived outcomes (and experiences) vary by the three sites, and if so, reasons?

From discussions with practitioners, there was no evidence to suggest that outcomes or experiences varied significantly across the three delivery sites. Practitioners emphasised the importance of retaining the core components of planned content in delivery, though recognised the need to adapt the way in which content is delivered to meet the needs of specific group dynamics (discussed below in section 2b). No difference by site was observed in parents or children as all IPE activities were undertaken with families operating in the Reading site.

2b. Do perceived outcomes (and experiences) vary by characteristics of families, and if so, reasons?

Where families had additional support requirements, adaptations were successfully put in place, according to PACT's MI. Adaptations included arranging extra staff support, allowing children with separation anxiety to have their sibling present, or changing the activity through which content is delivered to meet sensory needs. However, there was some evidence to suggest that perceived outcomes varied by family characteristics. As per our expectations, not having English as a primary language was a barrier to engagement with the programme and enablers to

supporting family engagement and outcomes included families' involvement in group support, buy-in to BB4K and regular session attendance.

English as an additional language

Practitioners described parents' programme experience was impacted in cases where parents spoke English as an additional language. One of the parents participating in the programme was a French native speaker, and practitioners said that they needed additional time to process and contribute to conversation. As identified in section 1b, the group element of the programme was an important mechanism for achieving outcomes, which indicates that they may not have been able to access the full benefit of the programme, potentially leading to different outcomes compared to those with strong English language skills. All parents interviewed for the process evaluation had English as their primary language.

BB4K could be adapted for delivery in other languages. However, BB4K staff told us that this poses practical challenges sourcing a translator who can attend all sessions. They also told us that this presents issues for the group dynamic and would mean the programme would most likely be delivered via one-to-one sessions.

> "If someone's level of English is not sufficient to take part in a group that gives us real issues … it's not always possible to find a translator, or if you can find a translator, not practical for them to necessarily attend for eight weeks in a row." –BB4K Manager

Involvement in group support

Practitioners recognised that experience of the programme and outcomes can vary depending on whether families receive group support or one-to-one support. In interviews with both parents and practitioners, it was highlighted that the group element of the programme was key both in terms of parents' enjoyment of the programme, and as a mechanism for achieving intended outcomes. When the programme is received via one-to-one support, this element is lost, which some practitioners felt could adversely impact outcomes which supports our expectations.

> "To get validation from other members of the group was probably the most helpful thing. To listen to their stories and see how their stories compared to yours – that's why the group aspect was probably the most important." –Parent

The families most likely to be offered one-to-one support to accommodate their needs were those where the parent or child had a disability or mental or physical illness. We did not speak to any families receiving one-to-one support as part of this study. In these cases, the family benefited from the offer of one-to-one support as groupwork was not feasible. However, practitioners emphasised the importance of groupwork in supporting families to reduce loneliness and isolation through connecting with others who have had similar experiences in the groups.

Buy-in to the programme

Practitioners discussed how outcomes can vary depending on whether parents are 'bought in' to the programme. They said that a small number of parents told practitioners that they felt compelled to be there as part of a child protection plan or because their social worker asked them to attend and therefore felt like it was not their choice to participate in the programme. Practitioners noticed that these parents often feel less engaged in the programme, less likely to meaningfully participate and therefore less likely to achieve intended outcomes.

> "There are some parents that probably didn't show as much progress they could have done for similar types of reasons where they felt like they were obliged to attend by someone else, not by us because of the circumstance and the family." – Practitioner

This highlights the importance of ensuring that parents, and referrers, are aware that the programme is entirely voluntary, to prevent cases of disguised compliance leading to poorer engagement and outcomes.

Attendance

It was not possible to tell whether the number of sessions families attended correlated to their outcomes due to small sample base sizes. Practitioners did not think that lack of attendance was an issue; however, they did report that parents who attended fewer sessions were less likely to achieve outcomes.

> "I think we've had one or two families that were very erratic in their attendance and that would have an impact on outcomes. But I don't think I've seen any parent or child not have a positive outcome in at least one or two of the areas that we assess." –Play Therapist

Parents told us that they wanted the programme to last longer to allow more time for group discussions and progress once the group dynamic and bond had been formed, suggesting that attending fewer sessions may have had an adverse impact on outcomes.

> "It was good, but I feel like it could have been longer, covered more ground, explored things a little bit more. I know it's only a short period of time, but I feel like there would have been once we got to know each other more group discussions more helping each other." –Parent

Implications for the programme

In interviews, practitioners generally felt that the programme was accessible for families with a variety of characteristics. Practitioners emphasised that they did not observe variation in outcomes across different types of families: they view families and their outcomes much more individualistically.

"I don't think we can come up with 'This group of families respond like this, that group of families respond like that.' I think it just really depends on the actual family." –Practitioner

Yet, several family characteristics have been identified which make outcomes less likely to be achieved. Parents who feel obligated to attend sessions by their support worker are less likely to be 'bought in' to the programme, and therefore less likely to achieve intended outcomes. Furthermore, families who don't have English as a primary language, and families where the parent or children have a disability or mental illness, are less likely to be able to engage in group sessions, which removes an important mechanism for achieving outcomes via the programme.

3: To what extent was the intervention implemented as intended?

What did we expect?

Prior to this study the BB4K programme was well established and defined with clear documentation, session plans and robust staff training and quality assurance processes in place. Throughout this study, BB4K was delivered by existing PACT staff and PACT management monitored fidelity and dosage by tracking dates of referrals and first sessions, reasons for offering one-to-one support and whether various assessment, triage and off-boarding processes had been undertaken. For this reason, it was expected that the intervention would be implemented as intended.

What did we find?

3a. Fidelity: To what extent was BB4K delivered as intended? 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'

Analysis of management information found that the programme was delivered as intended in almost all cases. All treatment families received an assessment call and triage meeting, and almost all received a home visit (only one family did not receive this). All families either received an end assessment with a practitioner or were referred on to other PACT services. Time between referral and initial session and details about staff training and quality assurance processes were not collected as part of this study.

Practitioners also reported that the programme was delivered mostly as intended. Some small changes were made to accommodate specific needs of families as they arose, but the core elements and learning content were not impacted.

For example, practitioners said that they decided to change the order of topics covered in weeks one and two ('naming feelings' vs 'inside vs outside hurting'), as they felt the latter was more appropriate to ease families into the programme. Practitioners also adapted activities in children's sessions depending on age, mood, or preferences. For example, they might carry out a

more physical activity if the children are particularly energetic, or a more creative activity if children are more interested in arts and crafts.

> "We often tweak some of the activities with the children depending on the children in the group. If it doesn't work, we change it: we're flexible." – Practitioner

Practitioners also reported that some families started the programme in the group sessions but transitioned to one-to-one support if it transpired that group format was not suitable. According to PACT's MI data, five families received one-to-one support instead of group sessions. Three of these were because they had missed sessions: either because they weren't available at group times, or the child's medical condition flared up. The other two were due to the child needing additional support due to, for example, heightened anxiety or behavioural issues.

Parent and children sessions were delivered on the same day as intended. Both parents and practitioners felt this was a strength of the programme. Parents did not have to source childcare for their child as they were taking part in a group at the same time as them (except for families with additional children not yet in school). It was also a mechanism for obtaining outcomes as the fact that the subject matter was aligned between the parent and child sessions meant that parents could discuss the sessions with their children after. This gave them another opportunity to embed learning from the session and bond with their children.

However, some parents felt that children were encouraged not to discuss the sessions with their parents, and their children had told them they could not discuss what happened during the session. Parents attributed this to the 'treasure chest', a tool used by BB4K practitioners at the beginning and end of every session to indicate to children that information shared by other children in the group should be kept confidential. Parents felt this encouraged children to lock their thoughts and feelings into the metaphorical treasure chest at the end of the sessions. However, practitioners highlighted the significance of this exercise in teaching children the importance of confidentiality within the group. They emphasised that, while children are free to share their own thoughts and experiences with others, they should not disclose what others have shared during the sessions. This is particularly important in contexts where some children may attend the same school, ensuring that sensitive information is not shared in that environment.

> "I think the treasure chest should be left open for them to be able to discuss it [their feelings] if they want to, because it feels like they're not allowed to discuss it." –Parent

3b. Feasibility: What were the barriers and enablers to implementing BB4K, and how were barriers addressed? 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'

The group setting, the relationship and trust built between practitioners and families, and home visits during assessment supported BB4K implementation. The main barriers to BB4K implementation included referral organisations referring ineligible families, recruiting and

training group facilitators, and funding initiatives to improve family access to the programme. Efforts to overcome these barriers had mixed results.

The group setting

As discussed in section 1b, a key mechanism and enabler to outcomes from the BB4K programme was the group element of delivery. Parents and practitioners also reflected that the group setting was key in enabling peer support and validation of shared experiences. Parents said that the opportunity to share their experiences with others who had been through similar circumstances in a non-judgmental space was valuable. Equally, parents commented that there was no pressure to share their feelings if they did not want to.

Relationships between practitioners and families

Parents agreed that staff were friendly and approachable and supported families by engaging with them via WhatsApp and arranging catch-up sessions if they missed a group session. The trusting relationship built between families and practitioners enabled families to feel safe and secure in group sessions.

> "It's been nice having it to look forward to. If something happens to you in your week, because it's weekly, you might think I can't come unraveled now, I can't really talk to anyone but I know on Thursday I'll be able to come and talk about it. It's just nice to have that to look forward to, to know you can come and let it out amongst people who get that." –Parent

Practitioners echoed parents, stating how much parents and children rely on the support they receive from practitioners and other families during the course of the programme.

> "We do have parents and children that, although they're with us for eight weeks for the course and the bit before and afterwards, you know, they really rely on that support and they bond with other parents and other children and staff members." –Manager

Children observed during the final session of Cohort 2 were comfortable with practitioners and each other, evidenced through relaxed body language. They showed genuine excitement to start sessions with practitioners and were comfortable sharing emotions in a group. During the start of the Cohort 2 session, when the children shared how they were feeling today, one child said they were feeling sad and the others comforted them, demonstrating peer support.

Home visits

Practitioners felt that home visits are an important factor laying the foundations for trusting practitioner-family relationships. Home visits take place after initial referral and triage and during the assessment stage, before group sessions begin. They are an opportunity for parents and children to meet a BB4K practitioner and ask questions about the programme. Home visits created an opportunity to address any anxieties that families have about attending groups, and make sure they have a friendly face when they attend the first group.

> "I think it's really helpful to meet the child in advance and then when they come into a new environment, then there is at least a familiar face to them. And you have seen them in their home environment where they are most relaxed, and the parents can have your one-to-one attention as well." –Practitioner

Parents agreed with practitioners, telling us that the home visits were an important part of their onboarding to the programme. It helped reassure them about how the programme would work and calmed their anxieties around attending.

> "[The home visits] was very nerve wracking because I thought they might be judgemental. But I couldn't have had a better first approach. They both came into my home and said 'wow, your home is lovely'. I just thought, thank God for that. It's that positive first impression … It was a very nice approach." –Parent

Ineligible family referrals

One challenge in implementing BB4K which practitioners faced was receiving referrals for ineligible families. Practitioners felt that some referrers misunderstand that BB4K is a programme for families in recovery and refer families who are in crisis and therefore ineligible for support, meaning that some families have to be turned away. While PACT makes efforts to educate referral organisations on the content of the programme and the eligibility criteria, a high turnover of staff within referral organisations could mean that this information is not always received by the appropriate referrers.

Difficulties recruiting and training staff

Another challenge that practitioners reported was recruitment and training of expert staff. According to practitioners, it is challenging to recruit staff with appropriate experience and qualifications. Furthermore, training inexperienced staff takes time, as staff have to have shadowed a group before they can facilitate their own, meaning that some group sessions will only have one experienced practitioner facilitating. Practitioners also felt that the short setup period for the pilot evaluation meant that staff training was condensed. There was no evidence collected to suggest poor-quality session facilitation.

Funding accessibility initiatives

Finally, practitioners felt they were restricted in the extent to which they could support accessibility requirements by the limited budget of the access fund. The budget was used up rapidly paying for taxis to ensure that families could travel to and from sessions, meaning that it could not be used to support access requirements more widely.

3c. Dosage: How much 1) group work, 2) one-to-one support work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?

As shown in Table 15 and discussed under Evaluation Question 1, attendance to groups was high with most (60%) families attending all scheduled group sessions and only one in five (21%) missed more than one session.

Some (15%) families received one-to-one support; however, it is not clear from the management information how well attended these one-to-one support sessions were. This is because attendance data is not broken out between groups and one-to-one support sessions, and some parents received a mix of group and one-to-one support sessions.

During their engagement with the programme, parents were told about the option of engaging with Bounce, an online resource for families giving them access to a range of materials and activities related to the programme content that they can use at home. According to management information data, only two parents engaged with the platform. Those few that did use Bounce spent very little time engaging with it overall (less than 10 minutes).

During interviews, parents in the treatment group were generally aware of the existence of the Bounce platform (when reminded of it) but appeared less familiar with its content or intended purpose, with no parents reporting use in either the treatment or waitlist control groups. One parent explained that their limited engagement with the platform was due to a lack of opportunity to bring the family together to explore the resource; there was little spare time outside of the demands of their lives. However, parents in the waitlist control group expressed that, despite PACT reaching out to waitlist families via email, they would have liked more engagement and support from PACT while they were waiting to be assigned to a group. This indicates there could be an opportunity to promote Bounce to waitlisted families as a means of meeting this need.

> "There hasn't really been much [communication from PACT] to be honest … I've had no actual contact from anyone in between … I think a check-in would be nice because they just left me to it." –Parent, waitlist control group

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)

Parents generally felt that content of the group session was acceptable; however, certain aspects were different to what they expected. For example, some parents were surprised that there were no joint parent–children sessions for the 6 to 11 age group, and felt that closer work with their children would have been beneficial in helping to improve their bond.

Children interviewed felt positively about the group and enjoyed the content. In the observation, the children in the 3 to 5 age group were excited to take part in the emotional check-in, and visibly looked more 'settled' in the room once they had gone through the welcome song. In addition, the children in Cohort 1 spoke very positively about the 'treasure chest', a tool used by BB4K practitioners at the beginning and end of every session to indicate to children that information shared by other children in the group should be kept confidential. They appeared to value the safe space that this created suggesting that children enjoyed the separate nature of BB4K as they could speak more freely than if they were with their parents.

Practitioners suggested that there could be stronger referral pathways from BB4K to 'Heart to Heart',[13] which focuses more on improving the parent–child relationship. However, some practitioners said that families found the separate groups acceptable, because it provided children with a safe space to share their feelings, and allowed for parents and children to discuss what they had covered in the sessions afterwards if they wanted to.

> "It's nice to have separate as well but maybe we alternate, have like an hour here where it's quite informative and then have an hour with the children for the things we do that are similar, then maybe have that connection with our feelings." –Parent

There were also some topics that parents wanted to cover in more detail – such as content on trauma bonding, how to bond with their child, and how to co-parent with their ex-partner.

Positively, parents expressed that the size of the groups created good opportunities for peer support without feeling overwhelming. They felt the time allocated to group discussion was the most valuable component of the session, and suggested that more time could be spent on this, instead of completing individual paper-based exercises.

"It can feel quite rushed to get through the handouts, and it leaves little time at the end for actual genuine discussion, which is the most helpful because it's the way you can actually connect, rather than on a sheet of paper." –Parent

Parents also expressed a desire for more sessions, as it can take a while to develop relationships with others in the group. However, practitioners felt that additional sessions could lead to families becoming too reliant on staff and the programme. Furthermore, parents continue to have access to their group network via WhatsApp chats, and some mentioned plans to meet up after sessions ended.

> "We looked at whether eight weeks is the right number of sessions. There's kind of a fine balance between building dependence in people and not giving them enough, and it's quite a fine line to tread, cause some people would quite happily, I think, come to us every week for the rest of the year and we could keep seeing them and keep doing work with them. For some people, eight weeks is kind of bordering on too much for them. It's kind of too invasive for them." –Manager

In the focus group with children, children indicated that, despite initial nervousness, they enjoy the group sessions and feel safe and comfortable during them. When asked how they felt after the sessions, all children said they felt happy, with one saying they felt relaxed and another wishing they could attend every day. When asked if they felt comfortable attending the sessions, children said that once they got to know the other children, they felt happy and comfortable.

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[13] Heart to Heart is a programme (developed by Clear Sky) which focuses on building the parent–child attachment relationship. This is a group programme for children, teens, and their parents to attend together across the age ranges of 5 to 9 years and 10 to 15 years.

3e. Adaptations: What adaptations have been made to make BB4K more acceptable to families and referring organisations?

PACT adapted BB4K across referral, assessment, group sessions, and delivery of the sessions. These adaptations were based on the findings from previous sessions and to ensure accessibility for as many families as possible.

Adaptations made to referrals

To make BB4K more acceptable to referrers, some work was done by PACT practitioners to make referrers better aware of what BB4K is and the main benefits of the programme, such as increased training to referrers and improved outreach. For example, sending out more literature and leaflets to less common referral pathways (doctor's surgeries and health visitors) and conducting increased training to social workers. Referrers interviewed requested shorter and easier-to-fill-out referral forms to streamline the referral process and minimise the time required from them.

> "The referral from my memory is very, very long and it asks us as referrers for a lot of information. That's slightly off-putting to me because if I have to sit down with the family and get all the information, I'm sure they will have to then repeat it once they start getting services as well. I would rather just Bounce Back ask them directly for all that information rather than us telling Bounce Back and then probably when they meet, they ask again." –Referrer

Adaptations made to session delivery

During assessments and home visits, practitioners gather information on access requirements and assess whether actions need to be put in place to provide extra support to families. MI analysis captures the adaptations PACT made to remove access barriers to BB4K sessions. For parents, these include:

- Offering one-to-one support instead of group sessions for parents with mental health difficulties
- Providing extra staff in groups to support parents with mental health or learning difficulties
- Ensuring sessions were held in a building with level access, with close parking, for one parent with a physical disability
- Integrating meetings with a parent's key worker after every group session to support one parent with an eating disorder. This enabled facilitators to discuss any potential triggers and ensure the parent was safeguarded.

For children, these include:

- Offering one-to-one support instead of group sessions for children with behavioural issues or learning difficulties
- Providing extra staff in groups to support children with behavioural issues, mental health, or learning difficulties

- Allowing siblings to attend group sessions to help children with separation anxiety.

Practitioners interviewed discussed adapting the session content to meet the needs of different age groups, who may have different grasps of concepts such as 'inside and outside hurting'. A practitioner gave an example of using tissue paper instead of paints during an activity for a child with autism and sensory issues.

> "I think it's very accessible … I think talking to a lot of parents, part of the reason why it works, is because they found it so accessible and so safe to attend because we do have those initial calls and contacts and visits where we do ask them what they need to make the group accessible to them and we will do everything we possibly can to enable them to feel safe, to feel comfortable to attend that first session." –Practitioner

The Access Fund also enabled PACT to pay for taxis for parents without transport options to travel to and from sessions. However, the budget was used up quickly, indicating high demand for this kind of support.

> "If you know that taxi's coming at that time every week, it makes you more likely to come. Whereas if you have to think about what buses you're going to get or it's on you to spend that money, it's maybe less likely that you'll come every week." – Manager

Parents interviewed expressed gratitude to PACT staff for the efforts made to make families feel comfortable engaging in BB4K. For example, a parent was thankful for PACT making sure there were snacks available that met their dietary requirements.

> "But they've said that you know the fact that they even went out of their way to buy gluten free biscuits help them really feel part of that group and not just kind of an outsider attending something." –Parent

4: Can the intervention be improved?

What did we expect?

During the evaluation setup stage, we discussed with PACT the most likely challenges to delivery BB4K may face, and thus opportunities for future improvement. These included staffing and training, referrals, waitlist engagement, home visits, session content and delivery, and improving access and engagement.

What did we find?

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?

Staffing and training

PACT increased delivery of BB4K for the purposes of the evaluation, and this required hiring some practitioners. New practitioners felt less confident in trauma-informed and reflective practices, and child-centred communication techniques when interviewed after Cohort 1 delivery. To improve new practitioner confidence with these elements, the practitioners suggested allocating more time to training and inductions, allowing certain topics to be covered in greater depth. They also suggested training should place more emphasis on concepts such as attachment organisation and their impact on parent–child relationships, particularly for practitioners who may lack experience dealing with domestic abuse cases.

> "Actually, to build some more time to do some training, we do a little bit before the course starts about child-centred language and using language that is not questioning children and giving them space, and the way we react to their behaviours and that we're non-judgemental, totally accepting. But maybe we need to put in some extra time to work on that – the reflective language." – Practitioner

Practitioners also recommended that BB4K support staff could better reflect the demographic diversity of its service users. Currently, most staff are White women, which does not reflect the diverse background of families experiencing domestic abuse and who may access BB4K. Relatedly, practitioners felt including people with lived experience in the recruitment process and providing them with on-the-job training to become support workers would enhance representation and engagement. This approach could help overcome the challenge of recruiting individuals who may not initially have formal experience in support work. As part of this pilot, PACT did recruit an Assistant Support Worker who lacked previous work experience in the field, helping to remove some of these barriers.

Referrals

Practitioners suggested increasing outreach to doctors to generate more referrals, as most referrals came from schools, self-referral and Women's Aid. Increasing the referral pathways could improve the diversity and volume of families supported by PACT. Strategies could include distributing informational leaflets to community medical practices, which would enhance awareness of BB4K among healthcare providers and potentially lead to increased referrals.

> "Maybe that's something we need to also think about pushing that out into the community more, into doctors' surgeries." –Practitioner

Parents also expressed that they would like to receive more detailed information at the point of referral. In interviews, parents have expressed a desire to better understand the programme's aims, course content, and session format, especially the separation of parents and children during sessions. PACT could consider developing written materials that clarify commonly misunderstood aspects of the programme. For example, that it is a recovery service, with separate parent and child group sessions. This additional information could alleviate parents' anxiety and build trust in the service, particularly for those who have previously had negative experiences with support services.

> "They should maybe explain a bit more about the course content and exactly the way it's going to be run in more detail, because we can get very anxious and nervous about what our children are going to go through and what's going to happen. And sometimes we find it difficult, even though we seek support services, to trust them, because they've not always turned out to be helpful, or supportive." –Parent

Several changes to the referral form themselves could also be made to improve the referral process. In its current form, referrers highlighted that the form was lengthy and time-consuming to fill out. They suggested shortening the referral forms by focusing only on information crucial to eligibility criteria, leaving other details to be collected later during the assessment or triage stage. This approach would save time for referrers and may increase referrals. However, PACT emphasised the importance of obtaining this information directly from referrers, as it aligns with a trauma-informed approach. This method allows a familiar person to provide the necessary details, sparing the individual from having to repeatedly share their story with multiple people.

> "I don't know why we as referrers need to give all this information. Some things are important, for example 'Has the perpetrator left the family home' because they are linked to the eligibility criteria but lots of things about their life, I think they could collect themselves rather than us having to spend that time." – Referrer

Additionally, adjustments to the language in the forms could make them more self-referral friendly. The current professional tone may not always be suitable or easy to understand for individuals making self-referrals. There is also the opportunity to include a question on how self-referrers learned about BB4K, which could provide valuable data for future outreach efforts. Furthermore, clarification is needed for certain questions, such as whether the perpetrator has "left the family home", as this is sometimes misunderstood if the perpetrator remains in the family home and the non-perpetrating parent has relocated, leading to referrals being inappropriately excluded.

Another consideration raised by interviewed practitioners was how best to identify and meet the needs of parents with a history of drug and alcohol use. Practitioners felt they could not effectively support individuals coping with drug and alcohol use.

> "If you've got a parent who has a background of substance misuse, or maybe themselves has come from maybe a care background … it's harder for the parents to put into practice … the learning because of their own upbringing." –Manager

Please see Appendix E for a full breakdown of referral sources based on PACT's MI data.

Waitlist engagement

Despite PACT reaching out to waitlist families via email, referrers and waitlisted parents agreed that more could be done to keep parents on the waitlist engaged with BB4K. For instance, PACT could implement regular phone check-ins with waitlisted parents to maintain engagement and provide reassurance about the programme. Parents felt this would increase their understanding of BB4K and help them feel more supported when waiting.

> "I had a phone call from Bounce Back; they went through a few things with me and then it went quiet … There hasn't really been much [communication from PACT] to be honest … I've had no actual contact from anyone in between … I think a check-in would be nice because they just left me to it." –Parent, waitlist control group

Home visits

Practitioners felt home visits could be arranged closer to the first session, so that introduction is more recent and families, especially children, are more familiar with the practitioners. The ability to conduct home visits at a more appropriate time is currently limited by staffing

> "So, they did become one-to-ones. One of the reflections I had was that we did the home visits in advance and actually had we done it slightly closer to the beginning of the group, I think that might have … for the child, at least … we might have been more familiar. It might have been more recent." –Manager

Session content and delivery

In interviews, parents emphasised that they valued the time allocated to group discussion. Some parents suggested that the format of sessions could be improved by increasing the time spent on group discussions, compared to the more individual paper-based exercises.

Parents also felt that the format of sessions could be adapted to focus more on strengthening the bond with their children. Some parents suggested that sessions could be alternated with combined parent–child sessions; however, practitioners instead suggested that this need could be met through increasing referrals from BB4K to the Heart to Heart programme, which more specifically targets child–parent attachments.

Another way in which session content could be improved is by increasing the continuity between topics covered each week. Parents suggested dedicating time at the start of each session to reflect on the previous week's topic, or using digital communication, like WhatsApp groups, to check in and share how they are applying what they have learned during the week.

> "Say like, Monday or even Friday there could be a half an hour Zoom call or WhatsApp call just to check in and see who's done self-care this week." –Parent

Finally, referrers expressed a desire to be kept updated on the progress of service-users during the programme. This could involve providing information on session attendance and progress,

which would help referrers maintain relationships with participants and better inform future referrals. However, this must be balanced with ethical considerations surrounding disclosure of information about families.

> "I sometimes get an email to say thanks for the referral and that's it. I don't hear anything else … I don't hear anything to say they've finished it … sometimes as their support workers, it'd be handy for us to know when that session has closed just so they are on our radar … so we're there to support them." –Referrer

Improving access and engagement

Since sessions run during school hours, parents in full-time employment may struggle to attend. Therefore, one way in which access could be improved is offering the option of evening sessions to provide flexibility for service-users who might otherwise face difficulties in attending due to work commitments. This was reinforced by the interviews with practitioners in both cohorts who saw the timing of the sessions as an accessibility barrier for parents who work full-time. They discussed offering evening sessions as a solution to this but did not further explore how feasible this would be.

Similarly, lack of childcare is a significant barrier for parents who have other young children not attending the sessions. One option to explore could be to offer a creche service in venues where the group sessions are held. To offer this, venues selected when scaling up would need to have enough space, and PACT would need to hire childcare professionals. However, practitioners highlighted that it can be challenging to source professional childcare for such a short period of time.

> "As much as we had some budget towards looking for childcare. Actually, a nursery isn't going to take a baby for half a day a week … It's really, really difficult to actually source that."–Manager

Language barriers also present a challenge, particularly for parents who speak English as an additional language. One proposed solution is hiring interpreters. However, this approach could impact group dynamics, which are an essential aspect of the programme. An alternative option is to provide groups in non-English languages, depending on common languages in areas scaled into, and predicted number of referrals.

> "I don't know if there would be any budget for, for example, interpreters and I don't know how it will work even if there was a budget, how effective it will be when a third party's sitting in the room or online and having to translate everything because there will be lots of families with different ethnicities. There will be lots of cultural nuances as well around domestic violence." –Referrer

Finally, addressing the needs of male survivors of domestic abuse could help increase access for this group. This could involve recruiting male support workers or hosting all-male groups to provide a supportive and inclusive environment, once again dependent on predicted number of referrals for male parents.

"Whereas historically, obviously it's vastly more likely that we're supporting female parents, we did quite a lot of work to remove gendered language from that to ensure that it is more accessible for people of different backgrounds or different genders." –Manager

Discussion

BB4K was mainly delivered as intended, retaining the core elements and learning content despite small changes made to accommodate specific needs of families. PACT practitioners' efforts to remove barriers to family participation went a long way in supporting engagement. Yet, barriers to referral, attendance, and engagement remain for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours.

Parents and children generally were positive about the intervention, feeling that content of the group sessions was acceptable and expressing a desire for more sessions and more detailed discussion of the content. Some parents would have also liked more information about the sessions at the point of referral, and some expressed the desire for closer work with their children. However, practitioners felt separate sessions were valuable, providing children with a safe space to share their feelings. Children were similarly positive; indicating that, despite initial nervousness, they enjoy the group sessions and feel safe and comfortable during them. Children also suggested that they enjoyed the safe space within group sessions and liked the separation.

Building trusting relationships enabled families to feel safe and secure in group sessions, and the group sessions themselves enabled peer support and validation of shared experiences. Barriers to implementing BB4K included PACT receiving ineligible referrals, difficulties recruiting and training experienced staff and the limited budget of the access fund, which restricted the extent to which practitioners could support accessibility requirements.

Practitioners, referrers, and parents recommended the following improvements to BB4K delivery:

- Extend new facilitator training, and emphasise training on trauma-informed and reflective practices, child-centred communication, and attachment styles and their impact on parent–child relationships
- Simplify the referral form, making it accessible to both professionals and parents self-referring
- Building on referrals from schools and Women's Aid, strengthen the referral pathways into BB4K, especially with social care and health partners
- Improve engagement with parents on the waitlist through practitioner check-ins, and promoting the Bounce platform
- Adjusting session content and delivery for more group discussion and better continuity across sessions
- Improve access for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with

English as an additional language, with other children who are not school age, or who work during school hours.

Conclusions

- Programme engagement was good for recruited families, as evidenced by more than half of families attending all sessions. However, recruited families were less diverse than the expected population of families experiencing domestic abuse. Therefore, assuming BB4K benefits families, and to improve BB4K access to families, PACT should focus on improving the number and types of referral pathways, and on improving the quality and clarity of communication and guidance around eligibility criteria to referrers. To further improve access to families, PACT should focus on overcoming access barriers for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours.
- BB4K was acceptable to recruited parents and children. The group element of the programme was important for parents' enjoyment of the programme, and as a mechanism for achieving parental self-efficacy. To help parents feel comfortable attending the sessions, it was important that they and their children had already built a trusting relationship with practitioners. Practitioners found that home visits were especially helpful for this and recommended scheduling them close to the first session to increase their impact. However, some parents would have liked more information about the sessions at the point of referral.
- Improved parent–child relationship was expected to be reached through better emotional regulation and communication of boundaries, which there was some evidence of from parents. Yet, practitioners attributed this relationship improvement to parents learning about how domestic abuse affects children's ability to emotionally regulate, suggesting it is another mechanism for this change. Some parents expressed the desire for closer work with their children through more group sessions.
- There was evidence that families benefited from BB4K in other ways: reduced loneliness and isolation; improved ability to emotionally regulate; and identifying healthy and unhealthy behaviour in others. The mechanisms for these outcomes were the group format of the sessions, the 'no judgement' environment and the trust and bond they built with other parents and the practitioners.
- To help understand the impact of providing one-to-one support compared to group support, PACT should track when a family receives one-to-one support instead of a group session going forward.

Limitations

Our pilot randomised control trial (RCT) design has important limitations. The small sample size means we cannot say with confidence whether families definitely benefited from BB4K. The short evaluation timescales means we cannot comment on sustained impact. The pilot was delivered in one region of England (South East) and the families that took part did not reflect

the diversity of families experiencing domestic abuse in England; this means results are not generalisable beyond the region and families who participated.

This evaluation was also subject to several limitations inherent to qualitative research. First, qualitative approaches typically involve smaller sample sizes, prioritising depth of insight over breadth. Consequently, there is a risk that broader trends or minority perspectives not represented within the sample may be overlooked. Second, the process of interpreting qualitative data is influenced by the researchers' own beliefs and experiences, which may introduce a degree of subjectivity into the findings. To mitigate these risks, interviews were conducted by multiple researchers, a bespoke analysis framework was employed, and findings were validated through director-led analysis and collaborative brainstorming sessions.

A further limitation of the evaluation was the difficulty in capturing the voice of the child. Although we collected evidence directly from children through a focus group and a session observation, these methods did not sufficiently allow us to understand children's experience of the programme. To mitigate this in future, we would aim to collect photographic evidence of children's engagement in the sessions as well as drawing more on practitioner observations of their progress throughout the programme. The existing trusted relationships that practitioners have with the children means they are well positioned to provide deeper and more meaningful insights into the children's experience.

COST OF BB4K

The costs below show additional costs of delivering BB4K compared to if it had not been delivered. Following the What Works for Children's Social Care (WWCSC) cost analysis guidance, we categorised costs into three groups: start-up costs, prerequisite costs, and recurring delivery costs.

Cost data was collected from PACT via a simple tool and accompanying guidance. Cost data relates solely to the costs associated with setting up and running BB4K groups and does not include any additional costs incurred as part of the evaluation activities. We originally planned to collect data both before and after delivery, but after reflection, we felt this was unnecessary given the short delivery time period. All cost data was therefore collected post-delivery for each cohort.

Cost data was collected in two stages, Cohort 1 and Cohort 2, and these stages covered all PACTs activities related to BB4K delivery during the following time periods: 1 January to 31 July 2024, and 19 September to 12 December 2024. Costs were not collected for the period over the summer holidays when no groups were delivered. As costs are organised by time period below, comparisons in the costs related to Cohort 1 group delivery compared to Cohort 2 group delivery should be avoided. For example, start-up costs are considerably higher for Cohort 1 as much of the start-up for Cohort 2 was conducted during this time period. Furthermore, delays in the recruitment of new practitioners during Cohort 1 meant that the Team Manager delivered some of the programme increasing costs compared to business as usual and some groups were delivered in a new site (Vale of the White Horse) which increased the setup costs compared to delivery in existing sites.

The total start-up, prerequisite, and recurring delivery costs for both cohorts combined was £119,089. This equates to about £3,608 per family. The costs of delivering BB4K to each cohort are broken down in Table 16 and Table 17 below. This calculation is based on the 33 families who participated in BB4K across Cohort 1 and Cohort 2. These figures represent the actual number of families to whom BB4K was delivered, as reported by PACT in the cost data form. This total does not necessarily correspond to the number of families included in the evaluation analysis, as the cost estimate reflects delivery rather than evaluation participation.

Table 15. Start-up, prerequisite, and recurring delivery costs of BB4K Cohort 1

Start-up costs			
Staff costs	BB4K Manager, BB4K Administrative and Database roles, Finance, Fundraising, IT and HR (recruitment) support	£15,532	
Non-staff costs	Staff travel	£300	
Staff training	Costs associated with training staff for BB4K	£310	
Prerequisite costs			
Overheads	Share of HR, Finance, office costs (calculated by time spent on project)	£16,782	
Recurring delivery costs		**West Berkshire**	**Reading**
BB4K Management Costs	Time spent on BB4K, multiplied by salary, and plus other staff costs, e.g. NI, pension, etc.	£5,666	£5,666
Delivery staff costs	Time spent on BB4K, multiplied by salary, and plus other staff costs, e.g. NI, pension, etc.	£8,337	£8,337
Venue hire	For group sessions	£533	£533

Other facilitation costs	Including staff travel, printing costs, costs of accessibility adaptations	£1,668	£1,668
Unit cost			
Cost per family	Based on 14 families	£4,666.50	

Table 16. Start-up, prerequisite, and recurring delivery costs of BB4K Cohort 2

Start-up costs				
Staff training	Costs associated with training staff for BB4K	£310		
Prerequisite costs				
Overheads	Share of HR, Finance, office costs (calculated by time spent on project) and some management	£12,918		
Recurring delivery costs		**West Berkshire**	**Reading**	**Vale of the White Horse**
BB4K Management Costs	Time spent on BB4K, multiplied by salary, and plus other staff costs, e.g. NI, pension, etc.	£3,115	£3,114	£3,864

Delivery staff costs	Time spent on BB4K, multiplied by salary, and plus other staff costs, e.g. NI, pension, etc.	£6,760	£8,025	£6,760
Venue hire	For group sessions	£960	£800	£2,980
Other facilitation costs	Including staff travel, printing costs, costs of accessibility adaptations	£1,662	£831	£1,662
Unit cost				
Cost per family	Based on 19 families	£2,829.36		

We also collected non-monetary costs for each cohort, including family time and volunteer time.

The non-monetary costs of BB4K in Cohort 1 are broken down in Table 18. The total family, child, and volunteer hours spent was 611 hours.

Table 17. Non-monetary delivery costs of BB4K Cohort 1

	West Berkshire	Reading
Parent's time	72 hours	96 hours
Children's time	72 hours	96 hours
Volunteer's time	84.5 hours	190.5 hours

The non-monetary costs of BB4K in Cohort 2 are broken down in Table 19. The total family, child, and volunteer hours spent was 504 hours.

Table 18. Non-monetary delivery costs of BB4K Cohort 2

	West Berkshire	Reading	Vale of the White Horse
Parent's time	84 hours	60 hours	84 hours
Children's time	84 hours	60 hours	84 hours
Volunteer's time	12 hours	12 hours	24 hours

INTERPRETATION

This pilot study was the first randomised control trial evaluating the implementation and efficacy of the Bounce Back 4 Kids Programme (BB4K) delivered by PACT, an adoption and family support provider.

We took a systematic approach to the analysis of all strands of data collection (impact and IPE) to generate insight that covered 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 data from all strands, we designed an analysis framework aligned with the research questions, enabling us to identify differences across parents, children, and stakeholder groups. An internal workshop was held to triangulate evidence, explore trends and themes, and draft programme recommendations.

The pilot study did not observe any statistically significant benefits for treatment group families in comparison to waitlist control group families on the primary outcome of parental self-efficacy between baseline and endline. Our findings should be interpreted in the context of the broader evidence base. Romano et al.'s (2021) meta-analysis included studies with sample sizes ranging from 20 to 223, with many showing promise despite non-significant results due to power limitations. Our sample of 46 treatment group families completing the endline outcome assessment falls within this range but limits our ability to detect the moderate effects observed. Our findings are consistent with findings in the broader literature; this suggests our study may have faced a Type II error. This means a false negative, or the study design failed to detect an effect; not that there was not an effect. Indeed, while endline differences were not statistically significant, midline results did show a moderate, statistically significant improvement in parental self-efficacy, and qualitative findings consistently supported positive experiences. Furthermore, the treatment group had more families who had a higher primary outcome (parental self-efficacy measured by TOPSE) score when controlling for baseline compared to the waitlist control group. There were no differences identified by any other characteristics after controlling for age of children and site.

For the secondary outcome of children's behavioural issues at home (measured by BAC-C), there were no statistically significant benefits for treatment group families in comparison to waitlist control group families. However, the treatment group did have more families who had a higher outcome score when controlling for baseline compared to the waitlist control group.

No change was identified for the other secondary outcome (parent–child relationship and bonding measured by CPRS). This lack of change was also evidenced by findings from the implementation evaluation. Parents reported that the programme sessions could be better designed to focus on the strengthening of the bond between them and their child. To achieve this, PACT may need BB4K to draw upon attachment, mentalisation and other approaches. The ToC hypothesises that improved parent–child relationship happens as a result of more and open communication between children and parents. Our null findings for parent–child closeness contrast with Anderson and Van Ee's (2018) review, which found combined interventions with joint parent–child sessions showed greatest success. This discrepancy may reflect BB4K's

limited joint sessions (one for older children, weekly for those aged 3 to 5) suggesting that the 'dosage' of joint work may be insufficient to impact this outcome within our evaluation timeframe. Future research should explore whether enhancing joint components while maintaining the benefits of separate sessions could strengthen outcomes.

The study found that the programme was delivered as intended, retaining the core elements and session content despite small changes made to accommodate specific needs of the families. The programme was generally acceptable to parents despite some wanting it to include more sessions and more focus on parent–child bonding. Attendance to the programme was good for recruited families, with over half of all families attending every session. Ways to improve attendance could include improving access for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours.

The study broadly validated the presence and importance of the causal pathways identified in the ToC. One such pathway evidenced through the implementation evaluation was the onboarding and triage process, particularly the home visit conducted by practitioners ahead of the first BB4K group session, leading to engagement with the programme. Parents and practitioners reported that the relationship and bond built through this interaction helped children and parents trust their Support Worker and feel safe and secure attending sessions. Some said they may not have attended at all without this. One practitioner suggested improving home visits by scheduling them closer to the family's first session. This approach would help families feel more familiar with the practitioner and better understand what to expect from the programme, which could in turn reduce anxiety around attendance.

Similarly, the study found that practitioners provided supportive, closed group sessions that allowed parents and children to connect with other families with similar experiences and create peer support networks. Parents felt that time allocated for group discussions was the most valuable component of the programme and practitioners reported that many parents go on to have access to their peer network via WhatsApp chats and meetups. Parents reported this reduced their feelings of loneliness and isolation. There was some anecdotal evidence that receiving the programme through received one-to-one support sessions instead of group sessions could adversely impact outcomes due to the importance of this mechanism.

These qualitative findings strongly support Anderson and Van Ee's (2018) identification of peer support as a critical mechanism. Parents' emphasis on group discussions as 'the most valuable component' aligns with their finding that group formats enable 'validation from other members.' This triangulation between our qualitative data and the broader literature strengthens confidence in this mechanism despite non-significant quantitative outcomes.

This evaluation contributes to addressing long-standing gaps in the evidence base (Rizo et al., 2011; Austin et al., 2019) while highlighting persistent challenges in serving diverse communities affected by domestic abuse. It addresses several gaps identified in recent systematic reviews. Unlike the heterogeneous interventions described by Austin et al. (2019), BB4K offers a manualised, replicable model. While Bacchus et al. (2024) found limited response interventions in high-income countries, our study provides detailed evidence of a UK-based

programme. Our moderate effect sizes, comparable to those found by Romano et al. (2021), combined with high acceptability and strong implementation fidelity, suggest BB4K represents a promising approach warranting larger-scale evaluation. However, the promise shown by BB4K must be balanced with recognition that current delivery models may inadvertently exclude families who could most benefit from support as discussed below.

Delivery limitation

The pilot study benefits from many strengths, including relatively good recruitment and retention rates, successful randomisation and waitlist design. However, there are also several limitations related to the implementation of the evaluation, which suggest that these findings should be viewed with caution.

Recruited families were less diverse than the expected population of families experiencing domestic abuse. There is evidence that culturally responsive adaptations are crucial for intervention effectiveness (Rai et al., 2023) and the single family with English as an additional language who struggled to fully participate exemplifies barriers that may systematically exclude minoritised communities. Future implementations should consider linguistic accessibility and cultural adaptations as core rather than peripheral concerns. In particular, to improve BB4K access to families who would benefit from it, PACT should focus on improving the number and types of referral pathways, and on overcoming access barriers for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours.

Recommendations and next steps

The evaluation findings have provided useful insight and evidence that informs the next steps. The recommendations for future work have been developed in consultation with the delivery partners and Foundations.

Research recommendations

1. Strengthening evaluation design and reach

To enhance generalisability, future research should explore alternative models that may better serve diverse communities. Wong and Bouchard's (2020) whole-family approach and Rai et al.'s (2023) emphasis on community-engaged adaptation provide frameworks for developing more inclusive interventions. Research designs should prioritise recruiting diverse samples from the outset, potentially through partnership with community organisations serving minoritised groups. Particular attention should be given to addressing access barriers – such as offering materials in multiple languages and accommodating the schedules of working parents – to ensure broader and more inclusive participation.

2. Validation of outcome measures

This evaluation draws on three validated outcome measures: the Tool of Parental Self-Efficacy (TOPSE), the Child-Parent Relationship Scale (CPRS), and the Brief Assessment Checklist for Children (BAC-C). TOPSE is designed to assess parental self-efficacy and is validated for use with parents of young children in the UK. The BAC-C is a behavioural and emotional screening tool validated for use with children who may have experienced trauma or adverse experiences, particularly those involved in child welfare or mental health services, including those in the UK. The CPRS measures the quality of the parent–child relationship and has been validated with parents and caregivers across a range of child age groups. The scale originates from the US but has been widely used in UK research and evaluations. There is a need to validate these outcome measures specifically for use with adults and children who have experienced domestic abuse. There is also a need to validate the CPRS for use in the UK-context.

3. Theory of change validation

While our implementation findings broadly validated BB4K's theory of change, Bacchus et al.'s (2024) identification of 'reflection on harmful gender norms' as a key mechanism was not explicitly captured in our evaluation. Future research should explore whether BB4K's content implicitly addresses gender norms through its group discussions, and whether making this more explicit could enhance outcomes.

4. Codesign and stakeholder involvement

Future research should embed codesign principles more deeply, involving both delivery partners, children, and parents in the development and refinement of interventions and evaluation tools. This participatory approach will help ensure that programme remain responsive to the needs and preferences of those they are intended to support. For this to be possible, the setup stage of a future evaluation must be extended.

5. Increasing the follow-up period

The relatively short interval between baseline and endline data collection limited the ability of this pilot evaluation to capture medium- and longer-term outcomes. Many of the intended impacts of the intervention – such as improvements in parent–child relationships, emotional regulation, or family stability – are likely to emerge gradually and may not be fully observable within a short timeframe. For example, Romano et al.'s (2021) meta-analysis found differential maintenance of effects, with internalising behaviors remaining stable but trauma-related symptoms declining at follow-up. Our five-month follow-up may have missed important patterns of change. Future evaluations should include multiple follow-up timepoints (e.g. 6, 12, and 18 months) to capture these trajectories to provide a more comprehensive understanding of the intervention's sustained effects, as well as any delayed benefits or potential fade-out over time.

6. Capturing the child's voice

Some of the children that PACT deliver BB4K to are very young (3 to 11 years old) and this made it difficult to capture their voices in the evaluation design. The impact evaluation relies on parents' reporting of child outcomes as we could not identify a validated measure for domestic

abuse survivors that was practical and ethical to use with young children. Throughout this study we collected evidence directly from children via a focus group and observations; however, these methods did not sufficiently allow us to understand children's experience of the programme. Future studies should explore other options for capturing the voice of the child.

7. Importance of a 6-month lead time for setup

A lead time of approximately six months would be more beneficial for effectively setting up the intervention. This period would allow more time to recruit and train staff and ensure all operational elements are in place. Crucially, it also provides more opportunity to engage families assigned to the waitlist control group, helping to build trust and secure their participation, which may reduce attrition. In this pilot, time for setup of the study was limited and meant that there was only three weeks between randomisation and the first group starting for PACT to onboard families and conduct home visits. This meant the intervention delivery team had to prioritise onboarding families in the treatment group, leaving limited capacity to maintain engagement with the waitlist control group. Additionally, school holidays restrict when BB4K can be delivered and when families can be recruited, meaning that timelines are not easily adjustable once the programme schedule is set. A longer lead-in period would provide greater flexibility and improve overall implementation readiness.

8. Additional resource needed to reduce the administrative burden of the evaluation on the intervention partner

Throughout this study many communication activities with families regarding recruitment, survey completion, and engagement in IPE activities were delivered by PACT. While this was beneficial to the study as it increased family engagement when they received communications from a trusted and known source, it placed significant strain on their capacity – particularly during peak periods of intervention delivery. Strategies to address low take-up, such as communicating with and following up with waitlist control group participants for survey completion, were managed alongside intensive recruitment and onboarding of families in the treatment group. On a larger scale, future evaluations would benefit from dedicated support – ideally one full-time equivalent (FTE) staff member – tasked with managing evaluation administration and maintaining relationships with waitlist control group participants to boost engagement. Allocating more resource to these activities would help ease the operational burden on delivery partners and support more robust and efficient evaluation delivery.

Lessons learned

Intervention delivery

What worked well

- The alignment of session structure and content between the parent and children's sessions helped parents to anticipate and manage conversations with their children after the sessions.

- The mechanisms PACT uses to identify and support parent access needs seem effective (e.g. home visits, assessment calls, one-to-one sessions, and the accessibility fund).
- Home visits are important for families to feel comfortable attending the programme.
- The group environment and discussions are an important aspect of the programme for parents and children – this was a key mechanism for change identified in the theory of change that the evidence supports.

Areas for improvement

- The programme's aim and activities need clearer definition. Parents and referrers expected the focus to be on parent–child relationships, with group activities involving both parents and children.
- Parents wanted more interaction between their group and their children's sessions (e.g. shared activities). This may have helped improve the secondary outcome of parent–child bonding. However, practitioners reported that separate sessions are valuable and provide children with a safe space to share their feelings.
- PACT could consider adding interpreter services, childcare, or evening groups to support attendance.

RCT delivery

What worked well

- The study's waitlist design worked well for this intervention and was acceptable to referrers and participants. PACT is used to operating with a waitlist, and groups can only take place at certain times of the year due to school holidays. Furthermore, many of the waitlist control groups went on to access the programme soon after their involvement in the evaluation ceased. We would recommend replicating this approach for any future evaluation.
- The randomisation mechanism supported ongoing recruitment. PACT shared their waiting list, and we used randomisation software to assign participants to the control or treatment group based on priority, inviting them to join in that order until the groups were full.
- Impact measures captured through parent self-completion survey were all suitable and parents reported that the survey was not too long or difficult.
- Online documents were used to easily and securely share information about recruitment and survey completion between PACT and IFF.
- Safeguarding approach supported safe delivery: Any safeguarding concerns were immediately raised with PACT and addressed following their internal procedures.
- Gaining consent: After randomisation, parents were informed about the evaluation, notified of their group allocation, and given clear, accessible guidance on the process and how their data would be used. They were also offered the option to opt out of the evaluation, but only one parent chose to do so, as they no longer wished to receive support.

- Incentives and PACT's communication was vital in encouraging survey take-up. Getting parents, especially in the waitlist control group, to respond to the survey was challenging due to their low engagement with PACT and IFF while on the waiting list. Effective strategies to improve the response rate included:
    - Offering incentives to all respondents at every survey – £10 for baseline, £15 for midline, and £20 for endline
    - PACT sending survey invites directly to parents, leading with the fact that control families will receive the groups eventually
    - Adding another waitlist control group in Cohort 2 to account for high levels of attrition
    - Getting the treatment group to complete the survey in their home visits or first and last sessions worked well.

Areas for improvement

- Some parents may struggle with literacy and be reluctant to disclose this at point of consent, affecting their ability to give informed consent. To combat this, management information (MI) could be collected at randomisation stage to help tailor communication surrounding the evaluation. For example, we could provide an animation or audio to explain aspects of the evaluation in a more accessible format.
- Some staff raised concerns about the ethics of randomising some participants to receive support sooner than others, particularly parents who were already on the waitlist for a long time. In future, families on the waitlist should receive clearer communication, including expected timings for receiving BB4K support, to manage expectations and maintain engagement with the evaluation. The Bounce platform could also be utilised to provide some level of support until they receive the groupwork.
- The sample lacked diversity raising concerns about inclusion. To improve, future studies should focus on improving the number and types of referral pathways and overcoming access barriers for families from minoritised ethnic groups, parents and children who are neurodivergent or have mental or physical health conditions, and parents with English as an additional language, with other children who are not school age, or who work during school hours.
- The study was not tested in rural areas where travel time to groups may impact attendance and outcomes, raising concerns about the generalisability of findings to these areas. To improve, postcode data could be captured and mapped onto deprivation indices and rural/urban classifications to conduct subgroup analyses if such groups naturally emerge in the sample.

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APPENDIX A: THEORY OF CHANGE

Bounce Back 4 Kids Programme Theory of Change

IFF Research

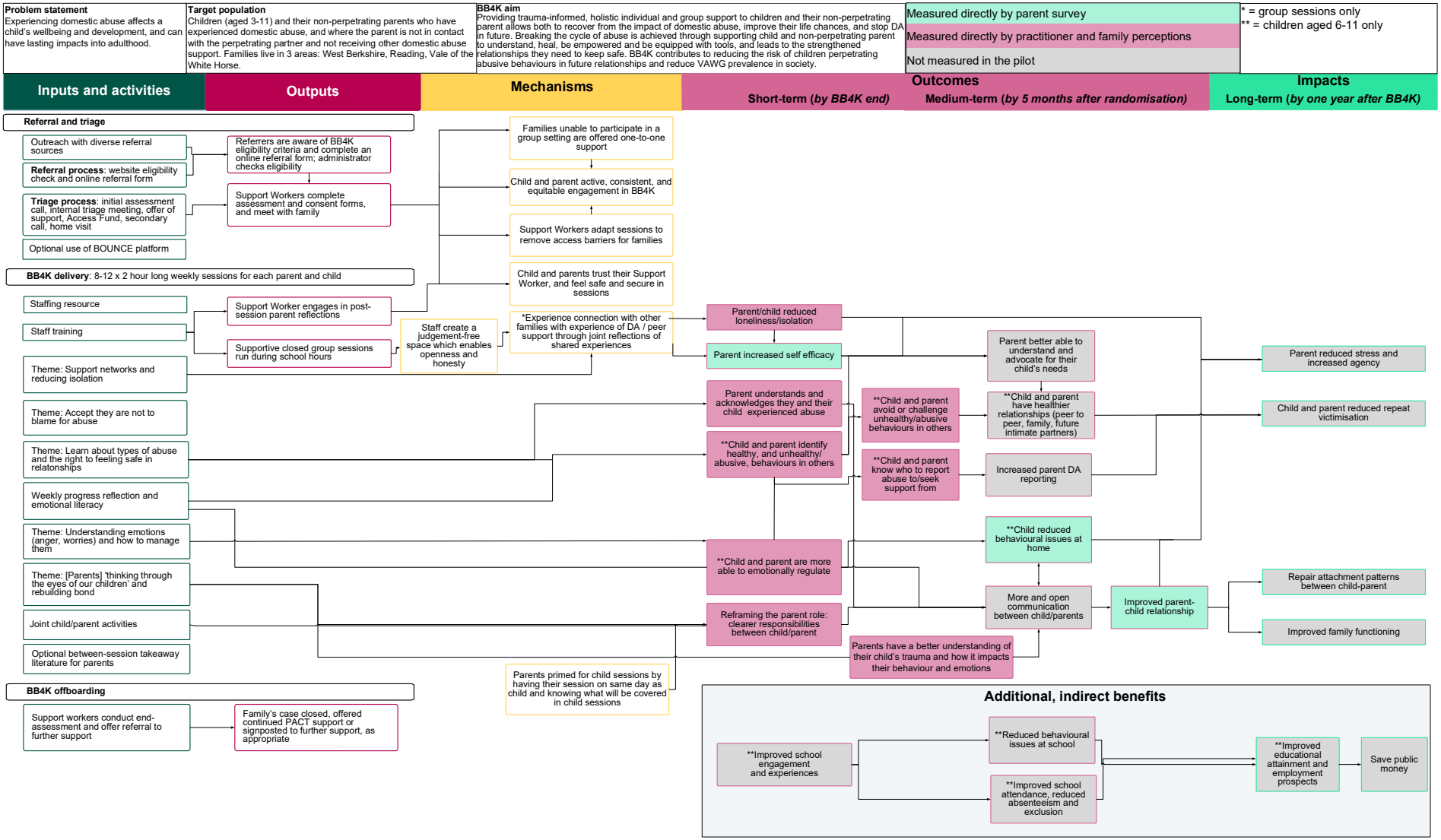
Problem statement
Experiencing domestic abuse affects a child's wellbeing and development, and can have lasting impacts into adulthood.

Target population
Children (aged 3-11) and their non-perpetrating parents who have experienced domestic abuse, and where the parent is not in contact with the perpetrating partner and not receiving other domestic abuse support. Families live in 3 areas: West Berkshire, Reading, Vale of the White Horse.

BB4K aim
Providing trauma-informed, holistic individual and group support to children and their non-perpetrating parent allows both to recover from the impact of domestic abuse, improve their life chances, and stop DA in future. Breaking the cycle of abuse is achieved through supporting child and non-perpetrating parent to understand, heal, be empowered and be equipped with tools, and leads to the strengthened relationships they need to keep safe. BB4K contributes to reducing the risk of children perpetrating abusive behaviours in future relationships and reduce VAWG prevalence in society.

Measured directly by parent survey
Measured directly by practitioner and family perceptions
Not measured in the pilot

* = group sessions only
** = children aged 6-11 only



Theory of change supporting narrative

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, in the short term BB4K aims to help parents understand that what they experienced was abuse, and 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. 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; improved parent understanding of child's behaviour and emotions; increased parent DA reporting; and reduced child behavioural issues), and the 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 was designed to assess impact in a robust way for three outcomes (highlighted in green in the ToC diagram 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 PACT website includes an eligibility checker for referrers to use and, if the referral is eligible, they automatically receive an online referral form to complete. Where the referral is deemed to be ineligible, PACT contacts the referrer to check their answers and confirm ineligibility.

Following referral, each family liaises with a Support Worker to conduct needs and risk assessments, assess suitability/readiness for recovery, begin to build trust with programme facilitators, and manage expectations. If any additional needs are identified, such as financial difficulties, poor mental health, family or civil court experiences, then PACT makes direct referrals on behalf of the service user to other specialist agencies. This could be a foodbank referral, support from legal advice charities, or referrals to mental health/counselling services, as appropriate. Additional needs relating to families' ability to access BB4K are also assessed, and where necessary the Accessibility Funding is used to address financial barriers which may have otherwise prevented families from attending. This in turn enables equitable access, so that all families can achieve outcomes regardless of personal circumstances.

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. Once the Support Worker has concluded that a family is ready for BB4K, they are added to a waiting list until a suitable group (according to age and location) is available.

Group delivery

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

Each BB4K group supports up to eight adults and eight children and includes eight weekly themed sessions (12 sessions for 3 to 5s), lasting 90 minutes. Each parents' session takes place simultaneously with the children's session. BB4K for children aged 3 to 5 years old involves joint parent and child sessions after each separate session. The group starts together, separates and then returns to do joint work in each session, finishing every week with parent and child dyad work. BB4K for children aged 6 to 11 involves one joint parent and child session during the final group session.

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 support sessions. 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 cases, a one-to-one support programme is delivered instead.

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. Groups are always delivered during school hours, during the school term, and 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.

Each session is facilitated by two to three staff members, including a support worker and at least one volunteer/student on placement to ensure participants receive the level of support they require. For younger children (3 to 5s) the programme includes a Play Therapist for the children's elements to better understand the behaviour and non-verbal communication displayed. The staff use trauma-informed activities and therapeutically informed techniques to simultaneously support parent and child to express their feelings and experiences, learn they aren't to blame, and understand the impact of trauma.

The trauma-informed approach means that PACT communicate clearly, concisely, and promptly with service users, and wherever possible avoid cancellation of any planned interventions

whether in person or remote. They work to a strengths-based approach and interventions include general principles from therapy such as rapport building, active listening, non-judgemental approaches and where possible tailoring what they offer to individual needs, respecting that a one-size-fits-all approach is not appropriate.

BB4K's weekly modules revolve around five key themes alongside the assumptions and mechanisms that lead to outcomes for families. The five themes are:

- Support networks and reducing isolation
- Accept they are not to blame for the abuse
- Learn about types of abuse and the right to feeling safe in relationships
- Understanding emotions and how to manage them
- Thinking through the eyes of our children and rebuilding bonds.

Further detail on these themes can be found in the intervention protocol (Foundations, 2024).

Optional access to the digital platform 'Bounce'

Participants also have the option to access 'Bounce'; the 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 learning and sustain outcomes. Currently, Bounce is most suitable for children aged 5 to 8 years (but older children can access this if they wish), and parents of children across all age groups covered by BB4K can use this with relevant content for them specifically.

In addition to 'Bounce', parents and children in the waitlist may access external support provided through schools or other agencies. Engagement with other services does not impact eligibility for BB4K, as long as their involvement in this support ends by the time their BB4K sessions start. For children this could include services such as Child and Adolescent Mental Health Services (CAMHS), Emotional Literacy Support Assistant (ELSA), play therapy and counselling, For parents, services available include Berkshire Women's Aid, Cranstoun, and A2Dominion. 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.

Staff

PACT prioritises the recruitment of empathetic and resilient staff, qualities that cannot always be taught but are essential to the programme's success. Alongside staff training, this is a key element that contributes to the creation of a judgement-free space that enables openness and honesty among parents during group sessions.

All staff members receive intensive inductions including specialist training on domestic abuse, the impact of Adverse Childhood Experiences (ACEs) and trauma, attachment, safeguarding/child protection, children and parent violence and abuse, and GDPR, as well as an

observation of a group session. 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 (non-mandatory training)
- 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. All full-time frontline staff receive monthly supervision sessions with the BB4K Service Lead. The BB4K Manager also conducts monthly supervision for all Service Leads as well as staff in back-office roles. Additionally, all staff are offered group clinical supervision. For part-time staff, supervision sessions are scheduled less frequently, approximately every six weeks.

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.

Adaptations

PACT's expert delivery staff are adept at coping with a wide range of needs and behaviours, equipping them to make small adjustments to incorporate challenging behaviours and addressing different needs. For example, they can ensure support is delivered in accessible buildings and can increase volunteers to facilitate group delivery. In this trial, PACT were not able to provide interpreters due to the financial limitations placed on the study.

Staff are able to support all adult DA survivors, irrespective of gender. Everyone is asked directly if they would feel comfortable being in a mixed gender group and, if not, they will be accommodated in a different group.

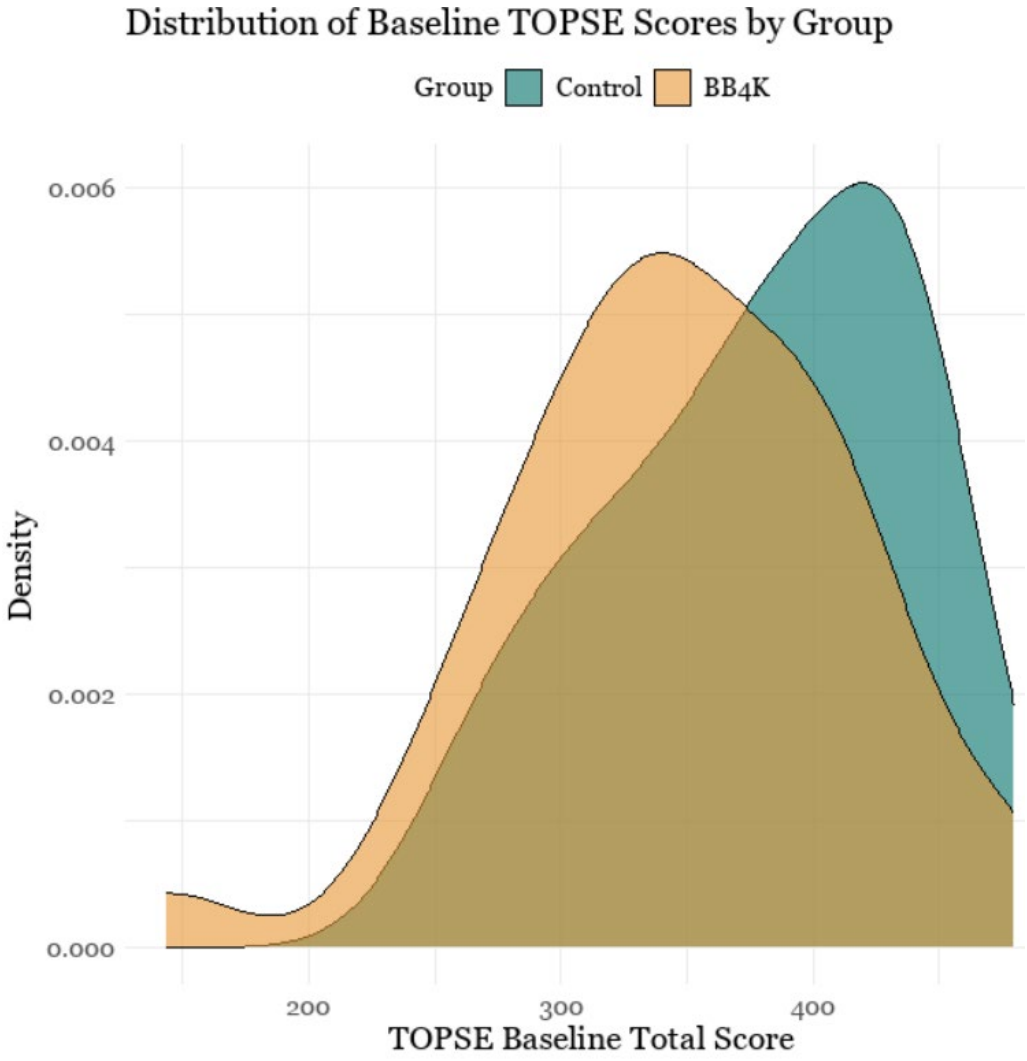
However, if for some reason the needs and risk assessments conclude that PACT is unable to provide a suitable group that meets the needs and circumstances, parents and children will be

offered individual (one-to-one) support which follows the same themed modules. This may also be preferable to families living in more rural locations who may struggle with transportation to the venue. Families offered individual support would be expected to achieve many of the same outcomes, such as identifying healthy and abusive behaviours and improved emotional regulation. However, they may not experience outcomes which are achieved though the mechanism of experiencing connections with other families with experience of domestic abuse, such as reduced loneliness and isolation.

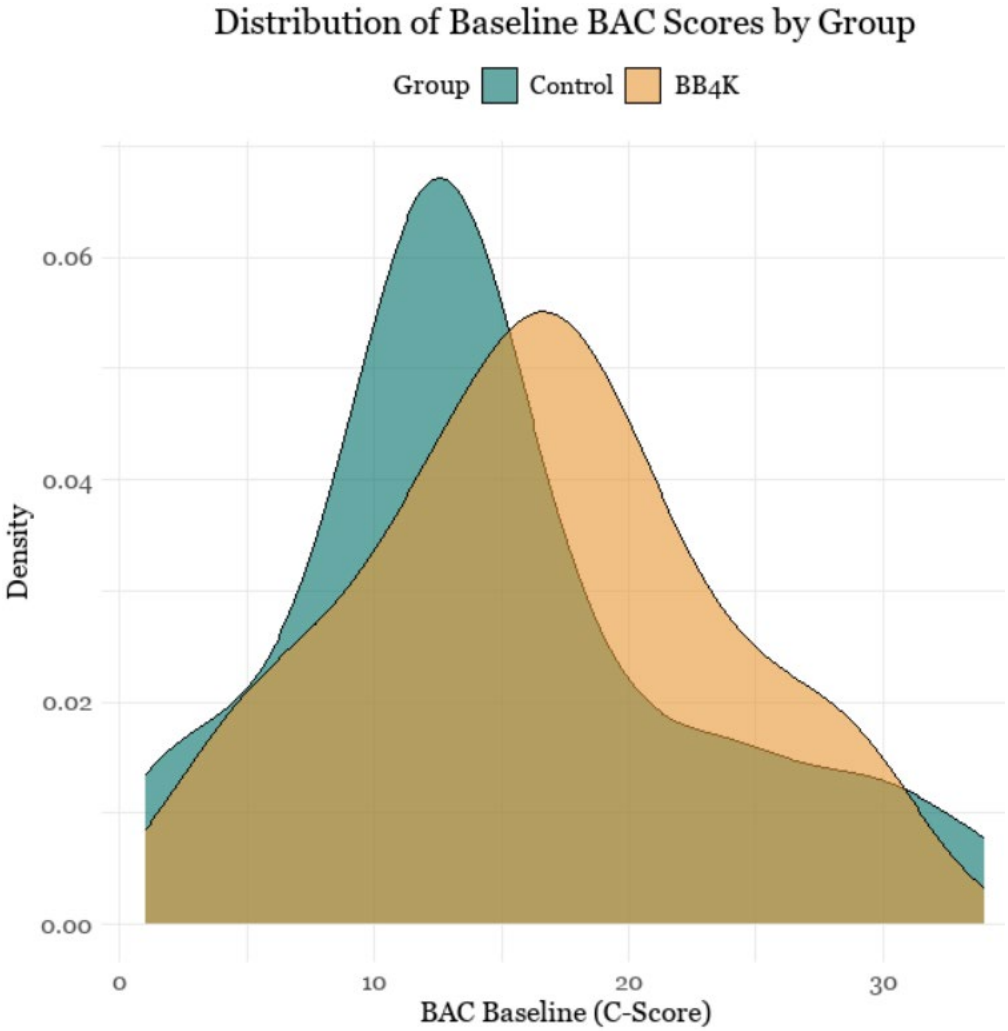
APPENDIX B: DISTRIBUTION OF BASELINE SCORES

The graphs in this appendix display the distribution of baseline scores for the outcomes for the treatment and control groups. Each group's scores are represented using a histogram with the horizontal axis showing the score values and the vertical axis showing the frequency of participants with those scores. The treatment group is shown in teal and the control group is shown in orange. The distribution indicates how scores vary within each group at baseline.

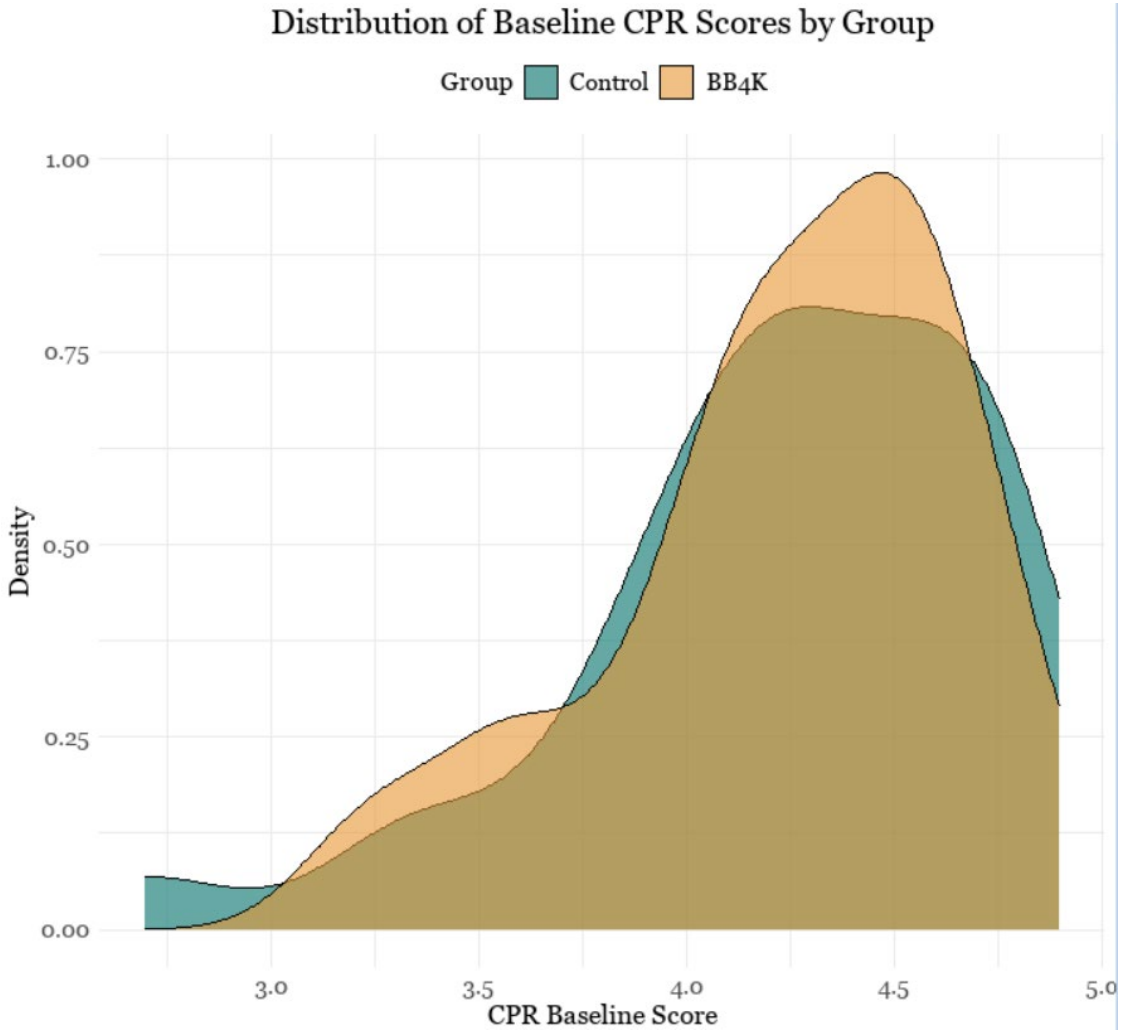
Primary outcome: Parents' self-efficacy (RQ1)



Secondary outcome: Child behaviour (RQ2)



Secondary outcome: Parent–child relationship and bonding (RQ3)



APPENDIX C: BREAKDOWN OF ATTRITION BY COHORT

Cohort 1 attrition

	Treatment	Control	Total
Recruitment target	16	16	32
Initial achieved recruitment*	16	10	26
Attrition from the BB4K programme	2	N/A	2
Attrition from the evaluation	1	2	3
Final number completing baseline and endline	13	8	21

Cohort 2 attrition

	Treatment	Control	Total
Recruitment target	24	16	40
Initial achieved recruitment*	19	20	39
Attrition from the BB4K programme	3	N/A	3
Attrition from the evaluation	1	10	11

	Treatment	Control	Total
Final number completing baseline and endline	15	10	25

*Defined as those who consented to take part in the evaluation and completed the baseline survey.

APPENDIX D: SUMMARY OF IPE QUALITATIVE FIELDWORK

	Wave 1	Wave 2
Senior leadership (Director of Community Services and Development, Service Lead, Manager)	Senior staff (N=4), via 1 online mini group, 75 mins, August 2024	Senior staff (N=4), via 1 online mini group, 75 mins, January 2025
Practitioners (Support Workers, Play Therapist, Psychology Student on placement)	Practitioners (N=5), via 1 online mini group, 90 mins, August 2024	Practitioners (N=3), via 1 online mini group, 90 mins, December 2024
Referrers (e.g. local authority (children's services, adult social care, and housing), schools, community partners, counselling services and other charities)	N/A	Referrers (N=3) via online interviews, 45 mins, February 2025
Parents – Treatment	Parents (N=5), via 1 in-person focus group, 1 hour, July 2024	Parents (N=4), via 1 in-person focus group, 1 hour, Nov 2024
Children – Treatment	Children (N=5), via 1 in-person focus groups, 1 hour, July 2024	Children (N=4), via 1 in-person observation of the child session, 1 hour, Nov 2024
Parents – Waitlist control	Parents (N=2), via online interviews, 45 mins, July 2024	Parents (N=2), via telephone interviews, 30 mins, May 2025
Total	**21**	**20**

*We engaged with different parents and children between waves 1 and 2, while the PACT staff interviewed included a combination of both new and returning team members.

APPENDIX E: BREAKDOWN OF REFERRAL SOURCES FROM MANAGEMENT INFORMATION

Referral Source	Total: n (%)
School	14 (26%)
Self-referral	12 (23%)
West Berkshire Children's Services	9 (17%)
Berkshire Women's Aid	7 (13%)
Early Help/Wellbeing hubs	4 (8%)
Brighter Futures (Reading children's services)	3 (6%)
Alana House	2 (4%)
Parenting Special Children	1 (2%)
Other professionals	1 (2%)