

BOUNCE BACK 4 KIDS: A RANDOMISED CONTROLLED TRIAL

Evaluation protocol

Intervention developer	PACT (Parents and Children Together)
Delivery organisations	PACT (Parents and Children Together)
Evaluator	IFF Research
Principal investigators	Kelsey Beninger and Sashka Dimova
Protocol authors	Kelsey Beninger, Sashka Dimova, Caitlin Webb, Millie Morgan, Katerina Cohnova, Lori Tyson
Type of trial	Full-scale randomised controlled trial
Age or status of participants	Children (aged 3–11) and their non-perpetrating parents/carers who have experienced domestic abuse, and where the parent/carer is no longer in a relationship with the perpetrating partner and not receiving other domestic abuse support
Number of participating local authorities	Eight delivery sites in Reading, West Berkshire, Wokingham, Oxford City, South Oxfordshire, Vale of the White Horse, Cherwell, and West Oxfordshire. An additional site (Slough) has been identified as a suitable ‘back-up’ site if referral numbers from the desired demographic groups are below target
Number of children and families	250 pairs of parents/carers and children in the intervention/treatment group, and 250 pairs of parents/carers and children in the waitlist treatment group
Primary outcome(s)	Parent/carer self-efficacy as measured with the Tool to Measure Parenting Self-Efficacy (TOPSE)



Secondary outcome(s)

Children's behavioural issues at home measured with the Brief Assessment Checklist for Children (BAC-C)

Summary

Bounce Back 4 Kids (BB4K) is a therapeutically informed group recovery programme for children aged 3–11 and their non-perpetrating parents/carers living in Reading, West Berkshire, Wokingham, Oxford City, South Oxfordshire, Vale of the White Horse, Cherwell, and West Oxfordshire. The programme is suitable for children and non-perpetrating parents who have experienced domestic abuse, where the parent/carer is not living with or in a relationship with the perpetrating partner and is not receiving other domestic abuse support. The model (which is explained in further detail in the [Intervention and Theory of Change](#) section) is designed to improve the safety, wellbeing, and stability of children and families and reduce re-victimisation.

BB4K has been running since 2010 and Foundations – the What Works Centre for Children & Families commissioned IFF Research to deliver a pilot evaluation of BB4K between April 2024 and July 2025. The pilot evaluation aimed to trial the research instruments, potential impact evaluation design, and methods, while also identifying and resolving potential problems ahead of a full-scale trial. The pilot was a two-armed, cohort waitlist randomised controlled trial (RCT). Research activities included three surveys delivered at set time points across programme delivery: before the group sessions began, at the final group session, and five months after randomisation. Qualitative discussions were also conducted with parents/carers, referrers, and PACT staff, and management information (MI) data was collected and analysed.

In total, 65 parent/carer–child pairs were recruited to take part in the pilot evaluation (35 to the intervention group and 30 to the control group). Of these, 46 provided outcome data at follow-up (28 who received BB4K intervention, 18 in the control group) and our analysis was based on these 46 participants.

The pilot evaluation found promising results. The primary outcome measured was parental self-efficacy as measured with the Tool to Measure Parenting Self-Efficacy (TOPSE). At midline, BB4K parents/carers showed a moderate, statistically significant improvement, supported by positive qualitative findings. At endline (six months post-randomisation), the effect remained positive but was not statistically significant, suggesting a larger sample would be needed to confirm impact. Secondary outcomes included child behaviour measured with the Brief Assessment Checklist for Children (BAC-C) and parent–child relationship (Child–Parent Relationship Scale, CPRS). A moderate but non-significant improvement in child behaviour was observed at endline, and no changes were found in parent/carer–child relationships through the impact evaluation. However, the implementation and process evaluation (IPE) findings indicated positive improvement in this area.

This full-scale RCT of BB4K will build on the pilot results and provide robust evidence of BB4K's effectiveness. The pilot was not designed to be powered. Scaling up within a full-scale trial will



increase statistical power to detect small or moderate effects of BB4K with statistical confidence. The full-scale RCT will also address key limitations of the pilot evaluation, such as a lack of diversity in the sample and potential ‘ceiling effects’¹ in the CPRS measurement.

Foundations commissioned the full-scale evaluation (with funding provided by the Evaluation Task Force) to build on the learnings from the pilot and strengthen the evidence base around effective approaches that tackle domestic abuse. Foundations is dedicated to raising the standards and volume of good quality research in the sector and is committed to providing an evidence base for social workers, leaders in the sector, and policymakers to support children and their families.

This evaluation seeks to evaluate delivery of BB4K in Reading, West Berkshire, Wokingham, Oxford City, South Oxfordshire, Vale of the White Horse, Cherwell, and West Oxfordshire. This is a full-scale randomised controlled trial (RCT) which will cover delivery from April 2026 to November 2028, during which time it is anticipated that Parents and Children Together (PACT) will be able to recruit 250 pairs of parents/carers and children in the intervention group, and 250 pairs of parents/carers and children in the control group.

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

The purpose of the impact evaluation is to analyse and examine impact on a range of short-term or medium-term outcomes. These questions will be explored via the delivery of an RCT. Two hundred and fifty children and their non-perpetrator parents/carers will receive the intervention immediately (i.e. right after randomisation), while 250 families will be allocated to the control group and will receive the BB4K service at a later date.

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

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

¹ 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.



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Background and problem statement

It is well established that domestic abuse is harmful to children, and this is reflected in Section 3(2) of the Domestic Abuse Act 2021, which acknowledges children as victims of domestic abuse in their own right. Evidence shows that domestic abuse is a pervasive problem in the UK, estimated to affect one in five children. It is the leading reason for referrals to Children's Social Care and the most common factor in both 'Children in Need' assessments and decisions to remove children from their homes (Crime Survey England and Wales, 2025). Research shows that experiencing domestic abuse in childhood can have a wide-ranging, substantial impact that can last into adulthood. Children who have experienced domestic abuse are more likely to have lower levels of emotional wellbeing and 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, Domestic Abuse Commissioner, 2025, Kitzmann et al., 2003).

Causal evidence on which programmes improve outcomes for children in families experiencing domestic abuse is limited. Previous feasibility work undertaken by Foundations (2023a), alongside the Oxford rapid review (Foundations, 2023b), shows that there are over 100 domestic abuse programmes operating across the UK, but only a small number have been evaluated through robust impact evaluations, making it challenging for decision-makers to plan for services that will provide support to every child and adult experiencing domestic abuse. Foundations is committed to developing this evidence base through evaluating promising practices. The aim is to generate actionable evidence needed to improve services for vulnerable families, so that more children can live safely at home and have happier and healthier lives.

As part of this commitment to improving the evidence base on 'what works' for children who are exposed to domestic abuse, Foundations commissioned an initial pilot evaluation of Bounce Back 4 Kids (BB4K) (Foundations, 2025). 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 contributed to an evidence base on implementing and evaluating groupwork therapeutic programmes, and a better understanding of what makes it more difficult or easier for families who have experienced domestic abuse to participate in these programmes. Building on the pilot evaluation, Foundations has now commissioned a full-scale RCT to strengthen the evidence around BB4K's effectiveness.



Intervention and theory of change

The focus of this section is on BB4K's intervention and theory of change (ToC). The information presented is synthesised from discussions with the Parents and Children Together (PACT) team concerning current delivery of practice. More information on the intervention can be found in the Intervention Protocol: <https://foundations.org.uk/wp-content/uploads/2026/05/bounce-back-4-kids-randomised-controlled-trial-intervention-protocol.pdf>

Overview

BB4K offers an alternative to individual and separate support services for children and their parents/carers recovering from domestic abuse. It uses a trauma and therapeutically informed group approach that simultaneously supports both children (aged 3–11) and their non-perpetrating parents/carers who have experienced domestic abuse and are no longer living with or in a relationship with the perpetrating parent. Other defining features of BB4K include consistency in support workers across sessions, high staff-to-service user ratio in group settings, and joint family activities alongside separate child and parent/carer group sessions.

Aim

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

Delivery organisation

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

Target population

The programme targets children (aged 3–11) and their non-perpetrating parents/carers who have experienced domestic abuse where the parent/carer is no longer living with the perpetrating partner, the relationship has ended (a breakup, separation, or divorce), and they are not receiving other domestic abuse crisis support. The eligibility criteria are further discussed in the 'Participants' subsection.

For this evaluation, dependent on PACT's recruitment, 500 parent/carer–child pairs will be included in the evaluation. This will include: 250 pairs of parents/carers and children in the



intervention group, and 250 pairs of parents/carers and children in the control group. If there is more than one child between 3 and 11 years old in the family, then the parent/carer can select a child that can benefit the most from the group element. PACT will offer one-to-one support for the other children in the family.

PACT has previously delivered BB4K in Reading and West Berkshire, Wokingham, Vale of the White Horse, Oxford City, and South Oxfordshire. Cherwell and West Oxfordshire are new delivery locations for the full-scale evaluation and have been chosen because PACT has previously received a number of referrals from operational partners in this area and to support the diversity of families recruited into the programme.

Theory of change

Figure 1 sets out the updated theory of change (ToC), a key output of the discussions with PACT and Foundations following the pilot evaluation and ToC workshop. The ToC sets out the mandatory inputs and activities (i.e. referral and triage process, group sessions, staff training, and offboarding) for successful delivery. The key inputs and activities are discussed in more detail in the sections below. The referral and triage process is essential to ensure parents/carers 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 because 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/carer and the child, and in turn can increase the parent/carer's agency and self-efficacy. As can be seen in the ToC, BB4K aims to improve the child's and the parent/carer'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. This helps to avoid the blurring of boundaries that can occur and the roles that children can take on as a result of abuse. For example, they discuss whose responsibility it is to pass messages between parents. As a result, it is anticipated that parents/carers and children can avoid unhealthy behaviours (e.g. poor emotional regulation, expressing emotions in harmful ways that could lead to hurting others, etc.) and will seek support when needed. This, in turn, supports family communication and communication between parents/carers and professionals who may provide support, and encourages positive decision making in relationships in the present and in the future. The ToC considers these improvements as essential elements for the medium-term outcomes (i.e. parent/carer is better able to understand and advocate for child's needs; healthier parent-child relationship; improved family communication; increased parent/carer reporting of domestic abuse-related incidents; and reduced child behavioural issues) and long-term outcomes (i.e. reduced parental stress; reduced repeat victimisation; repaired attachment patterns between parent/carer and child; and improved family functioning) to be realised.

It is important to note that the evaluation is designed to assess impact in a robust way for two outcomes (highlighted in green in the ToC in Figure 1): parental self-efficacy and child behaviour at home. 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. In the pilot evaluation, we also assessed parent-child relationship as a secondary outcome. However, the measure used (Child-Parent Relationship Scale, CPRS) was not validated for UK



families affected by domestic abuse and showed limited sensitivity, leading to ceiling effects² that restricted our ability to detect meaningful change. Given these limitations, this outcome will not be included in the surveys for the full-scale evaluation and will instead be explored qualitatively through the IPE.

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/carers.

The first step for anyone making a referral is to complete the eligibility checker on the PACT website.³ This checks key information to ensure that any families referred meet the project eligibility requirements. Where the referral is deemed to be ineligible, PACT contacts the referrer to check their answers and confirm ineligibility.

Where the referral is eligible, the referrer will automatically receive an online referral form to complete. Once completed, the referral will be reviewed by the Triage and Assessment Officer, who will ensure eligibility, conduct assessment calls (ensure suitability/readiness for recovery), and capture informed consent to participate in the evaluation. Informed consent is obtained from parent/carer and child because engagement is voluntary.

Following referral and before randomisation, each family liaises with a Support Worker to conduct needs and risk assessments, 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, with their consent, PACT makes direct referrals on behalf of the service user to other specialist agencies. These could be a foodbank referral, support from legal advice charities, or referrals to mental health/counselling services, as appropriate. Families referred to any of these services can still go on to access BB4K.

Each family has a pre-course meeting (home visit) to share information about the group, reinforce the benefits to children when their parents/carers participate, and help parents/carers prepare their children for the group. To ensure full accessibility, PACT staff also ask parents/carers to share their children's needs (such as learning, behavioural, sensory, and communication) so that suitable adjustments can be made. PACT operates an outreach model whereby groups take place in a setting that is easily accessible by, and close to, families.

² 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.

³ See: <https://www.pactcharity.org/bb4k/looking-for-support/bb4k-referral-form>



Format and mode of delivery

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

All sessions are delivered face to face, with the majority in a group setting located in private facilities, community halls, schools, or other similar locations. Sessions are delivered during school hours and during the school term, and last up to 1.5 hours per week. Groups are always delivered in the same place to ensure they are accessible and predictable for all. They are delivered with the school's cooperation, which enables parents/carers and children to attend without having to consider childcare for other non-referred children.

Transportation is facilitated where necessary. Two to three staff members – including a Support Worker and at least one volunteer or student on placement – attend each group to ensure participants receive the level of support they require.

For a small number of families, a group session might be deemed inappropriate due to a parent/carer's or child's special requirements (e.g. language barriers, not ready for a group setting, etc.). In these cases, a one-to-one programme that follows the same BB4K modules is delivered instead. This small number of families will be considered as participants of the trial if they are randomly assigned to the intervention group or control group.

In cases where more than one child has been referred with the same parent/carer, only one child will join the group sessions. The child selected to participate will be determined through conversations with the parent/carer about which child would benefit most from groups compared with one-to-one sessions. Other children above the age of 5 can receive one-to-one support, while those in the 3–5 group can go on to receive BB4K group sessions once their sibling has concluded theirs, if it is felt they would benefit from this support.

Staff training

All staff receive training, including observation of facilitating a full group. All Support Workers receive intensive inductions, including specialist training in domestic abuse, the impact of adverse childhood experiences (ACEs) and trauma, attachment, safeguarding/child protection, and data protection (GDPR). They all complete the following teaching or professional qualifications:

- EduCare – Adverse Childhood Experiences Level 2
- EduCare – Domestic Abuse: Children and Young People
- West Berks Domestic Abuse Champion training
- Training for delivering Healing Trauma⁴
- Special educational needs (SEN) training – e.g. Autism Spectrum Disorder Course, Dyslexia Course, etc.

⁴ See: <https://www.pactcharity.org/events/healing-trauma/>



- Keep Them Safe – protecting children from child sexual exploitation.

The majority of these training courses are completed once during the staff induction phase but can be repeated as and when a refresher would be helpful. Certain courses, such as safeguarding children, are repeated on a regular basis. 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 the family's trust.

BB4K group content and delivery

The BB4K groups consist of eight or 12 sessions which are up to 1.5 hours long each. The number of sessions delivered depends on the delivery method and the age of the children. Families receiving one-to-one support engage in eight sessions. Children aged 6–11 engage in eight group sessions. Children aged 3–5 engage in 12 group sessions as younger children may need more time to build relationships and a sense of safety.

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

Session content is explored below, alongside the assumptions and mechanisms that lead to outcomes for families.

Theme one. Support networks and reducing isolation

This theme encourages parents/carers and children to recognise their own support networks and links with support in the community. Reducing isolation and building social networks help to reduce the parent/carer's and child's loneliness and build their resilience and confidence. This can in turn lead to improved parental self-efficacy, increased agency, and reduced stress.

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

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



Theme three. Learn about types of abuse and the right to feel safe in relationships

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

Theme four. Understanding emotions and how to manage them

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

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

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

More information on the content of each session is provided in the Intervention Protocol: <https://foundations.org.uk/wp-content/uploads/2026/05/bounce-back-4-kids-randomised-controlled-trial-intervention-protocol.pdf>.

BB4K offboarding

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

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



Adaptation

PACT's expert delivery staff are adept at coping with a wide range of needs, including those that present through behaviours. They can make small adjustments to incorporate challenging behaviours and different needs (such as ensuring support is delivered in accessible buildings and increasing volunteers to provide group delivery etc.). BB4K is delivered in English; however, an Accessibility Fund will support the use of interpreters if required.

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

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

Additional online support

Families in the intervention and control groups can access the Bounce online platform; PACT will signpost to this, as is their standard practice. Bounce is a digital platform co-developed with ex-service users offering a range of tools, age-appropriate games, and e-learning to support children and parents/carers before, during, and after accessing BB4K in order to embed learnings and sustain outcomes. Bounce was utilised during the pilot evaluation and will continue to be available for parents/carers in the full-scale evaluation.

Business as usual

Families in the control group may access external support provided through schools or other agencies. Engagement with other services will not impact eligibility for BB4K, as long as their involvement in this support ends by the time their BB4K sessions start. In the survey, parents in the control group will be asked about any other support they have received, so that we can consider this in the outcome analysis.

In the pilot evaluation, it was uncommon for parents to be receiving external support at the time of starting the BB4K programme; therefore, access to external support is not expected to impact the sample eligible for randomisation.

For children, these could include:

- Child and Adolescent Mental Health Services (CAMHS): the NHS services that assess and treat young people with emotional, behavioural, or mental health difficulties
- Emotional Literacy Support Assistant (ELSA): sessions in schools typically held once a week across the length of a term and lasting between half an hour and an hour. A child could be offered one-to-one or group sessions, depending on need
- Play therapy



- Counselling or outreach services from other charities such as No5 Young People's Counselling Service, a Reading-based young person's counselling and mental health support service for anyone between the ages of 11 and 25
- SAFE!'s individual support services: an independent charity providing support to children and families around the Thames Valley who have been affected by crime or abuse through one-to-one and group sessions, and available to children age 5–18.

For parents/carers these could include:

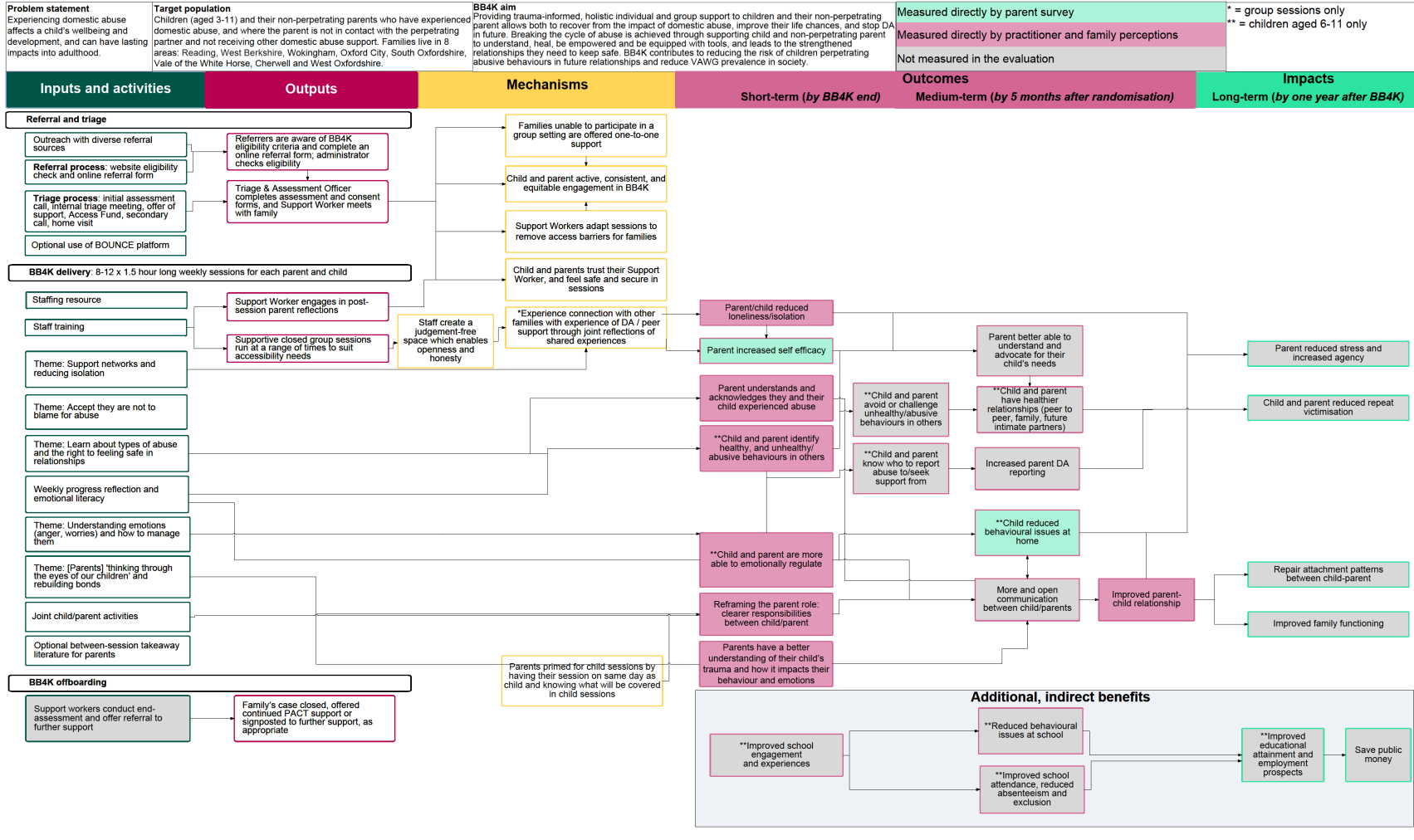
- Berkshire Women's Aid
- Cranstoun, a charity offering housing, health, and social care support to adults, children, and young people, including domestic abuse support
- A2Dominion, domestic abuse support services for adults in Oxfordshire.

Business-as-usual (BAU) services that parents/carers may access tend to focus on adults in crisis, at medium/high risk, rather than families who are now safe and ready for recovery. BAU for both parents/carers and children also typically provides individual support services, as opposed to group work that simultaneously supports the parent/carer and child.



Figure 1. BB4K Theory of Change

Bounce Back 4 Kids Programme Theory of Change





Impact evaluation

Research questions

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

RQ1. To what extent do parents/carers taking part in BB4K's group sessions have improved self-efficacy measured by the Tool to Measure Parenting Self-Efficacy (TOPSE) five months after randomisation compared with parents/carers who do not receive BB4K? (Primary outcome, medium-term)

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

RQ3. To what extent do BB4K's group sessions lead to improvements in the above outcomes at five months post-randomisation for certain groups of parents/carers and children taking part in BB4K compared with the same groups of parents/carers and children who do not receive BB4K? The subgroups examined will be:

- a. **Child age bands:** 3–5, 6–8, 9–11
- b. **Child gender:** male, female
- c. **Child ethnicity:** categorised as White/Non-White, depending on the distribution of participants.

RQ4. To what extent do parents/carers who were compliant with BB4K's group sessions (attended the required number of sessions for their child's age group and received at least 50% of sessions as group sessions) have improved self-efficacy, measured by TOPSE, six months after randomisation compared with parents/carers who do not receive BB4K? (Compliance analysis, medium-term)

RQ5. To what extent do parents/carers and children taking part in BB4K show improvements in parental self-efficacy (TOPSE) and reductions in child behavioural issues (BAC-C) at midline (at programme completion, roughly three months after baseline) compared with parents/carers and children who do not receive BB4K? (Early impact)

Design

The impact evaluation of BB4K will use a two-armed, individually randomised, waitlist-controlled design involving 500 dyads, comprising children (aged 3–11) and their non-perpetrating parents/carers. Participants will be recruited into and receive the programme in six staggered cohorts (Cohorts 1–6), which reflect waves of recruitment and programme delivery based on implementation capacity and practical considerations.

Randomisation will occur at the parent/carer–child pair level, allocating participants to either the intervention group or a waitlist control group. Families assigned to the intervention group will receive BB4K immediately, and those assigned to the control group will receive the programme after a waiting period.



The cohort structure allows for staggered recruitment and delivery over time, while maintaining random allocation within each cohort. Under the waitlist design, all families referred to BB4K will ultimately receive the intervention once their cohort’s treatment group has completed delivery. Waiting times for control-group families will vary by cohort, ranging from four to eight months, reflecting PACT’s delivery capacity and the impact of school summer holidays on scheduling. Randomising the start date of programme participation enables families scheduled to receive the programme later to serve as a comparison group for those receiving the intervention earlier.

There is only one treatment condition: children and their non-abusive parent/carer will receive BB4K sessions. In total, 250 parent/carer–child pairs referred to BB4K will be assigned to the intervention group. Delivery and fieldwork will take place over six cohorts between April 2026 and April 2029. Expected numbers in each cohort can be found in Table 1.

Table 1. Number of participants in each cohort

Cohort	Intervention group	Control group	Total
1	40	40	80
2	40	40	80
3	40	40	80
4	48	48	96
5	48	48	96
6	40	40	80

A total of 250 parent/carer–child pairs will be assigned to the control group. They will be given access to the new digital platform, Bounce, in addition to the business-as-usual support they are receiving from other services, before they receive the BB4K support (see [‘Business as usual’](#) for more information on the additional support available). For this evaluation, that means that we are assessing the effect of the group sessions rather than the full package of support offered as part of BB4K, which includes Bounce (but which is not required for all BB4K families to use). This has the benefits of offering support to the control group and may improve retention in the control group.

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



Table 2. Overview of trial and outcomes

Trial type and number of arms		Two-arm, cohort, randomised waitlist trial
Unit of randomisation		Parent/carer–child pairs (family level)
Block (stratification) variables		Delivery site and child’s age
Primary outcome	Variable	Parents’/carers’ self-efficacy
	Measure (instrument, scale)	Tool to Measure Parenting Self-Efficacy (TOPSE, a multi-dimensional parent/carer self-report of 48 statements within eight scales measuring parental self-efficacy. The score ranges between 0 and 60)
Secondary outcome(s)	Variable(s)	Children’s behavioural issues at home
	Measure(s) (instrument, scale)	Brief Assessment Checklist for Children (BAC-C; 20-item parent/carer self-report screening and monitoring scale. The total score is between 0 and 40)



Figures 2 and 3 show the participants' journey through the trial.

Figure 2. Participant journey flowchart

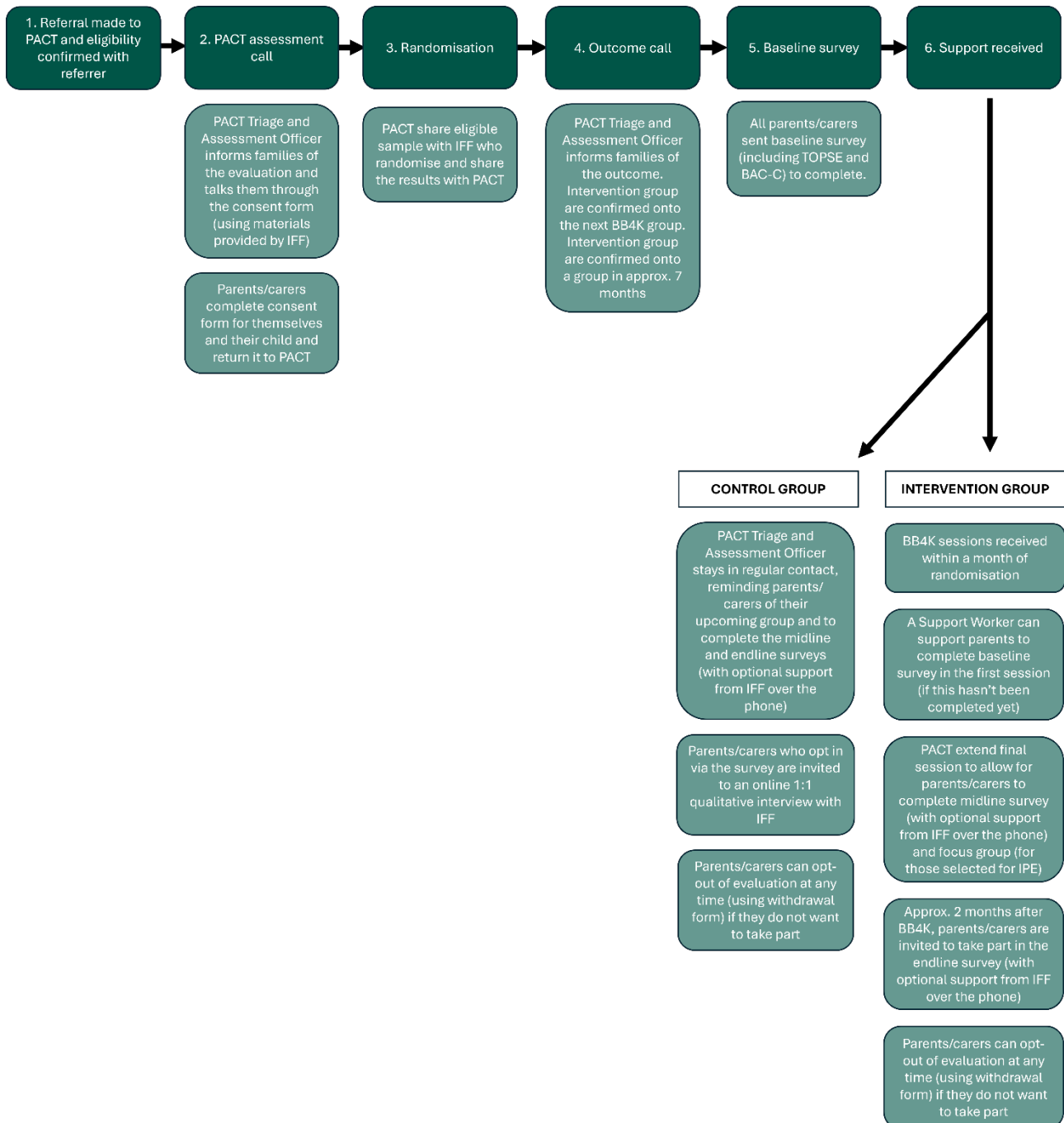
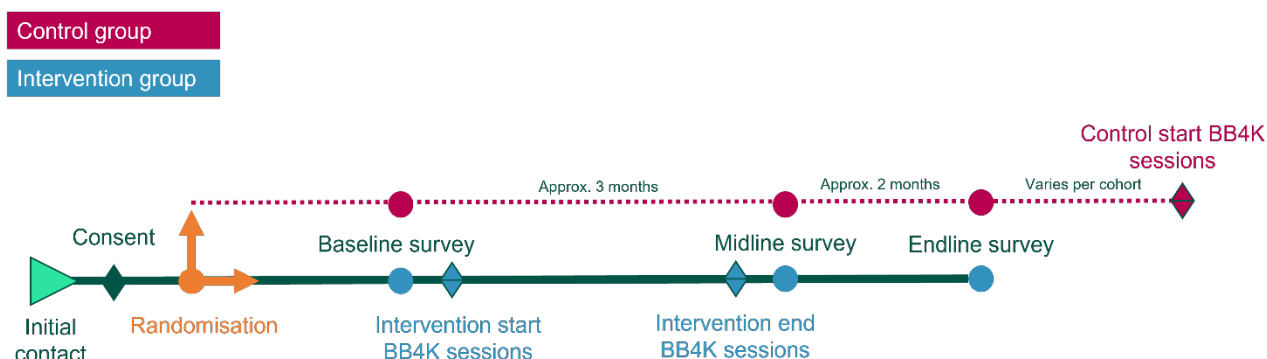




Figure 3. Participant journey diagram



Randomisation

Randomisation will occur at the parent/carer–child pair level after families have been referred to BB4K and informed consent has been obtained. Allocation into intervention or control will be done using block randomisation by child age (3–5, 6–11) and stratified by site, to support balance between groups across the participating age bands and delivery sites. In some cohorts, the number of eligible participants within a particular age band and site may be small. In these cases, it may not be possible to randomise participants within that group while maintaining viable programme group sizes. For example, if fewer than 12 children aged 3–5 or fewer than 16 children aged 6–11 are available at a given site, the entire group may be allocated to either the intervention or control condition rather than randomised within that subgroup. Where this occurs, efforts will be made to maintain overall balance across age bands and sites across the full set of cohorts.

Randomisation will occur at six different time points, corresponding to the start of each cohort (Cohorts 1–6). Waiting times for the control group will vary for different cohorts accessing programme delivery (between four and eight months) due to PACT’s delivery capacity and summer holidays. Cohort 1 (scheduled for April 2026) will include up to 80 parent/carer–child pairs. These will be randomised 1:1 to receive BB4K immediately (April–July 2026) or to the control group, who will receive BB4K five months later (September 2026). Subsequent cohorts will follow the same principles, with the number of families, treatment groups, and waitlist timing varying according to recruitment and PACT delivery capacity.

Table 3 summarises the randomisation dates, the number of groups and parent/carer–child pairs randomised in Cohorts 1–6, and the dates of programme delivery for intervention and control groups.



Table 3. Randomisation dates and delivery schedule

Cohort	Randomisation date	Maximum number of parent/carer–child pairs	Number of intervention groups	Intervention group delivery	Number of control groups	Control group delivery
1	March 2026	80	5 groups	Apr–July 2026	5 groups	Sept 2026 (5 months' wait)
2	July 2026	80	5 groups	Sept–Dec 2026	5 groups	Apr 2027 (7 months' wait)
3	November 2026	80	5 groups	Jan–Apr 2027	5 groups	Sept 2027 (8 months' wait)
4	July 2027	96	6 groups	Sept–Dec 2027	6 groups	Jan 2028 (4 months' wait)
5	February 2028	96	6 groups	Mar–July 2028	6 groups	Sept 2028 (6 months' wait)
6	July 2028	80	5 groups (no 3–5 groups)	Sep–Nov 2028	5 groups (no 3–5 groups)	Feb 2029 (5 months' wait)

Given the longer waitlist periods for some cohorts (e.g. eight months for Cohort 3 and seven months for Cohort 2), there is a potential risk of attrition or changes in participant motivation, expectations, or outcomes over time. To mitigate these risks, the Triage and Assessment Officer will keep in regular contact with parents/carers in the control group, reminding them of their upcoming groups and to complete midline and endline surveys. Participants will also receive clear guidance at recruitment and access to business-as-usual support while waiting for BB4K delivery, and retention will be monitored. Any differences in drop-out rates will be documented, and potential impacts on findings will be considered in the analysis.

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

Baseline characteristics of participants in the intervention and control groups will be assessed and reported in the analysis. Although randomisation is expected to produce groups that are



comparable at baseline, any observed differences may occur by chance and will be taken into account when interpreting the findings (Glennerster et al., 2013).

Participants

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

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

Sample size/MDES calculations

The BB4K efficacy trial will recruit 500 parent/carer–child pairs across six cohorts. This sample size is based on power calculations conducted in R, accounting for potential clustering of outcomes among participants attending the same group, expected attrition, and within-participant correlations.⁵

Assumptions for power calculations:

- Allocation: equal allocation to intervention and control groups
- Baseline/endline correlation: 0.786 for parent/carer–child participants as established in the pilot. Child-level correlations are not applicable
- Intraclass correlation coefficients (ICCs): 0 for site; 0.1 for intervention groups; 0 for family level. Although randomisation occurs at the parent/carer–child pair level, BB4K is delivered in group sessions. Participants attending the same group may therefore experience correlated outcomes due to shared facilitators and peer interactions. Power calculations therefore account for clustering at the intervention group level, assuming an ICC of 0.10
- Average group size: eight parent/carer–child pairs per group

⁵ Power calculations were conducted using IBM SPSS Statistics – R Integration Package.



- Power: 0.80 (80%)
- Significance level: 0.05, two-sided
- Level of intervention clustering: intervention groups.

This study is powered to detect an effect size of approximately 0.30 on the primary outcome, corresponding to a detectable 5% change in mean scores on the TOPSE. Based on the pilot study, we expect attrition of around 30%. Therefore, to account for this, 500 parent/carer–child pairs will be recruited in the trial supporting delivery across approximately 63 BB4K groups.

The sample size provides 80% power to detect an effect size of 0.251 on the primary outcome (TOPSE), assuming no attrition. Based on the pilot study, we expect approximately 30% attrition, which reduces the effective sample and results in a detectable effect size of around 0.30, corresponding to a 5% change in mean TOPSE scores. We have also considered sensitivity to different assumptions about attrition. For example, if attrition were lower (10–20%), the detectable effect size would be smaller (0.264–0.280).

The choice of a 0.30 effect size is informed by practical considerations from the pilot study, where we observed moderate changes in parental self-efficacy. As this is a novel intervention, there is limited prior evidence to guide expectations for effect size, so we have conservatively selected 0.30 as a meaningful and detectable difference while acknowledging uncertainty.

Subgroup exploratory analysis

During scalability planning, we explored the possibility of powering the study by ethnicity. However, it was deemed infeasible to recruit sufficient participants from minoritised ethnic communities for a fully powered analysis. BB4K does not apply specific targeting criteria based on ethnicity. However, delivery partners aim to ensure that the programme is accessible to families from diverse backgrounds through established referral networks and inclusive delivery practices. PACT will aim to identify least 60 parent/carer–child pairs from minoritised ethnic communities. Although this sample will not support statistically powered subgroup comparisons, it will allow for exploratory quantitative analyses. Additionally, the study will include a new IPE research question to specifically explore the experiences of families from minoritised ethnic communities qualitatively. This approach ensures that the evaluation captures insights into the experiences of families from minoritised ethnic communities while recognising the practical constraints of powering subgroup analyses.

Outcome measures

The impact evaluation is designed to focus on a subset of the outcomes outlined in the Theory of Change to ensure that data requests are proportionate, and to reduce the risk of chance findings.⁶ All measures were selected in collaboration with PACT following the pilot evaluation, where only those tests found to possess adequate levels of reliability and sensitivity were selected for initial review.

⁶ For more information see: <https://foundations.org.uk/our-work/resources/10-steps-for-evaluation-success>.



The full-scale evaluation will evaluate one primary outcome (parental self-efficacy) and one secondary outcome (children’s behavioural issues at home). This follows the pilot. However, although parent–child relationship was included as a secondary outcome in the pilot, ceiling effects and limited sensitivity led to its exclusion from the quantitative analysis within the full-scale evaluation. This outcome will instead be explored qualitatively within the IPE.

Table 4. Overview of outcome measures and expected calculations

Attrition %		30%	25%	20%	10%	0%
MDES		0.30	0.289	0.280	0.264	0.251
Baseline/endline correlations	Child	N/A				
	Participant (parent/child)	0.786				
	Social Worker	N/A				
Intraclass correlations (ICCs)	Family	N/A				
	Site	0				
	Group	0.1				
Alpha	0.05					
Power	0.8					
One-sided or two-sided?	Two-sided					
Level of intervention clustering	BB4K delivery group					
Average cluster size	8					



Sample size (parent/carer–child pairs)	Intervention	175	188	200	225	250
	Control	175	188	200	225	250
	Total	350	376	400	450	500
BB4K groups⁷	Intervention	21.88	23.5	25	28.12	31.25
	Control	21.88	23.5	25	28.12	31.25
	Total	43.75	47	50	56.25	62.5

The primary outcome (parental self-efficacy) will be measured by the Tool to Measure Parenting Self-Efficacy (TOPSE). The Brief Assessment Checklist for Children (BAC-C) questionnaire will be used to measure the secondary outcome (child behaviour). We provide the rationale for and more information on these selected measures below.

Primary outcome: self-efficacy

To answer RQ1, we will analyse whether parents/carers taking part in BB4K’s group sessions have improved self-efficacy (primary outcome), compared with parents/carers who do not receive the intervention immediately. Self-efficacy relates to an individual’s perception and expectation of how well they think they will cope in a given situation (Kendall and Bloomfield, 2005). To measure change in self-efficacy we will use TOPSE. This is a parent/carer self-report tool, and it was selected as a primary outcome measure because it is already used by PACT as part of usual practice and was considered most relevant for the programme theory. The questionnaire can be used with all parents/carers and is cost-effective to collect. The tool has been used in parenting programmes applied in different cultural, social, and educational contexts (Bloomfield and Kendall, 2012, Bloomfield et al., 2010). The questionnaire includes eight domains including: emotion and affection, play and enjoyment, empathy and understanding, control, discipline and boundaries, external pressures on parenting, self-acceptance, and learning and knowledge. Each six-item domain is then summarised in a score ranging from 0 to 60. The questions are based on the Likert scale of 0 to 10 points, where 0 corresponds to completely disagree and 10 completely agree. Internal reliability coefficients for the subscales range from 0.80 to 0.89, and the overall scale reliability is 0.94. The test takes 10–15 minutes to complete (Kendall and Bloomfield, 2005). The TOPSE questions will be included in the midline and endline surveys, alongside additional

⁷ Average group size; actual groups will include whole numbers of participants.



questions asking parents/carers to reflect on how their confidence has changed over time, to support analysis of change in outcomes.

Secondary outcome: child behaviour

To answer RQ2, we will use the BAC-C questionnaire (Tarren-Sweeny, 2012). BAC-C is a measure that can be used by the parent/carer 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/carers are asked to assess whether the behaviour occurred in the past four to six months. The test takes five minutes to complete. The total raw problem score ranges between 0 and 40, with high scores indicating that more problems are present. The BAC-C questions will be included in the midline and endline surveys, alongside additional questions asking parents/carers to reflect on how their child's behaviour has changed over time, to support analysis of change in outcomes.

Data collection

We will survey participants assigned to the intervention and control groups three times: at baseline (around one month after randomisation, but before support begins), at midline when the delivery of the programme is completed (around three months after the baseline survey is completed), and in a follow-up endline which will take place roughly two months after delivery is completed (around five months after baseline, and six months post-randomisation). In the pilot evaluation, we hypothesised that a two-month follow-up window would allow sufficient time for early outcomes to emerge and for the follow-up surveys to be completed in time for analysis. The midline pilot results supported this assumption, showing a moderate and statistically significant improvement in parental self-efficacy so we will continue with this approach for this evaluation.

IFF Research will collect data on both outcome measures (i.e. TOPSE and BAC-C) from participating parents/carers through self-administered surveys. Parents/carers will be given the questionnaires to fill in on their own without PACT present.

The Researchers scoring the data will not be blind to intervention allocation. If the parent/carer explicitly refers to their allocation (for example, mentioning participation in BB4K sessions), this will be documented for transparency, but such disclosures will not affect scoring.

The baseline and follow-up surveys will be sent via email and, 10 days later, IFF Research will follow up with reminder emails and telephone calls and offer to complete the survey over the phone to maximise response rates. Parents/carers in the intervention group will complete the endline survey in the final session. PACT will extend the last session by 15 minutes to give parents/carers time to complete the survey. Parents/carers will be encouraged to complete the survey on their own device (e.g. their phone), but PACT will provide an alternative if needed (e.g. using a PACT laptop).

Parents/carers in the control group will be sent the surveys via email at the same time points as the intervention group. PACT's Triage and Assessment Officer will stay in regular contact with these families and remind them of their upcoming BB4K group and to complete the surveys.

If parents/carers require research materials (email invitations, information sheets, consent forms, etc.) to be translated into their primary language to aid with comprehension, translations will be



available on request. However, the survey itself cannot be translated into alternative languages without impacting the validity of the outcome measurement scales.

The study acknowledges that the different approaches to outcome measure deployment between the intervention group and the control group has the potential to introduce different biases. The intervention group will have the opportunity to complete their baseline survey with the help of a PACT Support Worker, which could influence responses, for example by increasing the likelihood of socially desirable answers. Conversely, the control group receiving all measures via email may increase the potential of experiencing technical issues filling in the survey or not being able to ask for clarity on questions as they will be in less frequent contact with PACT.

To limit the effect of these factors, anonymity and confidentiality are emphasised in communication with participants, and clear standardised instructions are provided in the question wording. The Triage and Assessment Officer’s work will support waitlist family engagement. They will also offer technical support if needed.

Fieldwork will take place over six cohorts between March 2026 and April 2029. Table 5 provides the expected timelines for baseline, midline, and endline survey completion for all cohorts.

Table 5. Survey administration schedule by cohort

Cohort	Baseline	Midline	Endline
1	March–April 2026	June–July 2026	August–September 2026
2	August–September 2026	November–December 2026	February 2027
3	December 2026	April 2027	May–June 2027
4	August–September 2027	November–December 2027	January 2028
5	March 2028	June–July 2028	August–September 2028
6	August–September 2028	October–November 2028	February 2029

Fieldwork monitoring tools

We will use two digital interfaces to monitor response rates, and inform strategies to increase them. These interfaces will be automatically updated with data from the survey.

- A response rate dashboard will display the number and proportion of survey completions per cohort and per survey. The dashboard will compare response rates between intervention and control groups, between groups delivered at different sites, and between participants from White ethnicity groups and non-White ethnicity groups, to support monitoring of progress towards targets required for subgroup analysis (see below).



- A live survey response tracker will show the survey completion status of each pseudonymised participant. The tracker will include information about how many contact attempts each participant has received from IFF Research about the survey. This tracker will be shared with PACT’s Triage and Assessment Officer, who will follow up with respondents who have not yet completed the survey. For respondents who have completed the survey, the tracker will also include details of when and how their incentive voucher has been processed. The Triage and Assessment Officer will be able to refer to this if they receive queries from participants about the status of their incentive voucher.

Analysis plan

Primary analysis

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

The primary outcome related to RQ1 is the TOPSE score at follow-up,⁸ controlling for baseline TOPSE score. We will estimate the mean difference in TOPSE scores between participating families in BB4K and the control group participants. The primary analysis will use a mixed-effects model allowing for different outcome variance between the intervention group and control group arms, and heteroscedastic individual-level errors. The model will control for delivery site, child age⁹, and baseline TOPSE score via fixed effects.

Clusters in this analysis correspond to BB4K delivery groups, which include the parent/carer–child dyads attending the same programme session. A random effect is included for the intervention groups to model between-group variation. The model is not powered to investigate differences in treatment effects between sites.

The analysis model will be:

$$Y_{ijk} = \beta_0 + \sum_{k=1}^8 \beta_k s_k + \gamma Y_{0ijk} + \delta X_{ijk} + \theta t_{ijk} + t_{ijk} u_{jk} + (1 - t_{ijk}) r_{ijk} + t_{ijk} \varepsilon_{ijk}$$

- Y_{ijk} is the outcome at follow-up for parent/carer i in intervention group j and sites k
- There are eight sites $k= 1, 2, 3, 4, 5, 6, 7,$ and 8
- There are $j=62$ clusters corresponding to 31 intervention groups and 31 control groups
- β_k represents difference in outcomes between sites
- θ is the treatment effect.

In line with Foundations’ Statistical Guidance,¹⁰ the analysis will follow an intention-to-treat (ITT) approach. The analysis will include all randomised children and parents/carers in the groups to which they were randomly assigned, regardless of the treatment actually received, withdrawal from BB4K post-randomisation, or deviations in programme implementation. This principle is key to

⁸ The follow-up measure is used instead of the endline measure to allow ample time for outcomes to materialise.

⁹ As we stratify (block) by region and age.

¹⁰ See: <https://foundations.org.uk/wp-content/uploads/2026/05/foundations-statistical-analysis-plan-guidance.pdf>



ensuring an unbiased analysis of intervention effects. The difference between the intervention and control groups at endline will be expressed as a standardised effect size using Hedges' g with 95% confidence intervals. The primary analysis will also include detailed descriptive analysis: histograms, means, quartiles, and standard deviations, for all measures, groups, and time points. All analysis will be scripted to allow for transparency and replication and will be uploaded to GitHub.

If there is less than 5% missingness overall, we will undertake a complete case analysis as the primary analysis. However, it can be problematic to apply the ITT principle if parents/carers are not able to complete the outcome surveys. To deal with missing data we will complete the following analyses. First, we will report on attrition from analysis and attrition from BB4K, including reasons. Second, we will explore the extent of missingness, and then we will assess the pattern of missingness. To assess whether there were systematic differences between those who did not complete the outcome surveys and those who did, we will model missingness through a logistic regression model at follow-up as a function of key covariates, including treatment, age of child, and region to assess whether any covariates are associated with missing data.

For item-level non-response within an outcome measure (e.g. TOPSE or BAC-C), missing items will be imputed using a mean of the participant's completed items, provided that a sufficient proportion of items (e.g. at least 80%) has been completed. Although this approach maintains sample size and is simple to implement, it may slightly underestimate variability and assumes that missing items are similar to the participant's average responses.

If values on covariates are missing and the overall percentage of the missing covariate is over 5% and smaller than 40%, we will use multiple imputation of missing covariates. If a covariate has more than 40% missing, it will not be included in the primary analysis model, because imputing such a high proportion of values could introduce bias.

Secondary analysis

To assess impact for the secondary outcome (i.e. child behaviour) in RQ2, we will employ the same principles as the primary outcome analysis.

Early impact analysis using the midline survey

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

Those in the intervention group will complete the midline survey at their final BB4K session. The control group will be sent the midline survey to complete via email at the same time point.

Early impacts (RQ5) will be assessed using the same analysis strategy outlined for the primary outcome analysis.



Subgroup analysis

To answer RQ5, subgroup analysis will be conducted to explore potential heterogeneity in BB4K effects for the following participant characteristics:

- Child age: three categories based on the child group age bands; 3–5, 6–8, and 9–11 years old
- Child gender: two categories; girls vs. boys
- Ethnicity: categorised broadly as White/non-White, with the exact grouping to be confirmed after recruitment depending on the observed distribution of participants. This approach allows exploratory analysis while maintaining sufficient sample size and analytical feasibility.

For child age and child gender, the evaluation is not specifically powered to detect statistically significant differences; these analyses will be exploratory and interpreted cautiously. Similarly, analyses by ethnicity are exploratory and underpowered due to the smaller expected sample of participants from minoritised ethnic communities. During the scalability phase, it was agreed that PACT would aim to recruit at least 60 parent–child dyads from minoritised ethnic communities, which will allow exploratory outcome analysis and contribute to understanding engagement and potential differential effects.

BB4K effects within these subgroups will be explored by including an interaction term between the treatment variable and subgroup indicator. Given that these analyses are exploratory and underpowered, findings will be interpreted with caution and we will not report significance tests.

Where available, subgroup analyses will be considered in the context of the Theory of Change and existing evidence for heterogeneity in intervention effects. For ethnicity in particular, there is limited prior evidence on differential effects of domestic abuse programmes for children and families from minoritised ethnic backgrounds. Therefore, these analyses are intended to be hypothesis-generating, providing descriptive insights into how BB4K may work for different ethnic groups and informing future research and programme development.

Even with low statistical power, subgroup analysis can act as exploratory analysis to generate hypotheses and improve understanding of how the programme may work for different subgroups. Subgroup analysis will provide valuable descriptive information about the characteristics of different subgroups, contributing to a fuller picture of the diversity of families engaging with BB4K.

Compliance analysis

The primary analytical approach for the BB4K evaluation is intention to treat. In addition, we will explore the effect of BB4K among families who received the programme as intended, based on compliance with programme delivery requirements. This analysis will be conducted for the primary outcome only (parental self-efficacy) and will address RQ4.

Compliance will be defined at the parent/carer–child pair level and was agreed with PACT. Participants will be considered ‘compliant’ with the BB4K programme if they meet both of the following criteria:



- Attendance: missed no more than two sessions (3–5s attend at least 10 sessions; other age groups attend at least six sessions)
- Mode of delivery: received at least 50% of total sessions as group, as opposed to 1:1 (3–5s attend at least six sessions as groups; other age groups attend at least four sessions as groups).

PACT will record session attendance and mode of delivery for all participating families and will share compliance data with IFF. Compliance will be treated as a binary indicator, distinguishing families who met the compliance criteria from those who did not.

We will conduct a CACE (Complier Average Causal Effect) analysis to estimate the impact of BB4K on those who were compliant with the programme, as defined above (Angrist et al., 1996). This will be implemented using an instrumental variable approach, with random assignment to BB4k used as the instrument for compliance, and estimates using two-stage least square. This approach preserves the benefits of randomisation while allowing us to account for non-compliance in a robust and unbiased way.

Sensitivity analysis: controlling for impact of previous support

Participants' outcome scores at baseline may be systematically higher if they have recently (within the past 12 months) received support similar to BB4K or that shares BB4K's intended outcomes. The same could be true if parents/carers have received BB4K already – for example, with a different child (although, to be eligible to participate in the evaluation, parents/carers must not have participated in BB4K in the past 12 months). To explore the potential influence of prior support, we will conduct an additional sensitivity analysis in which a binary indicator from prior similar support will be included in the primary outcome model.

We will classify 'similar support' as support received within the past 12 months that meets at least one of the following criteria:

- Aimed at improving the participant's confidence as a parent/carer
- Focused on domestic abuse recovery
- Focused on domestic abuse recovery, delivered in a group setting
- The BB4K programme prior to the past 12 months.

For the intervention group, this information will be captured during the initial assessment calls. For the control group, this information will be captured via the baseline and endline surveys.

This analysis will help assess whether the estimated impact of BB4K is robust to participants' prior experience with similar support.

Contextual factors analysis

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



Implementation and process evaluation

Aims

The evaluation includes a robust implementation and process evaluation (IPE) to explore how BB4K has been implemented, whether that was as intended, how it is working, and the reasons it has/has not worked. It also explores perceptions of one intended impact: parent–child relationship changes. In line with the ToC, we will also look at mechanisms of change. This includes understanding the circumstances that were perceived to have best supported implementation (i.e. the implementation determinants), and the circumstances that best supported families’ perceived outcomes and the reasons for these patterns.

Research questions

Table 6 summarises the IPE research questions and approach to address each.

Table 6. IPE research questions and approaches

RQ1. Why does the intervention work, how, and for whom?	Approach
RQ1a. 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. This includes capturing views on one outcome: child–parent relationship)	Management information (MI) analysis, qualitative research with BB4K Managers, practitioners, volunteers, and parents/carers, and data collection on children’s perspectives



RQ2. Does the intervention work differently in certain conditions?	Approach
<p>RQ2a. Do perceived outcomes (and experiences) vary by the sites and, if so, what are the reasons?</p>	<p>Qualitative research with BB4K Managers, practitioners, and parents/carers and data collection on children’s perspectives</p>
<p>RQ2b. Do perceived outcomes (and experiences) vary by characteristics of families (child age group, type of abuse, children’s social care status, housing situation, duration taking part in intervention, ethnic group, whether English is a second language, whether the child has special educational needs and disabilities (SEND), child/parent/carer gender) and, if so, what are the reasons?¹¹</p>	<p>Qualitative research with BB4K Managers, practitioners, parents/carers, and data collection on children’s perspectives</p>
<p>RQ2c. To what extent are families able to 1) access and 2) engage with BB4K, and is it viewed as culturally inclusive for families experiencing domestic abuse?</p>	<p>Qualitative research with BB4K Managers, practitioners, parents/carers, and data collection on children’s perspectives</p>
RQ3. To what extent was the intervention implemented as intended?	Approach
<p>RQ3a (fidelity). To what extent is BB4K being implemented as intended, and consistent with the PACT model?</p> <p>To include qualitative exploration of a mechanism for change: ‘parents/carers primed for child sessions by having their session on same day as child, and knowing what will be covered in child sessions’.</p>	<p>MI analysis, staff quality assurance (QA) data, qualitative research with BB4K Managers, practitioners, referrers, parents/carers, and data collection on children’s perspectives</p>

¹¹ Since we are no longer measuring child–parent/carer relationship in the impact evaluation, we will ensure that child–parent/carer relationship is probed in the IPE. In particular, we will explore whether BB4K’s group sessions lead to different perceived outcomes on child–parent/carer relationship depending on age group. Our hypothesis is that the 3–5s group may experience greater improvement, because they have more joint parent/carer–child sessions than the older age groups.



<p>RQ3b (feasibility). What were the barriers and enablers to implementing BB4K, and how were barriers addressed?</p> <p>To include qualitative exploration of two mechanisms for change: ‘child and parents/carers trust their Support Worker and feel safe and secure in sessions’, and ‘experience connection with other families with experience of domestic abuse/peer support’.</p>	<p>Qualitative research with BB4K Managers, practitioners, referrers, parents/carers, and data collection on children’s perspectives</p>
<p>RQ3c (dosage). What is the level of engagement (including number of days attended), and factors influencing this, to the elements of BB4K by children and parents/carers, including referral, joining sessions, session experience, non-session experience, offboarding? How do CYP, parents/carers, Support Workers experience this? What level of attrition do we see from the programme?</p>	<p>Qualitative research with parents/carers and practitioners, MI analysis</p>
<p>RQ3d (reach). What proportion of families attend all scheduled group and one-to-one sessions, and how does attendance vary by family characteristics?</p> <p>Explore whether referral, participation, and drop-out trends vary by family characteristics/circumstances, where data is available:</p> <ul style="list-style-type: none"> • Demographics: gender, sexual orientation, ethnicity, disability, first language • Circumstances: whether child is on Child Protection or Child in Need plan; housing situation (temporary or permanent housing); abuse type. <p>We will also see whether referral source influences profile of families referred to and taking up BB4K.</p>	<p>MI analysis</p>
<p>RQ3e (acceptability). How acceptable do children and parents/carers find BB4K? (Content, number/duration of sessions, group size, ratio of worker/family, format of materials, timing of session including potential opportunity cost for children missing school)</p> <p>Explore differences in programme experience by family characteristics and circumstances.</p>	<p>Qualitative research with practitioners, referrers, parents/carers, and data collection on children’s perspectives</p>



<p>RQ3f (adaptations). What new and different adaptations have been made to make BB4K more accessible and acceptable to families and referring organisations?</p> <p>Explore families' access needs with BB4K staff and steps they made to meet these, and perceptions of appropriateness of those steps.</p>	<p>Qualitative research with BB4K Managers, practitioners, referrers, parents/carers, and data collection on children's perspectives</p>
<p>RQ4. Can the intervention be improved?</p>	<p>Approach</p>
<p>RQ4a. What (if any) changes are recommended to the design, procedures, or delivery approach of the BB4K programme to ensure it is accessible and relevant to families?</p> <p>BB4K staff and parents'/carers' ideas for improving access to and engagement with BB4K in the future.</p>	<p>Qualitative research with BB4K Managers, practitioners, referrers, parents/carers, and data collection on children's perspectives</p>

Design and methods

Management information data collection

We will analyse information relating to the implementation and delivery of the programme from the management information (MI) collected by PACT. This will help provide quantitative evidence on the adoption, fidelity, and integration of the intervention and provide the contextual basis for the qualitative IPE activity.

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

MI data will be collected at two time points per cohort: before randomisation (all referral information, e.g. demographics and contact information), and after the end of intervention group delivery (all information collected during group delivery, e.g. session attendance, whether access fund used).

Table 7 details the MI collected and how it will be used in the evaluation.



Table 7. Management information data collection

RQ1. Why does the intervention work, how, and for whom?	Data
<p>RQ1a. To what extent is the BB4K theory of change validated? (Evidence of outcome pathways, including input, activities, outputs, and mechanisms, as detailed in the BB4K theory of change)</p>	<p>E.g. use of access fund, support put in place for access needs</p>
RQ3. To what extent was the intervention implemented as intended?	Data
<p>RQ3a (fidelity). To what extent was BB4K delivered as intended?</p>	<p>Number of participants where: time between referral and first contact with PACT is less than 7 days; dates of first and last session 8/12 weeks apart; assessment call, triage meeting, secondary call, and home visit completed; post-session parent/carer reflections completed; end-assessment process completed</p>
<p>RQ3c (dosage). How much 1) group work, 2) one-to-one work, and 3) use of Bounce (the digital tool) do families receive, compared with the intended dosage?</p>	<p>Attendance and drop-out rates of families for group sessions</p> <p>Attendance and drop-out rates for one-to-one sessions</p> <p>Reasons for drop-out for group and one-to-one sessions</p> <p>Intervention and control group engagement with the Bounce digital platform: module completion, length of time spent accessing content</p>
<p>RQ3d (reach). What proportion of families attend all scheduled group and one-to-one sessions, and how does attendance vary by family characteristics?</p> <p>Explore whether referral, participation, and drop-out trends vary by family characteristics/circumstances, where data is available:</p> <ul style="list-style-type: none"> Demographics: gender, sexual orientation, ethnicity, disability, first language 	<p>Number, source, and profile of families that completed the programme</p> <p>Demographics: sex, sexual orientation, ethnicity, disability, first language, child SEND</p> <p>Circumstances: whether child is on Child Protection or Child in Need plan; housing situation (temporary or permanent housing); police involvement; number of children</p>



<ul style="list-style-type: none"> • Circumstances: whether child is on Child Protection or Child in Need plan; housing situation (temporary or permanent housing); abuse type <p>We will also see whether referral source influences profile of families referred to and taking up BB4K.</p>	
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Staff quality assurance data collection

Once per year, all Support Workers will have one of their sessions supervised and assessed according to the assessment areas detailed in Table 8. At the end of each year, PACT will share anonymised results from Support Worker quality assurance (QA), in the form of a completed QA form or paragraph summarising the outcome of the assessment. This data will be used as evidence towards IPE RQ3a ‘Fidelity: To what extent was BB4K delivered as intended?’

Table 8. Staff quality assurance data

Facilitator preparation	Arrives on time and is prepared
	Has all necessary materials organised
	Creates a welcoming and safe environment
Content delivery	Covers all key learning points
	Conducts activities as planned (or explains reasons for changes)
	Presents information accurately and clearly
	Uses visual aids/handouts/activities effectively (if applicable)
	Manages time effectively
Therapeutic techniques	Uses a variety of appropriate techniques (e.g. active listening, reflection, validation, adjusting language or tone to match service user comfort level)
	Employs techniques effectively and sensitively
	Adapts techniques to meet individual needs



Service user engagement	Encourages participation and interaction
	Responds effectively to questions and concerns
	Addresses challenging behaviours constructively
	Demonstrates respect for all participants
Overall effectiveness	Session is engaging and well-paced
	Participants seem to understand and benefit from the material
	Facilitator demonstrates strong group management skills

Qualitative research

The mainstage IPE will explore the perspectives of all stakeholders across two fieldwork waves, including BB4K Managers, staff, referrers, parents/carers, and data collection on children’s perspectives. Table 9 summarises the planned IPE qualitative fieldwork. A two-wave approach will enable us to capture insights at the start of the delivery period and again at the end, so we can see change over time and capture initial perceptions, experiences, and views on outcomes.

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

Table 9. IPE fieldwork schedule by audience

Audience	Wave 1 (Year 1)	Wave 2 (Year 3)	Total
Managers	1 online focus group (n=4)	1 online focus group (n=4)	2 online focus groups (n=8)
Support Workers, Play Therapists, and volunteers	1 online/in-person focus group (n=6) (legacy site)	1 online/in-person focus group (n=6) (new site)	2 online/in-person focus groups (n=12)
Intervention parents/carers	1 in-person focus group (n=6–7) (legacy site)	1 in-person focus group (n=6–7) (new site)	2 in-person focus groups (n=12–14)



Audience	Wave 1 (Year 1)	Wave 2 (Year 3)	Total
Control parents/carers	3 online interviews (n=3)	3 online interviews (n=3)	6 online interviews (n=6)
Referrers	3 online interviews (n=3)	3 online interviews (n=3) (new site)	6 online interviews (n=6)
PACT triage worker	Interview (n=1)	Interview (n=1)	Interview (n=2)
Total	N=24	N=24	N=48

Focus groups with intervention parents/carers were chosen over one-to-one interviews to make it easier for families to engage (hosted right after a scheduled BB4K session), and for safeguarding (hosted in a safe and familiar space and with their PACT practitioner in the building) and data protection reasons (does not require the sharing of parent/carer/child name, contact details with IFF). The use of focus groups also aligns with the IPE research questions and evaluation efficiencies (ability to capture more family views across the eight delivery sites compared with one-to-one discussions). IFF focus group moderators are highly experienced in delivering focus groups to ensure all voices in the group are heard. They are also trained to handle any safeguarding issues that may arise. One-to-one interviews will be offered to the intervention group if there is a need that means participating in a focus group could be a barrier for a particular parent (e.g. one-to-one interviews could be offered to those with a language barrier with the support of an interpreter).

BB4K Managers

Recruitment

We plan to engage four Managers in Wave 1 and four in Wave 2 of IPE fieldwork through online focus groups. Sampling is not required, because we are speaking to all leadership staff. To secure a convenient time for participants, our in-house specialist recruiter will reach out to participants one month ahead of fieldwork. To mitigate cancellations, at this time they will also agree a back-up time and will send a reminder two days before the scheduled appointment.

Fieldwork

We are planning to cover the following topics:

- **Implementation approach and experience.** During the interview we will use the Theory of Change as a guide to understand how the intervention has been implemented and delivered; explore where delivery has changed from planned and the reasons for this (e.g. workforce, local context, and required adaptations), explore the level of consistency or variation in support delivered and reasons for this (e.g. workforce availability/capability, family characteristics/needs; this includes equality, diversity, inclusion, and equity



(EDIE)); explore views on what has worked well/less well and why, challenges/barriers and mitigations to involvement, and areas for improvement (for all, including EDIE).

- **Perceived outcomes.** Whether/what outcomes are emerging (including any unintended consequences), whether outcomes are achieved at expected timescales, including mechanisms driving the achievement of these outcomes, evidence for any outcomes achieved, reasons for any outcomes not being achieved, any impact of their local contexts and external factors, and ways to strengthen outcomes in the future.
- **Reflections on delivery and lessons learned for moving into the future (including scaling up).** Areas that worked well and why in their local context – including what they intend to keep, and what might have worked better and why; the characteristics and circumstances of families that BB4K works best for.

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

Practitioners and volunteers

Recruitment

PACT already employs 6.7 full-time equivalent (FTE) Support Workers and two placement students/volunteers. To facilitate delivery of BB4K on a larger scale, PACT is recruiting and training a further 2.5 FTE BB4K Support Workers and Senior Support Workers, 1 FTE Triage and Assessment Officer, 0.6 FTE Administration Lead, 0.4 FTE Administrator, and an additional 2 student volunteers.

We plan to engage six staff/volunteers in Wave 1 and six in Wave 2 of IPE fieldwork through online/in-person focus groups. We will approach PACT for suggested contacts drawing on what we know about the key roles that are involved. IFF does not have access to personal contact details for these individuals so will be reliant on support from PACT administrators to make initial contact with them. It is acknowledged that this approach may result in PACT administrators creating a biased sample (almost ‘cherry picking’) for us to speak with, so we will ask them to email all Support Workers to ask them to get in touch with us if they want to take part. This also means that PACT Managers will not know who has taken part in the research and we minimise the risk of participants being picked because they will share positive thoughts.

We will also take into consideration the vulnerability of the volunteers, some of whom have lived experience of domestic abuse. Our approach will involve volunteers being interviewed in a group setting alongside the employed BB4K delivery team. The risks of doing this (i.e. power imbalances and volunteers not feeling they are able to be open and honest) have been discussed with PACT, who felt that this would not be an issue (due to the open and honest communication across the team generally). We will check with volunteers before the groups that they are happy with this approach. Although it is unlikely, if volunteers are uncomfortable with participating in a group, we will explore the possibility of conducting a one-to-one interview with them instead.

To secure a convenient time for participants, we will first speak with the Service Manager to identify days of the week/times of day when practitioners are most likely to be available – for example, whether we can extend a regularly scheduled meeting to include this discussion. If that is



not possible, our in-house specialist recruiter will reach out to participants one month ahead of fieldwork. To mitigate cancellations, at this time they will also agree a back-up time and send a reminder two days before the scheduled appointment.

Fieldwork

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

We are planning to cover the following topics:

- **BB4K awareness and understanding:** programme focus; eligibility criteria; sources of knowledge; any confusion with programme
- **Overall:** whether BB4K is working well and for which groups of families; key successes and challenges related to implementation
- **Referral and triage:** whether practitioners are able to identify and prepare families for support; experiences of assessment and consent forms, and meetings with families and associated mechanisms; what is working well/less well
- **Delivery experiences:** whether service is being delivered as intended, adaptations and reasons (for staff, volunteers, families); what is working well/less well, for each of group, one-to-one, and optional support
- **Perceived outcomes:** intended/unintended; evidence on outcomes; BB4K features enabling/preventing outcomes; variation by family characteristics (see Table 7 for details)
- **Suggestions for improvement:** achieving/sustaining outcomes; scaling BB4K: referral and triage, group/1:1 delivery, accessibility, and quality.

Referrers

Recruitment

We plan to engage three referrers in wave one and three in wave two of IPE fieldwork through online one-to-one interviews. BB4K referral sources include local authorities (children's services, adult social care, and housing), schools, community partners, counselling services, and other charities. We will know the volume and sources of referrals made to BB4K from the management information. Using that, we will identify the most and least common referral sources. We will provide an email invite template to PACT for them to inform their referrers about the evaluation and invite them to take part in an online discussion. This will stress the importance of their contribution, while ensuring they are aware of the voluntary nature of taking part. It will ask them to get in touch with IFF Research directly if they wish to take part in an interview or with any queries. If referrers are willing for their email details to be provided to IFF Research (via PACT) we will be able to follow up directly with them by further email and/or phone if possible, to discuss the evaluation, ascertain their willingness to take part, and schedule interviews. PACT will also attempt to recruit referrers who work closely with minoritised ethnic communities such as Sunrise



Multicultural Centre and AFIUK to gain insight into how the referral process works for families from these backgrounds.

Fieldwork

Initial thinking on topic coverage:

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

Parents/carers – Intervention

Recruitment

Two groups of six to seven intervention parents/carers will be selected to take part in the qualitative discussions from Cohorts 4 and 6, in the form of an in-person focus group. We will ensure one is selected from an existing PACT site, and the other is selected from the new site. Decisions about which site to choose will be guided by the demographic make-up of the groups and we will select groups that have a higher number of parents/carers from a minoritised ethnic background or with parents/carers who have English as a second language to allow us to explore the IPE research question related to EDIE. We will also aim to select parents/carers with diverse working patterns so that we can explore whether this impacts the accessibility of the programme.

Once selected, these groups will be notified about the research and PACT's Triage and Assessment Officer will share with them information about what this entails (e.g. the IPE information sheets). This will likely happen during their home visit or in their first BB4K session to allow parents/carers time to think about whether they want to take part and ask any questions ahead of time.

Parents/carers selected for the focus groups will be reminded of the qualitative discussion in their penultimate BB4K session to give them another opportunity to consider whether they would be happy to participate, and will be given the opportunity to opt out of participation. Explicit consent will be collected at the beginning of the focus group. We will incentivise all families who take part



in a discussion with a £40 voucher per family. As agreed with PACT, parents/carers will be given the choice of receiving an e-voucher via email or a physical voucher posted to them.

Fieldwork

The focus group will be conducted in person by IFF Research after the final BB4K session. This is so there is no need to share contact details or speak to families in the place where they may have experienced harm. PACT will extend the final group session to allow for parents/carers to take part in a 45–60-minute discussion group. Although this approach means that PACT staff will know which parents/carers and children have taken part in the qualitative discussions, we feel after discussions with our internal ethics team and PACT that this approach benefits from minimising other ethical and safeguarding risks. For parents/carers with English as an additional language who feel less comfortable speaking in a group setting, we will facilitate one-to-one discussions.

Initial discussion coverage for parents/carers:

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

Children – Intervention

Capturing children’s experience of the programme, for which we use the term ‘capturing children’s perspective’ (CCP), in the IPE is important for ensuring the findings reflect real lived experiences. As the children that PACT delivers BB4K to are very young (3–11 years old), it is difficult to meaningfully capture their voices in the evaluation design. During the pilot 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. Rather, the full-scale trial captures the children’s perspective (CP) by collecting practitioner reflections on children’s participation in the programme. While this means the CP will be captured by practitioner proxy, we consider this to be the best alternative, based on ethical and practical considerations from the pilot study. To mitigate the risk of bias in practitioner reflections, a training workshop will be delivered to practitioners ahead of data collection to explain the purpose



of the observation notes and provide examples of things to record to answer the practitioner prompts.

Recruitment

Two groups of intervention children from Cohorts 4 and 6 will be selected to take part in the IPE. These will correspond to the parent/carer groups selected. Parents/carers will be notified during home visits and their first BB4K group that practitioner observations on children's engagement, which may include photographic evidence of children's drawings for the 3–5-year-old groups, will be shared with IFF Research. Children will be provided with information sheets about the research. Parents/carers will be offered the opportunity to opt out on their child's behalf at this point.

We will also collect data on children's perspectives from an earlier cohort to test the data collection process; however, this data will not be included in the IPE analysis. This process will enable us to check for and align on the type and level of detail collected.

Fieldwork

At the end of each weekly session, it is routine practice for Support Workers to record their reflections on the session and any noticeable impacts on children. To optimise this existing process, the following prompts will be provided for practitioners to consider in their reflections, for three groups. Support Workers will capture these reflections in Lamplight. This data will be anonymised and shared with IFF Research to analyse over time.

In the case of children receiving group support, these reflections will be captured week-to-week for the group collectively (i.e. they will not be captured for individual children). For group reflections, individual children should not be named. Reflections do not need to cover all children in the group. Group session reflections will, however, take into consideration individual children and their unique context/background. In the case of children receiving support individually, practitioner reflections will be captured for individual children.



CCP Prompt 1: What did you observe about the children that suggested they were engaging well in the session, its content, and/or other people in the session?

This can include what you heard or saw. For children aged 3–5, this can include pictures of their drawings or sculptures, and an accompanying explanation.

CCP Prompt 2: What did you observe about children that suggested barriers to engaging in the session, its content, and other people in the session?

This can include what you heard or saw. For children 3–5, this can include pictures of their drawings or sculptures, and an accompanying explanation.

For both prompts, you may consider, as relevant:

- Signs of changes in loneliness/isolation
- Signs of changes in understanding of healthy and unhealthy behaviours in others
- Signs of changes in ability to manage their emotions
- Signs of comfort/ease or discomfort / distance with other people there (e.g. practitioners, parent/carer, other children)
- Signs of changing relationships with other people there (e.g. practitioners, parent/carer, other children).

The suggested length of each support worker reflection is ~200 words.

Where relevant, and if a Play Therapist is leading the 3–5-year-old group, Support Workers will collect photographs of any drawings or sculptures done by the children during the session, or of any other evidence of children’s engagement in the session, to support their observations.

Note: this will not include any images of the children themselves.

Parents/carers – Control group

Recruitment

We plan to engage three control parents/carers in wave one and three in wave two of IPE fieldwork through online interviews. For parents/carers in the control group, we will recruit for these interviews (1:1 lasting up to 45 minutes) from the baseline survey, which will include a question asking parents/carers if they are happy to be recontacted to take part in follow-up qualitative research. We will then select parents/carers to participate from those who agree to follow-up contact. We will ensure at least two of these interviews are conducted with parents/carers from minoritised ethnic backgrounds. IPE fieldwork is scheduled to take place with parents/carers in Cohorts 4 and 6 from September 2027. Parent/carers in the control group will have been randomised approximately one month before their interview and are expected to begin receiving the intervention around two months afterwards.

Recruitment will start with an email, giving them information about what would be involved, the voluntary nature, and what we would do with their data. We will then follow up with a call (where a contact number has been provided). Note that all recruiters are trained to follow all phone call



safeguarding processes (e.g. saying ‘wrong number’ if the person expected is not the one to answer the phone). This will be our primary mode of recruitment to minimise the burden on PACT; however, if this does not yield enough of a response, we will use the PACT Triage and Assessment Officer to reach out to parents/carers to ask if they would be willing to participate.

We will incentivise all families who take part in a discussion with a £40 voucher per family. As agreed with PACT, parents/carers will be given the choice of receiving an e-voucher via email or a physical voucher posted to them.

Fieldwork

Initial thoughts on topic coverage:

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

Analysis

Qualitative analysis

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

We use Framework Analysis (Ritchie and Lewis, 2003) to identify key themes from discussions and observations through deductive and inductive methods. Researchers actively listen, ask follow-up questions, and audio/video record interviews (with permission) to capture insights, including non-verbal cues. The bespoke framework is structured around the objectives (e.g. columns for enablers of community engagement activities, and variation by person’s needs, support types, regional ways of working, etc.), while allowing space for unexpected evidence to emerge. We upload audio recordings (with consent) to a secure qualitative analysis tool, Quirkos, to code and organise data. The coding is piloted with the first couple of interviews. A Senior Researcher checks the coding of 10% of each Researcher’s interview, providing feedback to improve specificity and clarity.

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



Next, Researchers undertake ‘mapping linkage’: exploring the ways that different parts of the data are connected. This is followed by ‘explanation’: identifying the reasons why the data fell out in the way that it did. During this stage, Researchers look for both explicit accounts (reasons given directly by participants) and implicit accounts (where Researchers infer an underlying logic based on participant views, context of the wider legal system, and power dynamics). To minimise bias, Researchers are reflexive in qualitative analysis. For example, reflecting on their own background, beliefs, experiences, and motivations, and how these may influence interpretations. As part of analysis, they consider contextual influences on interpretation, such as local delivery features. Finally, during Director-led analysis sessions, we further test and retest interpretation. Our academic partner, Professor Jane Callaghan, also attends the analysis sessions to bring her expertise in child wellbeing to test interpretation of findings.

Management information analysis

On receipt of data from PACT, a Researcher will conduct an initial check of the data received against our IPE MI plan and follow up with PACT to fill data gaps and clarify any discrepancies. After we are confident we have the correct data, our data services team processes the data (e.g. ensures consistent formatting; reorganises it for evaluation purpose) and creates an SPSS file and tables for descriptive analysis using a data specification the research team develops.

Triangulation

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

Analysis of harms

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



Cost evaluation

The overall aim of the cost evaluation is to understand the additional costs and, where possible, benefits of the programme compared with not delivering it. The key research question is: **What are the total costs of BB4K delivery and the unit cost per family?**

Our proposed approach is to calculate the **overall cost for BB4K delivery**, and the **unit cost per family and per delivery site**.

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

We will use a simple, clear spreadsheet tool, and accompanying guidance, for PACT to input costs. We will ask PACT to provide cost information for each group of families (cohort) and for each delivery site separately. This way, we can see the costs more clearly for different cohorts and sites.

We will ask PACT to provide information on the following cost categories after each of the six cohorts:

- **Prerequisite costs**
 - **Overheads:** share of HR, finance, office costs (calculated by time spent on BB4K)
- **Start-up costs**
 - **Staff costs** including salaries, National Insurance contributions, pensions for all workers including temporary and contract workers; if staff don't spend all of their time on BB4K, we will ask PACT to confirm the time allocated for the year to BB4K
 - **Non-staff costs:** staff travel
 - **Staff recruitment and training:** costs associated with hiring new staff and training them to deliver BB4K
 - **Volunteer costs** such as vouchers or reimbursement of expenses
- **Recurring delivery costs**
 - **BB4K management costs:** time for heads and management spent on BB4K, multiplied by salary, and plus other staff costs (NI, pension, etc.)
 - **Delivery staff costs** (Support Workers, Play Therapist): time spent on BB4K, multiplied by salary, and plus other staff costs (e.g. NI, pension, etc.)
 - **Venue hire** for group sessions
 - **Accessibility fund:** cost for removing family barriers to participation
 - **Other facilitation costs.** These include all of the costs for delivering the service including travel budgets, food, printing, etc.



Analysis approach

We will sum costs across the above categories to calculate:

- Total costs of BB4K delivery
- Unit cost per family
- Unit cost per cohort and per site.

We will separate non-monetary costs, including parent/carer time, child time, and volunteer time, and present these separately from monetary costs. Costs will be analysed post-delivery for each cohort, as was done in the pilot. This approach allows comparison across cohorts and sites while avoiding confounding from start-up differences (e.g. Cohort 1 may have higher start-up costs than later cohorts).



Ethics and participation

Ethical approval

Ethical approval was obtained from Foundations' Research Ethics Panel in February 2026.

Obtaining consent

Establishing whether individuals have the capacity to give informed consent can be difficult for some vulnerable people. At the point of assessment, parents/carers and children will be provided with clear and concise information sheets (and an animation) explaining the voluntary nature of the research, their right to withdraw at any point (and how to do this), and clear details of how their data will be used and stored. Parents/carers will be asked to complete a consent form giving explicit consent for them and their child to take part in the evaluation. For parents/carers who do not have access to the relevant technology to complete and return the consent form, written consent over email/text following receipt of the form will be considered sufficient. Participants will be encouraged to ask any prior questions by email or telephone to enable them to give informed consent. The privacy notices will contain an informed consent and data protection statement for respondents. In line with the Mental Capacity Act 2005 and Code of Conduct 2007, we assume that people have capacity to consent, unless established otherwise.

We will make sure the process of ensuring informed consent continues throughout the participants' interaction with us (i.e. does not end after recruitment). Participants will have the right to change or withdraw their data from the evaluation at any point during the evaluation. Families can opt out by completing the withdrawal form. This can be completed by PACT staff on behalf of parents/carers if they express a wish to withdraw verbally. Throughout the referral and assessment stages, it will be made clear that families can still access support even if they choose not to participate in the evaluation.

For impact data collection, parents/carers will be reminded of the voluntary nature of taking part at the start of each survey and they must confirm consent before they proceed through the survey.

For IPE data collection, intervention families will receive IPE-specific information sheets at the stage of home visits and will have the chance to ask PACT staff questions before they begin. Parents/carers selected for the focus groups will be reminded of this in their penultimate BB4K session and will be reminded of their right to withdraw at any point. This will be reiterated at the start of the focus group, where parents/carers will provide written consent and PACT staff will verify that informed consent was obtained.

Parents/carers will provide consent on behalf of children, as children are too young for meaningful written consent. Children will still receive age-appropriate information and be encouraged to voice any concerns via parents/carers or PACT Support Workers.

Control group parents/carers will be recruited through the baseline survey's re-contact question. Those who agree will receive an email with information and will sign a consent form specific to the IPE, in addition to the consent form they will have signed at the start of the trial. They will also give verbal consent at point of interview, including consent for audio recording.



PACT staff and referrers will give verbal consent at the start of their interviews, including for recording.

Consent process for Cohort 1

The process for gaining consent to take part in the evaluation in Cohort 1 will need to be slightly different from that outlined above. The majority of those who will be included for randomisation for the first cohort are already on PACT's waitlist. This means they have already been referred and received their assessment call (which is the call we are planning to use to explain the evaluation and gather explicit consent). As there are hundreds of people on PACT's waitlist and they are still in the process of hiring their Triage and Assessment Officer, it will not be feasible to conduct additional assessment calls with everyone on the waitlist to explain the evaluation and ask them to complete the consent form.

To address this issue, we propose to return to the process used during the pilot evaluation. This would entail emailing everyone on PACT's waitlist to notify them of the evaluation and what taking part would mean for them and their child. This email will include the evaluation information sheet, consent form, and information video. We will allow people at least one week to read and respond to the email and will ask people to respond to the email to let us know if they do not wish to take part in the evaluation. All those who agree to take part or do not respond to the email will be included in the sample shared with IFF for randomisation. They will all have previously consented for their information to be shared with external organisations for research purposes within PACT's data protection notice.

Once randomisation has taken place, PACT will arrange calls with all parents/carers to notify them of the outcome and book them onto the correct upcoming group. At this stage, they will explain the evaluation and the consent form in full. They will then ask everyone to explicitly consent to taking part via the consent form. As with other cohorts, written consent over email/text following receipt of the form will also be considered sufficient.

Incentives

For the impact survey, families will receive an incentive after each survey they fully complete. This process is automated: once a respondent finishes the survey and enters their email address, they will receive an email with instructions for claiming their e-voucher. If they choose a physical voucher instead, this will be posted to them within four to six weeks.

For the qualitative discussions, all families who take part will receive a voucher (physical or virtual, depending on preference). If a participant does not complete the full discussion or chooses to withdraw their data, they will still receive the incentive for any level of participation they have contributed.

Participation

Our approach to engaging participants in the evaluation will be inclusive and accommodating to ensure there are no barriers to anyone taking part. Our approach will include:



- **Co-design.** PACT has a group of experts by experience who have engaged with BB4K previously that they call their Bounce Back Buddies. This group has been consulted at various points during the pilot, scalability period, and set-up of the full-scale trial. Most recently they were consulted on the development of the information sheets and video, and their feedback, including slowing down the speed of the talking in the video and adding subtitles, was used to ensure our materials are accessible.
- **Impact analysis.** A minimum of 60 families from minoritised ethnic communities will be recruited to allow us to conduct exploratory impact analysis on whether families from minoritised ethnic communities experience BB4K differently from White British families. PACT will review their progress towards recruitment in six-month intervals and will consider extending their service to Slough, if necessary, to recruit the appropriate number of minoritised ethnic families. PACT will also be conducting community outreach and promotional activities to reach communities historically less represented in BB4K and establishing and/or strengthening referral partnerships with EDIE partners, such as Sunrise Multicultural Centre, the Sundial Centre, AFIUK (Oxfordshire), and Project Salama (Berkshire). PACT will also offer options for delivering BB4K on an individual basis for any referrals from families who speak English as an additional language and feel more comfortable to take part one-to-one.
- **IPE fieldwork.** IFF Research will select two of the parent intervention groups to conduct a focus group with at the end of the programme. Decisions about which site to choose will be guided by the demographic make-up of the groups and we will select groups that have a higher number of parents from a minoritised ethnic background or with parents who have English as a second language to allow us to explore the IPE research question related to EDIE.
- **Communication.** At the point of randomisation, IFF Research will collect information from PACT about participants' accessibility needs and communication preferences to help tailor our communication accordingly. We will also use varied communication methods to help potential participants understand what the evaluation is about and how they could be involved. Information will take different formats (e.g. short animation, information sheet, verbal) to ensure accessibility. Information will include a convincing rationale for participation and reassurances on confidentiality and how the information will be used.
- **Accessibility fund.** The evaluation will include an Accessibility Fund which will allow the BB4K team to address any barriers to families accessing the groups. This includes transportation and childcare costs.
- **Format.** Most of the fieldwork will involve group sessions (within the same setting as the BB4K sessions to ensure familiarity and accessibility). We will also ask participants what would support them to take part (e.g. having someone else present, taking regular breaks, etc.). Having the BB4K team on hand during the group sessions should also provide reassurance and help support minoritised groups to take part.
- **Research tool accessibility.** Although the budget does not allow for translation of all research materials or interpreted interviews, we will use the language capabilities of our specialist interviewing team as needed (they can provide high-quality interviews in up to 20 languages). We will also consider requests to translate materials on an ad-hoc basis as required. We will ensure that all online survey are accessible, and have built in opportunities for those with lower digital literacy to have support from either IFF Research



or PACT Support Workers. We will also make sure all research materials and tools use simple language and clear instruction, and are visually engaging and short.

- **PACT recruitment.** Where possible, PACT will recruit new Support Workers and volunteers from minoritised ethnic communities and/or who speak multiple languages.
- **Building trust.** Participants must feel comfortable and safe, and interviewers will need to build trust and empathy with participants. This will start with an icebreaker at the start of each interview/discussion (e.g. the interviewer telling the participants something about themselves). Interviewers are also skilled in ensuring their body language remains open, avoiding barriers between them and the participant, and being engaged and showing interest in the participant. Interviews will be conducted by someone of the same gender (unless otherwise agreed with PACT).
- **Ending participation.** It is our commitment that interviews/groups leave participants in the same state as before the interview. We spend a few minutes at the end reflecting and asking if they would like to be informed about the research outcome. We will offer participants a support leaflet with signposting to relevant organisations (everyone will be given one to avoid any stigma of some participants choosing to take one and not others). Topic guides will not include any emotive topics near the end and we will brief interviewers to ask additional 'light' questions if needed (e.g. plans for after the interview/discussion group). Please see IPE topic guide outline. Note that the support leaflet will be produced nearer the time of the fieldwork.

Safeguarding and mitigating distress

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

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

All those conducting interviews will receive refresher training with the fieldwork briefing on safeguarding and ethics in research relating to domestic abuse and will be thoroughly briefed on this specific project. Everyone on the team will be DBS (Disclosure and Barring Service) checked and will be selected for their experience conducting interviews with vulnerable groups. Regular team meetings and open lines of communication will enable Researchers to raise concerns directly with Project Directors.

Handling disclosures

The ethics protocol includes content on handling disclosures relating to domestic abuse. This will enable an interviewer to identify when an individual taking part in the research might be at risk of



harm, and the next steps for the interviewer. It includes lines to take when a participant discloses harm, FAQs, and contact details for support. We will inform Foundations of all cases of disclosure and how we responded. This will be reported anonymously unless prior consent is gained from the participant. Any legal information that is disclosed will be treated as confidential by the research team.

Participants may disclose current harm, abuse, or crimes. Information sheets and consent forms will clearly state that if participants disclose this, we will have to report it to relevant authorities.

Interviewer safety and wellbeing

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

All members of the research team are experienced in conducting research among vulnerable groups (including those with experience of domestic abuse) and will be fully briefed. Researchers will be assigned a 'buddy' within the research team who they can speak to before or after an interview about any concerns they may have. For in-person fieldwork, the buddy is responsible for tracking the location of the interviewer, keeping in regular contact, and alerting the Project Director if the interviewer does not respond at the agreed time. For virtual (as well as in-person) fieldwork, the buddy is also there to debrief with the interviewer and provide a space to decompress after each interview.

All those conducting interviews will receive refresher training with the fieldwork briefing on safeguarding and ethics in research relating to domestic violence and will be thoroughly briefed on this specific project. The key learning outcomes from this refresher training are:

- Awareness of what vulnerabilities might be seen during the BB4K evaluation
- Understanding how to conduct a good and secure interview by creating a safe space for themselves and the person they are interviewing
- Awareness of IFF Research's ethical principles, including trauma-informed approach
- Clarity on their responsibilities as an interviewer to keep confidentiality (and times they have to break it)
- Greater confidence in handling difficult interviews.

Researcher safety and wellbeing is considered throughout all stages of the research, recognising that analysing data can also carry significant emotional weight. Exposure to accounts of domestic abuse could lead to vicarious trauma, compassion fatigue, or cumulative stress, even when encountered indirectly through transcripts or interview recordings. To mitigate this, Researchers are encouraged to monitor their emotional welfare, take breaks when needed, and have regular



check-in sessions with the rest of the team to monitor welfare. All Researchers agree to report any issues directly to the Project Director and ask for support if and when required. Staff also have access to counselling support and a 24/7 helpline, should they seek external support.

Registration

The trial protocol will be registered with the Open Science Framework in March 2026.

Data protection

Data security

IFF Research takes all reasonable steps to ensure the safety and confidentiality of respondents' data, and of management and administrative data. IFF Research is registered with the Information Commissioner's Office under registration number Z5571698. IFF Research is accredited to ISO27001:2022, the international standard for information security, and certified under CyberEssentials and CyberEssentials Plus. Our server is located in a secure location in the UK, and we will create a secure folder exclusively for the use of this project.

Data transfers

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

Control of data

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

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

Special category personal data (e.g. age, gender, ethnicity) is processed for research and statistical purposes in accordance with the conditions of the UK Data Protection Act 2018 schedule 1 part 1.¹²

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



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

Interview recordings and transcripts

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

Publication of data

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

Future use of data

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



Personnel

Table 10. Staff names, roles, and responsibilities

Delivery team		
Name	Role	Organisation
Kathryn Warner	Head of Communities	PACT
Luke	BB4K Manager	PACT
[To be recruited]	Triage and Assessment Worker	PACT
Panda Phelan	BB4K Service Lead	PACT
Lydia	BB4K Service Lead	PACT
Rachael Grenz	BB4K Administrator	PACT
Giulia Savini	Database Officer	PACT
Colin Stevens	Assistant Management Accountant	PACT
Kate	Senior Bid Writer	PACT
Evaluation team		
Name	Role	Responsibilities
Kesley Beninger	Research Director (Co-Principal Investigator)	Co-PI, contract responsibility, design, and quality assurance
Sashka Dimova	Research Director (Co-Principal Investigator)	Co-PI, expert support for RCT design, impact analysis, and compliance analysis
Caitlin Webb	Senior Research Manager	Lead on ethics, PACT staff training, cost evaluation point of contact for Triage and Assessment Officer, contribute to analysis and reporting
Millie Morgan	Research Manager	Project manager, lead on MI data collection, contribute to analysis and reporting



Katerina Cohnova	Senior Research Executive	Lead on impact survey, contribute to analysis and reporting
Lori Tyson	Research Executive	Lead on IPE, contribute to analysis and reporting
Professor Jane Callaghan,	Director of Centre for Child Wellbeing and Protection, University of Stirling	Advisory, contributing to ToC, trial protocol and questionnaire development, analysis, and review interim and final report



Risks

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

Table 11. Risks and mitigating actions

Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Analysis	Full-scale RCT findings aren't generalisable to a rural population because it is too challenging to deliver BB4K in rural areas	High	Medium	Capture data on postcodes and map this onto deprivation indices and rural/urban area types to conduct some analysis on these groups if they naturally fall out in the sample.
Analysis	If some parents have previously participated in a programme that delivered similar support and achieved outcomes aligned with BB4K's aims, their baseline scores may already be higher. This could result in skewed analysis, potentially affecting the evaluation's accuracy	Medium	Medium	At referral, parents are screened for whether they are currently receiving any domestic abuse-type support, at a general level; then at assessment, confirm whether parents are receiving any support that shares BB4K's primary outcomes (in a sensitive way). If parents are receiving support that shares BB4K's primary outcomes, they can still be referred onto the programme, but we will conduct exploratory analysis to investigate whether there are any systematic differences in baseline scores between those who have received similar support and those who have not.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Analysis	Contamination – families randomised to waitlist control receive BB4K	Medium	High	Ensure participants and staff understand the importance of maintaining confidentiality about group assignments; capture this in these audiences' engagement materials, and in PACT staff training. A randomisation flowchart is available for PACT staff to support their understanding of the process and reduce the likelihood of contamination. IFF to monitor interactions to check for contamination: control group endline survey, control group qualitative research. Conduct compliance analysis in cases of observed non-compliance with assignment.
Analysis	Families who have taken part in BB4K before take part during the trial	Low	Medium	PACT's Triage and Assessment Officer checks history of BB4K access for any new referrals before confirming assessment goes ahead. If PACT feels it is important they receive the support again, they will be excluded from the evaluation but go on to receive BB4K support. NB: while unlikely to happen at large scale, this may affect total number of cohorts PACT needs to deliver to.
Analysis	Families in the control group receive other domestic abuse support while on the waitlist for BB4K, which makes findings harder to interpret	Medium	Medium	To explore the potential influence of other support, we will conduct an additional sensitivity analysis in which a binary indicator from prior similar support will be included in the primary outcome model.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Analysis	Different non-response to survey affecting validity and generalisability of impact evaluation findings	Medium	Medium	Clear communication around the survey – e.g. what it will include and when it needs to be completed at the onset. Responses to survey maximised using financial incentives for completion for control group, too. We also made the survey short and easy to fill in. We will employ strategies to make the survey easily accessible and offer parents online and phone versions for completion. We will also regularly monitor completion and we have multiple reminders in place to boost response. If non-response is high, we will conduct missing data analysis, including multiple imputation where appropriate and feasible. Findings of analyses with notable missing data problems will be interpreted with caution.
Analysis	Programme data for IPE not suitable/available	Medium	Medium	Set-up stage involves mapping available data and agreeing additional data to collect through PACT’s Lamplight (e.g. model fidelity, voice of child). Throughout the evaluation, the evaluation team will regularly review and assess evidence against the plan and clarify through discussions with PACT how to fill any gaps or clarify reason for any differences in quality/content. Reviews take place as relevant based on the evaluation activity happening (e.g. each survey, cost data, MI data), and then formally before interim reporting cycles.
Data collection	Parents may not access the surveys due to not being familiar with emails, limited literacy skills, or having English as an additional language	Medium	High	We will capture MI data, including accessibility needs/ preferred method of communication, at randomisation, and use this information to tailor survey administration to individual needs (SMS, emails, telephone interview). Evaluation materials can be translated on an ad-hoc basis for those with English as an additional language.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Data collection	Views of experts by experience (e.g. Bounce Back Buddies) are not sufficiently incorporated into evaluation design, which could mean data collection tools and evaluation approaches are inappropriate or inaccessible. This could lead to barriers to participation going unidentified, reduced response rates, or incomplete data	Low	Medium	During the scalability work, Bounce Back Buddies participated in a focus group, where elements of the evaluation were also tested with them. Bounce Back Buddies were also consulted during set-up to test and refine research tools. We plan to further consult Bounce Back Buddies or Foundations' experts by experience panel at the interim reporting stage.
Data collection	Children's perspectives are not captured effectively through observation, due to the impact on group dynamic of an external observer	High	Medium	IFF to create two factual reflective prompts aligned with the evaluation questions for practitioners to incorporate into their session reflections, enabling them to effectively document the child's perspective. If sessions are delivered by qualified Play Therapists (for the 3–5 age group), practitioner reflections can be substantiated by photographic documentation and interpretation of children's drawings or sculptures. Practitioner observations will be anonymised and shared with IFF to analyse over time.
Data protection	Data security breach leads to sensitive information being shared	Low	High	Stringent data security measures in place and IFF holds the ISO27001 and CyberEssentials Plus accreditations. Evaluation team trained on data breach escalation and resolution process. PACT's Support Worker training to reinforce importance of secure information sharing (no sharing names/contact details of families by email). Survey hosted on secure, encrypted platform; confidential information held in secure IFF file folder that only authorised team members have access to.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Safeguarding	Distress caused to participants through evaluation activities	Medium	High	Continued use of the existing safeguarding plan. All staff to complete safeguarding training prior to evaluation activities. Participants can be given a support leaflet with points of contact if affected by discussions in qualitative research. IFF and PACT to agree a designated staff member that participants can speak to if distressed.
Safeguarding	Parents are not able to provide true informed consent through an opt-out approach, if they do not read the email	High	Medium	We employ a multi-step approach to ensure consent is captured effectively. Initially, referrers will introduce the evaluation to families, supported by an information video to explain its purpose. Consent will then be formally collected during the initial assessment call with PACT's Triage and Assessment Officer and recorded in Lamplight. Finally, a consent question will be included at the start of the baseline survey, ensuring informed consent is explicitly confirmed before proceeding with outcome data collection. Throughout the referral and assessment stages, it will be made clear that families can still access support even if they choose not to participate in the evaluation.
Safeguarding	Parents with limited literacy skills may not reveal their difficulties, which can make it hard for them to fully understand an information sheet and give informed consent	Low	High	Animated videos aimed at parents can be used to explain parts of the evaluation.
Safeguarding	The wording of the survey questions isn't trauma-informed	Medium	Medium	Although we cannot change the wording of the questions because validated measures are being used, IFF will continue to collect feedback on parents' experience of conducting the survey, monitor responses weekly, and escalate any safeguarding concerns.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Sample	Parents with more than one eligible child are counted and randomised in two separate dyads	Low	Low	Referrer and family engagement materials make it clear only one child is eligible. PACT Triage and Assessment Officer reinforces this message during checks. PACT will only share one dyad per family in the sample to be randomised. IFF conducts sample checks ahead of any randomisation round.
Sample	Receive outcome data for fewer than 60 parent-child pairs from minoritised ethnic backgrounds – not enough for exploratory outcome analysis	Medium	Medium	IFF will work with PACT during set-up to refine referral pathways. Co-design work during set-up focused on refining engagement materials to resonate with more diverse families. Bespoke IFF dashboard offers live monitoring of survey responses and key info (ethnicity). Diverse parents are included in the IPE qualitative discussions so that we can explore impact qualitatively. PACT will monitor the profile of referrals received, and if we are not on track to hit the target of 60 families from minoritised ethnic backgrounds required for exploratory subgroup analysis, PACT will roll out bespoke groups in targeted communities within Slough.
Sample	Parents invited to participate in an interview for the process evaluation do not reply	Medium	High	PACT to hire a FTE Triage and Assessment Officer, who will be responsible for recruiting focus groups and interviews because they will have an existing relationship with families, making them more likely to respond. The Officer will employ a variety of communication approaches (including WhatsApp) based on the communication preferences of the parents.



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Sample	Due to fear of the unknown or feeling overwhelmed with paperwork (e.g. from police and other services), families are reluctant to engage with the evaluation, and we do not receive enough outcome data	Medium	High	We will provide families with a video to increase their knowledge of the evaluation, manage their expectations around what participating involves, and increase their confidence to take part. We will also support practitioners to have conversations with parents about the evaluation, through offering training/meetings and creating support materials (e.g. FAQs) to build their confidence in the evaluation purpose and benefits and handle queries.
Sample	Parents are deterred from participating because they don't feel that the support is for people from their communities	Medium	High	We will aim to feature diverse families in information materials. PACT's referral strategy details their diverse strategies for growing/maintaining referral relationships, including with minoritised communities.
Sample	Attrition – families drop out of BB4K	Medium	High	IFF and PACT to monitor attrition (and reasons) throughout delivery in fortnightly project catch-ups, and take steps to address reasons (where possible). Where attrition rates are unmanageably high, discuss with Foundations the possibility of PACT delivering to additional cohorts, to make up for the shortfall.
Staff buy-in	PACT Support Workers/ Triage Officer feel uncomfortable about randomisation or lack the necessary understanding to explain its purpose to service users. This can hinder their ability to encourage family participation in the trial	Medium	High	Implement training and meetings with staff to explain the purpose of the evaluation, benefits, need for randomisation, and how to approach conversations about surveys with service users. Supporting materials can be used to explain the purpose and benefit of the evaluation to aid these conversations (e.g. FAQs, animations, randomisation flowchart, etc.).



Risk category	Risk	Likelihood (L/M/H)	Impact (L/M/H)	Mitigation/recovery activities
Staff buy-in	Unmanageable burden on PACT staff around evaluation	Low	High	Evaluation activities built into PACT resourcing as part of budgeting and planning; clear strategy and ongoing communication with PACT; joint, live Gantt chart; diarised, regular meetings for decision making; written progress updates of key developments/progress. Assessment of existing data to avoid duplication of data collection. Commitment to working flexibly and collaboratively with the PACT team to minimise burden.



Timeline

This is a high-level timetable of the key activities. See the project timetable for further information.

Table 12. Timeline by project phase

Phase	Timing
Onboarding and set-up (including evaluation protocol, ethics, and data protection)	January to April 2026
Cohort 1 delivery and fieldwork	March to December 2026
Cohort 2 delivery and fieldwork	April 2026 to July 2027
Cost activities collection – Year 1	January 2027
Interim report – Year 1	January 2027
Cohort 3 delivery and fieldwork	August 2026 to December 2027
Cohort 4 delivery and fieldwork	April 2027 to May 2028
Cost activities collection – Year 2	January 2028
Interim report – Year 2	December 2027 to March 2028
Cohort 5 delivery and fieldwork	November 2027 to December 2028
Cohort 6 delivery and fieldwork	May 2028 to April 2029
Cost activities collection – Year 3	January 2029
Final analysis and reporting	February 2029 to June 2029



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