EVALUATION REPORT

Brandon Centre for Counselling and Psychotherapy for Young People: Systemic Integrative Treatment

Feasibility and pilot study report

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YOUTH ENDOWMENT FUND

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About the Evaluator

This independent report, funded by YEF, has been produced by a multi-disciplinary team based at the University of Hertfordshire (UH). The evaluation team has proven knowledge and competence in the field of youth violence and crime, and considerable experience conducting research involving vulnerable and at-risk children and families and evaluating the feasibility of different projects.

As members of YEF's Evaluation Panel with responsibility for evaluating four launch grant round family-focussed projects, the programme of work was led by Professor Joanna R Adler as Principal Investigator, with Professor Brian Littlechild, Dr David Wellsted, and Dr Tim McSweeney as Co-Investigators. Dr Muna Sabbagh assisted during feasibility fieldwork. Dr Caroline Cresswell joined the team during the pilot evaluation, leading on qualitative analyses of fieldwork thereafter. Natalie Hall and Amanda Busby from the UH Centre for Health Services and Clinical Research facilitated training for the project in the use of REDCap, oversaw processes to enable data capture, and conducted analysis of YEF's core measures data – collected by the project staff, using this software.

If you notice inaccuracies in this document, please report them to Professor Joanna R Adler: J.R.Adler@herts.ac.uk

List of Abbreviations

ACE	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ASB	Anti-Social Behaviour
ASD	Autism Spectrum Disorder
BC	Brandon Centre for Counselling and Psychotherapy
CAMHS	Child and Adolescent Mental Health Services
CBCL	Child Behaviour Checklist
CRIES-8	Children’s Revised Impact of Events Scale-Eight items
DSA	Data Sharing Agreement
DPIA	Data Protection Impact Assessment
ESYTC	Edinburgh Study of Youth Transitions (sweep 3 measure used)
GDPR	General Data Protection Regulation
IES-R	Impact of Events Scale-Revised
MOU	Memorandum of Understanding
MST	Multisystemic Therapy
NICE	National Institute for Health and Care Excellence
RCT	Randomised Control Trial
REDCap	Research Evaluation Data Capture system
SCORE 15	SCORE 15 Index of Family Functioning and Change
SIT	Systemic Integrative Treatment
TAU	Treatment as Usual
SDQ	Strengths and Difficulties Questionnaire
UH	University of Hertfordshire
YEF	Youth Endowment Fund

Executive Summary

The project

The Systemic Integrative Treatment (SIT) programme aims to use therapeutic support for parents and carers to reduce children's violence, crime, and anti-social behaviour. Developed and delivered by the Brandon Centre for Counselling and Psychotherapy (BC), SIT provides a 12-month intervention to the families and carers of 10-14-year-olds who are absent from school, displaying violent behaviour, misusing substances, or offending and have typically been referred by NHS Child and Adolescent Mental Health Services (CAMHS). SIT has two phases. During phase one, a therapist works intensively with parents and carers, meeting them several times a week and aiming to equip families with the tools and confidence to deal with the child's behaviour. Therapists draw on a range of therapeutic models (including cognitive behavioural therapy and family therapy) to deliver an individualised intervention for each family that varies in the type and intensity of support. Treatment may take place in the family home or in other environments where behavioural difficulties may occur. SIT sometimes includes direct treatment for the child, but most of the intervention is delivered by the therapist to the parent and carer. Phase two is during the second six months of the programme and is when therapist support tapers off and parents attempt to independently implement their learning.

YEF funded a feasibility and pilot evaluation of SIT. The feasibility study aimed to ascertain what factors supported or hindered delivery; examined recruitment, retention, and reach; and explored families' and professionals' perceptions of the intervention. The evaluation used interviews with six families and two referrers and a focus group with project staff, and analysed monitoring data collected by BC practitioners. Twenty-four families participated in SIT during the feasibility study, which ran from February 2020–July 2021. The pilot study then aimed to assess the potential improvements associated with SIT (as measured by outcomes including the Child Behaviour Check List, the Strengths and Difficulties Questionnaire and the SCORE 15 Index of Family Functioning and Change). It also aimed to describe the referral and screening process more fully, ascertain how many families completed the intervention, explore the potential for delivering SIT at a larger scale, and examine the implementation of the programme. It used interviews and focus groups with families and professionals in addition to analysing project monitoring data. The pilot ran from December 2021–April 2022. Forty-nine families were supported by SIT and were considered within the pilot study. Both the feasibility and pilot studies were undertaken during the coronavirus pandemic, requiring both the delivery and evaluation teams to adapt to challenging circumstances.

Key conclusions
The feasibility study identified the flexibility of support and building trust with families as key enablers of the SIT programme. Referrals were considered appropriate, and referrers from NHS CAMHS were positive about the process. Twenty-four families were initially enrolled in the programme. After three months, 17 parents and carers of 14 children were continuing the intervention.
The six parents and carers interviewed in the feasibility study had positive perceptions of SIT. All would recommend it to other families. They commended the flexible and intensive nature of support and had more positive perceptions of BC compared to alternative services they had previously experienced.
Limitations in data collection prevented the evaluators from confidently commenting on the potential impact of SIT on children's behavioural outcomes and family functioning. In the pilot phase, no more than 49% of parents provided data at any time point, while only very few children (6/49) completed any of the required measures. The evaluator is cautiously optimistic that the intervention was delivered as intended in the pilot study, despite modifications made due to the COVID-19 pandemic.
In the pilot study, as in the feasibility evaluation, all referrals were accepted, and 49 families were enrolled over the entire course of the feasibility and pilot studies. After six months, 73% of families were continuing with the intervention. This fell to 69% after nine months and 53% by 12 months. Although there were only a small number of families where the child was identified as Black, all five of these families had withdrawn from the intervention by nine months.

Several significant challenges would need to be resolved before proceeding to a randomised controlled trial, most notably, issues with outcome measure data collection.

Interpretation

The feasibility study identified the flexibility of support and building trust with families as key enablers of the SIT programme. Referrals were considered appropriate, and the two referrers interviewed (both NHS Child and Adolescent Mental Health Services [CAMHS] psychiatrists) were positive about the referral process; they noted positive changes in the families and reflected that the flexibility of the SIT programme was beneficial. All referrals made resulted in acceptance to the intervention.

The six parents and carers interviewed in the feasibility study noted that their children presented significant and multiple problems that had led to their referral. They perceived that the support provided by BC was key to ensuring that children made improvements, and their positive views of BC contrasted with their views of other services and agencies. The flexibility of the SIT programmes was particularly praised, including how flexible the BC therapists were about the location and timing of support. They also valued the intensity of support provided by BC therapists (with home visits or online contact two to three times per week and 24/7 on-call support where required). The small number of parents and carers interviewed would recommend the programme to other families. Flexibility was also championed by BC staff, who appreciated being able to work their appointments and support around the specific needs of families.

Limitations in data collection during the pilot phase prevented the evaluators from confidently commenting on the potential impact of SIT on children's behavioural outcomes and family functioning. Despite a promising start to data collection during the feasibility phase, by the close of the pilot phase, no more than 49% of parents had provided data at any time point, while only very few children (6/49) completed any of the required measures. The evaluator is cautiously optimistic that the intervention was delivered as intended in the pilot study (with some modifications made due to the COVID-19 pandemic). Up to 12 months of intervention were offered in two six-month phases as intended. One of the greatest impacts of the pandemic was the need to adapt some face-to-face interactions into online communication.

Forty-nine families were enrolled over the course of the feasibility and pilot study, and all referrals were accepted during both phases. After six months, 73% of families were continuing with the intervention. This fell to 69% after nine months and 53% by 12 months. By nine months, of those families that had dropped out (without formally completing the intervention), there was little difference in the ages of the children, their gender, or the referral source. However, all five of the families where children were identified as Black had withdrawn from the intervention.

The parents interviewed in the pilot study were positive about the SIT, indicating that the delivery of the programme was helped by the building of a therapeutic alliance and that they did not feel judged by the BC therapists. Two of them suggested that the changeover of therapists between the two phases (as a new practitioner is assigned to families at this point) may have impacted retention. Practitioners suggested that adapting or reducing the data collection requirements of the evaluation may support better retention in future.

Several significant challenges would need to be resolved before proceeding to a randomised controlled trial, most notably issues with core outcome measure data collection. For these reasons, YEF is not currently planning on funding further evaluation of the programme.

Introduction

Background

Brandon Centre for Counselling and Psychotherapy for Young People, known as Brandon Centre (BC), provides professional services in support of the psychological, social, sexual, and medical problems of young people aged 8–25 across north London boroughs. BC offers systemic integrative therapy, which is an adaptation of multisystemic therapy (MST).

MST was originally developed in the USA as an intensive home- and community-based therapeutic intervention with young people, their families, and wider networks, requiring high levels of staff training and commitment from all parties involved in the process. Evaluations have demonstrated some positive impacts on reoffending when MST is used with specific groups of young people who have offended, such as "serious and violent" offenders (Sawyer and Borduin 2011), young people convicted of sexual offences (Borduin et al. 2009), and young offenders with substance misuse problems (Henggeler et al. 2002). This includes one study of serious and violent young people who had offended, where reoffending rates by MST participants were significantly lower than those of individuals who had received "individual therapy" at almost 22 years post-intervention (Sawyer and Borduin 2011).

Findings relating to wellbeing have been generally positive, although not universally favourable in terms of recidivism. There have been fewer robust evaluations of MST beyond the United States, but some exist. A Canadian implementation found that the MST cohort were 10% more likely to reoffend than the treatment as usual (TAU) group (typically comprising probation supervision) (Leschied and Cunningham 2002, cited in Farrington and Welsh 2005). This has led to discussion on how MST programmes have been implemented elsewhere, raising questions about programme fidelity and transferability.

One of the earliest UK tests of MST was run by BC. MST was implemented alongside, rather than in comparison to, TAU. Results were favourable, with a reduction of non-violent offending during an 18-month follow-up recorded among the MST intervention group (Butler et al. 2011). The randomised control trial (RCT) findings led to support for MST as a commissioned service (NICE n.d.). More recently, again in the UK, Fonagy et al. (2020) conducted a larger-scale RCT of MST compared to TAU, finding no significant differences between the groups in criminal conviction, nor measures of wellbeing and mental health, by the final follow-up point at 60 months. Qualitative findings showed positive therapeutic relationships, with techniques learnt to foster better relationships.

Littell et al. (2021) conducted a systematic review of 23 international RCTs, most of which compared outcomes of MST for young people and families to TAU groups. They found that effects of MST on a range of outcomes, including criminal activity, delinquency, and behavioural and psychosocial measures, were not consistent across studies. Furthermore, the authors found high risks of bias along at least one indicator in the majority of the studies, which raised questions about the reliability of available evidence for MST. For example, one earlier trial had concluded that factors including ethnicity, problem severity, and how behaviours were perceived impacted upon both therapist adherence and service-user engagement, suggesting that such factors might, in turn, impact upon programme efficacy (Ryan et al. 2013).

More recently, suggestions were made about ways to improve clinical practice in delivering MST (Bunting et al. 2021). These included better embedding of cultural/acculturation differences from understanding behaviours that might lead to a referral through to ensuring that cross-cultural skills are acquired, maintained, and developed alongside other therapeutic skills. It is partly in response to the limitations in traditional MST that BC's intervention was derived. Systemic Integrative Treatment (SIT) was devised by the BC clinical team in 2017, after 14 years of delivering MST. Their reflection on the strengths and limitations of the MST model led them to produce an adaptation that better met the needs of the children and families BC serves, alongside others at risk of out-of-home placement not covered by MST.

Intervention

BC aims to respond to the psychological, wellbeing and social needs and challenges of young people under 25 years old. SIT is a community-based treatment programme, developed in accordance with NICE guidelines, to treat anti-social behaviour, chronic conduct disorders, and harmful sexual behaviour in children aged up to 16. SIT is designed to be a cost-effective, evidence-based alternative to out-of-home placements and/or treatment (in foster care, secure accommodation, and CAMHS inpatient admissions). Although based on MST, Brandon Centre Systemic Integrative Treatment (BC SIT) differs significantly in several areas while retaining some similarities, primarily in underpinning theory.

Key similarities include:

- Both are based on the social-ecological theory of change, which attests that a young person's behaviour is determined by the functioning of proximal systems in which they are embedded (family, school, peer, and neighbourhood) and the interplay between these.
- Like MST, SIT is an intensive, community-based intervention that works primarily with a child's parents or carers as well as the other systems around them.
- SIT and MST therapists provide 24/7 support for the family and wider network.
- Clear, measurable treatment goals are agreed at the outset of treatment between the referrer, the family, and the SIT team.

Key differences include:

- SIT intervention is provided over a year in a two-phase treatment model – six months intensive intervention and six months additional support. MST is a three-to-five-month intervention, typically without ongoing follow-up.
- SIT is more flexible in the interventions offered, tailored to each family and each problematic behaviour with an explicit intention to avoid overly focussing on behavioural therapy.
- SIT treatment includes direct intervention with the child where this is clinically indicated – but a child's willingness to engage does not determine suitability for treatment.
- Minimal exclusion criteria – SIT does not exclude referrals where a child has co-morbid diagnoses, nor high-risk presentations such as eating disorders and self-harming behaviours, although it requires children to be open to CAMHS in these instances.

The BC SIT intervention was manualised in 2020, is highly individualised and targets the interplay between home – seen as being the most enduring system for the young person – school, peers, and neighbourhood systems. The decision to design an intervention longer than a more typical MST programme was made by BC in response to feedback from families. The funding proposal submitted to YEF cited previous parental perceptions that support had ended too abruptly after five months, leaving families struggling to maintain progress. The proposal indicated that families had also expressed difficulty when interacting with professionals from other agencies who took different approaches to those espoused by MST. This was taken to mean that they could feel undermined. In some situations, small setbacks at home had led to exclusion from school or transfer to out-of-home care. Families reportedly felt that, with more support, they could have prevailed. This also informed the decision to include a dedicated transition phase within the SIT.

This report will examine process and pilot (before-after) outcomes for BC SIT.

Referral process

Referrals are received primarily from NHS CAMHS and social care across London. As part of the referral process, monthly meetings are held with an internal authoriser/gatekeeper and members of BC SIT. During these meetings, potential cases are considered alongside the availability and/or waiting list for intervention.

Screening

All referrals are screened for suitability by BC staff using a set of tools developed for this task, including the child behaviour checklist (CBCL; Achenbach and Rescorla 2001).

Participant Inclusion criteria

- The BC SIT intervention targets the home system: The young person is living at home or is in a long-term foster care placement or a short-term placement with an imminent plan to return the child home.
- The parent or carer has agreed to an initial assessment.
- The young person might be regularly absconding, being violent, engaging in substance misuse, offending, or displaying defiant, severe oppositional, or harmful sexual behaviour.
- Behaviours to be addressed must include at least one of: school refusal; regular absconding; violence; substance misuse; offending; defiant or severe oppositional behaviour; or harmful sexual behaviour (please see theory of change below).

Exclusion criteria

There were no active exclusion criteria. In other words, the reason for excluding a family from the intervention would be based on not meeting the inclusion/referral criteria outlined above.

Sample size

BC SIT had initially intended to recruit the families of 56 young people during their work commissioned by YEF. The final evaluation sample sizes are listed below and are elucidated later in the report for each phase. For the feasibility study (qualitative), there were 16 focus group and interview participants; additionally, quantitative data from 24 families were captured within the data audit (see appendix C).

Pilot: Qualitative – 12 participants in interviews and focus groups; Quantitative – data from 49 families (including 24 carried forward). The quantitative cohort includes those families that were initially part of the feasibility phase as the intervention and follow-up of clients recruited in the feasibility phase continued into the pilot phase. For this reason, the cohorts were combined in the pilot study, and earlier data were carried forward to the pilot evaluation to enable measurement of “distance travelled”.

Recruitment and follow-up

Following recruitment into the programme (t0), the clients were followed up at one (t1), three (t2), six (t3), and, where possible, 12 months (t4).

Intervention objectives

The primary SIT aims and objectives are:

- Reducing violence, crime and anti-social behaviour
- Improving educational attainment and reducing truancy and preventing permanent school exclusion
- Preventing children and young people being placed in care
- Reducing inappropriate and unnecessary CAMHS inpatient admissions and shortening the length of admissions
- Supporting children to return to family homes from alternative placements and remain at home, thriving.

Evaluation aim

The overall aim of the evaluation was to investigate the potential of BC SIT to improve young people's and their families' outcomes. The BC SIT evaluation progressed from feasibility to a pilot study, carrying forward quantitative data and incorporating additional families as they were accepted into the BC SIT. The pilot study had a cohort design (i.e. the entire group of families eligible to receive the intervention were followed up longitudinally). It assessed change over time in main outcomes and continued success of delivery. A further aim was to determine whether it is possible to deliver a large-scale evaluation of the intervention, i.e. readiness for trial. The outcomes listed below cover problem behaviour, emotions, trauma, family functioning, and engagement in criminal behaviour.

BC SIT evaluation objectives

- The main objective was to assess the improvement in emotion, problem behaviour, and family functioning, distress related to trauma, and reduction in engagement in criminal behaviour by the children involved in the programme.
- To assess the potential effect size of the BC SIT intervention, evaluated across the project's routine measures and those specified by YEF.
- To evaluate the methods for recruiting clients from the intervention's target population and retaining clients in the programme once enrolled.
- To evaluate the potential for delivering a larger-scale randomised trial.

Core measures

YEF specified a standard set of measures to be used and compared across a range of commissioned interventions and evaluations. This is referred to as the core measures dataset and is described in more detail in the data collection section below. First, we summarise the broad approach.

Primary outcomes

Psychological and emotional wellbeing:

- Strength and Difficulties Questionnaire (SDQ; Goodman 1997)
- SCORE 15 Index of Family Functioning and Change (Stratton et al. 2014)
- The Impact of Events Scale (IES; Weiss 2007) and the Children's Revised Impact of Events Scale-Eight Items (CRIES-8; Perrin et al. 2005)
- Edinburgh Study of Youth Transitions and Crime (ESYTC) – sweep 3 (McVie 2007)

Adherence to Intervention

- Adherence to the intervention was assessed by recording attendance at therapeutic sessions and monitoring additional, relevant information provided within follow-up assessments. It is worth restating here that the intervention was individualised. So, presenting needs and developing complexity may have influenced how, when, and which challenges were addressed within the BC SIT.

Service-user experience

Qualitative interviews were conducted with families to investigate their experience of participating in the intervention. Similar interviews were also conducted with service providers, referrers, and stakeholders. Qualitative interviews allowed an exploration of rich, in-depth information about interviewees' perceptions of BC SIT, but it is difficult to generalise from the findings. This could be noted as an evaluation limitation, as experiences reported may not be relevant to, nor representative of, all stakeholders and service users involved with the project during either phase of the evaluation.

BC SIT-specific outcomes

- BC SIT uses goal setting as a therapeutic method, and progress on the goals constituted an additional outcome for this programme.
- BC SIT routinely collated data via the CBCL (Achenbach and Rescorla 2001), which was also drawn on to assess progress.

Secondary outcomes

The CBCL included items relevant to intermediate outcomes for families. For the child, these were intended to include: reduced violence; improved engagement with key individuals; increased emotional self-management; and improved behaviour. For parents and family, these outcomes were intended to be: increased de-escalation skills; reduction in feelings of helplessness; improved confidence; improved community support networks; reduced social isolation; and improved wellbeing.

Long-term outcomes were intended to be: reduced offending; improved school attainment; and improved community responses to reducing violence. The longer-term outcomes are outlined in the theory of change below, but they could not be fully evaluated within the pilot study, as most occurred beyond the scope of the evaluation.

Ethical review

The University's ethics and integrity policies and processes can be seen at: https://www.herts.ac.uk/research/research-management/ethics-and-research-integrity. In accordance with this process, the evaluation had full approval from the UH Health, Science, Engineering and Technology Ethics Committee (protocol numbers: LMS/SF/UH/04101-feasibility and LMS/SF/UH/04697-pilot). Following COVID-19 and changes in the initial deadlines for both phases of this evaluation, amendments were resubmitted for further extensions. Data collation was eventually permitted until November 2022 under approval 04697 (see appendix A for each original approval).

Safeguarding

The same process was adopted for feasibility and pilot studies: Interview participants were made aware that there may have been situations, under the safeguarding framework, where there could have been a statutory obligation for members of the evaluation team to break confidentiality and provide information back to the organisation providing the intervention or other statutory bodies. Although it was made clear that the evaluation team would not process identifiable data, participants needed to be clear that for safeguarding reasons, anonymisation is not complete.

The initial intention was that evaluators would be following the safeguarding protocols provided by each grantee, working in close liaison with project managers from the grantee. Given the developments and dramatic changes to policy and process developed during the pandemic, the evaluators further developed our overarching practice, working in continued consultation with project managers. A summary of these safeguarding principles can be seen in the risk protocol available within the original pilot protocol. No safeguarding concerns arose during fieldwork, and none were found in the dataset (beyond those for which young people had initially been referred).

Consent

The information in this section pertains to both the feasibility and pilot evaluation. Most of the administrative data being collated for this evaluation were shared, stored, and processed under the principles of legitimate interest. Additionally, there were interviews undertaken (with service users, stakeholders, and service providers) that proceeded on the basis of legitimate interest, supplemented by informed consent. When providing information and gaining consent from young people, a multi-stage process ensured that parents, primary caregivers, and/or legal guardians were informed and provided consent where possible. Evaluators were mindful that in some circumstances, parental interests could have conflicted with young people's rights. In such circumstances, children's interests were prioritised.

When being invited to participate in interviews specifically for the evaluation, all prospective participants were provided with an Information Sheet and given time to read it fully before any interview. Any questions were satisfactorily answered, and if the participant was willing to participate, either written informed consent was obtained prior to the interview, or verbal consent was obtained and recorded as part of an online interview process. During the consent process, it was made completely and unambiguously clear that the participant was free to refuse to participate in all or any aspect of the pilot evaluation, at any time and for any reason, without incurring any penalty or affecting their continued involvement in the intervention. Information was provided in accessible, age, and cognitively appropriate ways; consent was treated as an ongoing process; consent and participation could be withdrawn without penalty; findings and data were anonymous where possible, confidential throughout and, where appropriate, depersonalised or anonymised according to principles both of the GDPR and UK anonymisation network framework. Please see appendices B and D for the materials used.

Data protection

The legitimate interest under which much of this evaluation proceeded rested on the fact that the intervention (and thus evaluation) sought to ascertain whether or not there might be a public benefit from the potential reduction in harm to/from the young people, their families, and wider communities. As data processors of the routine monitoring data and controllers of the bespoke (interview) data, evaluators were (and are) registered and fully compliant with the requirements of the General Data Protection Regulations (GDPR) (Regulation (EU) 2016/679) and the Data Protection Act 2018. The UH Cyber Essentials Certificate number is IASME-A-09513. This research was conducted in accordance with an agreed Memorandum of Understanding (MoU) and Data Sharing Agreement (DSA), which were informed by a comprehensive Data

Protection Impact Assessment (DPIA). These were all agreed between the grantee and evaluators, where possible, drawing on YEF general principles, as they developed.

Data transfer to the evaluator was in pseudonymised form and compliant with the DSA. Data storage was on secure servers. Access to the evaluation database was, and is, controlled and administered by UH Data Management, and access is via end-to-end encryption. The servers are protected by UH firewalls and anti-virus products and are patched and maintained (including back-ups) according to best practice.

The pseudonymised evaluation data will be electronically archived on secure servers for five years after the final evaluation reports have been completed. Access to the data will continue to be managed and only made available to members of the evaluation team, to YEF personnel, or, where necessary, for statutory regulatory processes. Privacy notices and information about the routine monitoring data were provided by BC to their beneficiaries/service users. For evaluation-specific information on the usage of data, please see appendices B and D.

Confidentiality

All data captured into the survey database remains anonymous to the evaluation team. Pseudo anonymity was achieved by providing each client with a randomly generated study ID, used in the dataset, that is unrelated to their personal details. All reporting only provides summary data, which avoids the potential to identify individual clients. Where quotes are included from qualitative interviews, identifying material has been appropriately modified.

By using a random ID to protect the identity of the beneficiaries and service users, the BC SIT team could provide the data required for the evaluation while maintaining a level of protection against disclosing clients' identities. The team adopted a relatively routine way to do this, which is for the grantee (BC) to retain a key that allows identification of the clients from the random code. If subsequent data linkage had been possible, then this key would also have allowed longer-term follow-up from public and institutional databases. Subsequent data linkage had originally been seen as desirable; however, it should be noted that BC was commissioned and began running the intervention before privacy notices and data protection implications of potential archiving had been fully worked through within the YEF. As such, their initial agreements with referrers and with clients did not make it clear that data might have been used in that way. Accordingly, it was agreed that if found suitable for a full trial, this intervention would need to adopt different principles and that, from the evaluation perspective, this study will not be moving into an internal RCT (where data might have been carried forward). This means that there will be no need to unmask the data because they will not be deposited in YEF's data archive.

Quality assurance

Evaluation staff reviewed data for errors and missing key data points at regular intervals and via two specified data audits. The pilot evaluation database was also programmed to generate reports on errors and error rates. Essential study issues, events, and outputs, including defined key data points, were monitored and documented.

Feasibility Study

Overview

Research questions

The key questions for the feasibility study were to better understand:

1. What factors support or interfere with the project's successful delivery?
2. What is the feasibility of the recruitment, retention, and reach for the intervention?
3. What are service users' and referrers' experiences and views of the intervention?

Success criteria and/or targets

BC SIT works with young people who are at risk of out-of-home placement, may be offending, have behavioural and emotional problems, and/or are not in school. Prior to the YEF commissioned delivery of SIT, BC indicated that by the end of treatment, and six months thereafter, 80% of referred young people would no longer be offending, would be living at home, and would be in mainstream school.

Methods

Participant selection

Based on initial projections to YEF and anticipated BC SIT caseloads, it was anticipated that approximately 25 children and their families would be recruited during the feasibility phase. For quantitative data, it was intended that the entire cohort would have been analysed. For qualitative aspects of this evaluation, sampling was purposive for professional stakeholders and largely intended to be opportunistic for children and parent/carer interviewees, using the SIT therapists as gatekeepers. BC SIT staff obtained initial consent from parents for the evaluation team to contact them and/or the children for whom they had parental responsibility. Several of the adults with parental responsibility never responded to the invitations we had sent following that initial approval to contact. Each parent who had agreed with their therapist to be approached was contacted up to three times before being dropped from further contact.

Referrers from CAMHS and stakeholders were also contacted by the evaluation team once initial consent for us to contact them had been obtained via BC SIT staff. BC SIT staff were invited to take part in two focus groups, one during the feasibility phase and one in pilot (both of which took place with those who consented), and two separate interviews were conducted with a manager, again once during the feasibility phase and once in pilot. Interviews and focus groups were run using video conferencing software and/or telephones, as agreed and possible with those participating.

Theory of change/logic model development

The theory of change was developed by the project in 2017. The inclusion criteria set by the SIT service (outlined above) are deliberately broad, and individualised ways of working are key to the intervention approach. BC SIT uses a specific assessment and intervention model – the SIT-AIM – to assess difficulties and devise interventions to address the key causal or maintaining factors for each referral behaviour. The intention is, thus, to target the diverse needs and challenges faced by young people and their families. Such variation is likely even in circumstances where the level of complexity may appear similar. As part of systemic integrative treatment, the BC SIT team would normally expect to work closely with other professionals engaged with the young person's family, including schools, social workers, mental health professionals, youth workers, and community groups attended by the young person. Where appropriate, this could also include youth offending officers and court officials. Here too, this leads to a wide range of potential families within the intervention at any one time.

It should be noted that the starting point for BC SIT's engagement with a family is whether the parents or carers are prepared to engage with the intervention team. If adults with parental responsibility were prepared to engage, then the intention was to provide an opportunity for the young person at the centre of the referral to have been drawn into the process. Figure 1 summarises the logic model. Inputs and outputs were tested during feasibility and pilot phases of the evaluation. Shorter-term outcomes were assessed during the pilot phase. Mid-/long-term outcomes were beyond the timeline of this evaluation.

Figure 1: Theory of change: Brandon Centre Systemic Integrative Treatment

Problem statement	The BC SIT service provides intensive systemic interventions to families and wider systems around young people at risk of out-of-home placement due to behavioural difficulties.		
Inputs	**Outputs**	**Short-term outcomes**	**Mid-/long-term outcomes**
Twelve months of intervention adapted from MST, retaining social ecology principles. Families are seen as often as needed, typically three sessions per week, with intermediate check-in calls and access to a 24hr hotline (online/phone). • Phase 1 (up to six months) aims to change young people's behaviour by targeting the proximal systems in which they are embedded – family, school, peers, and neighbourhood (and interplays between them). The starting point is the home system, seen as most enduring for young people. • Phase 2 is seen as a transition phase where parents are supported either to "stand on their own" and/or to draw on other appropriate services/agencies.	• Partnerships established with schools and community-based agencies/services to inform/identify work on anti-social behaviour. • BC SIT staff establish positive relationships necessary for provision of: ○ Family therapy ○ Cognitive behavioural therapy ○ Trauma-focussed therapy ○ Marital/couples work ○ Behavioural-based interventions. • Parental skills development.	By six months, 80% of young people will be: • No longer offending • Living at home • (Back) in mainstream school. Families will have: • Set goals • Shown improved functioning, such as independent management of children. Improvements on YEF's core measures will be observed in: • Emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviour (SDQ) • Quality of family life (SCORE 15) • Levels of distress due to traumatic events (IES-R and/or CRIES-8 • Self-reported delinquency (ESYTC).	For the child/young person mid-term: • Reduced violence • Improved engagement with key individuals • Better emotional self-management • Improved behaviour. For the parents/family as a unit: • Increased de-escalation skills • Reductions in feeling helpless • Improved confidence • Improved community support networks • Reduced social isolation • Improved wellbeing. Long-term outcomes were intended to be: • Reduced offending • Improved school attainment • Improved community response to reducing violence.
Impact	Young people will have moved towards responsibility and self-fulfilment. There will also have been mitigation of harms from psychological disturbance, maladaptation in adult and family relationships, mental ill health, and unwanted pregnancy.		

Data collection

The BC SIT evaluation draws upon different data sources and methods. These were designed to include the use of routine monitoring data collected by the project, core measures specified by YEF, and qualitative findings from interviews and focus groups. To better understand the ways in which SIT was intended to operate, evaluators also planned to run a workshop. This was initially intended to be for all four grantees being evaluated by this team to share and develop learning during inception. Due to scheduling challenges and then the onset of the COVID-19 pandemic, the combined workshop changed to a series of meetings and exchanges of materials between the evaluator and each grantee, with no cross-grantee sharing.

Interview protocols were designed to facilitate qualitative data collection from families, professionals, and referrers. The interview protocols can be seen in appendix B. They focussed on understanding the implementation process, including factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention, and reach; families' experiences and views of the intervention; and practitioner and provider perspectives on how the interventions had been implemented, developed, and delivered.

Quantitative data were collated by the grantee and then uploaded via REDCap; this is the web-based Research Evaluation Data Capture system. It is both a secure system and one that is relatively straightforward to learn how to use when entering data. Descriptive statistics were used for feasibility evaluation and inferential analyses conducted within the pilot phase.

It should be noted that the BC SIT and its evaluation were conducted under atypical circumstances. Commissioned in 2019 as part of the initial launch round of the YEF grants, intervention delivery was adversely affected by the first waves of the COVID-19 pandemic. Rather than working closely with families within their homes, nearly all delivery was moved to remote means, mainly relying on videoconferencing software. Where digital access was limited or other concerns, such as privacy, were being raised during video conferencing, telephone calls were also used. Similarly, evaluators also had to respond to COVID-19 lockdowns, infections, requirements for remote, then hybrid, working and implications for interviews (moving more fully to online than had been initially intended). Lastly, it should be noted that both evaluators and grantees needed to be responsive to emerging practices and changes from the commissioner, as YEF project management and evaluation teams formed, articulated and revised policies, guidance, and reporting requirements.

Data collection methods

All interviews and focus groups were conducted remotely (either by phone or online). With participant consent, interviews were recorded for the purposes of transcription. Fieldwork for the feasibility study was undertaken between November 2020 and July 2021. Please note that despite several repeated attempts, it was not possible to gain young people as research participants. They were approached via their parents, as agreed with the project and outlined above, but none consented to take part. It is concerning that no young people agreed to take part in interviews with the evaluation team. However, it may be useful to restate that the logic model requires adults with parental responsibility to engage with the programme. There is no requirement for young people to engage, although SIT therapist contact can be offered if deemed helpful. In addition, the very nature of the young people's problems accepted onto this intervention meant that they were often inclined to reject other services. This was evidenced by the number of parents who discussed other interventions they had received, which either they had not found helpful or from which they had been discontinued. In addition, young people's oppositional behaviour towards their parents' authority meant that attempts to engage them in research via the parents/carers and frontline staff might have caused more difficulties within those family dynamics, which would have been ethically unsound.

The majority of quantitative data collected comprises either data routinely collected within the BC SIT programme or the specified YEF core dataset. As far as possible, all identified quantitative data were collated by direct online entry to the REDCap system by members of the grantee team and stored securely on university servers. BC staff received training on data collection and use of the REDCap online system from the evaluation team.

Data collection, data entry, and queries raised by a member of the grantee team were conducted in line with the data management processes agreed between the grantees and the evaluation team. Data were routinely collected during the referral and screening process (as agreed with BC). Once clients had been accepted onto the intervention, the agreed core data was collected (t0), and follow-ups with the clients were indicated at one (t1), three (t2), six (t3), and 12 (t4) months (feasibility carried through to pilot, where possible).

Evaluation data

Routine monitoring data

The evaluation comprises analysis of aggregated and anonymised data collected by BC SIT relating to information about referrals into the service, the screening and assessment processes, and any formalised reviews. These data were also intended to enable the profile of the source population to be characterised. By monitoring referrals, the evaluation team hoped to assess whether appropriate referrals were being made (as measured against the referral criteria) and the extent to which selection bias may have occurred in accepting clients into the programme. In addition, the CBCL was incorporated into the evaluation as the service measure being routinely used by BC SIT.

Key demographic data

It was intended that BC SIT captured key client-specific and demographic data, including age, ethnic heritage, gender, relationship to other grantee clients, and index of deprivation.

Core measures

The BC SIT programme did not use any of the YEF-specified core measures prior to being commissioned by the YEF. The measures listed below were agreed by the grantees, evaluators, and YEF. Some had been suggested by this evaluation team in the original response to tender; others that had been suggested were rejected in preference to those that could be adopted/had already been adopted across a wider range of YEF commissioned evaluations. Table 1 summarises the core measures.

Table 1: Measures adopted by the grantees to facilitate evaluation

Measure	Purpose	Completed By:
Strengths and Difficulties Questionnaire (SDQ; Goodman 1997)	Evaluates anti-social or other behaviour problems	Adult with parental responsibility and young person
SCORE 15 Index of Family Functioning and Change (Stratton et al. 2014)	Typically used to track progress towards desired outcomes in family interventions	Adult with parental responsibility and young person
The Impacts of Events Scale, Revised (IES-R; Weiss 2007)*	Self-report measure of trauma/post-traumatic stress disorder (PTSD) that assesses the impact of identified stressful life events	Adult with parental responsibility
Children's Revised Impact of Event Scale – 8 (CRIES-8; Perrin et al. 2005)*	Specifically designed for children and young people over eight years old; also assesses the impact of stressful life events	Young person
Edinburgh Study of Youth Transitions and Crime – sweep 3 (ESYTC; McVie 2007)	A 19-item, self-report measure to assess young people's involvement in anti-social, potentially criminal behaviours	Young person

* Dropped during feasibility, in agreement with the YEF project team.

Table 2 summarises the methods adopted in the feasibility phase of this evaluation.

Table 2: Methods overview – feasibility

Research methods	Data collection methods	Participants/ data sources	Data analysis method	Research questions addressed	Implementation/logic model relevance
Qualitative	Evaluator interviews and a focus group	Families Referring professionals Project staff	Thematic analysis by the evaluator	1, 2, & 3	Test inputs and initial outputs. 12 months of intervention: Intensive support in phase 1 (first six months) Transitional phase 2 for the second six months. Treatment is individualised – the therapist works with parents on developing strategies/setting boundaries to achieve change in the young person's behaviour, moving to independent practice, then to addressing contributory factors, such as deviant peers, issues in the parenting subsystem, such as trauma, mental health, substance misuse, and reintegration into mainstream education.
Quantitative	Data entry by BC SIT staff with support from evaluators as queries arose	Measures uploaded to REDCap and analysed thereafter	Descriptive analysis by evaluation research team	1 & 2	Test inputs and initial outputs. Rate of referrals and successful engagement to test need and reach. Completion of measures at baseline to test/demonstrate use of core measures and readiness for pilot.

Analysis

Monitoring data were audited and descriptive reports generated that considered:

- Throughput – referral routes, acceptance and withdrawal/completion rates
- Screening – barriers and facilitators to acceptance on the programme
- Completeness of routine measure recording.

Qualitative interviews were analysed using deductive thematic analysis with key themes derived from the three research questions articulated above. Braun and Clarke's (2013) general framework was used to reduce and manage data without losing context, enabling the researcher to be immersed in the material. Thematic analysis was designed to be versatile and adaptable. In this instance, it was adopted to identify key issues and themes that had been presented by interviewees in response to the semi-structured interview and focus group schedules. This allowed themes to emerge within a framing provided by the research questions.

Timeline

Table 3 provides a summary of the activities completed within the feasibility phase. It should be noted that this phase was extended due to the disruption caused by early waves of the COVID-19 pandemic.

Table 3: Timeline

Date Completed	Activity
07.02.20	Evaluation workshops, initially intended to be for all four grantees, to share and develop learning during inception. Changed to a series of meetings and exchanges of materials between the evaluator and each grantee, here BC
07.02.20	Ethics submission and finalised feasibility plan
17.03.21	REDCap training, database set-up
17.03.21	Feasibility data audit
30.07.21	Feasibility fieldwork completion (focus group and interviews)
16.12.21	Feasibility analysis and reporting: preparation of slide stack amended by YEF to the delivery of a draft feasibility report
28.02.22	Production of summary feasibility findings for BC

Findings

Participants

Qualitative – informing all research questions

BC SIT parents – four did not respond, six were interviewed.

BC SIT referrers – one was not able to be interviewed (having left their position), two were interviewed, both were NHS psychiatrists.

BC SIT team – one manager and seven SIT therapists participated in the research (interview and focus group, respectively).

Quantitative – informing research questions one and two

Twenty-four families were enrolled during the feasibility phase, and four other families had cases closed early due to non-engagement.

Key characteristics of the children at the centre of each referral include:

- Gender
    - Six female (25%); 18 male (75%)
- Ethnicity (please note that this was not 100% completed)
    - The 88% completed records indicated three Asian (14%), two Black (10%), one mixed (5%), and 15 White (71%)
- Referrer (*Where was the participant referred from?*)
    - NB: One family had different referral sources in the parent and child arm.
    - 10 (41.7%) social worker, 12 (50%) other[1], one (4.2%) wellbeing practitioner, and one from the youth offending service.

Intervention Feasibility

Quantitative Findings

BC provided enrolled participant data. Although it was less clear how many people had been initially referred for screening, it was clear that the CBCL had been completed for each of the 24 enrolled families by the data audit (in March 2021). BC SIT staff engaged with the evaluation team productively several times in order to set up the system and review the effectiveness in entering data and in using the system, including after the audit of data entry. All families were given unique case numbers. Summary data collected at the audit point at the end of March can be seen in appendix C. Please note that by the end of the feasibility phase, additional

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[1] Please note that the categories for referral were agreed with each grantee. For BC SIT, the evaluation team were only asked to put in social worker. The vast majority of SIT referrals came from CAMHS or social care, either of which may have been subsumed within "other".

families had been enrolled, taking the total number of families to 36 by the end of August 2021. Descriptive data considered here were drawn from analysis of the data audit of 24 families.

The audit shows some solid data entry, including 100% completion of age, gender, and date of referral. Ethnicity was recorded in 21 of the 24 cases (87.5%). The audit was not designed to explore how screening was conducted, although two items were intended to be recorded as part of screening: index of deprivation and referral ID. It would seem that index of deprivation was not being collated, although 100% of referral IDs were provided. At baseline, 21 parent surveys had been uploaded from the CBCL and SDQ. For the other measures, data from 75% (18 parents) had been uploaded for the Score 15. Child surveys were at very low rates of completion, the highest being 25% (six children) for the SDQ. Only three children had completed the ESYTC. Adults' continuation data were also regularly entered. Several elements of the data monitoring did not seem to be being used systematically; this includes treatment goals not yet having been uploaded and neither IES (adult) nor CRIES-8 (child) were being routinely reported to the REDCap system. Lastly, it should be noted that not many children's surveys were being completed. This was probably because parents/carers are the key focus of the delivery model.

The comments column was found to be helpful for evaluators as well as BC SIT. For example, an early case closure could be interpreted as a positive outcome if families were now in a better position to manage without intensive support. In one case, the family successfully returned to CAMHS services, where there had been difficulties in that relationship before engagement with BC SIT.

The ongoing engagement between project and evaluation staff led to efficient data entry. If it had continued in this way, it should have been sufficient for data capture for the evaluation in terms of the targets for the project and in terms of "distance travelled" for adults, measured within selected tools over time. Ideally, by pilot, this would have included the addition of goals set, IES/CRIES-8, and more of the other child-completed measures.

Qualitative Findings

In this section of the report, we provide a summary of findings from the implementation process interviews and focus group conducted during the feasibility phase. Please note that themes considered here were consistent with those derived from the subsequent pilot phase of the evaluation. Qualitative findings will be considered in more depth at that point of this report.

Service-User Perspectives

One of the challenges for the evaluation of the project has been in gaining the engagement of children. What did seem to be a feature in relation to interviews carried out with families and in relation to the focus groups with staff was that autism spectrum disorder (ASD) and similar conditions were common features in referrals and acceptances. It is possible that children with additional neurodivergences would have found it particularly hard to engage in research. We tried various ways, as agreed with the project, to engage with the young people, but this proved impossible (see data collection methods). Family perspectives reported here are from the perspectives of the six adults interviewed, all of whom were parents or had parental responsibility. In carrying out the interviews and the focus groups, respondents were guided towards presenting their experiences and views in relation to the intervention; what had been of value to them, how and why, as well as what had not worked so well, and how the intervention felt to them in terms of their aspirations for their children and themselves.

All the families interviewed stated that there were significant and multiple problems presented by their children. All these areas need to be addressed as far as the parents/carers were concerned, and they did experience that BC SIT holistic support was key to the improvements that all reported. Common themes for the majority of parents/carers were the complexity and variety of the problems from their children, e.g. learning disabilities, ASD, attention deficit/hyperactivity disorder (ADHD), anxiety, depressive disorder, conduct disorder, school behaviour problems and refusal, and the demands on parents presented by managing these challenges.

Positive views of BC SIT were contrasted with experiences of other services and agencies. Several parents/carers spoke of how other agency professionals, particularly CAMHS, tended to see adults and their children on the agency's premises in an office. Neither they nor their children found this helpful. Again, several interviewees reported that appointments were not made/reorganised with the flexibility they needed. The majority mentioned how other agencies' assessments and interventions were not necessarily experienced by them as being framed around their needs or the issues identified by the family. Several families were trying to manage children with varying demands within hectic households. A majority mentioned how other agencies and/or professionals had been experienced by them as not dealing with the behavioural areas for which they were seeking help.

Several parents/carers stated how one area that had been valuable with BC SIT was in them getting to know the therapist in their own home/regularly online and being in contact two or three times a week by various means other than home visits, to check and support what the parents were trying to do. Several stated that their engagement had improved with other agencies, e.g. their work with CAMHS with their other children had been put on a better trajectory.

A few noted how in the past, they had felt labelled as being "bad parents" and been made to feel guilty about their parenting. None of them had felt blamed or guilty about needing help from the BC SIT team.

Did the parents notice improvements?

The SIT approach is seen as better than any other intervention they had experienced. Most parents/carers recognised that they had been reviewing progress with their therapist against clear aims set for them and their children and that this was done regularly, carried out at least every week, in different ways.

A few set out how reactions from their child – in relation to the new strategies being tried out with the support from project staff– could create worse behaviour initially. With the support of BC SIT staff, this had improved in the different families interviewed. Some stated that they had wanted to see greater improvements by the point of the interview. They would all recommend the programme to other parents.

Use of tools/standardised measures

The facilitative approaches and attitudes of BC SIT staff were felt to be as important as the actual methods used. However, one parent said that the core measures, such as the SDQ, were all too familiar. They had been completing this and other tools many times over the last nine years for multiple children, in addition to the one child referred to BC SIT. The parent does not find it so useful because:

1. They have used it so many times, so does not view it as useful now.
2. They question its value in terms of being able to address the distress and anxiety about what might be causing the behaviour, in part due to what might be classed as therapy talk.
3. Their son has learnt to answer in ways/with motivations that the questionnaire designers may not have anticipated. She felt that he had learnt to "work the tests".

This example highlights one of the key features that had not worked so well, among many areas that the same parent had reported to have been of value. They had wanted to talk about this right at the start of the interview as something that had obviously been a particular difficulty for themself and their child. Other parents'/carers' experiences and views about the use of the tools were not so explicit, although the majority of them had not found this element to be of use in the areas of value they had experienced within the intervention. It may be useful to note again that the SDQ was a measure imposed to meet evaluation needs; it was not a tool used within the earlier iteration of BC SIT.

Stakeholder Perspectives

Referrers

There were two interviews with referrers to the project. Both were psychiatrists in NHS CAMHS, a service which is the main referrer overall. They reported very positive responses to contact and referrals in:

- Discussing the suitability of the family for the project/discussions about screening
- Agreeing the work that could take place in the project
- How this would work in relation to the ongoing work from themselves in CAMHS.

In terms of key issues identified within the families, they experienced that the problem of child-on-parent violence is increasing, as were issues of ASD, ADHD, and school refusal. They were not referring, in the main, due to gang-related activities or child sexual exploitation.

One referrer stated that referral spaces to the project were held for the most high-need cases that were unlikely to benefit from TAU. The project took referrals for several siblings from one family to work with, which was experienced as being very valuable by one referrer.

They found the therapists proactive in giving feedback on how the BC SIT work was progressing and how they could each do their work with the family, together, to the best advantage. The referrers stated that they had seen positive changes in families they were working with. The referrers discussed the importance of how flexibly the project engaged with the families, which was very different from what they were able to do within their own agencies. Key features noted by the referrers included issues in setting boundaries and understanding when dealing with confrontational behaviour. The need for medication was an issue for a number of the young people; this was discussed with the project staff and how best to deliver behavioural and medical approaches in combination.

There had initially been some dilemmas regarding whether/when a family should be completely handed back to CAMHS, but during the feasibility phase, regular review meetings were instituted, and exit strategies were planned and enacted well. The main remaining concern from the referrers was that funding for the intervention would not be renewed, and they believed that it had provided a very valuable resource. One of the referrers coordinates and gatekeeps referrals from other staff in their trust and confirmed that in addition to the agreed numbers they had with the SIT, they were likely to spot-purchase additional places as needed.

Project staff

A focus group with front line staff was held in November 2020 between lockdowns. When asked about the main methods favoured in their work, staff made clear that they would normally have made home visits, but these had been very restricted due to COVID-19.

They identified that there are different compositions and different needs of families and individuals within them and that these can affect their work. To meet this diversity of presenting needs, there are several standard variations deployed, such as with single-parent families compared to work with couples. The latter could include forms of marital therapy, but both singles and couples may be considered for strategic family therapy alongside cognitive behavioural therapy for individuals within the family.

Staff tried to meet the need for flexibility, too, working their appointments and support around the needs of the particular family, including where parents were separated, enabling weekend visits and accommodating work patterns. Zoom was reported to be working well, although some parents prefer telephone consultations, and there had been technology issues because some families do not have the devices/data necessary to use online media.

The challenge of building trust with parents was a key theme, particularly in having to work through some of the more negative experiences from parents' previous experiences. Managing the parents and/or other family members' expectations around their – sometimes desperate – need for almost instantaneous change was also seen to be key. The provision of the 24-hour, seven-day-a-week service was seen as critical when parents were trying out new approaches. Staff reported that parents needed that backup and support, especially at times when they were dealing with what felt like crises associated with the changes.

There is continuous weekly review of the goals set and how well they are being worked on/achieved. It was seen to be important that staff do not come across as "blaming" the parents about their abilities. This reflects the non-judgemental approach identified by the parents interviewed.

Flexibility

Challenges in implementing non-judgemental approaches and helping clients to accept when things have to change for the service were mentioned. Conversely, if the session had to be cancelled by the parent(s), the workers would attempt to put this session in place again as soon as possible, trying to avoid issues in so doing. This was seen to compare favourably with other agencies; parents had told staff that if they missed an appointment, for whatever reason, it could take a long while to get another one in place.

Issues concerning the screening tools were raised relating to the amount of time taken to complete them. In particular, in the first phase, when families feel in crisis, going through the several different tools could feel like a bureaucratic and unhelpful procedure. One of the issues that was raised at several points through the focus group related to the issue of filling in forms and paperwork, especially where English is not members of the family's first language, placing pressure on therapists and families.

Despite this, they have found some of the tools to be helpful to use with referrals to be able to demonstrate developments and changes. They felt that the Score 15 and Edinburgh Youth Transitions scale may need to be delayed in implementation because of the immediacy of other challenges faced at the outset of working with families. This had been a particular problem where parents do not have English as a first language.

Manager

Five months after the staff focus group, in April 2021, an interview was conducted with a BC SIT manager (exact role not listed here to protect interviewee confidentiality). Many of the same issues resonated. The manager confirmed that they are regularly using the screening process, which includes interviews with referring agency gatekeepers. Within treatment, they use the CBCL tool, as this is key to their methods.

The manager felt that the Score 15 is problematic, as the parents had frequently reported finding the Likert scales difficult to navigate and understand. They estimated that to go through the different tools took 45 minutes or more to do at the beginning, which is normally acceptable, but that repeating every three months can become a burden for the families and staff, not least because of diminishing the use of the time available for actual therapy. Perhaps unsurprisingly, the project team also found that there were far fewer young people agreeing to complete the questionnaires.

What Worked?

There appeared to be a good level of initial and ongoing engagement with the families. Referrers to the project reported very positive engagement with project staff. They found the therapists proactive in giving feedback on how the BC SIT work with referred families was progressing. The referrers stated that they had seen positive changes in families engaging with the project.

Interviews with parents indicated overall very positive responses to the project. For parents, the very regular and flexible support, including the provision of the 24-hour, seven-day-a-week service, was significantly helping them to overcome difficulties. Alleviating feelings of disempowerment, failure, and low confidence was particularly important as they worked on developing better ways to parent their children.

Flexibility and responsiveness were important parts of parents' experiences of BC staff, contrasting positively with their previous experiences. Several parents stated that their engagement had improved with other agencies. They would all recommend the programme to other parents.

Lessons Learnt

Learning to be flexible has been key to the delivery of SIT. This is both in terms of means of delivery and how and when families are contacted and are able to contact the team. Although Zoom works well, some parents prefer or only have access to telephones.

Managing the parents' and other family members' expectations about the pace of and realistic extent of change that could be expected was important. Staff reported that families were sometimes desperate in their need for almost instantaneous change.

Particular emphasis was placed on the importance of the 24-hour service. This was seen as being vital to families at times of crisis, which may have included when they were trying out new parental management techniques suggested as part of the work with BC SIT.

One of the challenges for the evaluation of the project has been in gaining the engagement of children. This was reflected in challenges reported by the intervention team, particularly in completion of measures with children. Although there had initially been some issues and dilemmas in terms of when the family should be returned to CAMHS, review meetings are now held regularly. Exit strategies from BC SIT are planned and enacted well.

Impact of COVID-19

Both referrers spoke of how conflict had increased in families during COVID-19, with parents and children not getting breaks from each other and increasing pressure and tensions in the household. BC staff tried to meet the need for flexibility in delivery, and the approach developed appears to be working well from the points of view of referrers, staff, and parents. Some positive changes have been noted as a result of the forced changes imposed by responses to COVID-19. The staff envisage that these will be incorporated into their ongoing work.

Referrers and parents were positive in relation to how BC staff had dealt with the issues arising from COVID-19. BC staff were concerned at the start of the project with revamping the model, and the work was taking place in new ways developed in response to the COVID-19 restrictions. This had most impact on their home visits, and although not ideal, contact was maintained as appropriate and as agreed with families. Concerns remained about the inconsistent access to online engagement, although this was somewhat mitigated by the 24-hour, seven-day-a-week service, available by phone as well as online.

Logic model development

Theory of change

Despite the challenges of COVID-19, the feasibility review indicated that the BC SIT intervention was largely working in the ways in which it had been conceptualised. Some of the balance of inputs to the model had varied at different points. For example, some of the core measures were being implemented later in the process than initially envisaged. However, the type of inputs foreseen, outputs generated, and outcomes or impacts predicted have not been revised. As such, the logic model initially outlined was carried forward to the pilot phase.

Conclusion

Table 4: Summary of feasibility study findings

Research question	Finding
What factors support or interfere with the project's successful delivery?	The referrers had seen positive changes in families they were working with and stated the importance of the flexible manner in which BC SIT engaged with the families. Flexibility of support and building trust with parents were key themes. Referrers and parents were positive about how BC staff had dealt with COVID-19, with some positives resulting from these changes. The referrers found BC staff to be responsive and proactive in giving feedback on how the work was progressing.
What is the feasibility of the recruitment, retention, and reach for the intervention?	Interviews indicate that referrals were usually considered appropriate, most commonly coming from CAMHS. Referral rates were good, evidencing the need for this service. Demand for spot places on BC SIT was also a feature commented on in interviews with referrers. Referrals were considered appropriate insofar as all referrals made resulted in acceptance onto the intervention. Baseline recording on core measures looked promising, although it was not clear whether young people and adults with parental responsibility were filling out forms independently of one another. Using an electronic survey to capture data meant efficient data collection (avoiding the risks of paper-based data collection) and was used by grantees without difficulty. This allowed data capture for the evaluation, particularly when measures were completed by parents/carers. Continuation rates for follow-up work at the three-monthly intervals were generally good. Twenty-four families had been enrolled, and at three months, 17 parents and 14 children were indicated to be continuing with the intervention. Moving from treatment adherence to evaluation data, it can be concluded that data were starting to be uploaded, although potential for improvement was noted, particularly in regard to children's data.
What are service users' and referrers' experiences and views of the intervention?	Parents gave positive comments concerning initial and ongoing engagement, as well as the jointly agreed reviews of progress. They reported that the BC SIT approach was better for them than other interventions they had experienced previously. Sometimes, the parents had felt labelled by other professionals/agencies as being "bad parents" but not by SIT therapists. Non-judgemental approaches, as exhibited by the staff, were also important. The flexible and readily available support from BC SIT therapists to overcome difficulties in parents' development of more effective ways to parent their children was seen as particularly important.

Evaluator judgement of intervention feasibility

On the basis of the evidence from this feasibility study, the intervention could be seen to have been ready to move to a pilot phase. Core measures and screening tools were being deployed, and adult-completed measures were being consistently uploaded to the REDCap database. Referral rates were also on target. It should be noted that in the context of uncertainty engendered by COVID-19, the decision had been taken by commissioners to extend the grantees into a before and after pilot phase, without relying solely on feasibility findings. There was, therefore, limited evaluator judgement required as to whether to proceed to pilot.

Interpretation

By the end of the feasibility stage, up to August 2021, the project had been working with 36 families, with 56 being the maximum aimed for over the whole project, so on course for the target number of families.

BC had provided required referral/screening and participant data and engaged with the evaluation team positively in order to set up the system and to review effectiveness in entering data and using the system on several occasions, including after the audit of data entry in March 2021. The audit demonstrated that there was a good level of entry of the different agreed areas. Continuation data in tools usage were also being entered.

In relation to the use of tools for the evaluation, BC had made use of the CBCL, as well as Score 15, ESYTC, and SDQ, and the staff had been uploading data to the university's REDCap database. The ongoing engagement between project and evaluation staff had led to data entry in an efficient manner that, if sustained, would have allowed data capture for the evaluation sufficient to assess targets for the project and in terms of "distance travelled" by families, particularly by adults with parental responsibilities.

Interviews with parents/carers resulted in positive comments concerning initial engagement; planning; and ongoing review of the work; on updating and ongoing engagement on the progress of the work; and the reviewing of goals. Interviews with referrers also produced positive comments concerning initial engagement; screening; planning; and review of the work.

As well as the limitations outlined above, the low number of core measures from children could be problematic for evaluation. Also concerning was our inability to recruit any of the young people to participate in evaluation interviews despite three attempts with each family who had initially agreed to be contacted. As mentioned above, there was a risk that pushing for young people to take part in the research may have made matters worse in the families. Such issues affected whether young people were encouraged and/or prepared to come forward for interview. In learning from this, it may be valuable to consider whether a clearer protocol could be specified to facilitate how frontline staff and their managers encourage parents and young people to trust in the evaluation process sufficiently to come forward. This would have to be agreed, too, in ways that would endeavour not to make matters worse within the intervention.

Implications for pilot study

BC were not convinced by the imposition of IES-R or CRIES-8 measures of trauma, and these were not being completed. Completion of the SDQ and CBCL were promising. However, the main challenge for the evaluation was in gaining the engagement of children. Evaluators tried various ways, as agreed with the project, to engage with the young people, but this proved impossible. In the pilot phase, this became a greater priority, and efforts were redoubled to engage with the project in order to gain access to young people to inform the evaluation (something that unfortunately continued to be a limitation). It was also important to specify success criteria around readiness for a potential trial.

Pilot (Pre/Post-Test) Study

Study overview

Research questions

The pilot phase evaluated six broad aims designed to assess whether there were predicted improvements in children and young people's behaviour and wellbeing. This can be best thought of as a short-term assessment, exploring potential changes within young people and their families from before, during, and shortly after completion of the intervention. The research questions were designed around quasi-experimental principles. In setting levels for retention and completion, a pragmatic approach was taken, in broad accord with best principles such as those articulated by Eldridge et al. (2016) or Thabane et al. (2010).

As with feasibility, the pilot evaluation was also designed to assess the process of implementation from professional and referrers' perspectives. The aims and associated research questions are shown in Table 5. Please see the link to the pilot protocol here.

Table 5: Aims and research questions

Aim 1: To evaluate improvement in core outcomes over time comparing baseline to 3, 6, 9, and 12 months	
Research Question	**Measures**
Describe the client sample at baseline.	Participant demographic information fields requested
Describe the magnitude and direction of change in behaviour.	SDQ
Describe the magnitude and direction of change in family functioning.	SCORE 15
Describe changes in trauma.	IES, CRIES-8*
Describe changes in engagement in crime.	ESYTC*
Where possible, describe and evaluate the effect of baseline status on change over time.	All measures listed for this aim
Describe progress towards achieving goals at six months for clients engaged in the programme.	CBCL, bespoke fields and notes in database
Aim 2: Evaluate effect size	
Research Question	**Measures**
Estimate the likely effect size of the BC SIT on behaviour.	SDQ
Estimate the likely effect size of the BC SIT intervention on family functioning.	SCORE 15 and CBCL
Aim 3: Describe the referral and screening process	
Research Question	**Measures**
Describe the flow of young people from referral, through evaluation, to engagement on the programme, including reasons for not progressing on the programme.	CBCL, plus additional notes
Evaluate potential bias in selection by considering sample characteristics at different points in the referral process and,	CBCL plus additional notes

where possible, comparison across subgroups, e.g. referral sources.	
Aim 4: Client retention and data completion	
Research Question	**Measures**
Do more than 66% of clients complete the intervention?	End of intervention form, end of study form, and additional notes
For clients who complete the intervention, are more than 80% of the outcome measures completed?	End of intervention form, end of study form, SDQ, SCORE 15, IES*, CRIES-8*, ESYTC*
Aim 5: To evaluate the potential of delivering a larger-scale randomised trial. Assessment to be made of the following success criteria:	
Research Question	
Referral: If bias in the referral process is identified, can this bias be addressed?	
Retention: At least 75% of young people and their families should be retained in the intervention, or evidence that retention can be addressed would be needed.	
Completion: At least 80% of outcome measures at baseline, three, six, nine, and 12 months, or evidence that completion can be improved in a larger-scale trial.	
Given the likely required sample size for a larger-scale trial: a. What population size is required to achieve that sample size? b. Can likely delivery centres with a sufficient population be identified?	
Aim 6: To assess implementation process	
Research Question	**Measures**
Has the intervention been implemented with fidelity?	Interview/focus group
Have service users felt engaged?	Interview/focus group
How responsive has the intervention been to service users, staff, and volunteers (where appropriate)?	Interview/focus group

*Although initially intended as core measures for both adults and children, BC SIT determined that trauma was not a relevant outcome criterion in all referrals, so IES and CRIES-8 are not included in effect size analyses below. Similarly, ESYTC was not routinely completed and is also not included in effect size calculations.

When considering processes of referral, it should be noted that the intention was that the proportion of families recruited from those referred would be captured as part of the fourth aim. It is also critical to test whether recruitment is unbiased and to understand and address any reasons for bias that may be found within recruitment; this is the focus within Aim 5. Typically, there is attention on the lack of recruitment from particular minoritised groups or under-served communities. It is important to understand whether these biases are present in the process of identification and induction of clients into the study, as it may lead to overestimation of the effectiveness of the intervention.

To consider whether challenges to retention can be addressed (Aim 5), the kind of evidence to assess might include digital exclusion, where a proportion of families did not have access to the media required to engage in the intervention during lockdown nor to complete the electronic surveys for evaluation. For the evaluation, the SIT service also attempted to encourage self-completion by providing paper versions of the surveys to families. Another retention challenge might relate to literacy of the clients or cultural differences in how they experienced the intervention and its underlying assumptions. Additional information on data sources is provided in the section below.

Success criteria and/or targets

The project's initial success criteria (as articulated in the proposal for funding) were that by the end of treatment and six months thereafter, 80% of young people will no longer be offending, will be living at home, and will be back in mainstream school. As the intervention lasts up to 12 months, this could not be assessed for all referred families within the duration of the pilot, but it will be considered where data are available. It should be noted, however, that the self-report delinquency data (measured on the ESYTC) was always likely to be seen as most relevant in cases where young people were already known to have offended. This was not a prerequisite for referrals, being one of several possible inclusion criteria. As such, the project's intention to reduce the proportion of young people offending would not necessarily be applicable in all cases.

From an evaluation perspective, the main success criteria for the pilot will be the potential to scale up the intervention to meet a sufficiently large sample size. The sample size for a trial to evaluate effectiveness of the intervention will be estimated from evaluation of the potential effect size. Key criteria to assess evidence of promise were based on the research questions articulated in Aim 5 in Table 5 above.

Methods

Participant selection

Quantitative analyses were conducted on the entire dataset uploaded to REDCap, i.e. both routine monitoring and specified core measures. At different time points, there were different numbers of records uploaded. In some cases, this was to do with challenges in measure completion/uploading; in other cases with family completion/withdrawal (see Findings).

To assess the implementation processes, the evaluation team anticipated inviting up to five children and their parents, carers, or legal guardians to participate in an interview to inform the pilot evaluation, subject to the agreed procedure of the therapists on the project discussing with the parents and young people whether they were willing to be approached by the evaluation team. Professional stakeholders (up to five initially envisaged), including managers and delivery staff, were also sampled purposively. We therefore proposed to conduct interviews, individually, jointly, or within a group, as appropriate, with up to 15 participants associated with BC SIT. Recruitment processes were the same as those articulated in the feasibility section above.

Data collection

The BC SIT evaluation draws upon different data sources and methods. These include the use of routine monitoring data collected by the projects, core measures specified by YEF relating to project participants, and qualitative data from interviews and focus groups with project participants and professional stakeholders.

Data collection methods

As with the feasibility phase, the majority of quantitative data collected comprises either data routinely collected within the BC SIT programme or the specified YEF core dataset. Again, it was uploaded to the REDCap system by members of the grantee team and stored securely on university servers. Here too, data collection, data entry, and queries raised by a member of the grantee team were conducted in line with the data management processes as agreed between the grantees and the evaluation team. Follow-ups with the clients were indicated at one (t0), three (t1), six (t2), nine (t3), and 12 (t4) months (feasibility data having been carried through to pilot, where possible). Routine monitoring, evaluation, and core measures were the same as in the feasibility phase. Table 6 provides a summary of the data collection schedule.

Table 6: Schedule of planned data collection and assessments

	Referral	Screening	Baseline (t0)	3 months follow-up (t1)	6 months follow-up (t2)	9 months follow-up (t3)	12 months follow-up (t4)
Demographics	X						
Programme-specific process	X	X					
SDQ			X	X	X	X	X
SCORE 15			X	X	X	X	X
IES-R*			X	X	X	X	X
CRIES-8*			X	X	X	X	X
ESYTC*			X	X	X	X	X
Goal setting and attainment			x		x		
End of intervention or engagement form				To have been completed if a client withdraws or when they complete the intervention.			

*Determined as not relevant to the intervention by BC SIT.

Please note that where families had been enrolled for long enough, then it was intended to compare 12-month data against baseline to assess distance travelled by the end of the transition phase.

Data sources

To simplify descriptions of the data, we use "clients" to encompass the young people and/or families being considered for intervention, as appropriate. Data were captured separately for young people and their parents or carers. Please note that each client sub-set was recorded in both aggregated and disaggregated ways to allow the evaluation to capture the different referral routes and their different potential experiences of the intervention. For each of the aims articulated in Table 5 earlier, we here list the data source:

Aim 1: To evaluate the direction and magnitude of change in core outcomes over time and for BC SIT to assess progress towards achieving goals.

The key data source was the data collected on the REDCap database. The source data for goal setting and attainment have been extracted from the client notes held by BC SIT. Transcription and transfer of anonymised goal-related data for clients from BC SIT to the evaluation team was an ongoing process on a data format separately specified.

Aim 2: To evaluate effect size.

The effect sizes were estimated from the core dataset specified in Aim 1.

Aim 3: To describe the referral and screening process for the BC SIT programme.

Data relating to screening and referral were requested, and where possible, these were incorporated into the REDCap database. Where the relevant data could not be captured in this way, the source data were the records held by the grantee. Again, transfer of anonymised data was an ongoing process on a data format separately specified.

Aim 4: Client retention and data completion.

Attendance at therapeutic sessions and the client completion record were intended to allow evaluation of engagement in the BC SIT intervention, and the database record provides information on data completion.

Aim 5: To evaluate the readiness of delivering a larger-scale randomised trial.

Evaluation of this aim utilised all the data collected in a summary process after all other aims were evaluated.

Aim 6: To assess implementation process.

The key focus of the pilot qualitative work was to better understand matters that support or interfere with the intervention's delivery; the ongoing implementation processes of the intervention's recruitment, retention, and reach; alongside service users' experiences and views of the intervention. The interviews helped us to further assess acceptability of and engagement with BC SIT by families. Interviews with practitioners and referrers also helped us to assess whether and potentially how successfully processes might be managed and upscaled.

All interviews were conducted by the evaluation team and recorded, usually via video conferencing tools. In some instances, these were sound files only to conform to participant preference.

Table 7: Overview of intended methods

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Research questions addressed
Secondary analysis	Routine monitoring data collected by BC SIT (including core measures)	Those referred, screened, accepted, discharged, AND completing BC SIT services. Includes progress against outcomes, measured using YEF's core measures	Descriptive and, where appropriate, inferential statistics	Aims 1 through 5

Primary data collection	Qualitative interviews	Purposive sampling of professional stakeholders (N=5) and opportunistic sampling of parents/carers (N=5) and children (N=5) accessing BC SIT services	Thematic analysis	Aims 1 through 6

Analysis

This section outlines the analytical strategy adopted within the pilot evaluation. Aims will be considered in turn, explaining how they were assessed. The findings of those assessments will then be presented in subsequent sections of this report.

Aims 1 and 2: Assess the direction and magnitude of change in the main outcomes for the families in the programme; assess the potential effect size of the intervention.

The analysis will consider each of the YEF core measures independently, the CBCL, and progress against the goals set within the BC SIT programme for each client. The initial analysis will be considered through descriptive statistics for the sample as a whole at all time points, including all demographic and other factors. The analysis will describe change over time as a mean change from baseline and estimated effect size (with confidence intervals) at three (t1), six (t2), nine (t3), and 12 (t4) months.

It was intended that sensitivity analysis would consider the influence of baseline characteristics and missing data. As the dataset is small, any models would have to constrain the number of variables included. The analysis would seek to demonstrate gross effects of baseline variability and missing data (by replacement of missing values) and interpret any influence on the observed change over time. However, the data completion rate was too low to allow for meaningful interpolation of data; thus, sensitivity analyses will not be reported in the findings section below. Although the sample size was always going to be somewhat modest, there are different ways to evaluate the effect of missing data. A particular method was not specified a priori, as the aim of the evaluation is exploratory (i.e. a pilot study).

BC SIT goal attainment was to have been characterised as the graded progress against goals for each family. Where there was more than one goal for a client, identification of the main goal would have been used. Progress against the goals was to have been characterised on the scale in a contingency table and summarised as a median with interquartile range. The intention to assess goals would be for individual goals to be measured in a standardised way using the goal attainment scaling protocol outlined by Turner Stokes (2017). At the start of treatment, three to five goals were usually agreed between the therapist, referrer, and family, related to referral behaviours. During the evaluation, it became clear that these goals, too, were highly individualised, making the intention to standardise them overambitious.

Aim 3: Describe the referral and screening process.

Analysis of the referral and screening process will be descriptive. A flow chart will be used to show the flow of clients from referral through screening to completion of the intervention. Focus will be placed on why clients are not selected for the intervention at each stage. Descriptive analysis will seek to evaluate, through tabulation, the extent to which selection of clients is subject to bias, excluding particular groups of clients. Numbers of clients will be small, but where possible, analysis will use χ2 to aid interpretation of the data.

Aim 4: Evaluate client retention and data completion in the programme.

For families starting the programme, retention to the end of the programme is important. Retention is defined as completing at least 66% of treatment sessions. This can be through missing sessions intermittently or regularly across the treatment period or by withdrawing from the programme early.

The number of families failing to attend scheduled appointments will be estimated, with the number and proportion of missed appointments and assessment sessions at each time point described. Overall adherence to the intervention (appointments) will be estimated as an overall proportion of appointments missed for each family and the proportion of families attending at least 66% of treatment sessions. Characteristics of families that do and do not complete the programme will be tabulated, and differences will be highlighted.

Data completion will be tabulated for each outcome. The choice of limits to define treatment adherence is a difficult challenge for evaluations, but most studies have limits between 66% and 75%. In general, limits can be defined by the intervention team, which make a judgement about the minimum number of therapeutic sessions that should be attended to achieve a reasonable therapeutic effect. However, this is only informative where clients are required to attend a high proportion of available sessions to achieve the desired clinical outcome.

In practice, adherence determined in this way tends to have a biphasic distribution; that is, clients tend to attend therapeutic sessions or not, and attendance is either very low or greater than two-thirds. By using a 66% limit, the analysis allows for measurement error inherent in small samples without being too penalising (Midgley et al. 2018). This also means that if non-adherence is a significant issue, it can easily be detected and flagged.

Aim 5: Evaluate success criteria

Readiness to progress to a larger-scale efficacy or effectiveness trial will be assessed. A sample size will be estimated following analysis in Aim 2. The progression criteria will consider the potential to deliver a trial of this magnitude.

Progression to a larger-scale efficacy or effectiveness trial will consider four main criteria.

1. Bias in the referral process and whether any bias can be addressed.

Bias will be evaluated by highlighting any differences between families that start therapy compared to those that are referred but are not accepted on to the treatment programme. The reasons for not progressing will be listed.

2. Retention of clients in the intervention.

Retention is an important secondary indicator of bias. Retention will initially be evaluated by determining whether BC SIT are successful in retaining at least 75% of families that start the programme. Secondary analysis will consider any apparent differences between families that do and do not complete the programme.

3. Sufficiently robust and unbiased data completion.

Data completion for each of the outcomes will be tabulated. Data will be defined as complete for scales where sufficient data for each outcome have been completed to evaluate a scale score. There is an allowable margin of missing data for each scale that allows for pro rata estimation of the scale score for a client. Where more responses are missing than the margin on any one scale, the data point (scale score for that client) is declared as missing.

4. Whether a trial of sufficient magnitude could be delivered

Analysis will proceed by tabulating the assessed outcomes from analysis of each of the first three aims and any mitigations identified in the qualitative analysis. This will provide a summary statement of the success criteria, any bias in selection, and any adjustments that can be made in future studies. The potential number of recruiting centres will be estimated by considering how many young people and families could be recruited from each treating centre per year and the total number of treating centres required to achieve the required sample size.

Aim 6: Assess implementation process.

Interviews and a focus group were conducted from November 2021–February 2022. Data were transcribed sufficiently for thematic analysis. Due to the richness of the dataset, the evaluators have incorporated emerging themes more fully within this analysis and moved towards a more inductive analysis than initially outlined in the pilot protocol. Narrative fields from the REDCap database containing information, such as matters perceived to impede or facilitate positive outcomes, were also incorporated into the qualitative analysis. The evaluation of BC SIT was one of four family-based interventions being delivered and evaluated concurrently by this team. This meant that emerging themes could be developed for each grantee, and it would be possible to conduct a secondary analysis across all four interventions subsequently.

A reflexive approach was taken whereby transcripts were closely read, and themes and related sub-themes were developed, first transcript by transcript, then tested and refined against the cohort as a whole. Analysis was split into two sets: i) professional stakeholders (incorporating implementation practitioners, managers, and referrers) and ii) families (incorporating those with parental responsibility for the child). Themes initially created were shared within the research team to test for consistency and provide a degree of inter-rater development. This resulted in some shifting of sub-themes and reframing of themes. Analysis then continued, in this reflective way, to develop a thematic map, and the findings are presented below.

Timeline

Table 8: Timeline

Date Completed	Activity
16.12.21	Data sharing protocol renegotiation and transition to before-after pilot
24.02.22	Before-after pilot inception, including finalised pilot protocols and fieldwork completion
30.04.22	REDCap data download
30.06.22	Data analysis (pilot data); cleaning and preparation of data for archiving
30.09.22	Submission of draft final reports
30.12.22	Final report drafting, peer review and revision (feasibility and pre-post pilot)

Participants

Qualitative fieldwork was completed with 12 people: three participants with parental responsibility and nine professionals/stakeholders. No young people could be recruited to pilot interviews. It should be noted that there were 11 parents who had initially given consent to be contacted, but after null responses on three occasions, it was determined it would be intrusive and inappropriate to follow up with further invitations. Given the challenges of incorporating families' views into the implementation process elements of the evaluation, we asked the project to provide us with examples of feedback that they had received. It is acknowledged that such data may be likely to be positively skewed. However, the team were sent both challenging and supportive examples and thus felt it appropriate to utilise these comments, in a limited way, to bolster the data considered in the qualitative analysis. If an extract below has been drawn from such feedback, it will be marked clearly (e.g. Parent/Carer, x (project feedback)).

Quantitative data were provided for 49 families, all of whom had been enrolled on the programme between 10/07/2019 and 11/12/2021. Table 10 below provides demographic data for those families that initially engaged with BC SIT. At study completion, data provided by BC SIT indicated that 22 families had completed (44.90%); 12 families were ongoing (24.49%), and 15 families withdrew (30.61%). A retention rate of 34/49, or 69%, was indicated at the end of the pilot phase.

Findings

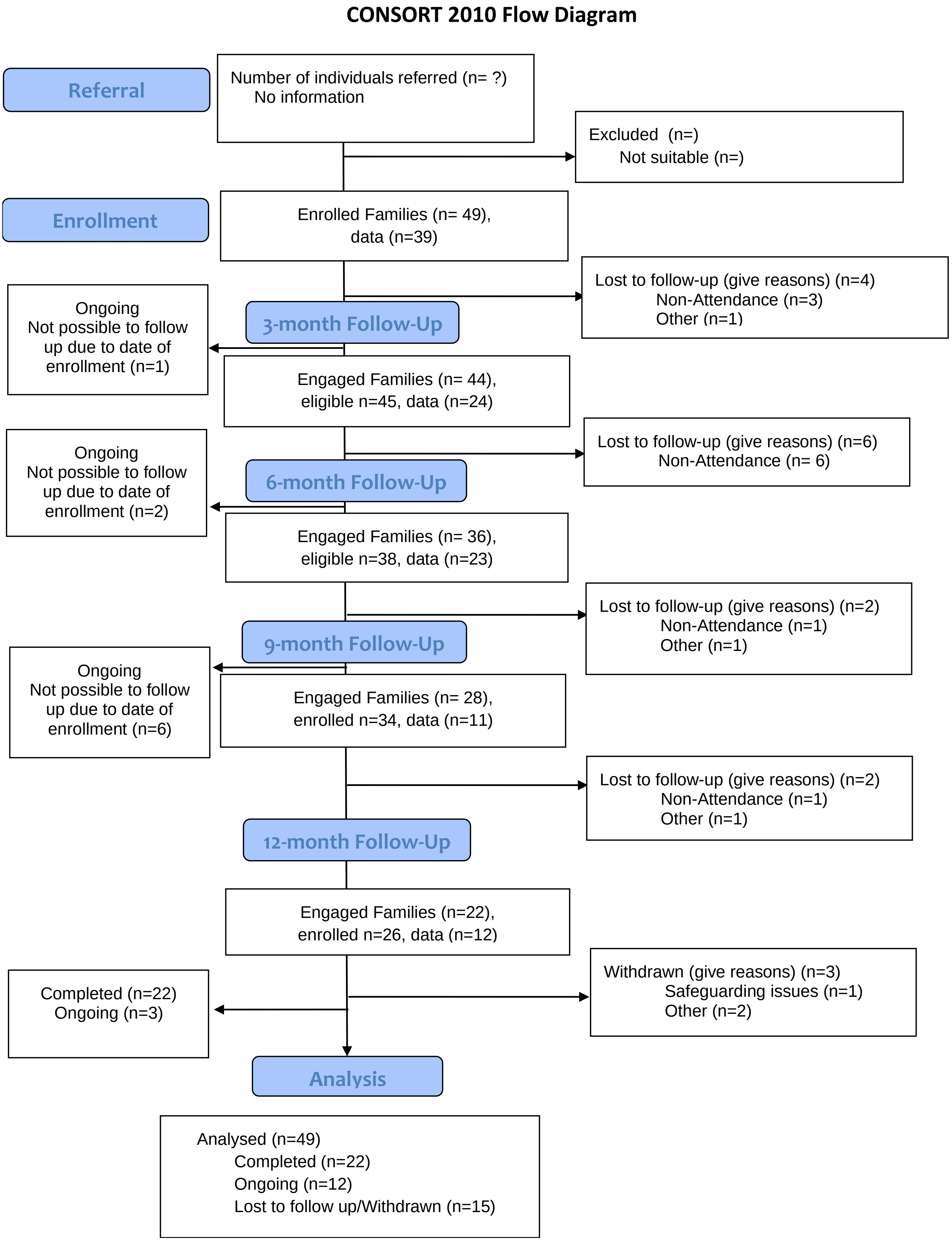
In this section, data are presented in the easiest order for interpretation and in ways that show how the analysis was built. All aims will be covered. We start with Aim 3 and then move back to Aims 1 and 2. For each aim, quantitative findings are presented first, then, where possible, relevant qualitative themes are considered. The last aim evaluated, Aim 6, is entirely assessed through qualitative analysis.

Aim 3: The referral and screening process

Referrals to the BC SIT programme came through gatekeepers who reviewed each individual case based on the inclusion criteria and capacity of the BC SIT programme. The gatekeepers then approved or rejected all referrals, with approved referrals being passed on to BC SIT for assessment. No data have been provided on the number of families reviewed but not referred, nor any details on the screening process (data as specified in Table 9) carried out via the gatekeepers. At the point of assessment, enrolment was based on the willingness of the family to engage with the programme. On request for further information, it was reported that all cases referred were enrolled on the programme. It is not possible to comment further on the risk of bias in the referral or screening process. Forty-nine families were enrolled during the feasibility and pilot period. At enrolment, the average age of the children was 12.5 years, and 67% were male. The majority were White (53%) or mixed race (16%). Most families were referred by social workers (42%) or from other sources; again, most likely to be from psychiatrists (39%) (see Table 10).

Please see Figure 2 for a CONSORT type flow chart to illustrate what is known about referrals. Of those considered to have withdrawn for evaluation purposes, 11 were withdrawn for non-attendance; one was withdrawn with the agreement of the programme in order to prioritise the needs of an older sibling; two were withdrawn due to lack of clarity about where the referred child would be living; and the last case was because no appropriate educational setting could be found.

Figure 2: Flow chart to represent the referral process



Within the qualitative research, practitioners suggested that the process of referral and screening requires reconsideration for potential subsequent cohorts. A main criterion for referral was reported as “risk of violence and criminality, so they were all on the same path” (Practitioner #1). One practitioner suggested the intervention should be focussed upon the younger age range as “the urgency around younger kids is much higher, as well, in professional systems” (Practitioner #4). The practitioner also explained that successful engagement and retention is more likely when referral ages are lower and when parents feel more empowered.

Aim 4: Client retention and data completion

Table 11 provides a summary of the families followed up and the data collected at each time point. The programme did not report the number of sessions attended by the families, making it impossible to assess engagement in the programme from this perspective. The programme did report the number of families withdrawing from the programme, and it is this measure that is used to assess treatment engagement.

Retention of families in the study remains strong at six months (73%) and at nine months (69%), dropping off sharply by 12 months (53%). Of the 15 families that had been lost-to-follow-up at nine months (Table 18), there was little difference in the ages or gender of the children or the referral source into the service in the group compared to the children who remained in the evaluation. However, by nine months, all the families where children were identified as Black had withdrawn from the study; no other withdrawal rate differences were found between other groups, irrespective of heritage or minoritised status. In general, retention of families in the study is strong to nine months, but loss of all the children with a Black heritage (n=5) does indicate a risk of bias in outcomes for this particular group.

Alongside the evaluation, BC SIT kept their own service delivery records. These were continued until the end of 2022, thus extending several months beyond the data collection phase of the evaluation. As part of generating this report, BC SIT indicated that from 2020–2022, 89% of young people were in education by the end of treatment; 95% of young people had committed no further offences by the end of treatment; and 91% of young people were living at home at the end of treatment with all of these outcomes, sustained at six-month follow-up.

For adults, data completion (Table 11) was moderate to six months and poor thereafter. The children did not engage in data completion, with less than 15% of measures completed at any time point. The ESYTC was only completed by three children at baseline and four children at three months. Where measures were undertaken, the parents completed the CBCL, SDQ, and Score 15. At baseline, 65% or more of these measures were completed. At three and six months, completion was between 46% and 49% and fell below 29% by 12 months. Given the very low level of data completion, it was not possible to undertake any meaningful analysis of the available data to indicate the sources of bias. We note that all the families with Black children left the study without being reported to have completed the programme. There is, therefore, a significant and unquantifiable risk of bias in estimating the outcomes in general, notwithstanding the differences in the heritage of the families leaving the programme early.

Data completion rates from young people can clearly be seen to be unsatisfactory. Although better, data completion rates from adults were also less than ideal. To try to understand better the reasons for low completion rates, the evaluation team explored the comments field from the REDCap database. From those notes, it seems that several routes to gain questionnaires were attempted but largely resisted by families. A common note relates to the intensity of intervention and feeling that questionnaire completion would just be too much on top of it. Several notes indicate that questionnaires were left with families to post back, and this seems to have been particularly unsuccessful with young people. In some notes, therapist capacity is cited as a reason for not gaining back the questionnaires, and in others, it is clear that therapists offered to help complete the questionnaires via the phone or online, alongside providing the alternative of posting them back. Although not stated explicitly, it seems fair to conclude that the questionnaires required for the evaluation were seen as a bolt-on to the intervention, not embedded within treatment sessions, and generally regarded as one imposition too many, particularly during periods of lockdown.

Table 9: Data intended to be collected at each time point

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	X						
Gender	X						
Ethnicity	X						
Referrer	X						
Date of referral	X						
Family ID		X					
Index of Deprivation		X					
CBCL			X		X		X
Treatment Goals FID's			X		X		X
Living Status			X		X		X
SDQ			X	X	X	X	X
Score 15			X	X	X	X	X
IES/CRIES8			X	X	X	X	X
ESYTC			X	X	X	X	X
Study End Form							X

Table 10: Demographic data collected for families enrolled

		Enrolled
number		49
Child's age mean (sd)		12.49 (1.35)
Child's gender n (%)	Male	33 (67.35%)
	Female	16 (32.65%)
	Prefer not to say	-
Race n (%)	White	26 (53.06%)
	Black	5 (10.20%)
	Asian	2 (4.08%)
	Mixed	8 (16.33%)
	Other	3 (6.12%).
	Not provided	-
	Social Worker	38 (41.67%)
Referrer	Wellbeing Officer	17 (17.71%)
	YOS Worker	2 (2.08%)
	Other	37 (38.54%)

Table 11: Data collected at each time point

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
	Referred Families n=49		Families enrolled n=49	Enrolled n=45 Eligible for follow-up n=44	Enrolled n=38 Eligible for follow-up n=36	Enrolled n=34 Eligible for follow-up n=28	Enrolled n=26 Eligible for follow-up n=22
Age	42 (85.71%)						
Gender	49 (100%)						
Ethnicity	44 (89.80%)						
Referrer	49 (100%)						
Date of referral	64 (66.67%)						
Family ID		49 (100%)					
Index of Deprivation		0 (0%)					
CBCL			P: 39 (79.59%) C: 5 (10.20%)	P: 23 (46.94%) C: 5 (10.20%)	P: 23 (46.94%) C: 1 (2.04%)	P: 11 (22.45%) C: 0 (0%)	P: 14 (28.57%) C: 0 (0%)
Treatment Goals			?		?		?
Living Status			?		?		?
SDQ			P: 35 (71.43%) C: 6 (12.24%)	P: 24 (48.98%%) C: 5 (10.20%)	P: 23 (46.94%) C: 1 (2.04%)	P: 11 (22.45%) C: 0 (0%)	P: 12 (24.49%) C: 0 (0%)
Score 15			P: 32 (65.31%) C: 4 (8.16%)	P: 23 (46.94%) C: 4 (8.16%)	P: 23 (46.94%) C: 1 (2.04%)	P: 11 (22.45%) C: 0 (0%)	P: 12 (24.49%) C: 0 (0%)
IES/CRIES-8			-	-	-	-	-
ESYTC			C: 3 (6.12%)	C: 4 (9.30%)	C: 0 (0%)	C: 0 (0%)	C: 0 (0%)
Study End Form			4 (8.16%)	6 (12.24%)	2 (4.08%)	2 (4.08%)	Completed 17 (34.69%) Withdrawn 3 (6.12%) Continuing 3 (6.12%)
Last time point			1 (2.04%)	2 (4.08%)	6 (12.24%)		

Note: Treatment Goals, Living Status and IES/CRIES-8 were not added to the data collection form. Due to the timing of follow-up (after March 2022), some families could not be followed up at the indicated interval.

Additional insight into challenges with both intervention retention and data completion can be gained from examination of information provided as part of the assessment of implementation process. Two parents and carers identified that the changeover of practitioners as part of phase two negatively impacted continuity of support that had been benefitting them:

> *“I ended the BC-SIT intervention early as the transition at six months was too difficult for me, and us as a family, to handle. We had spent six months building up a close relationship with a therapist, so the expectation to work with someone different, and to start a new relationship, was extremely challenging and is why we didn’t continue. […] I would just have preferred more consistency from the intervention by working with one person all the way through.”* (Parent/carer #11; project feedback)

> "[By] *six months [...], we were kind of stopping working with our therapists, moving on to the psychologist and going, 'Can we please keep the same therapist?'* [We] *didn't really want to change, and that was very difficult. There wasn't like, continuity. And then this psychologist pops up I was very unsure of, and that was a difficult transition, but at that point, anyway, he* [young person] *just went, ‘Right, I'm bored,’ really, and he was fed up [...] And off he went, on his terms. It had to be on his terms. We couldn't coax him, nothing, we'd stepped back, over to him."* (Parent/carer #2)

Another practitioner suggested the screening and initial engagement processes need rethinking to help maintain reasonable retention rates and manage caseload:

> *“*[On] *the initial screening,* [we] *assign a therapist to them, and this can all take up to five or six weeks. And then for whatever reason, the family withdraw before the treatment has started, or two to three weeks in, but we haven't had any engagement. And that is something that we had to learn from, is that something that we're going to have to factor into our way of working [...] I guess just having the YEF project, just with the monitoring how that's going, we've become more aware of it. And there's a bit of pressure, but that pressure isn't necessarily a bad thing. But I think when we first set out and put in our bid, we were more optimistic about the numbers that we could just churn out, and now we're having to think more carefully about how we can make sure a family are signed up."* (Practitioner #1)

For retention, the practitioner also recommended an additional layer of communication with families to build familiarity with practitioners and help maintain their engagement, albeit acknowledging some of the challenges faced when building that initial engagement and in demonstrating credibility:

> "[Once] *the family are enrolled, we need to improve another checkpoint earlier on to say, we're four weeks in, are we seeing the engagement and that we suggest that this is a family that progress further, or are we not? And where that's the kind of conflict for us, is that we've also said that this doesn't give up on families. We do understand that things happen, and it's hard to trust a new professional."* (Practitioner #1)

Practitioners have also suggested that the current process for data collection needs to be adapted. This is despite acknowledgement that current data collection methods help practitioners understand the families they work with:

> "[Questionnaires] *might just sometimes feel like a pain in the neck and the family might just think, 'Oh my God, this is another thing you're asking me to do, on top of all the other things that you're just asking me to do.' But, in a way, it can be a way of sort of building the engagement, if that's a struggle at the beginning, just starting off with the questionnaires can just be enough to find out more about a family, and what's going on for them in that moment."* (Practitioner #5)

> *"I suppose when we were more face-to-face, which we're getting back to now, bringing the questionnaires with us and kind of sitting there while they're going through them has been more helpful for families, from what they're telling me.*" (Practitioner #6)

Another practitioner suggested paring back the quantity or frequency of data collection requirements:

> "[It's] *just a huge amount for families to fill in. I think particularly the young people, and not that we've had much response from them, but if we were to be able to get more young people doing it, I just can't imagine them sitting down, and filling out what would take about an hour of questionnaire completion every three months. So whether there's just a different way in which we could get that data from young people, or slim down the questionnaires, or something that we just hook them in a bit easier, I think would be super helpful."* (Practitioner #1)

This flags some of the difficulty in completing the core measures. Another practitioner raised the method of data collection, particularly in terms of scale and repetition, as potentially creating some unease in the relationship:

> "[The] *volume of the questionnaires, and how much sometimes you present the family with how much they have to answer, it can feel overwhelming.* [It] *doesn't get you off on the best foot, necessarily.* [Often], *they've done five versions of the questionnaires already when they were admitted to CAMHS, or when they were accepted onto social care, or if they had been off for an ASD assessment, they've done them so many times."* (Practitioner #5)

One practitioner suggested reconsidering whether goal-oriented monitoring data is beneficial for measurement of progress towards intended outcomes:

> "[In] *terms of monitoring data around the three major outcomes, which is, is a young person at home, in school and out of any trouble in the community, I think that remains relevant and is really helpful for us to track up to six months after closing. In terms of [...] sort of monitoring the individual goals or behaviours for each case, I think that can depend very much on what those goals are. So, when you've got really tangible goals around school attendance, or how many episodes of physical aggression have we had this week, it can be much easier to follow than others. Like verbal aggression, we want to reduce by 80 per cent, for example. It can be quite difficult to score and I think, as a team, this is something that we've struggled with for quite a few years, is trying to score these behaviours out of 10. And they can feel quite abstract, especially if we're getting families to feedback on that."* (Practitioner #2)

This extract mirrors some of the difficulty the evaluation team found when first attempting to analyse the data provided on goals – they can be very variable, and it is not realistic to expect them to be comparable, even when scaled. The same practitioner also recommended that when a young person is regressing in terms of outcomes measurement scoring, then this data should be used to inform phase two of the intervention:

> *"I don't know if there's scope for thinking about how we analyse that data around if [...] things are starting to deteriorate, how does that match up to engagement and how many sessions we're having, or whether the family are engaging in phase two? That kind of thing. So there is scope for getting more information, I think, just using the information that we're already gathering, in terms of how we analyse it."* (Practitioner #2)

Other practitioners also highlighted the need to measure progress and regression effectively and frequently to inform plans for direct work:

> "[It] *could show some type of progression, whether that be for better or worse, in terms of how they've been getting on throughout the weeks. And then that could be like another useful tool in terms of us being, okay, well, this area is improving, this area is not improving, what do we think about that?"* (Practitioner #7)
>
> "[What] *would also be good, is to capture that* [therapist baseline scores] *for the whole course of treatment, because right now it's captured all of phase one, intensive. So, if that could be introduced [...] within phase two, so we can see the continuation, and the progression or deterioration even, that would be great."* (Practitioner #8)

In addition to outcomes data, one practitioner suggested qualitative feedback from families might be sought to gain a well-rounded picture of the impact of the intervention:

> *"There are some more open questions, actually, in some of the questionnaires: 'How have you found it?' And they're like, 'Oh, X is totally transformed to how we were at the start'. So things are dramatically improved, but there doesn't seem to be consistency with the answers that they're giving. And I think families just struggle to think about the last three months, rather than thinking about what it was like at its very, very worst. [...] So there is quite a lot of reminding, like, okay, but they haven't seen that in the last few months. And then when you prod a bit more they're like, 'Oh no, we haven't actually'."* (Practitioner #1)

Aims 1 and 2: The direction and magnitude of change in the main outcomes and the potential effect size

Tables 12 to 17 summarise the outcomes at each time point (baseline to 12 months). The responses from the children are included for completeness, but given the small number of completed measures, not much can be gained from considering these measures. For parents, the SDQ remains high at three months but falls at six and nine months and continues to fall by 12 months. The SDQ impact score shows a similar fall over time, but a marked fall by three months, indicating that impact reduces more quickly than the overall measure. The Score 15 shows a gradual fall over time for parents from baseline to 12 months. The CBCL (Tables 16 and 17) shows a sharp fall (23 points/100) at three months, which continues to fall at six months (38 points) and at nine and 12 months (49 and 50, respectively), although the number of respondents at six months and nine months is small (n=10 and n=13).

There is some indication (Table 19) that the families that left the study were different to the families that remained in the study. Families who left had higher mean scores for the Score 15 but lower scores for the CBCL, indicating worse family functioning and lower problem behaviours among children at baseline in families that left the programme early. This may indicate a problem in interpreting the outcomes, as this indicates that families that were not functioning as well tended to leave the study and presents an interesting question about the profile of these families compared to those who remained in the programme.

The small size of the cohort means that further systematic, quantitative analysis of the reasons behind withdrawal and/or bias is not possible. Additional qualitative exploration of the uploaded notes provided by the grantee was undertaken to see if further light could be shed on the withdrawal rates. This post hoc, qualitative exploration was partly because the team was aware that the feasibility stage had identified some instances when early withdrawal could be seen as positive, for example, if family transition to “standing on their own" had occurred sooner than expected within the transition phase. Findings are reported here to aid understanding of the quantitative data.

Irrespective of heritage, where notes have been provided, the main reason given for withdrawal or non-completion was non-engagement. Occasionally, a breakdown in the relationship with the therapist or a change of therapist was mentioned. Also, occasionally, positive interpretations could be inferred. For example, one family’s note read: “Successful end to treatment. Three key indicators met: Child in school, living at home and no convictions”. It may be worth noting that, in this case, there had been no data completion from that child. In another case, also with no child-completed measures, the family is indicated to have reported “positive change”, and in a third family, the therapist reports positive change while noting that the family felt it was insufficient. In a few of the early closures, there were external pressures that the notes indicated were out of their control, such as housing or education place. Overall, it seems fair to conclude that examination of the notes showed that in a minority of cases, there were some positive indicators of change, but mostly non-engagement and other reasons for early completion could not be seen as a positive outcome.

The ESYTC is not interpretable, given that only three (baseline) or four (three months) children completed this measure. As the number of families remaining in the study was low, and the proportion of missing data was high, only observed change over time is reported. No attempt was made to evaluate adjusted differences, given the extent of data loss, and no attempt was made to evaluate a sensitivity analysis, as imputed values would overwhelm the observed values, making interpretation impossible.

Change over time indicates that the programme does have a significant positive impact on child behaviour and family functioning, at least up to six months, but given the data completion problems already noted, this should be treated with some caution, despite statistical significance. Beyond six months (during the transition phase), interpretation becomes more challenging as more families withdraw from the programme. Although foreseeable and potentially desirable for the intervention, the falling data completion rates pose a problem for evaluation.

During phase one, there is a rapid and sustained fall in problem behaviours (CBCL) from three months (-23.0, t=3.6, p<0.01), which continues to six months (-38.3, t=7.2, p<0.01) and through phase two, to 12 months (-49.7, t=6.0, p<0.01). Although the SDQ and Score 15 fall by three months, the change is not significant (-0.2, p>0.05, and -5, p=0.06, respectively) but is significant at six months (-3.5, t=2.1, p=0.05, and -7.6, t=2.6, p=0.02, respectively). The fall in the SDQ is maintained through transition to 12 months (-8.7, t=4.3, p<0.01) but is not maintained for the Score 15 (-4.2, t=1.6, p>0.05). The lack of a sustained change in the Score 15 potentially reflects the earlier finding that families that remained in the study had better family functioning at baseline (see above) and benefitted less from the programme with respect to family functioning but may have been better placed to benefit more from other elements of the programme (as evidenced by SDQ and CBCL findings).

There is a low to medium effect size for the programme intervention (before-after) for the SDQ and the Score 15 at six months (d_z=0.44 and d_z=0.57, respectively). While the effect size continues to grow to 12 months for the SDQ (d_z=1.2), this must be treated with due caution given the small number of respondents (n=13). Undoubtedly the effect size for the fall in reported problem behaviour (CBCL) is large (d_z=0.76 at three months, d_z=1.6 at six months, and d_z=1.7 at 12 months).

Table 12: Mean score and standard deviation for total SDQ score across each time point

	Baseline n=35			3 months n=23			6 months n=23			9 months n=11			12 months n=14		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	18.71** (4.32)	10	27	18.26** (5.79)	10	27	15.65* (7.12)	2	27	14.09* (6.07)	3	22	10.71 (6.45)	2	23
	Baseline n=6			3 months n=5			6 months n=1			9 months n=0			12 months n=0		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	19.67** (9.31)	6	33	20.6*** (2.51)	17	23	23*** (0)	23	23	-			-		

Note. 4-band solution for cut-off scores of SDQ (rounded to nearest whole number). *=slightly raised than average **=High ***=Very high

Table 13: Mean SDQ impact score and standard deviation across each time point

	Baseline n=35			3 months n=21			6 months n=19			9 months n=11			12 months n=11		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	7.03*** (2.56)	0	10	3.48*** (2.77)	0	10	3.42*** (3.13)	0	10	4.36*** (2.69)	0	8	2.18** (2.82)	0	8
	Baseline n=3			3 months n=3			6 months n=1			9 months n=0			12 months n=0		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	Min	max
Impact	3*** (1.73)	1	4	6*** (2.65)	4	9	5*** (0)	5	5	-			-		

Note. 4-band solution for cut-off scores of SDQ (rounded to nearest whole number). *=slightly raised than average **=High ***=Very high

Table 14: Mean and standard deviation for the SCORE 15 and its dimensions across each time point

Parent	Baseline n=32			3 months n=23			6 months n=23			9 months n=11			12 months n=14		
	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Total score	43.97 (11.0)	26	64	38.65 (10.21)	23	56	36.61 (9.38)	20	56	35 (9.25)	20	50	33.43 (7.26)	19	44
Average score	2.93 (.74)	1.73	4.27	2.58 (.68)	1.53	3.73	2.44 (.63)	1.33	3.73	2.33 (.62)	1.33	3.33	2.23 (.48)	1.27	2.93

Child	Baseline n=4			3 months n=4			6 months n=1			9 months n=0			12 months n=0		
	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Total score	45.5 (18.5)	22	66	44 (12.73)	29	56	60 (0)	60	60	-			-		
Average score	3.03 (1.23)	1.47	4.4	2.93 (.85)	1.93	3.73	4 (0)	4	4	-			-		

Note. The total score gives a possible score of between 15 and 75; the average score gives a possible score between 1 and 5.

Table 15: Mean and standard deviation of number and average frequency of acts (ESYTC) across baseline and three months for all children responding

	Baseline n=3			3 months n=4		
	Mean (sd)	min	max	Mean (sd)	min	max
Acts reported	2.33 (4.04)	0	7	2.5 (2.38)	0	5
Frequency	1 (1.73)	0	3	2.34 (1.95)	0	4.6

Table 16: Estimation of outcome and treatment effects (comparison to baseline) at months three and six

Outcome measure	Total n	Baseline			3 months			Comparison 3 months - baseline					6 months			Comparison 6 months - baseline				
		n	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	n	m	sd	N	diff	t (p)	d_z	CI (95%)
Parent																				
SDQ	106	35	18.71	4.32	23	18.26	5.79	23	-.17	-.12 (.91)	.02	-3.26 – 2.91	23	15.65	7.12	21	3.52	2.06 (.05)	.44	-.05 – 1.10
Score 15	103	32	43.97	11.0	23	38.65	10.21	23	5	2.00 (.06)	.42	-.20 – 10.20	23	36.61	9.38	20	7.6	2.56 (.02*)	.57	1.38 – 13.82
CBCL	110	39	80.87	23.16	23	59.87	24.79	23	22.96	3.64 (.001*)	.76	9.77 – 36.03	23	48.09	26.7	21	38.33	7.23 (.001*)	1.58	27.27 – 49.65
Child																				
SDQ	12	6	19.67	9.31	5	20.6	2.51	3	-1.67	-2.50(.13)	-1.44	-4.54 – 1.20	1	23	0	1	-5	-	-	-
Score 15	9	4	45.5	18.5	4	44	12.73	2	-5.5	-3.67 (.17)	-2.59	-24.56 – 13.56	1	60	0	1	-8	-	-	-
ESYTC	7	3	2.33	4.04	4	2.5	2.38	2	1.5	t=1.00 (p=.50)	.71	-17.56 – -20.56	0	-	-	-	-	-	-	-
CBCL	11	5	99.5	32.43	5	72	14.25	2	10.5	t=7.00 (p=.09)	4.95	-8.56 – 29.56	1	114	0	0	-	-	-	-

Note. *= Significant difference of at least .05 level.

Table 17: Estimation of outcome and treatment effects (comparison to baseline) at months nine and 12

Outcome measure	Total n	Baseline			9 months			Comparison 9 months - baseline					12 months			Comparison 12 months - baseline				
		n	m	sd	n	m	sd	N	diff	t (p)	d_z	CI (95%)	n	m	sd	N	diff	t (p)	d_z	CI (95%)
Parent																				
SDQ	106	35	18.71	4.32	11	14.09	6.07	10	5.3	2.46 (.04*)	.78	.42 – 10.18	14	10.71	6.45	13	8.77	4.30 (.001*)	1.19	4.33 – 13.21
Score 15	103	32	43.97	11.0	11	35	9.25	10	2.9	.77 (.46)	.24	-5.57 – 11.37	14	33.43	7.26	11	4.18	1.59 (.14)	.48	-1.67 – 10.04
CBCL	110	39	80.87	23.16	11	11.91	6.07	10	48.8	5.81 (.001*)	1.84	29.79 – 67.81	14	11	7.42	13	49.69	6.03 (.001*)	1.67	31.75 – 67.63
Child																				
SDQ	12	6	19.67	9.31	0	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-
Score 15	9	4	45.5	18.5	0	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-
ESYTC	7	3	2.33	4.04	0	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-
CBCL	11	5	99.5	32.43	0	-	-	-	-	-	-	-	0	-	-	-	-	-	-	-

Note. *= Significant difference of at least .05 level.

Table 18: Characteristics of the children who completed the course (or ongoing) and those who withdrew

		Completed/Ongoing	Withdrew	Test of significance
n		34	15	
Child's age mean (sd)		12.52 (1.38)	12.92 (.1.32)	t= -.89, p=.38
Child's gender n (%)	Male	23 (67.65%0	10 (66.67%)	χ^2=.004, p=.95
	Female	11 (32.35%)	5 (33.33%)	
	Prefer not to say	-	-	
Race n (%)	White	20 (58.82%)	6 (40%)	χ^2=12.74, p=.01*
	Black	0	5 (33.33%)	
	Asian	2 (5.88%)	0	
	Mixed	6 (17.65%)	2 (13.33%)	
	Other	2 (5.88%)	1 (6.67%)	
	Not provided	4 (11.76%)	1 (6.67%)	
Referrer	Social Worker	12 (35.29%)	8 (53.33%)	χ^2=.5.57, p=.14
	YOS Worker	0	1 (6.67%)	
	Wellbeing Practitioner	5 (14.71%)	3 (20%)	
	Other	17 (50%)	3 (20%)	

Note. *= Significant difference of at least .05 level.

Table 19: Comparison of mean scores between children who did or did not complete the study

	Completed		Withdrawn		Test of significance
	n	Mean (sd)	n	Mean (sd)	
Parent					
SDQ	23	19.48 (4.44)	12	17.25 (3.84)	t=1.47, p=.15
Score 15	20	40.4 (9.98)	12	49.92 (10.51)	t=-2.56, p=.01*
CBCL	27	86.22 (21.31)	12	68.83 (23.46)	t=2.28, p=.03*
Child					
SDQ	6	19.67 (9.31	0	-	-
Score 15	4	45.5 (18.50)	0	-	-
ESYTC	3	2.33 (4.04)	0	-	-
CBCL	4	99.5 (32.43)	0	-	-

Note. *= Significant difference at .05 level.

Additional information on the impact of the intervention was provided within the implementation process interviews, where a common theme related to empowerment of adults with parental responsibility. One parent/carer explained that difficult circumstances at home with the young person and their poor school attendance had become normal. Being on the programme provided a sense that "no, this is really not a tolerable long-term situation" (Parent/carer #1). According to this parent/carer, programme practitioners empowered them to try a different approach in response to the presenting difficulties:

> *"In terms of what was most effective,* […] *from my point of view, I thought* [the] *more important thing was the clarity. He used to get really worked up about lack of clarity, so it was really clear about what the consequences for what you do* [...] *And the rewards, yeah, were really, really clear and to stick to*

> *it.* [The] *sense of permission to do things, and that was really important to me as well.”* (Parent/carer #1)

Another parent/carer highlighted how they were encouraged to try and not be reactive and to establish boundaries:

> *"Totally backing off, over to him, and then using very clear structures of consequence and reward, and things that matter to him. So, one, two, three rule: right, if it's violence, it's three and go in time out. […] Which he did, and I was surprised that he did that, but I think the backing off over to him.* [Trying] *to control and cajole didn't work, and* [we] *stopped all that. And he's now kind of grown into that space and is flourishing. [...] And I think it was the permission to do that, that made all the difference."* (Parent/carer #2)

Although individualised to each family’s context, there are techniques taught to adults with parental responsibility consistently. It is postulated as being important for parents/carers to try to understand the child’s reasons behind their behaviours and for families to consider which approaches may be more or less beneficial for them:

> "[They] *stepped in, and they were helping me in ways to do things differently, instead of shouting at my son and constantly [...] sort of at him, 'Come on, you need to go to school, you need to go to school!' And he was trying to say, 'This is not working for me', but I wasn't hearing that [...] He's like a different child; he's so relaxed. It's like he's got a future, something to look forward to. And he said, ‘For once, someone listened to me and helped me, and listened to what I want to do’.”* (Parent/carer #3)

Other examples from the direct feedback also endorsed the view that the techniques families had learnt had value:

> *“We had oppositional behaviour which was very strong, and what the work with Brandon Centre gave us was two things – the knowledge, and the emotional support and back-up to put that knowledge into action, and they were both essential.”* (Parent/carer #4; project feedback)
>
> *“Since finishing BC SIT, we have been using the non-violent resistance approach, which has been working really well for us. We learnt really useful techniques during the sessions, which have been really easy to use, so things are going much more smoothly now.”* (Parent/carer #6; project feedback)
>
> *“We’re extremely grateful for the support that we got from the BC-SIT team; it was very useful and really saved us!”* (Parent/carer #7; project feedback)

Parents and carers indicated that their own sense of wellbeing had improved, as they came to feel less disempowered and less isolated:

> "[I] *was doing this all by myself for almost two years. Because even then, like, how did you cope? It's like, so stressful. My family was worried that I might have a mental breakdown or something because it was stressful. But once they stepped in, they just really took that stress off me. I'm so grateful, honestly."* (Parent/carer #3)

It was also highlighted that accessing group NVR sessions helped to ease a sense of being alone:

> "[It] *was just a very mixed group of all social groups, all backgrounds.* [The] *kind of people we might have imagined meeting in other contexts, if we didn't have to be there [...] When you're first trying to ask for help, and there's a real fear of asking for help in relation to something like this. There's always the worry, are you going to end up having your kids taken away? Are you going to be judged as being a terrible parent or whatever? And, just an assumption that if you can't get your kids to school, people will assume that you don't care enough. So that was quite nice to see, that they were people [...] facing similar kinds of levels of violence and things."* (Parent/carer #1)

Other parents/carers also spoke about how the guidance and support they received through the programme led to significant changes in their children since the intervention began:

> *"Initially, he decided he was willing to go to school, but he wouldn't do homework. And then a few weeks later, he decided that he was going to do homework. Now, he's coming at or near the top of his class in pretty much everything, brilliant."* (Parent/carer #1)
>
> *"We did learn helpful things from the intervention, and things have improved. There are still ups and downs, but* [child] *is now in education and knows the consequences of actions, so it has got a little easier."* (Parent/carer #11; project feedback)
>
> *"He's* [gone] *from being a bit of a monster to being very affectionate, very loving, really sharing. A different child, a genuinely different child.* [His] *life trajectory and ours could have gone down one path very easily. It's gone on a totally different trajectory, and I feel so positive and hopeful and completely transformative."* (Parent/carer #2)

Another parent/carer highlighted that their child began to lead the way through their education:

> "[One] *of the things that [...] I think was the transformative thing, was having it so that* [young person] *took control of his own situation.* [In] *the end, it was him deciding, 'Oh, I'm not going to be a loser and throw away my life, I'm going to go to school'. And then he would* [talk] *about what he wants to do for A-levels and going to university. Having previously been, 'I can't face carrying on until 16, and I would rather be dead'.* [He's] *got himself up in the morning. It was such a sudden thing; suddenly he gets himself up in the morning, he gets himself ready. If we had no interaction with him in the morning, he would go off to school on time."* (Parent/carer #1)

The positive impact on young people in terms of behaviour and wellbeing has had a positive effect on family life, with relationships between family members becoming more harmonious:

> *"*[There is] *no violence at all;* [he is] *very affectionate. Just so different.* [In] *families where there's more than one child, I mean, for our older son, this also had a huge impact on him, and his happiness, his wellbeing. So, if there's more than one child, then working out how much this thing costs per child, [...] it's not just the one child may be getting helped."* (Parent/carer #1)
>
> "[We] *do stuff as a family. We sit down together. All of those weren't happening before, and it's just like 'I just want to be in mine; I just want to be in my room; I just want to be left alone'. Now, we sit together pretty much every day. We eat together now, so, yeah, it's a big turnaround."* (Parent/carer #3)

Aim 5: Evaluation of success criteria

1. Bias in the screening and referral process [MISSING/RED]

It is impossible to comment on bias in the screening and referral process, as no data were provided on this process.

2. Retention of families in the programme [Amber]

It is noted that a significant number of families remain enrolled in the study to nine months (34/49 or 69%), which indicates that the programme is able to engage with the families over a considerable period of time. However, by 12 months, only 26 families remain enrolled (53%). It is also notable that there is a considerable difference between the families that remain enrolled in the programme and those who have left at nine months, with all the children identifying as Black leaving the programme and those families that leave reporting worse family functioning but fewer problem behaviours. Where the programme is designed to extend to 12 months, this indicates a significant risk of bias in outcome assessment which cannot be easily corrected.

3. Sufficiently robust and unbiased data completion [Red]

Data completion is poor, never exceeding 49% at three and six months for adults, and with only very few children (n=6/49) completing any measures at all. By 12 months, adult data completion is down to a maximum of 29%. This indicates a considerable challenge for evaluation of the programme.

4. Can a trial of sufficient magnitude be delivered? [Red]

There are significant issues with the pilot study data that are a barrier to progression to a randomised trial for the BC SIT programme. While enrolment in the programme remains strong to nine months (67%), loss-to-follow-up beyond this is high. In addition, data completion is very low (<50%), even for those families remaining in the programme, and is non-existent in any meaningful way for children. Lastly, there is indication of statistically significant bias in retention of families with children identifying as Black and in families with poorer family functioning at baseline.

The outcome measure of focus for a trial would need consideration. While the (before-after) effect size is large for the CBCL (d_z=1.6 at six months), the effect size for the SDQ is much smaller (d_z=.44 at six months, and d_z=1.2 at 12 months, but with a small sample). A study designed to evaluate the SDQ as an outcome would have to assume a small effect size (d=0.3) for a parallel groups design and a sample size in excess of 400. If the study could be convincingly designed with the CBCL as the primary outcome, then the required sample size could be much smaller (d=0.5, α=0.05, 1-β=0.9, n=70 per group without adjustment for dropout).

Given the lack of data on referral and screening, the level of loss-to-follow-up, and the level of core measure non-completion, there are significant challenges to overcome to recommend progression to a full trial without considering the requirement for a control intervention and before considering the likely need for additional study sites to meet the sample size necessary. Given that the current study site recruited around 50 clients, then it is possible that, on a crude estimate, up to 16 study sites would be required to allow for data loss on follow-up. If amelioration of data loss can be convincingly demonstrated, then it might be possible to achieve the target sample size with eight sites.

Aim 6: Implementation process

Interviews and focus groups were completed with nine professional stakeholders, eight of whom were practitioners engaging in direct work with families and one manager[2]. Service users who participated in interviews included three parents or carers, all involved in the programme. As aforementioned, feedback provided directly to BC professionals will be augmented within these findings and referenced as project feedback to distinguish this from evaluation data. This feedback was provided by eight adults with parental responsibility. Consideration of Aim 6 will be presented in four broad subsections: implementation fidelity; engagement; responsivity; and unforeseen or other findings.

Implementation fidelity

Programme fidelity is assessed by consideration of whether delivery could be seen to align with the inputs identified under the logic model; this includes matters such as duration of intervention and dosage (frequency of intervention). Two novel features of the SIT, when comparing it to a more standard MST programme, are its length and that the programme is split into two phases. Despite some families being unsure about the transition to a different practitioner (see Aim 4), differences between the two phases of BC SIT were commented upon favourably by practitioners:

> *"I think we're definitely seeing much less anxiety at the end of phase one [...] It really is working as a safety net for families, and just offering that confidence. And I think the other thing to say about that, is just obviously last year we didn't have as much experience of phase two. We had quite a clear idea of what we wanted it to look like, and what we thought it was going to do […] So, it's been quite helpful I think just to structure it a little bit more, so we now have kind of three levels of phase two, so minimum would be monthly sessions."* (Practitioner #2)

Another practitioner noted that the phased approach allows for a tailored response to family circumstances:

> *"I think one of the challenges is that, of course, family, well, all famil[ies] are complex, but needs are, to some extent, never ending.* [We] *actually learn to* [identify] *what we can do in the context of phase two; so help [...] empower them* [to] *become independent."* (Practitioner #3)

The second phase aims to sustain family resilience and provides additional support where needed. The continuing phased support has been seen as a way to sustain progress, where parents or carers can continue to access support if there are signs of regression:

> *"Offering 12 months of treatment to a family, I suppose it provides quite a lot of comfort, and with assurance that 'I've got enough time to make mistakes, to understand what I'm doing wrong', and then also have the time and support from phase two to actually overcome those bumps on the road."* (Practitioner #5)
>
> *"Well, just, a family was telling me, which just ended phase two, that they felt very hopeless during phase one, and often that's the case because the behaviour is worse there, of course. In phase two, yeah, when there are some incidents, that kind of feeling can come up, but usually because there are*

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[2] To minimise backwards identification likelihood, all are referred to below as "practitioner" when attributing extracts.

> *more resources, they are more able to actually understand what's going on. And with minimal support from myself, things get back on track and they can contain their own anxiety."* (Practitioner #3)

The process of handing over between practitioners within the transition developed further during the pilot. This was also seen as contributing to positive outcomes:

> *"So previously, the same phase one therapist would have the case for a year and would do the phase two, and I think the way it's set up now is exponentially better [...] Because the risk is, when you're involved that intensively, you just kind of never really leave, and you end up being intensive for a year, which is not manageable or sustainable, so having that separation. I think also, we've got evidence from the families that it's working, because I have, and I don't know about any of the other phase one therapists, but I haven't had any contact from a phase one family saying, 'Oh, we really miss you, come back, please!' That's not happened at all. Instead, it's been held by* [Practitioner] *from that phase two perspective, and it's clearly working.* [We're] *not having families refusing to move on to phase two, or anything like that. So, it seems like a really helpful therapeutic structure to have around it."* (Practitioner #4)

Although some parents did find the transition between two therapists to be too challenging to persist with phase two, other parents were more matter of fact or positive about the change of therapist. For example, one parent told us:

> "[It was] *intensive for six months, meeting three times a week with an assigned therapist, and then at the end of the six months, no more contact with that therapist, and then working with the psychologist after the six months."* (Parent/carer #2)

Another parent/carer highlighted the value of offering early guidance in responding differently to children and then phasing out support as families become more resilient:

> "[In] *terms of the actual support itself, I suppose there are two different aspects. There's the model of support itself, and was that effective? And then there's also the individuals providing it. And, I mean, thought it was very successful on both accounts. The people involved were very good, and then the actual model I was more dubious about at the beginning of* [it]*; it's entirely based on us changing what we do with him, rather than injecting him with something [...] I mean, it's a family-centred approach rather than an individual behaviour-focussed approach."* (Parent/carer #1)

Practitioners also considered challenges in delivery of the programme that have potential to negatively impinge on their relationship with families. One barrier when working as part of a multi-agency team arose due to conflicting approaches in responding to "risk behaviour":

> "[We] *have to try and align the other systems working around this young person. And sometimes our approach is different* [from] *how they approach the family, and that is obviously a massive barrier.* [The] *kind of examples, things that we've come across quite often is, say, like social workers are there with their safeguarding cap on, and some of the interventions that we recommend might provoke an escalation. And we might see the child acting out more, and it might be some kind of risky behaviour that we clinically view as being maintained and managed, and it's predictable and we're there to support the family. That they're* [named partner] *kind of pushing against because it's seen as*

> *heightening the risk, and they're telling the family he's not to do it, then we're in conflict there.* [That's] *part of how we work, we have to treat the kind of system as well, and how we treat the family, and we're up against a barrier with a parent, and how would we address that, and the skills that we'd use. And it varies; it varies across organisations, and it varies across families and how they're perceived by the professional network.* [We] *need to get the social worker, the police, the school* [aligned], *because if they're not and then there's a kick-off at home, it's going to undermine what we've just asked parents to do."* (Practitioner #1)

Although this clearly shows that the practitioner is acting in fidelity with the programme's aims – engaging with systems around the family, including other agencies – it also shows how challenging engagement can be in practice, potentially undermining work with families and bringing additional difficulties in maintaining engagement between the intervention and families. It is to engagement that this report now turns.

Have service users felt engaged?

Participants described a process by which trust developed over the course of the intervention, helping to build and sustain engagement.

> "[It] *was a huge investment of time from them, and I'm aware that that must be a very expensive intervention. But feeling that there was that much time and space made for us also made you feel valued.* [You] *didn't feel that you were just trying to squeeze things quickly into a brief session, but there is really time to actually really take things back down to first principles and build back up. […] I, initially, was feeling, this isn't working. We kind of felt like we were going through the motions, in order to show that we were committed parents, and then suddenly things changed at about six months."* (Parent/carer #1)

The building of therapeutic alliance was a common theme that emerged from service-user interviews and feedback. This includes good-quality relationships between families and practitioners. One parent/carer remarked that the practitioners seemed genuinely invested in helping the family, which enabled them to open up about their situation:

> *"My personal experience is that the Brandon Centre is the only service that we've ever encountered where there was a genuine attempt to make things better.* [It] *really felt heartfelt, and when you're dealing with families like this, it's that qualitative thing that you cannot really describe that is everything, it's everything. When we were speaking to the therapist, we felt she cared, she did care, it made us better able to communicate with her."* (Parent/carer #5; project feedback)

An interviewee echoed this sentiment:

> *"*[The] *sense of a good relationship with them at the beginning did then help not give up later on, when you've then put a lot of time, and initially not much happened. As in, like it took a lot longer to get the response from it than I thought it would. And I think, probably if you hadn't had such a good relationship with the person, you'd be more likely to give up."* (Parent/carer #1)

Another parent/carer indicated that not feeling judged for their circumstance and being understood had provided the resolve to overcome difficulties:

> *"I was worried [about] feeling really judged and told what we needed to do. [...] So we were dealt with really respectfully, on side with us, and I think rather than the 'them and us', [it] was, let's work together, let's spend time together, let's work things out together.* [The] *flak from school was horrible. And what do we do? We really want him to go in, then for them* [practitioners] *to go, 'That's okay, don't push him into school, you don't need to do that'.* [The] *fact they'd got it, is something we would have never done on our own or known how to handle. So gave us permission."* (Parent/carer #2)

Is the intervention responsive?

When considering responsivity in the implementation of an intervention, it is important to consider how service users feel they were responded to and whether the context of their situation was acknowledged appropriately. Those who work with an intervention, such as referrers or other stakeholders, should also feel comfortable in how a programme team responds to them. Service users felt the support they received through the programme made them feel less embattled:

> "[Looking] *at what happened at the beginning, and to feel valued, to feel that someone was hearing us, was really important and not to feel alone. Suddenly we didn't feel alone and at sea […]. Maybe it's a lack of community, I suppose, and so many families are really isolated from support groups, and I wonder if that makes it more difficult. [...] Another word I want to add into it was 'hope'.* [It] *felt so hopeless at the beginning, and they were saying, 'One day, he will be going into school' […] And he's done that and more, and so keep hoping when we were going, 'Uh-uh.' It was amazing to have that support and hope. Oh, I'm getting all teary now - it's amazing!"* (Parent/carer #2).

Parents and carers recognised that the routes suggested to try new approaches with their young people had led to marked improvements in children's emotional wellbeing and abilities to express how they are feeling. The extract below also demonstrates that a need had been seen and a suggested response provided by BC SIT:

> *"He had a few one-to-one sessions, I think, with* [practitioner], *which made a difference, because I know the session is more about working with mum, to help mum to help the child.* [They] *kind of stepped in, because it was a difficult situation, because he doesn't talk much, and you couldn't get through to him. Having the one-to-one,* [he] *opened up a bit and was saying how he feels, and that definitely did make a difference."* (Parent/carer #3)

Flexibility in what was offered and how it was offered is part of the individualised response envisaged as part of this programme. An example of how this might happen was elucidated by practitioners, demonstrating both fidelity and responsiveness of programme delivery:

> *"Then if we have any sort of issues or changes to the system,* [a practitioner] *could go in with some booster sessions, maybe, seeing the families once a week for a period of three weeks to get something back on track. And we also have a crisis level, which gives us the option to go into the family quite intensively […] So, I think that's working quite well."* (Practitioner #2)
>
> *"So, when we go in more intensively, we are focussed on a specific piece of work. It can be self-harm or helping with school attendance."* (Practitioner #3)

Non-judgemental support was particularly important to parents/carers when they might have been dealing with the pressure of multiple communications from other agencies and navigating the respective systems:

> *"*[It] *helped in the sense that in my – for me, it helped me to be calmer dealing with my son, because I was getting stressed, because the school is phoning me, social services are phoning me: What is happening? And, basically, it felt like they were saying, 'You're not a good parent,* [and] *your child needs to be in school, what are you doing about it?' So having the Brandon Centre involved, it makes it easier for me, because they sort of intervened on my behalf, where they will speak to the authorities on my behalf, while they work with me."* (Parent/carer #3)

> *"*[It was] *extremely helpful to have the presence of a highly intelligent and experienced therapist in the middle of a constantly changing network who was understanding and empathic. It particularly helped when navigating communication between a number of different places, such as between psychiatrists, school, and the police."* (Parent/carer #8; project feedback)

Parents and carers identified a need for greater focus on the child, particularly in terms of wider support. One parent/carer suggested that one way to respond more effectively would have been for BC to increase involvement in schools:

> *"It was very helpful at the time although not sure of the extent to which it has sustained. It would be helpful if the Brandon Centre could be proactive in informing the school about who they are and what their purpose is in supporting* [child]. *It felt like the school weren't always sure why the Brandon Centre was involved, or how much weight they should give to the Brandon Centre's involvement or opinions during the intervention. If this had been proactively discussed early on, the school might have been more on board with Brandon."* (Parent/carer #7; project feedback).

Despite the intention of phase two being one of transitioning to standing without the support of the intervention, some service users did indicate that they would have liked greater aftercare. Two parents/carers suggested that ongoing touchpoints would have been beneficial for young people to maintain progress:

> *"There were definitely some good things about the support. For us, it ended up just being work with the parents, not with the child, but that was still helpful. There was no sense of checking in after the intervention was finished, which would have been nice as it felt quite abrupt."* (Parent/carer #9; project feedback)

> *"Our therapist was brilliant, and my husband and I learnt a lot from the intervention. The main problem is that everyone was working with us as parents and there was no focus solely on* [young person]. *Realistically,* [they] *may well not have engaged with one-to-one work; however, we've learnt and implemented all we can as parents and we need* [child] *to have support now."* (Parent/carer #10; project feedback)

One parent saw value in earlier intervention so that concerned families do not reach crisis point before support is offered:

> "[I] *wonder if schools – at that stage, junior school, before things get really bad, if they had a way of identifying those kids, where do they then refer parents to support? What can parents do? I think input early on, because you're saying with the kids who get missed, input there, I think would have made a huge difference. It wouldn't have got so bad. So, I don't know, educating somehow, working*

> *with junior and infants, junior schools on that, could really pick up these kids perhaps, and kind of help get things in place so they don't go way off."* (Parent/carer #2)

As already noted, there were significant changes to delivery engendered by responses to COVID-19. One of the greatest impacts was on face-to-face delivery, hindering a practitioner's ability to maintain relationships with families and requiring flexibility:

> "[In] *terms of doing it remotely, one issue is when we have a problem with engagement. So, in that case, sometimes I go in more and do a face-to-face session, which I did at least for one or two sessions."* (Practitioner #3)

> *"I think that's what you can get from a face-to-face-like delivery, is you can use it as a tool to kind of build that therapeutic relationship. Whereas if you're just firing off an email and saying, open this Word document and highlight the numbers that you feel are applicable, it feels quite disconnected from everything."* (Practitioner #6)

Other positive findings, such as reduction in a child's anxieties, also led to some unexpected perceived benefits of the intervention:

> *"If it had been quicker to get the assessment, he might well have got an autistic diagnosis [...]. From about the age of three until about the age of 11, he behaved as you would expect a high-functioning autistic person to behave.* [He] *never had autism, but I think he had a lot of anxiety. And the anxiety could easily have been interpreted as autism, given the figures [...]. So I think there is an interesting potential value of going through that kind of process, before making a lifelong diagnosis."* (Parent/carer #1)

Another parent/carer who benefitted from the programme felt the need to put something back into the process. They would like to have their voice heard to encourage other families going through similar circumstances:

> *"I need to write to them and say it. Actually, this is something on my to-do list. So, a parent gets introduced to the Brandon Centre, and I want to write a letter to them on the beginning of their journey. So, I would say, if they've been referred to the Brandon Centre, they must be having a really, really tough time. On the plus side, though, they're in the right place for some really genuinely fantastic support, and to feel a sense of hope. And say at the end of our journey, our journey began with these things and now, well, it's ongoing. These things have changed, and our lives are so very different. So, hang on in there, and lucky you to have the support of the Brandon Centre; […] it's going to be a really difficult process,* [but] *there is hope."* (Parent/carer #2)

Evaluation feasibility

The pilot evaluation allows us to draw conclusions about each of the key aims, albeit with some caution around the completeness of data recording.

Aims 1 and 2: The direction and magnitude of change in the main outcomes and the potential effect size:

For parents, the SDQ remains high at three months but falls at six and nine months and continues to fall by 12 months. The SDQ impact score shows a similar fall over time but a marked fall by three months, indicating that impact reduces more quickly than the overall measure. The Score 15 shows a gradual fall over time for parents from baseline to 12 months. The CBCL shows marked, sustained, statistically significant falls across the evaluation, although the number of respondents at six months and nine months is small.

Change over time indicates that the programme does have a significant positive impact on child behaviour and family functioning, at least up to six months. Beyond this, the interpretation becomes more challenging as more families withdraw from the programme.

In general, there is a sustained fall in problem behaviours measured on the CBCL and in parental responses to the SDQ. On the Score 15, initial improvement is not maintained to the end of the evaluation. The lack of a sustained change in the Score 15 may reflect the differences between those families that remained in the study and those that left. Specifically, those who remained had better family functioning at baseline (see above) and so benefitted less from the intervention with respect to family functioning.

The effect size for the programme intervention (before-after) is fairly limited for the SDQ and the Score 15 at six months. Although the Score 15 effect drops away, the effect size continues to grow to 12 months for the SDQ, although again, it is worth noting the small numbers by that point. The effect size for the fall in reported problem behaviour (CBCL) is large and sustained.

No sensitivity analyses could be conducted, given the large amount of missing data. It is acknowledged that the COVID-19 pandemic was a significant factor in preventing completion of outcome measures during the pilot period. However, it remains possible that families that did not provide data at follow-up were not responding as well to the programme as those families that did provide data. This is particularly likely given the withdrawal rates (see Aim 4). The outcomes, therefore, need to be treated with caution.

Aim 3: The referral and screening process

No data have been provided on the number of families referred, nor any details on the screening process as implemented. It is, therefore, not possible to comment on the risk of bias in the referral or screening process.

Aim 4: Client retention and data completion

Data completion for adults was moderate to six months and poor thereafter. The children did not meaningfully engage in data completion, with less than 15% of measures completed at any time point. The BC SIT team did not report the number of sessions attended by the families but did report the number of families withdrawing from the programme. It is this measure that was used to assess engagement.

Retention of families in the study remains strong at six months, the end of phase one, and at nine months, dropping to just over half the cohort at 12 months – the end of phase two. Of the 15 families that had been lost-to-follow-up at nine months, there was little difference in the children's ages, gender, or the referral source into the SIT when compared to the children who remained in the evaluation. However, all the children whose ethnicity was listed as Black had withdrawn from the study. Although the number is low (five families), the loss is statistically significant and indicates a risk of bias in outcomes for this particular group.

Aim 5: Evaluation of success criteria

Using the traffic light system drawn on above, it can be concluded that none of the success criteria were met, three were missed (red), and one may be possible to meet (amber). Specifically, we were unable to comment on potential bias in the screening and referral processes (missing/red). Retention of families in the intervention was moderate. However, data completion rates were disappointing, meaning that we cannot say that there were sufficiently robust, unbiased processes for data completion. These three success criteria lead us to conclude that the fourth one is unlikely to be met: The BC SIT is not ready to proceed to a trial of sufficient magnitude based around the YEF core measures. It may, however, be possible to deliver a trial of sufficient magnitude if data completion could be improved and bias mitigated and if a trial was largely concerned with the CBCL as the outcome measure. It would also depend on the identification of a suitable control intervention, would possibly require additional sites, and would need to assess whether families would be willing to be randomised to control or intervention.

Aim 6: To assess implementation process

There are three main questions to be answered in interpreting the qualitative aspects of the evaluation. These relate to implementation fidelity, service-user engagement, and programme responsiveness.

Implementation fidelity

The evaluation was run during the period in which implementation was strongly affected by COVID-19. Remote engagement was particularly challenging and would have contributed to the poor data completion rates. It is particularly noticeable that the vast majority of young people did not complete the measures. This may be because the intervention works most closely with parents. Also, it is possible that the delivery of measures to the families, leaving some to complete them on their own, was less likely to work with children than adults. In other interventions, the core measures were incorporated into treatment sessions. Although it was acknowledged that they could be time consuming, they could also be used to facilitate aspects of the intervention themselves.

The intervention was designed to be implemented in two phases. This seems to have been faithfully delivered. Phases were clearly delineated and identified as leading to positive outcomes by several interview/focus group participants. One of the developments made during the evaluation period was to change the therapist delivering the interventions when families completed phase one and entered into the second transition phase. Initially, the same therapist would have supported the family through both phases. Who delivered the intervention, and whether it is the same person throughout both phases, is not something that was covered within the logic model and therefore cannot really be assessed in terms of implementation fidelity. Practitioners felt this change worked well, although, from the family perspective, the transition was not universally smooth.

Service-user engagement

As already noted, quantitative assessment of children’s responses was not possible due to their low engagement with the core measures or with the interviews conducted within the evaluation process. This seems to have mirrored young people’s general engagement with the intervention. Several of the comments from parents/carers that were sent in feedback or mentioned in the interview identified that they would have liked more BC SIT support from therapists directly working with the child in their care. Notes in the files also indicated that some difficulties were being experienced by therapists in engaging some children. Obviously, this is disappointing, but the key criterion for BC SIT’s engagement with a family is whether the parents or carers were prepared to engage with the intervention team, not whether the child at the centre of the referral was themself prepared to engage.

It is reassuring, therefore, to see the high rates of family retention overall despite the issues already noted with withdrawal. The interviews and feedback show that families greatly appreciated the support and empowerment facilitated through the intervention. The qualitative findings indicate powerful transformations that are recognised and appreciated. From the adult perspective, we can say that service-user engagement in the intervention was high initially, although some problems with engagement do appear for a minority of families during the second, transition phase.

Programme responsiveness

Relationships between families and SIT staff were generally seen as being positive. It was clear that families felt listened to and appreciated the new skills and techniques they were being taught. They also appreciated that they were being treated as individuals when it came to looking at how to advise them about their particular family in their particular context. In a complementary manner, they also appreciated not feeling alone and recognising that there were other families going through similar situations to their own.

When considering lessons learnt during the evaluation and what could help or hinder the development of positive outcomes within BC SIT, the thoughtful reflection from therapists demonstrates their willingness to respond to the needs of individual families and to assess ongoing development of the intervention. For example, they considered ways in which to better balance the tensions that sometimes arose when working with a family alongside other agencies. The BC SIT team also suggested ways to improve communication and initial engagement with families, including during the referral and initial enrolment. The willingness to respond to feedback and engagement with referrers, as well as families themselves, will be crucial in how the intervention team responds to the findings regarding which families withdraw or are otherwise lost through non-engagement.

Evidence of promise

Having addressed the research questions through the evaluation aims above, this section will consider the implications of the findings to the logic model (see Figure 1).

In the initial inputs, it is clear that up to 12 months of intervention was being provided in two phases. Although there were some difficulties experienced by a few families during transition, the difficulties do not seem to relate to the initial inputs. That said, the importance of differences noted in family functioning and difficulties experienced by the families at baseline data measurement might offer areas to consider exploring further within the early phases of delivery.

From the data collated, it is impossible to know how these observed differences may or may not have been interrelated with family heritage. We note that the initial logic model did not consider potential differences in heritage or other matters of diversity, culture, and inclusion. The intersections between race, culture, structural, and health inequalities go beyond this evaluation, particularly given the small numbers in this cohort. These matters are increasingly being acknowledged in healthcare and clinical practice, however (e.g. Fitzgerald and Hurst 2017), and may have had an impact on the outcomes here. We did not test quantitatively for potential harmful effects of the intervention; qualitative findings that went beyond the predicted outcomes were largely related to the impacts of COVID-19.

Partnerships with local schools and community-based agencies are identified in the logic model in both the initial inputs and immediate outputs. It appeared from the sources of referrals and from interviews or focus groups that there were generally good relationships with other agencies. Some challenges in multidisciplinary working were noted by interviewees, but no evidence suggests that there were significant or systematic problems.

Several of the short-term outcomes could not be assessed within the evaluation, particularly those relating to offending behaviour. Other outcomes can be shown to have happened, but their efficacy could not be assessed, for example the setting of goals. Predicted outcomes on core measures were observed in relation to the CBCL and SDQ, but it was either not possible to assess the other measures or changes were not sustained. Lastly, assessment of the mid- to long-term outcomes was beyond the scope of this evaluation.

Overall, it is possible to be cautiously optimistic that the logic model was a fair reflection of what was found in the evaluation. Although significant modification would not be necessary prior to future research, there may be some refinement worth considering in relation to intersections between culture and engagement, how the logic model is implemented in practice, and on what basis evidence of efficacy is assessed.

Readiness for trial

As discussed in the findings and evidence of feasibility sections, it may be possible to conduct a full trial, but the intervention is not ready currently. In particular, it would be important to be sure of:

1. Whether the CBCL could be adopted as the outcome measure in favour of the YEF core measures
2. If sufficient evidence could be gathered to indicate that data completion can be improved from adults with parental responsibility and, particularly, from children
3. Whether screening and referral processes are robust
4. Whether retention during the transition phase can be improved
5. Whether the current programme would be able to increase capacity or if other sites could be identified
6. Whether a suitable control intervention could be identified that is not subject to too much heterogeneity yet suitably reflects the fairly heterogenous target group
7. Whether families would be willing to be randomly allocated to intervention or control arms of a trial.

Conclusion

Table 20: Summary of pilot study findings

Research question	Finding
Core outcomes over time	There are statistically significant, positive changes demonstrated on the CBCL and SDQ sustained over time. Initial improvement in SCORE 15 measures was not sustained beyond nine months, by when several families had been lost to the evaluation. The families remaining had better initial scores on the SCORE 15 and, thus, may have had less room to continue improving family functioning. The large proportion of missing data makes further interpretation difficult. It is acknowledged that the COVID-19 pandemic was a significant disruptive factor in preventing completion of outcome measures during the pilot period.
Effect size	For the CBCL, the reported effect size was large, indicating a robust, positive effect of the intervention. Although more modest, the SDQ effect size also indicates a positive effect.
Referral and screening	Referral and screening processes are based on the same criteria and could not be separately assessed. BC SIT staff worked closely with people they identified as gatekeepers to the service to ensure that they understood the intervention's aims. Monthly meetings were held with referrers to assess likely cases, ensure ongoing use of the inclusion criteria, and to consider whether the service had space to provide the intervention. This means that all cases referred during the evaluation were deemed to be suitable but that the processes behind them could not be assessed.
Retention and data completion	Retention with the programme was acceptable until nine months, although it should be noted that this does not match the proportions of recorded data required for the evaluation. It is fair to say that family retention to treatment was satisfactory until nine months, but data collation was less successful, being compromised both by COVID-19 and decisions made about pursuing measure completion.
Potential to move to a randomised trial	There remains the potential to complete an appropriately powered trial, but several significant issues would need to be addressed in order to recommend progression to a randomised trial. In particular, the incorporation of the specified core measures needed for evaluation would have to be rectified, or the CBCL used as the only outcome measure.
Fidelity of intervention	The intervention itself was delivered as intended, with some modifications made for COVID-19 but broadly in line with the underpinning intentions.
Service user engagement	As noted above, the service's files show an acceptable retention rate through the initial phase, although retention becomes problematic during the transition phase when some families complete and others withdraw from the programme. Also, it was clearly difficult to gain service-user engagement in completing the core measures. Notes indicate that the most frequent reason given for withdrawal is lack of engagement. Implementation process interviews indicate that service-user engagement for many families was very good, with the relationship between family and therapist being identified as critical to helping or hampering positive outcomes. Here too, COVID-19 is likely to have been disruptive.
Intervention responsiveness	Again, responsiveness is largely related to relationships and context, here between referrers, schools, and community agencies, as well as families. Although the evidence available was somewhat limited, the intervention does seem to be responsive. At its best, the perceived responsiveness of practitioners is part of what helps families stay engaged and successfully complete the intervention.

Evaluator judgement of intervention and evaluation feasibility

There are solid indicators of positive before and after changes from the adult-completed CBCL and SDQ; however, data completion rates were poor and were the main reason for red and amber indicators across the success criteria. With some refinement of the logic model, consideration made of how to improve retention, and better data completion rates, then BC SIT might be able to improve upon these positive outcomes and address potential bias found. At the moment, we cannot recommend that a full trial using the YEF core measures be pursued.

Interpretation

As noted in the introduction, MST has been relatively well researched, with BC being an early site of its successful implementation in the UK. The BC SIT was designed to go beyond the original MST intervention, not just in duration of support but also in the depth of enrichment the programme team could bring.

There were several positive findings relating to the quality of tailoring of the therapy and how well some families felt listened to by practitioners. The suggestions on ways to manage children's behaviours and challenges were appreciated by parents, carers, and, in some cases, siblings and extended family or friends. There were also some areas for improvement and/or further investigation. The most important for future research would probably be engagement with core measures and data completion in general.

Another area for further consideration relates to the data on bias and withdrawal. The measures indicate some differences in the families that stayed and who left the programme. This is something that has previously arisen in evaluations of MST. It may be worth noting again the point made in the background to this report, where Ryan et al. (2013) had concluded that ethnicity and problem severity could influence both therapist adherence and service-user engagement. Here too, these matters seem to have had some impact on outcomes. When considering how to respond to those families lost from the intervention, it may be useful to start with the suggestions for clinical practice included in Bunting et al. (2021).

Retention could also have been influenced by the challenge some families reported in the switch between therapists. When checking the notes to understand more about bias, change in therapist was noted as a problem in several records. It may be worth BC SIT considering the impact of the change of therapist – both on families and therapists – and whether there may be additional ways in which to militate against potential problems that might arise while maximising the benefits that could be realised through the managed and planned change in therapist. Lastly, it should again be noted that it is not possible to know the full extent of the effects that COVID-19 had on the families involved in this intervention and their capacity to engage or remain engaged in the programme.

Core measure completion was low; this may be related to the measures being sent to some families rather than completed with them (either online or face to face). Also, a point was raised that many of these families have seen the measures multiple times. For example, CAMHS may ask families to complete parent and child outcomes measures before, during, and after an intervention. If a parent has sought help for themself, they too may have been seeing similar scales, or even some of the same ones, every week. Measure fatigue may have been at play.

The particularly poor completion of child measures also reflects that BC SIT works more closely with parents than with children. The interviews, low completion of core measures from children, and notes about children's reluctance to engage combine to mean that the evaluation did not gain children's voices. Another area that was harder to assess than initially envisaged was in monitoring the goals set with families. This is something that practitioners raised as an ongoing challenge in delivering the programme. While goal setting may be very useful for therapeutic conversations and to help focus on progress, we would not recommend that assessment of goals be taken forward for quantitative evaluation in future research of this type.

When considering the transferability and generalisability of the findings presented in this report, there are some limitations as well as future implications to be considered. The first limitation is the difference between retention rates and data completion rates. The latter would have to be improved substantially before a full trial could be comfortably started. The former would also need to be looked into, given the significant differences found in those families that completed/stayed engaged when compared with those that withdrew from the intervention. It should also be noted again that the second phase is one of transition. For some families, early completion is a positive outcome. This may pose difficulties for future research. It is relatively straightforward to ensure that those who successfully completed a programme are analysed separately from those who withdrew from a programme (something ensured in this analysis). Although it is harder to deal with a moving endpoint to an intervention, the complexity can be addressed when subsequently considering "dosage" effects or within cost-benefit analysis, for example. A bigger challenge is how to ensure follow-up throughout a trial duration with those families that complete therapy early. This problem can affect other evidence-based interventions. In some cases, this can be mitigated by way of a developer-prescribed "critical dose"[3].

Another potential limitation relates to the participant implementation process assessment. As this element is qualitative research, generalisability is not really a relevant criterion. The similarity and consistency across many of the themes considered is reassuring, but it should be noted that the views expressed by those who participated may not be consistent with those that would be found from a different set of participants had they been recruited. This is particularly noteworthy given the lockdowns and other responses to COVID-19 that may become a decreasing part of intervention reality. Assessment of the implementation process may have been enhanced further by an attempt to interview families that had been assessed as suitable for the intervention but that decided not to enrol in it or to disengage before intervention began.

The findings indicate some bias in retention to the intervention, and additional caution needs to be exercised regarding the data completion rates. It is possible that those who did not complete the measures differed in some additional way that was not accounted for in this design. Lastly, this evaluation did not consider the nature of what a control intervention might look like. For most of these families, there is no "TAU". It would therefore be necessary to consider what a control intervention might look like and who would provide it.

Future research and publications

At this point, we cannot recommend a full trial broadly adopting similar principles to this design. Further work on engagement and retaining families in the BC SIT might concentrate on further exploration of the differences identified between those families that stayed with the intervention and those that withdrew early without successfully completing it. One potential way to increase families' engagement within the

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[3] With thanks to a reviewer for this suggestion.

evaluation might be to provide short surveys that can be completed on any digital device. It should be noted, however, that children may not have their own smartphones and that some families will not have any such devices. Any non-interview method runs the risk of maintaining barriers, such as literacy, comfort, and privacy issues, but this could still be a complement to existing methods.

Lastly, it would be useful to understand more about the ways in which family functioning at baseline may be being assessed and/or being responded to by therapists and how this may affect families' trajectories through the programme.

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Appendices

Appendix A: Ethics Approvals

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.

DATE 01/04/2020

Protocol number: **LMS/SF/UH/04101**

Title of study: A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Prof Brian Littlechild (CI) Dr David Wellsted (CI)
Ms Helen Munro-Wild (CI)
Prof Joanna Adler (PI) from LMS.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 01/04/2020 To: 30/10/2020

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Dr Tim McSweeney

FROM Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair

DATE 30/09/2021

Protocol number: **LMS/SF/UH/04697**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid: From: 30/09/2021 To:

31/03/2022

Please note:
Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.
Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO Tim McSweeney

FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair

DATE 16/03/2022

Protocol number: **aLMS/SF/UH/04697(1)**

Title of study: A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Joanna Adler David Wellsted Brian Littlechild

Modification: detailed in EC2. (Extension to November, 2022).

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Appendix B: Feasibility Interview Materials

Information Provided to Potential Interviewees

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS (‘ETHICS COMMITTEE’)

FORM EC6: PARTICIPANT INFORMATION SHEETS

1 **Title of study**

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Brandon Centre

Information for a Child/Young Person Potential Interviewee

SOME INFORMATION ABOUT THE RESEARCH

1 We’d like to ask you if you’d be interested in taking part in some research. But before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you’d like.

Thank you for reading this.

2 **What’s the research about?**

One of the projects you’ve been seeing –Brandon Centre - is working to prevent young people aged between 10 and 14 from getting caught up in crime and violence by offering them (and sometimes their parents) the best possible support, as early as possible. Researchers from the University of Hertfordshire (UH) are talking to people who are getting this support to see if they think it’s helpful.

3 **Do I have to take part?**

No. It is completely up to you whether to take part or not.

4 **How long will my part in the study take?**

One of the researchers will ask you some questions about the project and the support they’ve been giving you. This shouldn’t take more than 30 minutes.

5 **What will happen to me if I take part?**

A UH researcher will arrange with an adult who looks after you, or a member of staff at the project, a good date, time and place for you to meet and talk about the support you’ve been getting. With your permission, the researcher may want to record your chat with a small voice recorder. This will make things easier and quicker as they won’t have to make notes of what you’re saying. If you’d rather they didn’t record it that’s fine – please just tell them when you meet. After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a ‘thank-you’ for taking part in the research. You’ll have to sign a piece of paper just to say you’ve received this.

6 **Will anyone get to see or hear what I say?**

We won't record or use your name in the research. All the information about you will be held safely and securely by UH. What you tell us is confidential (so no-one else will see or know what you've said).

7 **What happens with the information I give you?**

We will use what you and others tell us to say whether the support that the project offers is useful and helpful to young people. We can also make suggestions about how things can be improved so that young people get more or better help. But nobody will be told what you have said about the project.

8 **Can anything we talk about be shared with others?**

If you tell the researcher from UH that you or another person is at risk in some way then by law we would have to share that information with the project, and possibly other people too, in order to protect you or the other person.

9 **Who has reviewed this study?**

This study has been reviewed and approved by the UH, Science, Engineering and Technology Ethics Committee.

The UH protocol number is **LMS/SF/UH/04101**

10 **Who can I contact if I have any questions?**

If you have any questions about the research then you can telephone or email one of the UH researchers: either Brian (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this research, then please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and thinking about taking part in this study.

Information for a Parent/Carer/Guardian Potential Interviewee

1 Title of study

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Brandon Centre

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 What is the purpose of this study?

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 How long will my part in the study take?

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of Brandon Centre.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

7 How will my taking part in this study be kept confidential?

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 30th October 2020). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 **What will happen to the data collected within this study?**

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 **Who has reviewed this study?**

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 **Factors that might put others at risk**

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 **Who can I contact if I have any questions?**

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Information for a Practitioner/Stakeholder Potential Interviewee

1 Title of study

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Brandon Centre

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish.

Thank you for reading this.

3 What is the purpose of this study?

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage (up to 17th July 2020) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you in any way. If you have any concerns about taking part, please discuss this with your manager and/or supervisor.

5 How long will my part in the study take?

If you decide to take part in this study, then you will be invited to speak with a researcher from UH to answer some informal questions about your views and experiences, and this will take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and participate in an interview (or possibly a focus group) in order to answer a set of questions about the work of the YEF-funded project.

The interviews/focus groups will be conducted by an independent researcher from UH.

The researcher will ask you about your views on the work you and others are doing with children and/or families receiving YEF-funded support. We are interested in your opinions and there are no right or wrong answers. With your permission, the interview will be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 30th October 2020).

7 How will my taking part in this study be kept confidential?

Participant confidentiality will be respected. We will use an anonymity code rather than your name and your organisation will not be identified. Anonymised data will be kept for up to five years after which it will be securely destroyed. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 30th October 2020). Audio files will only be stored on computers belonging to UH and will only be available for the purposes of data analysis. All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 What will happen to the data collected within this study?

We will use the data collected to assess the feasibility of the YEF-funded projects. UH is the data controller for the study. This means we are responsible for looking after your information and using it properly. No personal data (e.g. names) or details of your organisation will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

The data collected as part of the study will be stored electronically, in a password-protected environment, for up to five years, after which time it will be destroyed under secure conditions. All such data will be anonymised prior to storage. Any data collected in hard copy by UH (e.g. copies of consent forms) will be stored in a locked cupboard until 30th October 2020, after which time they will be shredded.

9 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04101**

10 Factors that might put others at risk

Please note that if, during the study, any unlawful activity becomes apparent that might or had put others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent for Family Participation: Feasibility Interview Phase

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

Brandon Centre

(UH Protocol number **LMS/SF/UH/04101**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial b

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number})** for the interview phase of the above study. I have had the opportunity to consider the information abou interview, ask questions and have had these answered satisfactorily. ☐
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights bei ected. ☐
3. I understand that the information collected about me and my child will be used to support other r ch in the future, and may be shared anonymously with other researchers. ☐
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

____________________	____________________	____________________
Name of Parent/Carer/Guardian	Date	Signature
____________________	____________________	
Name of child	Your relationship to the child	
____________________	____________________	____________________
Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Consent form: Stakeholders/Practitioners

A feasibility study of a Youth Endowment Fund (YEF) Family Therapy Focused Project Brandon Centre

(UH Protocol number **LMS/SF/UH/04101**)

1 I confirm that I have been given a Participant Information Sheet giving details of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to me. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it. I understand that this study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that a voice recording will take place and I have been informed of how this recording will be used.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of participant……………………………………..…Date…………………………

Signature of (principal) investigator……………………………………………………Date…………………………

Name of (principal) investigator *[BRIAN LITTLECHILD / TIM MCSWEENEY]*

…………………………………………………………………………………………………

Topic Guide for use with Families

- How did you first hear about the project?
- What did you find valuable/attractive in what you were told about the programme at the start of it?
- What did you see as the main challenges you and/or your family had when you were first referred to the programme?
- What hopes had you about how the programme and how it might help you/your family when you were accepted?
- What were your concerns, if any, about engaging with the programme?
- What help/support had you tried before, if anything, and had any of these things been successful in any ways at all? Has your involvement in this programme been any different in terms of positive changes for you/your family?
- What has worked well while you have been on the programme - for you? For your family?
- What have you found most difficult or unhelpful on the programme so far?
- How far do you think things have changed in a positive way as a result of your involvement with the programme (so far)?
- What have you found most challenging in terms of keeping up with the demands of the programme, and in making changes whilst on the programme (so far)?
- What other factors do you think have affected for you/your family - whether things have got better (or not) since you started the programme? For example, other help and support you have received, what is happening at school, with friends/acquaintances etc.?
- What has changed least in relation to 1) the challenges you/or family were facing when you started the programme 2) in relation to what you had hoped for as a result of at taking part in the programme?
- Have other members of your family experienced any changes from your involvement in programme so far? If we were to ask others involved with yourself and your family, such as school staff etc., what do you think they might say as to whether there have been improvements in the challenges you are experiencing?
- Have you looked at your/your family's progress with the challenges you were experiencing when you came onto the programme with your worker, and if so how did you do this, and in what ways did you think there had been improvements (or not)?
- If we were to ask your worker, what do you think they would say 1) the main things that have been positive in terms of change for you/or family, 2) things maybe still need to be worked on rather more?

Topic Guide for use with Stakeholders/Practitioners

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?

- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?

- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?

- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?

- How have you reviewed progress with them, and the outcomes so far of your interventions?

- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.

- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?

- If we were to ask them what the main areas of positive change had been, and why, what you think they might say?

- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?

Thank you….

Debriefing

If you have been affected by any of the issues we have discussed during the course of the research then please consider approaching a member of the project team for advice and support. Alternatively, the following sources of advice, support and information may be useful.

1. Childline

Call free on 0800 1111 or get in touch online at https://www.childline.org.uk/get-support/

2. Samaritans

The Samaritans are available 24 hours a day, 365 days a year to support you with whatever you're going through.

https://www.samaritans.org

Tel: 116 123

Email: jo@samaritans.org

3. Ask to speak to one of your school teachers

4. Contact your local GP or NHS Direct

NHS 111 can help if you have an urgent medical problem and you’re not sure what to do.

Call 111 on your phone or go to https://111.nhs.uk/

5. Emergency services

In an emergency, contact the emergency services.

Tel: 999

University of Hertfordshire School of Life and Medical Sciences Risk Assessment Form

Ref No:	
Date:	
Review Date:	

For assistance in completing this form, please see the Guidance Notes at the end

ACTIVITY INFORMATION	
Name of Assessor/ Contact details	Name: Dr Tim McSweeney Email address: t.mcsweeney@herts.ac.uk Ext no: 5284
Title of Activity	A feasibility study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.
Location of Activity	It is envisaged that fieldwork for the study will be undertaken either on the premises of the service being evaluated (ASSIST in Northamptonshire, Family Support, Brandon Centre and RISE Mutual, all of whom deliver service in London), or remotely over the phone or online (e.g. using Zoom software). Where necessary and appropriate, some interviews with parents and carers may be undertaken in public spaces (e.g. cafes).
Description of Activity Please attach a copy of the protocol, procedure, SOP etc applicable.	The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The feasibility study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the feasibility study are to better understand: the factors that support or interfere with the intervention's successful delivery; the feasibility of the intervention's recruitment, retention and reach; and, service users' experiences and views of the intervention.
Personnel Involved	Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI), Ms Helen Munro-Wild (CI) and Prof Joanna Adler (PI) from LMS.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED		
☐ Animal Allergens ☐ Biological Agents (see COSHH) ☐ Chemical Compounds (see CoSHH) ☐ Compressed/liquefied gases ☑ Computers ☐ Electricity ☐ Falling Objects ☐ Farm Machinery ☐ Fire ☐ Glassware Handling	☐ Hand Tools ☐ Ionising Radiation ☐ Office Equipment ☐ Laboratory Equipment ☐ Ladders ☐ Manual Handling ☐ Non-ionising Radiation ☐ Hot or cold extremes ☐ Repetitive Handling ☐ Severe Weather	☐ Sharps ☐ Slips/trips/falls ☑ Stress ☐ Travel ☐ Vacuum systems ☐ Pressure systems ☐ Vehicles ☑ Aggressive response, physical or verbal ☐ Workshop Machinery
The above is not an exhaustive list – all other hazards should be listed here. Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.		

HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in absence up to 3 days Moderate Damage or Loss Moderate Environmental Impact Group 2 Biological agents	2	Trivial (2)	Trivial (4)	Tolerable (6)	Tolerable (8)	Moderate (10)
Injury or Health Disorder – resulting in absence over 3 days Substantial Damage or Loss Serious Environmental Impact Group 3 Biological agents	3	Trivial (3)	Tolerable (6)	Moderate (9)	Moderate (12)	Substantial (15)
Long Term Injury or Sickness – resulting in permanent incapacity Extensive Damage or Loss Major Long Term Environmental Impact	4	Trivial (4)	Tolerable (8)	Moderate (12)	Substantial (16)	Intolerable (20)
Death Serious Structural Damage Environmental Catastrophe Group 4 Biological agents	5	Tolerable (5)	Moderate (10)	Substantial (15)	Intolerable (20)	Intolerable (25)
Note on Risk Classification: 1-4 Trivial 5-7 Tolerable 8-12 Moderate 13-16 Substantial >20 Intolerable	→ Likelihood	1	2	3	4	5
		Almost Impossible	Unlikely – possible exposure every 1-3 years	Harm is possible	Harm is likely to occur	Harm will occur or is very likely to occur.

ASSESSMENT OF RISK CLASSIFICATION			
Hazard	Likelihood Score	Severity Score	Risk Classification
Stress	3	1	3 (Trivial)
Emotional discomfort or distress	3	1	3 (Trivial)

Aggressive response, physical or verbal	3	1	3 (Trivial)

EFFECT OF RISK CLASSIFICATION	
Risk Classification	Action
Trivial	No further action required. Activity can begin.
Tolerable	No additional controls required. Current controls must be maintained and monitored.
Moderate	Reduce risks if cost effective. Implement new controls over an agreed period.
Substantial	Activity cannot begin without major risk reduction.
Intolerable	Activity must not begin.

RISK CONTROL MEASURES

Are the local code of practice and/or local rules adequate to control the risks identified?

Yes

Please list.
Please list all additional measures required.

Local Code of Practice and Local Rules applicable:

All LMS health and safety rules will be followed including ‘LMS Health and Safety Codes of Practice’, the ‘BPS Code of Ethics & Conduct (2009)’ and ‘BPS Code of Human Research Ethics (2014)’.

Additional Measures: All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences).

The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected on service premises, online (via video conferencing) or over the phone.

As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

HEALTH SURVEILLANCE ISSUES	
Persons at Special Risk	Children at risk of involvement in crime and violence, their parents, carers or guardians, and professionals working with them.
Health Surveillance Measures (including symptoms and signs of exposure)	It is possible that some respondents may experience distress, or become aggressive (verbally) as a consequence of recalling their experiences of crime and/or violence.
Exclusions	Respondents must be consenting service users of the YEF funded project or a professional stakeholder linked to the delivery of these interventions.

	SIGNATURES			
	Staff/PhD student/MSc student/Undergraduate	Name (Print)	Signature	Date
Assessor	Staff	Tim McSweeney		26/02/2020
Supervisor (if Assessor is a student)	N/A			
Local Health and Safety Advisor / Laboratory Manager	Health and Safety Lead (Psychology)Staff	John Bain		27/02/2020

GUIDANCE NOTES.

This Risk Assessment is the legally required written record of the Risk Assessment for an activity. It must include all known risks and hazards involved in the activity, to the best of the assessor’s knowledge. Both the Risk And CoSHH Assessments must be signed off by signatories prior to work starting. No changes may be made to this document without being countersigned by all signatories.

The purpose of this Risk Assessment is to identify risks arising from specific activities and substances and put into place safe working practices to minimise these risks.

Copies of this Risk Assessment must be available at all times during the period of the activity.

For clarity and help in filling this form in, please read the following notes:

ACTIVITY INFORMATION

Name of Assessor - contact details must be included here.

Title of Activity – this should be brief but specific to the details here.

Location of Activity – any rooms, buildings or venues where this activity will be carried out must be included.

Description of Activity – a brief description of the activity proposed. This MUST include any materials used, classes of substances used (e.g. micro-organisms) equipment used and analytical and preparatory processes and techniques if they are being used. Do not forget to include by-products of any activity.

Personnel Involved – anyone who will be present in the area during the activity. This should be groups of people where possible, e.g. undergraduate students.

TYPES OF HAZARD LIKELY TO BE ENCOUNTERED

This is a list of the more common hazards likely to be encountered within Life and Medical Sciences. Tick those that will be encountered during the proposed activity. Any additional hazards must also be included here.

HAZARD ASSESSMENT

This table is the heart of this assessment. By looking at the severity of the consequence of being exposed to a hazard and measuring that against how likely this may happen you can calculate how much risk is involved.

Severity x likelihood = risk.

If the proposed activity has a high risk (i.e. a high number) then control measures will need to be put in place.

RISK CONTROL MEASURES – Refer and list the local codes of practice, guidelines and local rules of the area where the activity will be carried out for *minimum* safe practices.

Additional Measures– this details the measures that can reduce the risk. For example – using volatile solvents in a fume hood, or arranging for interviews to be conducted in a public place.

ASSESSMENT of RISK CLASSIFICATION

Hazard – this is a list of all hazards encountered in the activity as identified earlier.

Likelihood Score – this is a measure of how likely it is that a hazard will occur. Identified from the Hazard Assessment table

Severity Score – this is a measure of how severe exposure to any given hazard can be. Identified from the Hazard Assessment table. Use the highest score for each hazard.

Risk Classification – this is the result from the Hazard Assessment table and will be one of the following words – trivial, tolerable, moderate, substantial or intolerable.

EFFECT OF RISK CLASSIFICATION – this table indicates whether the proposed activity can begin and if other controls must be put into place.

HEALTH SURVEILLANCE ISSUES – this looks at how hazards can specifically affect health of people coming in contact with the proposed activity.

Persons at Special Risk – this must include anyone who has a special health issue with hazards involved – e.g. pregnant women, specific allergic reactions, asthmatics, immune-suppressed individuals etc.

Health Surveillance Measures – this must include symptoms of exposure to hazards involved. For example, chemicals and drugs can cause dizziness and drowsiness. Outside working can involve extremes of temperature i.e. summer and winter working.

Exclusions – this should include a list of anyone who should not take part in this activity, e.g. pregnant women, or anyone with a pacemaker.

SIGNATURES – all required signatures must be completed before work can commence.

Assessor – this is the person who has filled in the Risk Assessment.

Supervisor – an academic member of staff with responsibility for the assessor if the assessor is a student.

Local health and safety advisor – a named person who is familiar with the area specified for the activity to take place. A list of current local health and safety advisors for each Department is given below (removed for publication of Appendices):

DEFINITION OF TERMS

HAZARD - a potential source of harm

HARM – personal injury or damage to property

RISK – a combination of the likelihood of harm arising from a hazard and the severity of that harm.

RISK ASSESSMENT – identification of hazards and a classification of the risk they produce.

RISK CONTROL – physical control and/or the safe system of work required to reduce the risk to acceptable levels.

Appendix C: Feasibility Data Audit

Brandon Centre Systemic Integrative Treatment

All data provided by Brandon is for participant families (referral/screening data not included – all participants referred were enrolled).

Table 1: Data Intended to be Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	X						
Gender	X						
Ethnicity	X						
Referrer	X						
Date of referral	X						
Family ID		X					
Index of Deprivation		?					
CBCL			X		X		X
Treatment Goals FID's			X		X		X
Living Status			X		X		X
SDQ			X	X	X	X	X
Score 15			X	X	X	X	X
IES/CRIES8			X	X	X	X	X
ESYTC			X	X	X	X	X
Study End Form							?

NB 18 months t(5) was initially considered as well.

Data Collected

Screened: 24? All participants have been enrolled – were there others who were deemed unsuitable?
Enrolled: 24
Followed up:
- *3 months: 17 parents, 14 children*
- *6 months: 13 parents, 11 children*
- *9 months: 5 parents, 5 children*
- *12 months: 3 parents, 3 children*

Table 2: Actual Data Collected at Each Timepoint

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)	9 months (T3)	12 months (T4)
Age	24 (100%)						
Gender	24 (100%)						
Ethnicity	21 (87.5%)						
Referrer	24 (100%)						
Date of referral	24 (100%)						
Family ID		24 (100%)					
Index of Deprivation		0 (0%)					
CBCL			P: 21 (87.5%) C: 5 (20.8%)	P: 12 (66.7%) C:2 (11.1%)	P: 10 (76.9%) C: 0 (0%)	P: 2 (40%) C: 0 (0%)	P: 1 (33.3%) C: 0 (0%)
Treatment Goals FID's			?		?		?
Living Status			?		?		?
SDQ			P: 21 (87.5%) C: 6 (25%)	P: 12 (66.7%) C: 2 (11.1%)	P: 10 (76.9%) C: 0 (0%)	P: 2 (40%) C: 0 (0%)	P: 1 (33.3%) C: 0 (0%)
Score 15			P: 18 (75%) C: 4 (16.7%)	P: 12 (66.7%) C: 1 (5.6%)	P: 10 (76.9%) C: 0 (0%)	P: 2 (40%) C: 0 (0%)	P: 1 (33.3%) C: 0 (0%)
IES/CRIES8			?	?	?	?	?
ESYTC			C: 3 (12.5%)	C: 2 (11.1%)	C: 0 (0%)	C: 0 (0%)	C: 0 (0%)
Study End Form							2

Treatment Goals FID's, Living Status and IES/CRIES8 not added to data collection form.

<u>Baseline Assessment dates:</u>
Enrolment dates complete for all families, although sometimes only on one of parent or child record rather than both. 7 enrolment dates after date of first (SDQ) questionnaire.
Based on baseline assessment date, numbers with long enough follow up are:

- 3 months: 18
- 6 months: 13
- 9 months: 5
- 12 months: 3
- 18 months: 0

Referral/Screening Data: 24 young people screened

Referral Data to be collected:

- Age (*Date of Birth*)
    - 100% Complete – entered in parent and child arms
    - Service users aged 10-15 years
- Gender (*Gender*)
    - 100% complete
    - 6 female (25%), 18 male (75%)
- Ethnicity (*Ethnicity*)
    - 87.5% complete, although some seem to be nationalities rather than ethnicities
    - 3 Asian (14.3%), 2 Black (9.5%), 1 Mixed (4.8%), 15 White (71.4%).
- Referrer (*Where was the participant referred from?*)
    - 100% Complete, but 12 were "other"
    - One participant (FAM040) with different referral source in parent and child arm
    - 10 (41.7%) Social Worker, 12 (50%) Other, 1 (4.2%) Wellbeing practitioner, 1 YOS Worker
- Date of Referral (*Date of referral*)
    - 100% compete
    - Range 10/07/2019 - 21/11/2020

Screening data:

- Family ID (*Family ID*)
    - All given unique case numbers
    - One participant (child) record with participant ID in place of Family ID (UH046)
    - Do records FAM026 and FAM024 relate to the same child? (Same DOB, date of referral, date of enrolment)
- Index of Deprivation
    - Not collected

Participant Data: 24 cases (parents and children)

Baseline

- CBCL
    - 21 parent surveys complete (87.5%)
    - 5 child surveys complete (20.8%)
- SDQ
    - 21 parent surveys complete (87.5%)
    - 6 child surveys complete (25%)
- Score 15
    - 18 parent surveys complete (75%)
    - 4 child surveys complete (16.7%)
- Edinburgh (ESYTC):
    - 3 child surveys complete

7 participants with date of enrolment after the first (parent) survey was completed. Date of enrolment missing for 1 parent but was completed for that child.

3 months
6 participants with date of enrolment 1st Dec 2020 onwards (i.e. too soon for 3 month follow up).

Records for 18 families (17 parents and 14 children) out of possible 18, but 5 families answered no questionnaires.

- SDQ:
    - 12 parent surveys complete (66.7%)
    - 2 child surveys complete (11.1%)
- Score 15:
    - 12 parent surveys complete (66.7%)
    - 1 child survey complete (5.6%)
- Edinburgh (ESYTC):
    - 2 child surveys complete (11.1%)
- CBCL (not due at three months):
    - 12 parent surveys complete (66.7%)
    - 2 child surveys complete (11.1%)

6 months
11 participants with baseline assessment 1st September 2020 onwards (i.e. too soon for 6 month follow up).

Records for 13 parents and 11 children out of possible 13, but 3 families answered no questionnaires:

- SDQ:
    - 10 parent surveys complete (76.9%)
    - 0 child surveys complete
- Score 15:
    - 10 parent surveys complete (76.9%)
    - 0 child survey complete
- Edinburgh (ESYTC):
    - 0 child surveys complete
- CBCL:
    - 10 parent surveys complete (76.9%)
    - 0 child surveys complete

9 months
19 participants with baseline assessment 1st June 2020 onwards (i.e. too soon for 9 month follow up).

Records for 5 parents and 5 children followed up out of possible 5, but 3 families answered no questionnaires:

- SDQ:
    - 2 parent surveys complete (40%)
    - 0 child surveys complete
- Score 15:
    - 2 parent surveys complete (40%)
    - 0 child surveys complete
- Edinburgh (ESYTC):
    - 0 child surveys complete
- CBCL (not due):
    - 2 parent surveys complete (40%)
    - 0 child surveys complete

12 months
21 participants with baseline assessment March 2020 onwards (i.e. too soon for 12 month follow up).

Records for 3 parents and 3 children followed up out of a possible 3, but no records for 2 families:

- SDQ:
    - 1 parent survey complete (33.3%)
    - 0 child surveys complete

- Score 15:
    - 1 parent survey complete (33.3%)
    - 0 child surveys complete
- Edinburgh (ESYTC):
    - 0 child surveys complete
- CBCL:
    - 1 parent survey complete (33.3%)
    - 0 child surveys complete
- Study End Form:
    - Completed for 1 family on schedule and 1 family where case closed early.

18 months

No participants have been in the study for 18 months.

Appendix D: Pilot Interview Materials

Please note that the pilot materials were not substantively different from those adopted during feasibility. Minimal changes related to the transition from feasibility to pilot phase of the evaluation. One example of each set of amendments is included here for completeness with the changes highlighted.

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS (‘ETHICS COMMITTEE’)

FORM EC6: PARTICIPANT INFORMATION SHEETS

Parent/Carer/Guardian Information Sheet

NB: Changes to the versions for children and young people and for stakeholders and practitioners were in line with those below. Otherwise, they were the same as versions shown in Appendix B.

1 **Title of study**

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project: Brandon Centre

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand what the research is about and what you are being asked to so. Please take the time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

3 **What is the purpose of this study?**

The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF’s purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. This independent study is being conducted by a team of researchers from the University of Hertfordshire (UH) who are evaluating the work of four family-focused interventions: ASSIST, Family Support, Brandon Centre and RISE Mutual. The key questions for the pilot study are to better understand the factors that support or interfere with the project’s successful delivery and, service users’ experiences and views of the intervention.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete the interview. You are free to withdraw at any stage (up to 31st March 2022) without giving a reason. A decision to withdraw at any time, or a decision not to take part at all, will not adversely affect you and/or your child in any way.

5 **How long will my part in the study take?**

If you decide to take part in this research, then you will be invited to talk with an independent researcher from UH to discuss your views and experiences of the support that you and/or your child has received. This may take approximately 40-50 minutes.

6 What will happen to me if I take part?

A member of the UH research team will arrange a meeting with you at a mutually convenient date, time and location. You will then be asked to complete a consent form and tell the researcher about your views and experiences of Brandon Centre.

The conversation with the researcher from UH is confidential. With your permission, what you discuss may be audio-recorded for the purposes of transcription and data analysis, but the recordings will be destroyed at the end of the study (i.e. by 31st August 2022). After the UH researcher has asked you all their questions, they will give you a £10 Love2shop voucher as a 'thank-you' for taking part in the research. You'll have to sign a piece of paper just to say you've received this.

7 How will my taking part in this study be kept confidential?

Your confidentiality will be respected at all times. We will use a code rather than your name. Your anonymised data may be kept for up to five years after which it will be securely destroyed by UH. Consent forms will be stored in a lockable cabinet separately to other study data and will be destroyed upon completion of the study (i.e. by 31st August 2022). All electronic files will be stored on UH secure servers which are firewalled and password protected.

8 What will happen to the data collected within this study?

We will use the data collected to assess how effective the YEF-funded projects are. UH is responsible for looking after your information and using it properly. No personal data (e.g. names) will be shared and all data will be anonymised. The results of the study will be used to inform future planning for the work of YEF. Any research reports will not identify you individually.

9 Who has reviewed this study?

This study has been reviewed by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/SF/UH/04697**

10 Factors that might put others at risk

Please note that if, during the study, any unlawful activity becomes apparent that might or has put you or others at risk, UH may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

11 Who can I contact if I have any questions?

If you would like further information, or would like to discuss any details personally, please get in touch with us, in writing, by phone or by email: either Brian Littlechild (tel: 01707 284423, email: b.littlechild@herts.ac.uk)Tim McSweeney (01707 284285; email: t.mcsweeney@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB.

Thank you very much for reading this information and giving consideration to taking part in this study.

Parent/Carer/Guardian Consent Form: Pilot Interview Phase

A pilot study of a Youth Endowment Fund (YEF) Family Therapy Focused Project

Brandon Centre

(UH Protocol number **LMS/SF/UH/04697**)

Name of project evaluation leads: *Brian Littlechild (tel: 01707284423, email: b.littlechild@herts.ac.uk) or Tim McSweeney (01707284285; email: t.mcsweeney@herts.ac.uk).*

Please initial b

1. I confirm that I have read the information sheet dated **{insert date} ({insert version number}**) for the interview phase of the above study. I have had the opportunity to consider the information abou ☐ interview, ask questions and have had these answered satisfactorily.
2. I understand that my, and my child's, participation in the interview is voluntary and we are free to withdraw or change our mind at any time without giving any reason, without our support or legal rights bei ☐ ected.
3. I understand that the information collected about me and my child will be used to support other r ☐ ch in the future, and may be shared anonymously with other researchers.
4. I agree to having the conversation with me and my child audio-recorded. ☐
5. I confirm that I am happy for me, and my child, to take part in the interview. ☐

______________________	______________________	______________________
Name of Parent/Carer/Guardian	Date	Signature
______________________	______________________	
Name of child	Your relationship to the child	
______________________	______________________	______________________
Name of Person taking consent	Date	Signature

2 copies – 1 to the parent/carer and 1 to University of Hertfordshire

Please note that for the pilot phase, there were no changes to the topic guide used with families and the debrief remained the same as in the feasibility phase. Changes to the topic guide adopted with professionals have been highlighted below.

Topic Guide for use with Practitioners/Stakeholders

- Can you please describe the main elements of the programme which you are carrying out with children and/or parents (if applicable)? Please describe the main purpose of it, main methods and skills utilised, and the aims of it?

- What you think the main challenges have been in relation to engaging with the parents (if applicable) and young people in terms of meeting the aims of the programme/interventions so far?

- If we were to ask the children/parents/carers in the families what they had hoped for at the beginning programme and whether this was being achieved or not, what do you think they might say?

- What do you think are the main strategies/elements that you have employed in terms of how you have engaged with the children and parents/carers in the families (if applicable)?

- How have you reviewed progress with them, and the outcomes so far of your interventions?

- What's the most reliable and appropriate way of measuring the intervention's outcomes?

- As you know, we are collating statistics in relation to referrals, acceptance, progression rates etc. We would like to explore with you your views on the families referred so far, the appropriateness of those referrals/acceptances, and any issues about engagement. Please tell us about your general views on these areas.

- If we were to ask the children/parents/carers in the families their views on how well they have engaged with the programme, and the value of it, what do you think they might say?

- To what extent do you think the project achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap)?

- If we were to ask them (the families) what the main areas of positive change had been, and why, what you think they might say?

- In terms of the children and/or families accepted on to the programme, to what extent do you think you have managed to keep to the main elements/focus of it, and how much have you had to adapt what you do in relation to the ongoing work in light of reviewing the effectiveness of it?

- Do you think the intervention is ready for full scale efficacy testing (e.g. using a randomised trial)?

Thank you….

Ref No	
Date	
Review Date	
	OFFICE USE ONLY

SCHOOL OF LIFE AND MEDICAL SCIENCES
UNIVERSITY OF HERTFORDSHIRE

Life and Medical Sciences Risk Assessment

The completion of this is an integral part of the preparation for your work, it is not just a form to be completed, but is designed to alert you to potential hazards so you can identify the measures you will need to put into place to control them. You will need a copy on you when you carry out your work

	General Information			
Name	Dr Tim McSweeney	Email address	t.mcsweeney@herts.ac.uk	
Contact number	*Ext 5284*			
Supervisor name (if student)		Supervisor's e-mail address (if student)		
Supervisor's contact number				

	Activity	
Title of activity		A pilot study of four Youth Endowment Fund (YEF) Family Therapy Focused Projects.
Brief description of activity		The Youth Endowment Fund (YEF) has received £200m from the Home Office to be spent over 10 years. YEF's purpose is to prevent children and young people from getting caught up in crime and violence by making sure that those at greatest risk receive the best possible support, as early as possible. Its focus is on early intervention with young people aged 10-14 in England and Wales. The pilot study will involve a team from the University of Hertfordshire (UH) evaluating the work of four family-focused interventions (ASSIST, Family Support, Brandon Centre, RISE Mutual). The key questions for the pilot study are to better understand: the extent to which the intervention achieves its intended outcomes (as measured using YEF's 'core measures' and REDCap); views on the most reliable and appropriate ways of measuring the intervention's outcomes; whether the intervention is considered ready for full-scale efficacy testing (e.g. using a randomised trial); how, if at all, have aspects of design or delivery changed and adapted (e.g. in relation to enhancing participant recruitment, retention or outcomes); and, service users' experiences and views of the intervention.
Location of activity		*Online using REDCap (Clinical Trials Database system*
Who will be taking part in this activity		Dr Tim McSweeney (CI), Prof Brian Littlechild (CI), Dr David Wellsted (CI) and Prof Joanna Adler (PI) from LMS.
	Types of Hazards likely to be encountered	

X Computers and other display screen	☐ Falling objects	☐ Farm machinery		☐ Fire
☐ Cuts	☐Falls from heights	☐ Manual handling		☐ Hot or cold extremes
☐Repetitive handling	☐ Severe weather	☐ Slips/trips/falls		X Stress
☐Travel	☐ Vehicles	X Aggressive response, physical or verbal		☐ Workshop machinery

Other hazards not listed above		Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.

	Risk Control Measures
	List the activities in the order in which they occur, indicating your perception of the risks associated with each one and the probability of occurrence, together with the relevant safety measures. *Describe the activities involved.* *Consider the risks to participants, research team, security, maintenance, members of the public – is there anyone else who could be harmed?* *In respect of any equipment to be used read manufacturer's instructions and note any hazards that arise, particularly from incorrect use.*

Identify hazards	**Who could be harmed?** *e.g. participants, research team, security, maintenance, members of the public, other people at the location, the owner / manager / workers at the location etc.*	**How could they be harmed?**	**Control Measures – what precautions are currently in place?** *Are there standard operating procedures or rules for the premises. Are there any other local codes of practice/local rules which you are following, e.g. Local Rules for the SHE labs? Have there been agreed levels of supervision of the study? Will trained medical staff be present? Etc*	**What is the residual level of risk after the control measures have been put into place?** *Low Medium or High*	**Are there any risks that are not controlled or not adequately controlled?**	**Is more action needed to reduce/manage the risk?** *for example, provision of support/aftercare, precautions to be put in place to avoid or minimise risk or adverse effects*
Computers and other display screen.	Research team.	Prolonged periods of computer use.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice'.	Low.	No.	No.
Aggressive response, physical or verbal.	Research team, other people at the interviewees' location.	Being subjected to an aggressive response, or physical or verbal abuse in reaction to some of the issues and topics being discussed.	All LMS health and safety rules will be followed including 'LMS Health and Safety Codes of Practice', the 'BPS Code of Ethics & Conduct (2009)' and 'BPS Code of Human Research Ethics (2014)'.	Low.	No.	No. The scope for any harms, hazards and risks to the safety of the investigators are considered negligible as it is envisaged that all data will be collected online (via video conferencing) or over the phone.

Stress.	Participants and research team.	In response to some of the issues, views or experiences reported during the course of an interview.	All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities, ensuring people are not directed again to services in which they have had negative experiences).	Low.	No.	All fieldworkers are experienced, trauma-informed researchers. As PI, Professor Joanna Adler is available to debrief any members of the research team who experience distress as a consequence of the data gathered during the course of the research (e.g. through qualitative interviews).

List any other documents relevant to this application		The ‘BPS Code of Ethics & Conduct (2009)’ and ‘BPS Code of Human Research Ethics (2014)’.

	Signatures				
Assessor name	Tim McSweeney	Assessor signature		Date	*16/09/2021*
Supervisor, if Assessor is a student		Supervisor signature			
Local Health and Safety Advisor Lab Manager	Jon Gillard	Local Health and Safety Advisor/ Lab Manager signature			*16/09/2021*