EVALUATION REPORT

Family Support – The Transition and Resilience Project

Feasibility and pilot study report

Joanna R Adler, Tim McSweeney, Caroline Cresswell, David Wellsted, Natalie Hall, Amanda Busby and Brian Littlechild

July 2023

University of Hertfordshire UH

YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people from becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activity.

And just as important is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work and that we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together, we need to look at the evidence and agree on what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart, it says that we will fund good work, find what works and work for change. You can read it here.

For more information about the YEF or this report please contact:

Youth Endowment Fund
C/O Impetus
10 Queen Street Place
London
EC4R 1AG

www.youthendowmentfund.org.uk

hello@youthendowmentfund.org.uk

Registered Charity Number: 1185413

Contents

About the evaluator 4

Executive summary 6

Introduction 8

Feasibility study 166

Pilot (Pre/Post-Test) study 40

References 72

Appendices: 75

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 UH research team has proven knowledge and competence in the field of youth violence and crime, 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, UH was given responsibility for evaluating four launch grant-round family-focused projects. The programme of work was led by Professor Joanna R Adler as Principal Investigator and Dr Tim McSweeney, Dr David Wellsted and Professor Brian Littlechild as Co-Investigators. Dr Rosemary Davidson assisted during pilot fieldwork. Dr Caroline Cresswell also joined the team during the pilot evaluation, leading qualitative analyses of fieldwork thereafter. Natalie Hall and Amanda Busby from UH's Centre for Health Services and Clinical Research facilitated training for the project in the use of the Research Evaluation Data Capture system (REDCap), oversaw processes to enable data capture and conducted an analysis of YEF's core measures data collected by the project staff using REDCap.

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

List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ASB	Antisocial Behaviour
ASD	Autism Spectrum Disorder
ASE	ASE Mentoring (Active Successful Engagement)
CBT	Cognitive Behavioural Therapy
CRIES-8	Children's Revised Impact of Events Scale-Eight item
DfE	Department for Education
DSA	Data Sharing Agreement
DPIA	Data Protection Impact Assessment
ESYTC	Edinburgh Study of Youth Transitions (sweep 3 measure used)
GCSE	General Certificate of Secondary Education
GDPR	General Data Protection Regulation
IES-R	Impact of Events Scale-Revised
IIP	Intensive Inclusion Practitioner
LBHF	London Borough of Hammersmith and Fulham
MoJ	Ministry of Justice
MOSAIC	MOSAIC Social Care Case Management System
NICE	National Institute for Health and Care Excellence
REDCap	Research Evaluation Data Capture system
SCORE 15	SCORE 15 Index of Family Functioning and Change
SDQ	Strengths and Difficulties Questionnaire
TIC	Trauma-Informed Care
TIC+	Teens in Crisis Counselling
T&R	Transition and Resilience programme
WSIPP	Washington State Institute for Public Policy
UH	University of Hertfordshire
VR	Virtual Reality (Software)
YEF	Youth Endowment Fund

Executive summary

The project

The Transition and Resilience (T&R) programme provided support to families, aiming to strengthen the home environment, empower families to make positive changes and improve children's behaviour. Schools referred 10- to 14-year-olds who were at risk of exclusion and showed evidence of antisocial behaviour (ASB), poor attainment or early childhood trauma to the London Borough of Hammersmith and Fulham (LBHF) Family Support service, which ran the intervention. Families were typically offered up to six months of support, usually for around one hour per week, delivered to the children directly in schools or at home. There were up to six components offered, including intensive support from an inclusion practitioner; group work and peer mentoring; 'Brain in Hand' (personalised support accessed via a phone or iPad that draws on cognitive behavioural therapy (CBT) to support children); counselling sessions delivered by Teens in Crisis Counselling (TIC+); mentoring delivered by Active Successful Engagement (ASE); and a virtual reality (VR) intervention that aims to improve children's decision-making delivered by Round Midnight. The components that were offered were tailored to support young people's specific needs and aspirations.

YEF funded a feasibility and pilot evaluation of the T&R programme. The feasibility study aimed to ascertain what factors supported or interfered with the successful delivery of the programme, whether the intervention's recruitment, retention and reach were feasible and what service users felt about it. Forty-six families participated in the intervention during the feasibility phase, and 15 participants (including eight professionals, four parents/carers and three children) took part in focus groups and interviews for the feasibility evaluation. The pilot study then aimed to describe the referral and screening process, assess family retention, ascertain the readiness for a larger scale evaluation, evaluate the implementation process and assess the direction and magnitude of changes in child behaviour and family-functioning outcomes over time. Seventeen participants (including five young people, five adults with parental responsibility, and seven professionals) were interviewed for the pilot, while quantitative data for a total of 89 families involved were analysed. Quantitative measures used related to the delivery of the programme (including data on referrals, screening and assessment processes), demographic data and some core measures [including the Strengths and Difficulties Questionnaire (SDQ), a measure of behaviour, and the SCORE 15 Index of Family Functioning and Change (SCORE 15)]. The evaluation was undertaken from February 2020 to May 2022. Both the feasibility and pilot studies took place during the COVID-19 pandemic, requiring both the delivery and evaluation teams to adapt to challenging circumstances.

Key conclusions
During the feasibility study, the COVID-19 pandemic and consequent social distancing measures had a profound impact on the project. The first lockdown prevented delivery and necessitated amendments to the original model of delivery. Recruitment was still effective. Family Support developed strong relationships with schools to facilitate referrals, and the referrals made by school partners were generally considered appropriate. It was clear that demand for the programme was considerably higher than the supply of places.
In the feasibility study, the small number of parents and children interviewed identified a range of benefits and improvements that they attributed to the programme These included supporting children's transition to secondary school and improving behaviour. Overall, these interviewees had a positive experience. Areas for improvement suggested by participants included extending the length of the intervention and more communication from the intervention team.
The pilot found that programme retention was satisfactory, with the programme reporting that 60% of families completed the intervention. However, measure completion rates were low, with only 49% of families providing data six months into the programme. Poor data reporting meant that it was also not possible to fully assess the referral process.
Despite changes caused by COVID-19, the programme was broadly implemented as intended and in alignment with the logic model. One change made during the feasibility phase was to remove the Brain in Hand, CBT-informed, personalised phone and iPad support, as this was not being used.

The evaluator judges that the T&R programme was not ready for a randomised controlled trial. Several issues would need to be addressed before proceeding to further evaluation, most notably improving data collection.

Interpretation

During the feasibility study, the COVID-19 pandemic, reorganisation and redundancies in the delivery team and social distancing measures had a profound impact on the T&R programme, preventing the delivery as originally planned. This was despite the intervention and its partners demonstrating considerable flexibility and adaptability in their approach, an important strength in its implementation. One of the main challenges identified in relation to engaging children during COVID-19 was their (typically limited) access to technology, devices and data. However, recruitment was still effective. Family Support targeted schools according to levels of deprivation and exclusion and developed strong relationships with them to facilitate referrals that were generally considered appropriate. It was clear that demand for the programme was considerably higher than could be met within the commissioned level of places.

In the feasibility study, the small number of parents and children interviewed identified benefits and improvements that they attributed to the programme. These included supporting the transition to secondary school; improving behaviour; children becoming aware of topics linked to bullying, gangs, knife crime, self-esteem and careers; and becoming more confident in expressing themselves. Overall, interviewees were positive about their experiences with the intervention. Evaluation participants' suggestions for improvement showed that they had faith in the intervention. However, they wanted it to last longer, and parents wanted to feel more informed about the activities being run with their children.

The pilot study suggested that programme retention was satisfactory, with the programme reporting that 60% of families completed the intervention. However, data completion rates were low, with less than half of families (49%) providing data six months into the programme. Despite changes that had to be made for COVID-19, the programme was broadly implemented as initially intended and in close alignment with the logic model. The evaluator also judged that families found practitioners to be approachable, accessible and trustworthy. Indeed, when interviewed, the few parents and children described having straightforward and easy access to practitioners, building relationships and bonds with practitioners and they emphasised the merit of a whole-family approach. However, it was clearly difficult for intervention staff to gain participant engagement in completing the core evaluation measures, particularly from parents/carers.

One change that was made during the feasibility phase was to remove the Brain in Hand, CBT-informed, personalised phone and iPad support from the programme. This specific element of the project was not widely used, particularly by younger children who did not generally have access to mobile devices. Similarly, schools would not permit the use of mobile phones during school hours. In terms of the core outcome measures, for children, the reported changes over time across various measures of behaviour and family functioning were positive. Very few parents completed the core measures, as outcome measurement collection was severely hampered by the COVID-19 pandemic. This evaluation was designed without a counterfactual group, so we cannot be confident that improvements reported by children were solely a result of the T&R programme.

The evaluators judged that the T&R programme was not ready for a randomised controlled trial. Several issues would need to have been addressed before proceeding to further evaluation, most notably whether data collection could be improved. Although the pandemic impacted the quality of data collection, even in these circumstances, the level of measure completion in this evaluation was low. YEF is, therefore, not currently proceeding with any further evaluation of the T&R programme.

Introduction

Background

This is a report of an evaluation of the Family Support T&R programme delivered within the LBHF. The T&R programme no longer runs, although the council has committed to taking forward learning from it (LBHF 2022) and does still run the Family Support Service. T&R offered support through trauma-informed and systemic practice (Centre for Systemic Social Work 2018) embedded within a signs-of-safety approach. It was an intensive wraparound project delivered in the borough, recruiting via school-based referrals.

Delivery included peer and professional mentoring, counselling, use of VR software, group work and one-to-one support. As the name of the intervention suggests, referrals were most concentrated around points when a young person would be expected to experience significant change. Major transitions would typically be between school years six and seven (approximately 11 years old), from primary to secondary education, but could also be between years nine and 10 (approximately 14 years old), from middle to high school and when studying for GCSE examinations. Points of transition may also include times of significant personal change.

Intervention

Family Support T&R advocated for and supported children. They intended to enable the progression of outcomes by understanding the family context and a child's basic rights (UNICEF 1989). The programme aimed to strengthen the home environment and empower families to make positive changes. Safeguarding and protecting children was fundamental to their service delivery. Whilst the focus of work stayed on the child of concern, they ensured that the pathway of support encompassed the whole family, considering all children within the family unit. The intervention was predicated on the understanding that each family has their own defining features, and the programme worked at points of prevention as opposed to crisis.

The intervention in context: the literature

Trauma-informed practice and research have become increasingly prevalent, particularly in relation to adverse childhood experiences (ACE) (CDC 2020). What a trauma-informed approach (TIA) means varies across implementations, but a useful way to conceptualise it and the principles at the heart of most trauma-informed care (TIC) are usefully summarised by the University of Buffalo Institute on Trauma and Trauma-Informed Care (2019). Essentially, rather than providing services to treat one or more particular aspects of trauma, TIA seeks to be engaging and accessible, thus intending to avoid worsening trauma by not acting in ways that would be harmful (University of Buffalo 2019). However, variance in how TIC or TIA are enacted reflects one of the challenges noted by NICE, which concluded that: "*There is very little evidence demonstrating measurable impact of TIC or TIA. The evidence that does exist is of a low quality and come*[s] *almost exclusively from the US"* (NICE Guideline NG116, 2018, p. 149). One year later, the NHS Long Term Plan clearly advocated TIA in the care and support of young people in the Health and Justice System (s12 p. 118, NHS England 2019). Despite this recommendation, there is still a limited systematic evaluation of TIC (Asmussen et al. 2022).

The wraparound approach was developed in the US. It is a holistic, family- or young person-centred approach designed to provide comprehensive support to a young person presenting with mental health and/or behavioural difficulties. A consensus statement on its operating principles was reached by the National Wraparound Initiative (Bruns and Walker 2008). The main principles centre on ways of working in

a family-centred, community-embedded way within multi-faceted, culturally aware teams. Wraparound has been shown to be promising and/or effective by the Washington State Institute for Public Policy (WSIPP) analyses (2020).

There is some evidence that mentoring can be an effective early intervention (Joliffe and Farrington 2008). The national evaluation of the Youth Justice Board Mentoring Schemes failed to demonstrate a reduction in offending behaviours; one of the resulting recommendations was that delivering mentoring to younger children who were at risk of offending may be more effective (St James-Roberts et al. 2005). The strength of the mentoring relationship seems to be critical to reducing reoffending. An international meta-analysis (Tolan et al. 2013) found stronger effects when mentoring meetings were in-depth and frequent, emphasising emotional support. More equivocal findings have been noted where mentoring relationships break down (Tarling et al. 2004).

Delivery

It was originally intended (before COVID-19) that delivery would be split between schools (60%) and Family Support premises (40%). Four cohorts were intended to run over the commissioned period, with 25 families in each cohort. Within each cohort, the intervention was designed to last for six months, although T&R managers indicated that it could be concluded early or extended if the need was demonstrated. Delivery relied on maintaining school and family commitment to the intervention. Various intervention components initially offered included a family practitioner intensively supporting the child and family; group work and peer mentoring; Brain in Hand (personalised support accessed from phone or iPad that was withdrawn during the feasibility phase); TIC+ counselling sessions (TIC+ n.d.); VR-based intervention (Round Midnight n.d.); and ASE Mentoring (ASECIC.org.uk n.d.) providing up to six support sessions at the end of the intervention.

All six elements of the intervention described above were intended to be delivered by the respective practitioners and organisations named, based on young people's presenting needs. All elements of the intervention would form part of the T&R offer but could be tailored and adapted to the needs and wishes of participants. An earlier T&R pilot had operated in Hammersmith and Fulham when the service had established links with local schools and services. Schools were thus selected based on local knowledge and an understanding of need developed by the T&R service. An integral element of the T&R intervention was the support offered by two intensive inclusion practitioners (IIPs) who had experience in working with vulnerable young people. This support was enhanced through the offer of additional input from the specialist providers (TIC+ counselling and psychotherapy, Round Midnight and ASE Mentoring).

Referral process

Referrals were expected to be from schools. Criteria for referrals included impulsive behaviours, ADHD, being aged between 10 to 14 years, having school attendance issues (e.g. being considered at risk of exclusion), experiencing early childhood trauma or demonstrating low educational attainment. In practice, T&R refined the application of these referral criteria and mechanisms as the project delivery progressed (see Findings).

Screening

Screening was conducted by T&R's two IIPs. The screening process considered the inclusion criteria below and general areas of need using the MOSAIC social care case management system.

Participant inclusion criteria

The inclusion and referral criteria focused on the following:

- The child's age (10 to 14 years)
- Risk of school exclusion
- Evidence of ASB, impulsivity and/or hyperactivity
- Low school attainment
- Early childhood trauma.

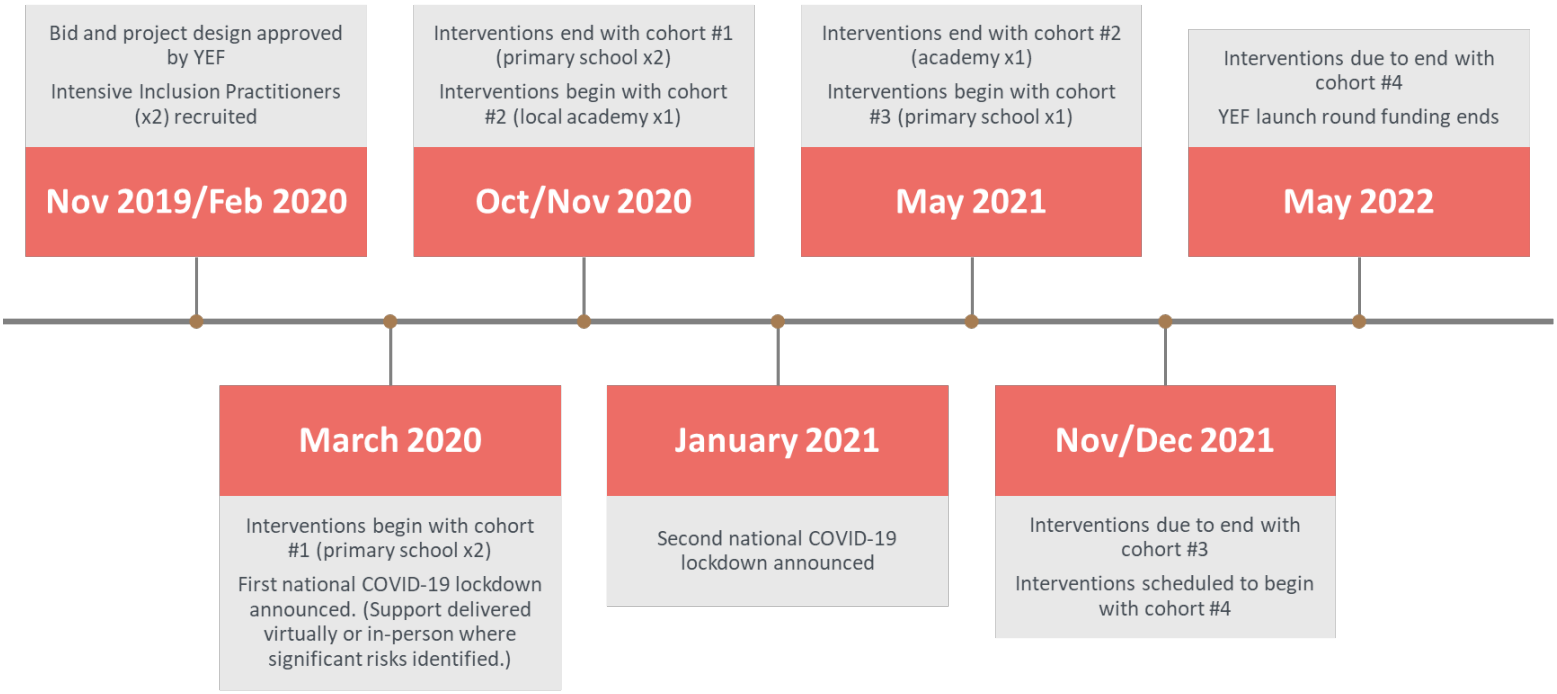
Behaviours to be addressed must have included at least one of the following: school refusal, regular absconding, violence, substance misuse, offending, defiant or severe oppositional behaviour, or harmful sexual behaviour. To be included in the intervention, children needed to be within the age range and meet at least one of these criteria. In practice, multiple criteria were usually met.

Exclusion criteria

The original exclusion criteria were stated as not meeting the inclusion/referral criteria outlined above. These were developed further during delivery to include pragmatic stances on matters that stakeholders may have felt would make it difficult to provide appropriately sustained intervention (e.g. if a young person was moved to a care placement out of the delivery area).

Figure 1: Key milestones and timeline for the Family Support Transition and Resilience Programme

Please note that this timeline incorporates extensions made due to COVID-19.



Sample size

Family Support T&R originally envisaged working with families of up to 100 young people in cohorts of up to 25 families. It was originally intended that these 100 referrals would be made by December 2020 and completed by autumn 2021, i.e. that there would be four cohorts over the duration of the YEF-commissioned delivery. Within the initial timeline for delivery, it was also intended that 25 families (one cohort) would be recruited during the feasibility phase. The programme had been previously pilot tested in two schools. It was intended that referrals would come from those schools and others across the borough as engagement was widened during programme delivery. The final evaluation sample sizes are listed below and elucidated further in the report for each phase.

As originally intended, four cohorts of T&R were delivered, but the final numbers of families who started the intervention were a little lower than envisaged, 89 rather than 100. Within the evaluation, for feasibility, 15 interviewees (eight professional stakeholders, four parents/carers and three children) participated in the assessment of the implementation process.[1] In the pilot phase, 17 participants (five young people, five adults with parental responsibility and seven professionals/stakeholders) took part in the assessment of the implementation process. For quantitative assessment, the entire dataset of 89 families was analysed.

Recruitment and follow-up

It was intended that the IIPs would engage with children and families for up to six months. Onward referrals could be made to mentors beyond that for up to 10 sessions. Following recruitment into the programme (t0), the clients were followed up for this evaluation at one (t1), three (t2) and six months (t3).

Aims and objectives

The overall aim for the feasibility and pilot evaluations was to investigate the potential for Family Support to improve children and young people's school attendance and offending outcomes. The outcomes listed below cover problem behaviour, emotions, trauma, family functioning and engagement in criminal behaviour.

Family Support objectives

- The main objective was to assess potential improvement in emotion, problem behaviour, family functioning, distress related to trauma and reduced engagement in criminal behaviour by the children involved in the programme
- To assess the potential effect size of the Family Support intervention
- 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 to deliver a larger-scale randomised trial.

[1] Please note that Family Support underwent multiple organisational changes during the feasibility assessment. As such, they had not uploaded monitoring data in time for the quantitative data audit during the feasibility phase, although they were using the measures articulated.

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 outlined below.

Primary outcomes

Psychological and emotional well-being:

- 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, McVie 2007) – sweep 3.

Adherence to Intervention

- Adherence to the intervention was assessed by recording attendance at therapeutic interventions and follow-up assessments. It is worth restating here that the intervention was tailored to individual child needs. So, presenting needs and developing complexity may have influenced which elements of the T&R programme were offered to any one child.

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. The use of qualitative interviews allows for an exploration of rich, in-depth information about interviewees' perceptions of T&R, but it is difficult to generalise from the findings. This is a limitation, as experiences reported may not be relevant to, or representative of, all stakeholders and service users involved with the project during either phase of the evaluation. Nevertheless, it provides insights that the quantitative research component would not have been able to uncover alone.

Family Support Transition and Resilience Programme – specific outcomes

One key short-term aim of the T&R programme is to keep young people engaged in school. This would minimise the opportunity for offending as well as maximise the likelihood of sustaining their education. By keeping children in school, there should also be fewer opportunities for others to exploit them or for them to become involved in criminal activity. Being in school can be seen as a form of incapacitation (see, for example, Bell, Costa and Machin 2021). Educational attainment gaps are also demonstrable between those school pupils who offend when compared to all other school pupils (Crosweller, Stafford and Bathgate 2022, drawing on DfE and MoJ data). The mechanisms by which differential offending outcomes occur are unclear, but early analyses (DfE and MoJ fig 11 p. 19 2022) indicate that both authorised and unauthorised absences from schools are particularly high among young people who offend.

T&R also articulated a range of longer-term outcomes linked to improved educational (reduced truancy and exclusions and improved attainment) and offending outcomes (fewer children subject to Youth Offending Orders). These outcomes are outlined in the Logic Model below (Figure 2), but they cannot be evaluated within this study, as most would be expected to occur beyond the delivery and evaluation timeline.

Figure 2: Logic Model: The Family Support Transition and Programme

Problem statement	To prevent children and young people from getting caught up in crime and violence by providing a positive experience of their school transition, particularly between years 6 and 7.		
Inputs	**Outputs**	**Short-term outcomes**	**Mid/long-term outcomes**
• IIP support • Group work • Peer mentoring • Brain in Hand mobile app • TIC+ counselling • VR software • ASE mentoring	Schools support children to access the programme. Families are engaged with the programme. Children access, engage with and complete a range of interventions offered by the programme.	Improvements (as measured using YEF's core measures) observed in relation to: • any emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour (SDQ) • quality of family life (SCORE 15) • levels of distress experienced due to traumatic events (IES-R and/or CRIES-8), and • self-reported delinquency (ESYTC).	Improved educational outcomes (e.g. reduced levels of truancy and exclusions, improved educational attainment). Improved offending outcomes (e.g. fewer children subject to a Youth Offending Order).
Impact	Improved educational and offending outcomes for project participants (reduction in Youth Offending Orders).		

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: Ethics 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 to 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. 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 potential participant was willing to take part, 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, and findings and data are anonymous where possible, confidential throughout, and where appropriate, depersonalised

or anonymised according to principles both of the General Data Protection Regulation (GDPR) and UK anonymisation network framework. Please see appendices B and C.

Data protection

The legitimate interest under which much of this evaluation proceeded rested on the fact that the intervention (and thus evaluation) seeks 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, UH is registered and fully compliant with the requirements of the 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).

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 backups) according to best practices.

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, YEF personnel or, where necessary, for statutory regulatory processes. Privacy notices and information about the routine monitoring data were provided by the grantee to their beneficiaries/service users.

Confidentiality

All data captured in the survey database remains anonymous to the evaluation team. Pseudonymity was achieved by providing each client with a randomly generated study 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 T&R team could provide the data required for the evaluation while maintaining a level of protection against disclosing clients' identities. The evaluators adopted a relatively routine way to do this, which is for the grantee to retain a key that allows the 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. As it was agreed that these studies will not be moving into an internal randomised control trial (where data might have been carried forward), there will be no need to unmask the data, as there is nothing to 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 the following:

1. factors that support or interfere with the project's successful delivery
2. feasibility of the project's recruitment, retention and reach, and
3. service users' experiences and views of the intervention.

Success criteria and/or targets

T&R had initially intended that 100 young people would have been enrolled by December 2020. During the feasibility phase, the project worked with four schools – three primary and one academy. By the end of the feasibility stage in August 2021, the project had completed its work with pupils in three of these settings, engaging a total of 46 children and their families. Work with cohort four was ongoing at the time of data collation for the feasibility study, feeding into the pilot assessment. Two key reasons for the lower numbers reported are that the feasibility fieldwork ended before the end of T&R's work with the first four schools and the impact of COVID-19 on delaying access.

Methods

Participant selection

The cohort was created via the referral and screening mechanisms outlined above. The four schools initially self-identified eligible pupils using T&R's referral criteria. Potential clients were then screened. If suitable and if families agreed, they were then enrolled. Based on initial projections to YEF and anticipated IIP caseloads with each school cohort, 25 children were to be recruited from each school.

For quantitative data, it was intended that the entire cohort would be analysed. For qualitative aspects of this evaluation, sampling was purposive for professional stakeholders and largely opportunistic for children and parent/carer interviewees, using the IIPs as gatekeepers. Family Support workers 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 invites that were sent following that initial approval to contact. Each parent who had agreed with their worker to be approached was contacted up to three times before being dropped from further contact. Referrers and stakeholders were also contacted by the evaluation team once initial consent for us to contact them had been obtained via T&R staff. Interviews and focus groups were run using video conferencing software and/or telephones.

Theory of change and logic model development

The theory of change was developed by the project at the time of applying for funding from YEF. Figure 2 (above) summarises a logic model subsequently refined with the evaluation team during the early part of the feasibility phase. Inputs and outputs were then tested during the feasibility and pilot phases of the evaluation. Shorter-term outcomes were assessed during the pilot phase. Mid/long-term outcomes are beyond the timeline of this evaluation, particularly in relation to whether or not the young people become

subject to a Youth Offending Order. T&R was an intervention that recognised additional stress and anxiety that children are likely to feel during points of transition. The intention was to develop resilience for a number of reasons, including for general well-being and improved family and school functioning. For young people, change was expected to operate through improvements in executive functioning skills. Developing executive functioning skills should lead to better cognitive functioning and emotional regulation. It could be expected that a young person's planning, self-control, organisation, working memory and time management might all show improvement.

Data collection

The Family Support T&R 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.

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. It had been intended that descriptive statistics would be utilised for feasibility evaluation and that inferential analyses would be conducted within the pilot phase. In this instance, both were carried over to the pilot phase.

It should be noted that the T&R programme 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. When schools were closed down, delivery within them immediately stopped. Even when they reopened for vulnerable pupils and children of key workers, schools were dealing with so many competing priorities that the importance of making referrals to Family Support was not always recognised. Additional challenges were faced by the T&R delivery team, as they were subject to changes in service organisation and resourcing within the council.

Evaluators, too, needed 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).

Data collection methods

Fifteen people participated in focus groups and interviews: eight professional stakeholders, four parents/carers and three children. Recordings were transcribed prior to being analysed thematically.

The majority of quantitative data collected[2] comprises either data routinely collected within the T&R programme or the specified YEF core dataset.

As far as possible, all identified quantitative data was collated by direct online entry to the REDCap system by members of the grantee team and stored securely on university servers. The evaluation team trained T&R staff on data collection and use of the REDCap online system.

Data collection, data entry and queries raised by members of the intervention team were dealt with 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 Family Support T&R). Once clients had been accepted into the intervention, the agreed core data was collected (t0), and follow-ups with the clients were indicated at one (t1), three (t2) and six (t3) months. It had been intended that feasibility data would be carried through to the pilot phase wherever possible. In this instance, the project had collated data but was delayed in uploading it, so data analyses for the feasibility phase are limited to the process data, not including quantitative findings (which were carried through to the pilot phase).

Evaluation data

Routine monitoring data

The evaluation was intended to comprise an analysis of aggregated and anonymised data collected by Family Support T&R relating to information about referrals to 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.

Key Demographic Data

As initially intended, Family Support T&R captured key client-specific and demographic data, including age, ethnic heritage, gender, relationship to other grantee clients and index of deprivation.

Core measures

The T&R programme did not use any of the core measures prior to being commissioned by the YEF. The measures listed below were agreed upon by the grantees, evaluators and YEF. Table 1 summarises the core measures.

[2] Although not reported until pilot

Table 1: Measures adopted by the intervention to facilitate evaluation

Measure	Purpose	Completed By:
Strengths and Difficulties Questionnaire, SDQ, (Goodman 1997)	Evaluates antisocial 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, this also assesses the impact of stressful life events	Young person
Edinburgh Study of Youth Transitions and Crime – sweep 3 (ESYTC) (McVie 2007) [Young Person completed]	A 19-item, self-report measure to assess young people's involvement in antisocial, potentially criminal behaviours	Young person

Please note that although the measures were implemented, they were not uploaded by the Family Support team in meaningful numbers until after the transition from the feasibility to the pilot phase. This was largely due to the challenges faced by the delivery team, particularly those arising from the pandemic, as articulated in the opening to the data collection section. Table 2 summarises the intended methods for the feasibility study.

Table 2. Methods overview – Feasibility

Research methods	Data collection methods	Participants/data sources (type, number)	Data analysis methods	Research questions addressed
Secondary analysis (carried forward to pilot, not separately analysed).	Routine monitoring data collected by Family Support (including core measures).	Those referred, screened and accepted to Family Support. Includes initial progress completing outcome measures.	Descriptive statistics.	RQ 1 & 2
Primary data collection.	Qualitative interviews.	Purposive sampling of professional stakeholders and opportunistic sampling of parents/carers and/or children accessing Family Support services.	Thematic analysis.	RQ 1, 2 & 3

Analysis

In the feasibility phase, T&R faced several additional challenges that meant that very limited quantitative monitoring data had been uploaded to the REDCap database. The records were carried over and are considered in the report of the pilot phase below. Findings for feasibility centre on the qualitative interviews. These were analysed using deductive thematic analysis, with key themes derived from the three research questions articulated above.

Timeline

Table 3. Timeline

Date Completed	Activity
07.02.20	Evaluation workshop initially intended to be for all grantees to share and develop learning during inception. This changed to a series of meetings and exchanges of materials between the evaluator and each grantee.
07.02.20	Ethics submission and finalised feasibility plan.
17.03.21	Database set-up and REDCap training completed.
17.03.21	Feasibility data audit.
16.12.21	Completion of feasibility analysis and preparation of slide stack (amended by YEF to delivery of draft feasibility reports).
28.02.22	Production of summary feasibility findings for Family Support.

Findings

Participants

Table 4. Participant recruitment to feasibility evaluation interviews

Group	Consents received	Interviews achieved
Adult (parent/carer)	7	4
Children aged 11–13	4	3
Professional stakeholder	8	8
Total	19	15

Table 4 indicates the number of potential and actual participants recruited by the evaluation team for the implementation process evaluation. Forty-six children with their families had been enrolled in the Family Support programme by this time, but the feasibility data upload process was hampered by funding, staffing and reorganisation challenges faced by Family Support through the feasibility phase.

Intervention feasibility

Referrals from the first school reportedly started in April/May 2020, and work was completed in the fourth school in May 2022 (see Fig. 1 above). Fieldwork for the feasibility phase was conducted between December 2020 and July 2021. An audit of the core measures collected by the project conducted on 5 March 2021 showed that data relating to 11 children had been uploaded to REDCap. The paucity of available quantitative data meant that quantitative analysis was postponed to the pilot phase. The feasibility findings collated here are drawn entirely from the primary, qualitative interviews.

Stakeholder perspectives

Referral, assessment and initial engagement

The Family Support service and a number of its stakeholders had worked in the borough for many years and had therefore established links with a diverse range of local services, schools and families. YEF's launch grant round funding presented an opportunity to develop, integrate and refine existing work. Interviewees considered local knowledge and existing relationships advantageous in identifying the most appropriate schools to work with for the YEF-funded project. Work during the feasibility phase, therefore, involved generating referrals via existing relationships with some schools alongside developing new links with other sources.

Referrals tended to be from more deprived areas within the borough, representing a varied ethnic mix. There were diverse needs identified across the referred cohort, including anxiety, autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). There were also specific vulnerabilities identified associated with the transition to secondary school, including concerns around personal safety and risks of grooming.

During the feasibility phase, there was a continued intention for the project to focus on engagement with both primary and secondary school cohorts. Levels of deprivation and exclusion rates were two key considerations for the project when selecting schools to target. Other important factors included identifying schools making requests to the local authority for support, referral rates to children's services and

intelligence or other reports indicating children were at risk of exploitation. Taking cross-borough referrals – where a child attended school in one local authority area but lived in another – was considered difficult and therefore avoided due to data sharing issues.

The referrals made by schools were generally considered appropriate. It was clear that demand for the project's services considerably outstripped supply:

> *"So we go in with the practitioners, with the school pastoral care, the head teacher, and they will have a list of children. Some of them came to the sessions with lists of like 50 kids … So we literally went through each young person … we had to make some of those tough choices"* (Stakeholder #3).

Given the levels of demand, the aim for referrers and the delivery team became to *"strike a balance"* catering to the range of needs being identified at referral. This necessitated additional exclusion criteria being imposed by the T&R team and other stakeholders (e.g. evidence of instability in care placements) in order to target support at those considered most likely to engage and benefit:

> *"We wanted to work with young people who were displaying … behaviours that we could support, rather than kind of trying to firefight with the young person through what is probably a very, very difficult time"* (Stakeholder #3).

The nature and extent of any ongoing engagement with other services also emerged as an important consideration when determining suitability, even when all referral criteria had been met. Stakeholders described how much early work was undertaken with both schools and parents to explain the nature of the project, answer their questions and offer reassurance to build and sustain trusting relationships. This involved attempting to break down potential barriers to engagement and addressing misconceptions about the project. Approaches included the production and distribution of project-specific materials, drop-in sessions, school assembly presentations and one-to-one meetings:

> *"We've got some really good relationships with the schools, but it was a different concept for them as well, so we really had to engage them … I went, and I gave a talk to the parents. Like a coffee morning with the leaflets making really clear what it is and what their involvement would look like and what … we would expect"* (Stakeholder #3).

One stakeholder commented that engaging parents in primary schools was easier than with secondary schools. Some initial *"teething problems"* were reported in securing timely parental consent for the first school cohort, with delays encountered when trying to reach parents. Few parents had reportedly declined an offer to engage with the project. Refusals were often attributed to prior (negative) experiences with services, concerns around confidentiality, the potential for social services involvement (and any stigma associated with this) and a sense that families simply felt *"overloaded"* because of pre-existing service contacts or the demands now being placed upon them by COVID-19:

> *"I think they're just apprehensive. They get fed up. People come in, you know, some of these families we're working with have had family support workers and social workers, and psychologists and schools, and people in and out of their lives for years for some of them, […] and it's like, 'Here we go again'"* (Stakeholder #3).

T&R adopted a modified assessment process from one used within the wider Family Support service – the MOSAIC social care case management system adapted for T&R-specific needs. This assessment considered a broad range of domains, drawing upon information from multiple sources, including parents/carers, social

workers, schools and children, and incorporated a risk assessment. After completing this assessment, practitioners reported that they aimed to identify and co-produce initial targets and goals for the child and (where appropriate) family:

> *"We also do a risk assessment, and we arrange an initial meeting where we sort of share what the goals are for the project, and then we establish some targets – basically that we then carry forward [goals] through regular meetings from then on – and agree how we'll work with the family. And the family sets goals as well … I think it's really important that we bring the family's views in from the start"* (Stakeholder #1).

Interventions and support delivered

There was an ambition and desire, through YEF's launch round funding, for the project to support children's decision-making and to develop an evidence base around 'what works'. A key task identified was to achieve a consensus between the project, school and young people on roles, responsibilities and expectations linked with the project. One ongoing challenge was to ensure – where possible – that schools would avoid suspending or permanently excluding pupils who were engaged with T&R.

> *"I think schools were not completely on board with us … We might be only working with the young person for three weeks. They might decide that this young person has, you know, done so many things wrong, and they want to exclude them. Three weeks was not enough time for an intervention to … really impact on that young person"* (Stakeholder #3).

One new element considered within the feasibility evaluation was to integrate VR within the project:

> *"… so many things have already been tried with young people, particularly* [the] *issue around youth violence, but there's so little evidence really that tells you what works and what doesn't work. And, you know, lots of things have been done before, and it's let's just try and do something different"* (Stakeholder #2).

Once accepted onto the project, each child was allocated to one of the IIPs. Different options and approaches were reportedly used to engage a culturally diverse population, including offering access to translation services. Matching children to practitioners based on gender was a further consideration that incorporated young people's preferences.

It could reportedly take some time to identify and understand the main aims or goals a young person was seeking to achieve through T&R. Common concerns highlighted by interviewees as being the focus of the intervention included confidence, self-esteem, school attendance, educational attainment and 'gang' issues:

> *"We get a little bit of information from the school on why they refer to us, and we kind of work with that without trying to put this idea into their head. But yeah, I think it takes a while … A lack of confidence is a massive thing. You know, self-love, it's not there. We have young people who are, you know, scared of gangs in their area and are afraid to go to certain locations. We have young people who are uncomfortable with their weight and their self-image … Often, they don't even know it until we start having these discussions, and then they realise, 'Yeah, I'd like to work on this'. Or some never say what they want to work on. We just sort of figure it out as the time goes on …"* (Stakeholder #4).

Stakeholders described how increasing levels of anxiety had become a focus of intervention during lockdown. Anxiety had been amplified by factors such as pre-existing health needs and concerns about the

consequences should they catch COVID-19; being isolated from wider social support networks by social distancing measures; financial insecurity (sometimes linked to redundancies and job losses); and problems accessing social support in a timely way. For some, this had reportedly been accompanied by increasing levels of self-harm and general mental health deterioration.

Largely consistent with initial intentions, the core elements of the project were described as one-to-one weekly support with the IIPs, access to various workshops, counselling support and mentoring. More intensive forms of support and intervention were offered, in conjunction with statutory services, to more children presenting with more complex needs and circumstances. Additional assistance was provided for schools via regular liaison with the assigned IIP.

For children, engagement with the project was intended to provide an opportunity to build a relationship with a dedicated practitioner over an extended period of time and the option to access counselling support. Given the levels of demand for these services and associated waiting lists, the latter was viewed as a considerable benefit.

One interviewee noted that stressing potential reductions in risk of exclusion rather than reducing violence was more appealing and appropriate when promoting the project to parents:

> *"I think some parents might run a mile or be quite upset if we contact them and said, 'Hi, we're doing a project about reducing youth violence, and we'd like to invite your child to participate'. So some of the language we use is a lot more gentler … about the risks of what happens to young people when they are excluded"* (Stakeholder #1).

Another commented that the key objectives of the project were to improve both child and family resilience with a view to reducing the risk of exclusion, facilitating a de-escalation of problems, and supporting the transition to Year Seven. There was recognition that the sequencing and timing of intervention are important in order to allow the IIP to build a relationship with a child and family before introducing other elements of support. This was also important to avoid overwhelming children and families with the level of intervention offered:

> *"Some families wanted to see* [us] *every other week as opposed to weekly because it was just, there's too much going on and too many people contacting them. So, they'll have counsellors or external agencies that will also* [be] *working with the family, and it would just sort of get too much. It will bombard them a bit too much"* (Stakeholder #4).

Home visits by the project team were constrained by COVID-19 guidance. In cases where safeguarding issues were prominent, these visits still happened "using extreme caution" (Stakeholder #4). As social distancing measures began to ease in June 2020, opportunities emerged for more face-to-face sessions in non-school settings (e.g. a community centre), focused on supporting Year Six children about to make their transition to secondary school, though not all families were keen to re-engage with services on a face-to-face basis following lockdowns.

Stakeholder interviewees reported that some families had sought a more explicit focus on improving educational attainment, drawing on project support, rather than an emphasis on broader well-being and emotional needs. These families had pushed back on and resisted the offer of home visits (see also service user perspectives below):

> *"With this cohort, the family were happy because we were at the school, and it all took place at the school. The first cohort, we had resistance with home visits and that sort of connection to social services or the local authority and that, and they don't like that"* (Stakeholder #4).

Stakeholder interviewees stressed the importance of involving the schools and parents in conversations regarding issues being identified, goals achieved and ongoing needs as young people transitioned to secondary school:

> *"We had arranged 'team around family' meetings at the end with all the Year sixes with their primary school, the secondary school, parents and us so that we could establish what we were going to do moving forward. This was incredibly helpful, I think, because it just sort of highlighted the support that we had offered and what support needs to be continued"* (Stakeholder #4).

Not all parents or carers were fully engaged at all times, especially where there was parental conflict. In some instances, older siblings served as the link to the family:

> *"We have to kind of work within the family system to a certain point and find the way that works … in any given family situation"* (Stakeholder #1).

Throughcare and aftercare support

Ensuring that any changes observed during the project are maintained by children and their families once the intervention ends was important for the project's medium and longer-term goals. ASE Mentoring was seen as being an integral component of the project, and a three-way meeting was scheduled between the IIP, mentor and child at the end of the six-month period of contact. This was offered to all participants and was universally seen as a particularly effective form of throughcare. It was also seen as a useful additional resource for schools, one that they could potentially access for other students beyond T&R:

> *"As we close, we pass on to them, and they do some more specific work with young people … And so just provide that ongoing support because a lot of the young people are really vulnerable at the moment because there's so little opportunities for them outside of school … we have the opportunity now to help them engage with other things that might be really beneficial"* (Stakeholder #1).

Implementing YEF's core measures

A review with families and professionals occurred every six to 12 weeks to ensure progress towards agreed goals. The project sought to facilitate the 'team around the family' meetings involving children, parents and other services in order to review progress and adjust goals. There was recognition of the potential role of the core measures within this process, but there were numerous pressures on time, availability and resources that could hamper these efforts:

> *"Like parents are working full-time. There might be single-parent families. I've got some parents who are full-time carers to profoundly disabled siblings. Some carers, you know, or full-time parents to younger children. So, there are lots of barriers. Schools are definitely busy as well, and so are other agencies"* (Stakeholder #4).

There was an emphasis on ensuring project participants were clearly informed and understood why data relating to the core measures was being sought:

> *"When people start talking about data* [they] *switch off a bit sometimes. So, it's just being really clear about why that's really important … It's how it's pitched, isn't it? And it's that relationship that you have with that particular child or family … because I think the data then that you get back is much more accurate and richer"* (Stakeholder #2).

One interviewee was open-minded about the use of the YEF-specified core measures – especially the extent to which they could be used as a supplement or serve as an alternative to MOSAIC. Another interviewee was concerned that the self-report delinquency questions may identify or generate safeguarding issues that raised questions about how disclosures may be managed. Other elements may be difficult for children and parents to answer or be 'uncomfortable'.

Accuracy and reliability of responses where core measures were implemented by a practitioner versus directly entered by the service user onto a tablet device were indicated to have been potentially problematic:

> *"Then there's that Catch-22 situation in terms of how honest are they going to be if they answer your questions when you ask them, or if they're doing it on their own … We obviously monitor what they say because they are also very smart. They know when they should or shouldn't be saying things and what might happen if they do disclose certain information"* (Stakeholder #4).

For another stakeholder, engagement with the core measures still remained something of an unknown quantity midway through the project.

Service user perspectives

How families heard about the project and why they agreed to engage

All parents recalled having first heard about the project through the school, which was offering new starters support during the transition to secondary school. The initial materials provided were considered to have been both clear and useful; however, two interviewees seemed unaware that the support would have been linked to the project's referral criteria:

> *"I don't know what their criteria were for who and why, but I just assumed it was something they offered to all new starters"* (Parent #1).

> *"I saw a leaflet on the desk at school with my name on it. I asked the teacher about it and gave it to my dad … I was just going along with it because I was happy to, but I didn't really know what it was all about"* (Child #1).

Families agreed to engage with the project for different reasons. One parent reported that they had liked how participation in the project was optional but that the child had initially been worried about being labelled *"a bad boy"* with behavioural problems. This prompted a discussion involving the school and project to reassure the child that their attendance was voluntary and withdrawal was possible at any time. This parent recalled the child subsequently being *"over the moon"* after attending the first session and continued attending the project for another six months.

Another parent interviewee described how their daughter had reached a crisis point at school behaviourally, which prompted them to reach out to the school for support. Subsequent contact with the project was considered to have been prompt within two or three weeks of the initial contact with the school, and all

forms of assistance were welcomed by the parent. The hope for both parent and child was for the project to offer an outlet to discuss concerns and manage feelings and emotions.

One parent recalled how their child was attracted to the project because of the support it offered around issues linked to risks of involvement in crime, dealing with peer pressure, managing the transition to secondary school and the offer of access to workshops and out-of-school activities. Another parent was keen for the project to help build her son's confidence and self-esteem and also to support him in his transition to secondary school. One child reported having no concerns about engaging with the project and found it appealing that most of the support would be delivered in school, whilst a parent remarked that their interest in the project was piqued by the support for their child through the cultural changes during the transition to secondary school:

> *"You're getting away with a lot more in primary. You know, certain protocol and procedure in secondary that you wouldn't have to do in primary, and that all does affect the child's learning if they're not comfortable"* (Parent #1).

Families' views on the support provided

Families offered their views on the nature of the support provided and highlighted how it was experienced. The focus of the intervention was described by child interviewees as wide-ranging, centred on managing the transition to secondary school and longer-term aspirations and goals. One child reported no differences between the work of the T&R team and that of ASE, but another drew a clear distinction between the focus of the work with IIPs (which explored anti-bullying, careers and activities) and discussions undertaken with ASE Mentoring (which appeared to address issues like violence, knife crime and gangs in greater depth).

> Q: *"Did they talk about things like keeping out of trouble or worries about knife crime and violence?"*
>
> C: *"Err,* [ASE Mentoring] *and them are talking about it, but* [the IIPs] *didn't mention it a lot … It was mainly careers and like anti-bullying and stuff. I really liked talking to them about it … I think* [ASE Mentoring] *are mentioning knife crimes and stuff, and they are mentioning about 'be positive about yourself'. I'm finding it good. We watched this video about a kid that was in knife crime and gang violence, and then they really showed us, like, what would happen if you go down that path"* (Child #1).

Two children reported completing some group-based work with another child in their year group but that most of the contact involved one-to-one work with the IIP and mentor. Another child interviewee recalled only having one-to-one contact (not group work) once a week, at school, for about an hour. This respondent seemed equally comfortable with either online or face-to-face forms of contact. Shorter, 20- to 30-minute sessions were also considered sufficient and appropriate; one child stated, *"I felt like I didn't need much more"* (Child #2). Intensity and frequency of contact (i.e. weekly for up to an hour) were also considered appropriate by parents, although one parent suggested that more contact could perhaps have occurred outside school hours.

Parents described how the support had been largely restricted to online and in-school settings. They did not recall that home visits had been offered, and some expressed scepticism about the value or convenience of this type of input:

> *"I don't remember that being offered. It depends what they're doing. If they're just talking to him, then maybe not because they could do that online"* (Parent #1).

> *"Not really home visits. At school works well because it's not gonna fit in at home. I have another child"* (Parent #4).

Parents reported having the option of speaking with practitioners during the weekly online sessions, either via MS Teams or WhatsApp. While the content of sessions remained confidential, parents indicated that they felt informed about the support given and progress being made and that they could raise their own concerns. This was reassuring, as parents could build familiarity with the practitioners and be updated on their child's participation:

> *"Everything was straightforward. It just told you what they were gonna work on, the different activities they're gonna do. Yeah, so it was fine. They explained everything on there. I got the email, and I had the leaflet. And also, I would receive phone calls throughout the time he was with them, basically about what was going on.* [The IIP] *always called me"* (Parent #4).

> *"I used to raise my concern if I was worried about a subject, and they were telling me, 'OK, next session, I am gonna make sure that I talk with him and have a good conversation'. So, I had good feedback from the mentor"* (Parent #2).

The support offered by the project was primarily aimed at the referred child rather than being more broadly focused on other family members, although other siblings were offered assistance:

> *"That was perfect because I was trying to do as much as I could as a parent on my side, but I felt like that extra support definitely did help"* (Parent #3).

> *"[The IIP] told me about a course that my elder son was able to join, and he did. So they did offer support to the rest of the family"* (Parent #4).

None of the interviewees reported any experiences of completing the core measures, but it was not always clear whether they had been *asked* to complete them:

> *"The only paperwork I filled in, I think there were two consent forms"* (Parent #4).

One parent commented that the six-month T&R contact period could have been longer and considered it *"a shame"* that the relationship with the IIP had to be transferred to ASE Mentoring:

> *"My son used to love that mentor. Six months … I think the period is short. By the time they have that relationship with the mentor, they have to change it to another project, which is a shame. But I was happy with the mentor, my son was happy with the mentor. Even my son was saying, 'Why do they have to change to have another mentor?' It's a shame"* (Parent #2).

Other interviewees stated that contact with the project was extended, and the handover with ASE Mentoring was generally considered to have been a well-managed, positive experience. The 'open door' offer of ongoing support was also reassuring, and parents were grateful for the offer to 'look out' for the child going forward:

> *"[The mentor] said if I needed to, I could call and talk to them anytime"* (Child #2).

> *"She had two mentors … the first had their time and moved on but replaced their services with* [named mentor] *… I* [knew] *it was going to be for a limited amount of time, I think they initially said six months, but it went on longer than that because it was for the whole [academic] year. […] I feel like with that, I'm quite satisfied that if I do need support, I'm able to contact them, and they've made*

themselves available for that. So, I do feel comfortable in terms of, if there's any risk, I know what to do, and I know that it'll work" (Parent #3).

In contrast, a different parent (Parent #2) commented that they had no communication or contact with ASE Mentoring, while another (Parent #4) felt this could perhaps have been longer, given disruptions related to COVID-19:

> *"I've never heard from the mentor, which is crazy. It's just my son will come and say, 'OK, I've seen him today', but I don't have his contact number, I don't even know the name. I've got no clue, which is crazy"* (Parent #2).

> *"He went to another service, ASE Mentoring, but that also was short-lived as well. It didn't last long neither. COVID has just ruined everything because sometimes they just couldn't do all of the sessions because, I don't know, COVID issues"* (Parent #4).

The impact of COVID-19

COVID-19 and associated social distancing measures had a profound impact on the project, leading to reorganisations, redundancies and, with the first lockdown, a full move to remote/online delivery, gradually including school-based work again as it became somewhat possible. Therefore, the operating model – as originally envisaged in the proposal to YEF and outlined in the intervention section above – had not been delivered as intended. These challenges were compounded by children, teachers and project staff having to self-isolate and the continual disruption caused by this uncertainty. Stakeholder interviewees reported *"real struggles"* (Stakeholder #8) and significant disruption during the first COVID-19 lockdown at such an early stage in the programme's implementation, particularly in terms of the impact on engaging and working with schools and families. This period was consistently seen as a steep learning curve, but one during which important lessons were learnt:

> *"I mean, it's not how we envisaged it at the beginning. But, you know, we've just had to adapt really because of COVID … what we had in mind in the beginning and what we've sort of ended up with are a bit different"* (Stakeholder #2).

The intervention established a steering group at an early stage to ensure oversight and regular communication between the different partners. There were, however, problems convening and maintaining the steering group following the first national lockdown in March 2020.

The capacity of schools to engage was also constrained by COVID-19. The scope to engage with the project was diminished by the focus of schools on switching to and delivering remote forms of learning, leading to delays in securing and agreeing upon approvals that impacted the continuity of the service offered to some students transitioning to Year Seven. Even as the country began moving out of lockdown and things started to reopen, it was very difficult to gain access to schools for the IIPs to have a consistent, physical presence.

Staff sickness and self-isolation requirements also had persistent impacts on delivery throughout the feasibility stage when project managers and staff reported feeling as though they were in a *"perpetual state of firefighting"* (Stakeholder #2). This disrupted timelines and required additional adaptations; specifically, some forms of intervention switched from weekly to fortnightly contact, and the input offered by TIC+ counselling was increased. These changes were made to ensure the needs of the young people were being met and regularly reviewed.

Remote engagement and the completion of virtual assessments could be challenging:

> *"At the moment, I'm doing them because I'm in isolation; I'm doing them virtually. So I find, definitely, you know, some parents actually don't have the time, or they might be sharing things that … are quite upsetting for them … It would be a lot nicer to be able to go and meet parents face to face and do that* assessment" (Stakeholder #1).

One of the main challenges was children's (typically limited) access to technology, devices and data. Digital poverty was recognised as a major barrier to engagement during lockdown for some young people who may already have been struggling to attend or attain at school, where home environments may not have been conducive to learning (e.g. because of restrictions on space or noise). Setting up and ensuring access to devices was time-consuming and not always straightforward:

> *"I got some loan phones for some young people that came about a SIM card that had WhatsApp enabled so that we could do calls … We helped apply for the government laptops …* [but] *… the delay getting them meant that they had been without it* [for nine months]*. Some families really struggled … I had to go around and help set them up … so it took a bit of support from us, but hopefully, you know, they're going to be really useful going forward"* (Stakeholder #1).

Engagement with young people themselves had also been diminished during periods of lockdown. Project staff co-ordinated their efforts with both families and other services so as not to overburden young people, particularly when they had been asked by schools to be online for the equivalent of almost an entire school day:

> *"Come three or four o'clock, they just don't want to do it, but it's about trying to be creative in how we engage them … It might take us a few more days to reach or get to speak with a family, but practitioners are persistent as well, so we can usually get families to engage at some level"* (Stakeholder #8).

Despite various adaptations being offered and implemented in response to social distancing measures, some families opted out of virtual or remote forms of contact. For those that opted in, there was some concern expressed that the quality of subsequent engagement suffered. Privacy and confidentiality issues were highlighted as concerns for some young people, and ensuring children were ready and available online at designated times also presented challenges:

> *"It's not the preferred option for a lot of children who prefer that physical face-to-face counselling … but that means that sometimes the engagement isn't as robust when it's remote. It just isn't"* (Stakeholder #2).

Some activities had to be adapted or postponed indefinitely by the need for social distancing and the inability to engage in them remotely. Other aspects, like the proposed use of VR, also had to be curtailed. Where it could be used, however, VR was considered a powerful tool for helping children work towards agreed goals:

> *"We managed to do it in August. We had … safety measures in place. You know, the room was laid out, and each young person was assigned the numbered headset. They had a number there on a desk … We managed to deliver it safely, and I think it's one of the best bits of what we do … This is like a one-off where we got as many of the 22 as we could in that room for a day"* (Stakeholder #1).

Unintended benefits arising from social distancing measures

The lockdowns and social distancing could have heightened families' sense of social isolation, yet professional stakeholders noted that some children had demonstrated improved resilience:

> *"What was interesting is a lot of young people who could still attend school, either because their parents were key workers or because they were particularly vulnerable, reported that 'I love school now … Now that I've had that time in a smaller class with less distractions, less pressure, I can do it'"* (Stakeholder #1).

It was also noted that with the switch to virtual and online forms of delivery, levels and frequency of contact with some parents had increased:

> *"An unexpected positive from COVID is that we've been able to step up our game with the connection and the communication with the parents because we've had to call them more often than we would normally if we were just to go into a school. So, it's made them more comfortable to hear from us and to see us"* (Stakeholder #4).

This was mirrored by some of the parent interviews. Although COVID-19 restrictions curtailed face-to-face meetings with project staff, at least some children adjusted well to the mixed form of engagement:

> *"I just allowed him to answer his phone – take the call, and do whatever they need to do. And he enjoyed that. You know, because it's his bit of privacy, so he can talk about whatever he wanted to talk about"* (Parent #4).

The project was also required to find new ways of engaging and working with partners and services, and this reportedly accelerated progression towards the use of online working and intervention. All project partners were reported as showing considerable flexibility and adaptability in delivery in response to pandemic-related restrictions:

> *"The partners have thought about different ways to do things, so it was kind of innovative as they've gone along. That's been the kind of positive to take from COVID and lockdown: the way that the providers have responded. They've been adaptable. None of them have let us down. You know, if we've needed training, they're phoning us and saying, 'We can't obviously do it physically. What can we do instead?'"* (Stakeholder #3).

What worked well during the feasibility phase?

Stakeholders

Interviewees described how the project needed to *"hit the ground running"* and had successfully delivered training on the use of different systems and aspects of the intervention at an early stage in its delivery. Flexibility in adapting the model to changing circumstances was viewed as an important strength of the project during the feasibility phase. An example of this included extending the length of support offered to the first cohort of Year Six students to ensure they received ongoing support once they had transitioned to Year Seven.

Arrangements were considered to have been most effective when the IIPs had been integrated into schools and given full access to space and resources that enabled them to deliver the intervention. Although having a dedicated, private space within the school setting was important, securing this could be a challenge,

according to two stakeholders. The relationship built with schools was seen by stakeholders as one of the key strengths of the project that allowed it to effectively engage with them (during a uniquely difficult period) about vulnerable pupils and support their transition to Year Seven:

> *"I'm glad that we were able to deal with the respective schools about their transition and really give them a good picture of this young person that, you know, this is what works for little Johnny.… You know, we can't control what the school do, but we can at least try and sign off on a good footing* [because] *those first experiences make a big difference for a young person"* (Stakeholder #3).

Other perceived strengths of the project included the clear model that it offered and delivered, combining one-to-one support, workshops, counselling and mentoring, and the close involvement of the local authority (including buy-in at a senior level), which was seen as a positive development for enhancing the project's ability to upscale and ensure some potential for longer-term sustainability:

> *"I think that adds so much just to conversations I'm having with families with young people and their teachers. I think it's added so much value"* (Stakeholder #1).

The IIPs were seen as skilled and dedicated practitioners who deftly co-ordinated the various parts of the programme, offering children and their families integrated support that might have been otherwise difficult or impossible to access.

Finally, a celebration event – added to the delivery to mark the 'graduation' of the first cohort – was seen by one stakeholder as a powerful demonstration of the children's increased resilience, who had come together in difficult circumstances and as a diverse group, to celebrate their achievements:

> *"Because actually six months ago, I don't think it would have been like that and how they have responded to adversity … It's all about negotiation, disappointment; things going wrong, things going right … That for me is the bigger picture: that things are not always going to go well, but what are you going to do about it?"* (Stakeholder #3).

Families

One very positive parent reported they had seen "huge differences" in their child, who became "more settled in school" and received fewer detentions, which they attributed to the mentoring support. For one of the child interviewees, the support helped them be more considerate of others and to reflect on the impact of their behaviour:

> *"I think it was just kinda learning to take other people's perspective into consideration and learning how the way I react will affect the way they react to me"* (Child #2).

Another child realised benefits from the opportunity to discuss and consider a broad range of topics with the project, such as "anti-bullying and career", how to "get out of gang-related violence" and "be positive about yourself" (Child #1).

Parents commented that their children enjoyed the weekly one-to-one sessions (and the children confirmed this), had derived benefits from them and that there had been an improvement in their behaviour over time. Clearly, some children may find it hard to discuss any issues or anxieties at home or with school staff. To the parents, part of the value of the project was that it gave their children a chance to express themselves openly in a safe and neutral setting:

"It's during school, so he sees it as just another part of the school day, and it's once a week. It's not something it talks about … but generally, it's good. He says he enjoys it, and I ask him, 'What do you feel you're getting out of it? Does it make understanding school or being in school any easier?' And he's said, 'Yes, it has'" (Parent #1).

One parent, in particular, recalled how the project had intervened and advocated on their behalf over a disciplinary matter at school. This intervention was appreciated by both the parent and child and seen as one highlight of their contact with the project:

"[The child] *had gotten into some trouble at school, and school were trying to discipline him, but it was unfair what they were doing. And I told* [the IIP] *what school were doing, and even though I made my concerns clear to the school, because they wanted to put him into another school for like a week or so, and I made my concerns clear that that's not going to happen. So* [the IIP] *sent an email to the head of year and head teacher raising these concerns, and hey ho, they came back and said they had a re-think about it"* (Parent #4).

Lessons learnt: Stakeholders and families

Implementing new projects necessitates an element of risk and a willingness to learn through innovation. The project offered the Brain in Hand application (app) during the feasibility phase. This is a CBT-based app to support children in building their executive function, with a focus on decision-making, reducing anxiety and offering support at crisis points. In total, 40 licences were commissioned for the project, 29 referrals received and 19 licences activated. Almost all activations related to the first cohort engaged by the project. There was gradual recognition that, for a range of situational and practical reasons, this specific element of the project was not being widely used. This was largely due to parents – particularly of younger children – being reluctant to encourage children to have access to mobile devices, whilst schools would not permit the use of mobile phones during school hours.

In Spring 2021, the Brain in Hand team took the decision to refund the second half of its Year Two allocation and step away from the project. Despite this, the support offered by the service was acknowledged by a number of professional stakeholders as having therapeutic benefits, and a small number of children did use, engage with and benefit from this particular element of the project. There was recognition, too, that aspects of the intervention, especially when linked to the use of mobile devices, should be targeted at an older age group and be context appropriate.

One potential proposed area for expansion raised during fieldwork included consideration of undertaking developmental work with pupils in Year Five, meeting the referral criteria, to prepare them for the transition to secondary education. Opinion was mixed on whether this was an appropriate age group to target. Some stakeholders suggested that offering support to a smaller number of students referred from a wider range of schools might assist with ensuring that "*we actually get in young people who need the support that we're offering*" (Stakeholder #3).

The culture, ethos and working practices in schools can vary considerably, and it was noted that ways of working may need to be adapted accordingly. One stakeholder referred to the potential for T&R to support schools in delivering more TIAs and embedding these principles within their ethos:

"I think it is a capacity issue. I would think it's a cultural issue too because I pick up on some of the language … that they use … it's not very child friendly, shall we say … it's pretty much the opposite of

trauma-responsive school behaviour really, […] but they need a lot of support to change the way they work with children and young people" (Stakeholder #2).

Reducing the frequency of face-to-face contact to fortnightly or identifying smaller cohorts to work with more intensively were other proposals put forward for enhancing the effectiveness of the project. There appeared to be an appetite among some schools to offer a considerably longer intervention period (i.e. up to 12 months) for certain children and families; this was also echoed by some service users. However, there was also recognition that an intervention of this duration and intensity may not appeal or be appropriate for all. There was a call to embed more reflective organisational learning. The scope for this had been hampered during the feasibility phase because of the upheaval caused by COVID-19. Going forward, one suggestion was that the programme better stagger delivery of the different elements, minimising the risk of activities being skewed towards the latter stages of the intervention. Another interviewee stressed the importance of ensuring that there are dedicated resources available to support monitoring and data collection linked to the intervention's activities:

"I think I would really like to have somebody to, even if it was just sort of a part-time person, to work with us around all the data; so getting that really nailed down. Because I think a part of the problem is the time factor because we're all kind of doing a full-time job, and then on top of this, we've got the project as well … I would cost in a dedicated element on that. Even if it was just … 15 hours a week or something" (Stakeholder #2).

Generally, family experiences of the intervention had been positive, and it was often difficult to identify or propose areas for improvement:

"I think overall it was really good. I wasn't sure what to expect, but they did meet my expectations – if not more, in terms of it worked for the reasons I asked for it and how it changed [my child]*"* (Parent #3).

Where suggestions were put forward, these tended to focus on the need for longer periods of intervention being offered by the programme for at least some children and families. One child interviewee suggested a greater focus or emphasis on knife crime and gang-related issues "*and stuff that* [ASE Mentoring] *is doing"* (Child #1). One parent suggested that there could be more communication from and involvement with the project, a clearer understanding of the issues and approaches being used and an opportunity to sit in on some of the sessions in order to better understand how, as a parent, the issues being discussed might be addressed at home.

Logic model development

As can be seen in Figure 3 (below), a slight rejig to the logic model was made to remove Brain in Hand before moving forward to the pilot phase of the evaluation. In all other respects, the logic model was unaltered.

Figure 3. Theory of Change: The Family Support Transition and Programme

Problem statement	To prevent children and young people from becoming involved in crime and violence by providing a positive experience of their school, particularly in transition between Years 6 and 7.		
Inputs	**Outputs**	**Short-term outcomes**	**Mid/long-term outcomes**
• IIP support • Group work • Peer mentoring • ~~Brain in Hand mobile app~~ (withdrawn after 2021) • TIC+ counselling • VR software • ASE Mentoring	Schools support children to access the project. Families are engaged with the project. Children access, engage with and complete a range of interventions offered by the project.	Improvements (as measured using YEF's core measures) observed in relation to: • any emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour (SDQ); • quality of family life (SCORE 15); • levels of distress experienced due to traumatic events (IES-R and/or CRIES-8); and • self-reported delinquency (ESYTC).	Improved educational outcomes (e.g. reduced levels of truancy and exclusions, improved educational attainment). Improved offending outcomes (e.g. fewer children subject to a Youth Offending Order).
Impact	Improved educational and offending outcomes for project participants (and fewer Youth Offending Orders).		

Conclusion

Table 5: Summary of feasibility study findings

Research question	Findings
Q1 – What factors support or interfere with the intervention's successful delivery?	COVID-19 and the social distancing measures introduced in response to the pandemic had a profound impact on the intervention, leading to reorganisations and redundancies. The operating model – as envisaged in the original proposal to YEF – had not been delivered as intended due to the adaptations required in response to the various COVID-19-related restrictions imposed from March 2020 onwards. One of the main challenges identified in relation to engaging children during COVID-19 was their (typically limited) access to technology, devices and data. The quality of engagement was widely perceived to have suffered once virtual and remote forms of intervention were implemented.
Q2 – Are the intervention's recruitment, retention and reach feasible?	The relationship built with schools was considered one of the key strengths of the project, allowed it to effectively identify vulnerable pupils and support their transition to secondary school. The referrals made by schools were generally considered appropriate by the Family Support T&R team. It was clear that demand for the programme's services considerably outstripped supply, as schools would often generate a larger pool of referrals than the intervention had the capacity to engage. However, it was not possible to assess retention, quality or completeness of routine monitoring data or the YEF-specified measures within the feasibility phase. The decision to move to the pilot and the decision for these assessments to be made as part of the pilot evaluation itself were made by the commissioners.
Q3 – What are service users' views and experiences of the intervention?	Parents and children identified a range of benefits and improvements that were attributed to the project. Overall, the experience of the intervention had been a positive one for service user interviewees, but with several suggested areas for improvement being proposed (e.g. longer periods of intervention being offered by the project for at least some children and families and more communication from and involvement with the project).

Evaluator judgement of intervention feasibility

During the feasibility phase, T&R had successfully engaged with four schools – three primary and one academy. By the end of the feasibility stage in August 2021, the project had completed its work with pupils in three of these settings, engaging 46 children and their families. Work with cohort four was ongoing.

The frequency and intensity of the contact (weekly for up to an hour) offered by the intervention was generally considered appropriate by parents, given concerns about the potential adverse impact of any increase on class attendance. Parents and children identified a range of benefits and improvements that they attributed to the project, including the children being more:

- settled in school and experiencing fewer detentions
- considerate of others' views and reflective about the impacts of their behaviours
- aware of topics linked to bullying, gangs, knife crime, self-esteem and careers
- confident in expressing themselves openly in a safe and neutral setting, and
- willing to reach out to the project, which had successfully intervened and advocated on behalf of the child and family.

Interviews with professional stakeholders highlighted several issues and recommendations for future development, including:

- offering support to fewer children, referred from a wider range of schools
- reducing the frequency of face-to-face contact to fortnightly or identifying smaller cohorts to work with more intensively
- ensuring a sharper focus on embedding more reflective organisational learning within the project, and
- revising the project model to ensure that delivery of the different elements could have been better staggered.

Overall, the experience of the project had been a positive one for family interviewees, and it was often difficult for them to propose areas for improvement. Where suggestions were put forward, these included a focus on perceived needs for:

- longer intervention provision for at least some children and families
- greater emphasis on knife crime and gang-related issues
- more communication from and involvement with the project
- a clearer understanding of the issues and approaches being used by practitioners, and
- an opportunity for parents/carers to sit in on some of the sessions between practitioners and children (to develop their understanding).

Interpretation

COVID-19 and the government guidance had profound impacts on the project, leading to reorganisations and redundancies. The operating model had, therefore, not been delivered as intended. There was a

significant disruption during the first COVID-19 lockdown, at such an early stage in the project's implementation, particularly in terms of its impact on engaging and working with schools and families. These challenges were compounded by children, teachers and programme staff having to self-isolate and the continual disruption caused by this uncertainty. One of the main challenges identified in relation to engaging children during COVID-19 was their (typically limited) access to technology, devices and data. The quality of engagement was widely perceived to have suffered once virtual and remote forms of intervention were implemented. This was despite the intervention and its partners demonstrating considerable flexibility and adaptability in their approach and recognition of the importance of their flexibility in adapting the model, an important strength of T&R during the feasibility phase.

The core elements of the programme included one-to-one weekly support with IIPs, access to various workshops, counselling support and mentoring. ASE Mentoring support was offered to all participants and was universally regarded as a particularly effective form of throughcare and aftercare once work with IIPs and other elements of the intervention had been delivered. Some VR work was delivered and continued into the pilot phase. However, by spring 2021, the CBT app, Brain in Hand, was withdrawn.

Levels of deprivation and exclusion rates were two key considerations for the project when selecting schools to target, and referrals made by schools were generally considered appropriate, albeit at a higher rate than the intervention's capacity. Considerable effort had been devoted to engaging both schools and parents at an early stage of the project in order to explain the nature of what was being offered, answer their questions, provide reassurance and try to build the foundations for an effective working relationship. The T&R team had successfully overseen training in the use of different systems and aspects of the intervention at an early stage in its delivery.

Arrangements were considered to have been most effective when the IIPs had been integrated into schools and given full access to space and resources that enabled them to deliver the intervention. The relationship built with schools was considered one of the key strengths of the programme, which allowed it to effectively identify vulnerable pupils and support their transitions.

Implications for pilot study

A key focus for the pilot phase of the evaluation is to assess the extent to which the intervention has achieved its intended outcomes using YEF's core measures and assessing change over time. Measuring progress towards client goals was considered an integral part of the work undertaken by both T&R and wider Family Support service but could not be tested quantitatively during the feasibility phase.

There was recognition of the potential contribution of the suite of core measures to inform and improve the work of the intervention and demonstrate its impact. Despite this willingness, an audit of the core measures collected by the grantee conducted on 5 March 2021 showed that data relating to only 11 of the 46 children being worked with at that point had been collected and recorded on REDCap. Implementing the measures themselves and then uploading them for evaluation was particularly challenging for T&R. In part, this was because data recording was delayed during an extended process to recruit and embed the two IIPs, alongside the organisational upheaval and switch to remote forms of delivery catalysed by COVID-19.

The importance of the relationship between practitioner and client was highlighted in shaping the completeness and quality of the core measures data being collected. In this context, it may also be worth

noting that during the feasibility phase, the evaluation team's understanding is that T&R were collecting paper copies and then uploading them in batch lots rather than collecting and simultaneously entering the data directly into REDCap. For those who considered the measures, there was reportedly scope to adopt them as a supplement or alternative to some existing forms of assessment. Conversely, there were some concerns expressed about the extent to which some items (e.g. self-report delinquency questions) may identify or generate safeguarding issues and the accuracy and reliability of responses to such questions.

During the feasibility phase, and in the context of uncertainty engendered by COVID-19, the decision had been taken by commissioners to extend Family Support T&R into the before and after pilot phase without relying on feasibility findings. There was, therefore, no evaluator judgement required as to whether or not to proceed to pilot. Decisions informed by the evaluators largely revolved around carrying data forward from feasibility into pilot, including in instances where data had not been uploaded but had been collated during the feasibility phase.

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. This can be best thought of as a short-term assessment, exploring potential changes within young people and their families 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 families', professional and referrers' perspectives. The aims and associated research questions are shown in Table 6. Please see the link to the pilot protocol here: https://youthendowmentfund.org.uk/wp-content/uploads/2022/09/YEF-Family-Support-Pilot-study-plan-FINAL.pdf

Table 6: Aims and research questions

Aim 1: To evaluate improvement in core outcomes over time comparing baseline to three and six months	
Research Question	**Measures**
Describe the client sample at baseline.	MOSAIC
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
Aim 2: To evaluate effect size	
Research Question	**Measures**
Estimate the likely effect size of the Family Support T&R intervention on behaviour.	SDQ
Estimate the likely effect size of the Family Support T&R intervention on family functioning.	SCORE 15
Aim 3: To describe the referral and screening process	
Research Question	**Measures**
Describe the flow of young people from referral through evaluation to engagement in the programme, including reasons for not progressing in the programme.	MOSAIC plus additional notes
Evaluate potential bias in selection by considering sample characteristics at different points in the referral process and, where possible, comparison across subgroups, e.g. referral sources.	MOSAIC plus additional notes

Aim 4: To assess 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 readiness for 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 and six 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 the implementation process	
Research Question	**Measures**
Has the intervention been implemented with fidelity – i.e. according to its intended delivery model?	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

Additional information on data sources is provided in the section below. Also, please note that the feasibility research question regarding whether the intervention's recruitment, retention and reach were feasible is covered in the reporting of pilot phase Aim 4.

Success criteria and/or targets

The main success criteria for the pilot assess the potential to scale up the intervention to meet a large sample size. The sample size for a trial to evaluate the effectiveness of the intervention was estimated from the evaluation of the potential effect size. Key criteria to assess evidence of promise were based on the research questions articulated in Aim 5 within Table 6 above.

Methods

Participant selection

Quantitative analyses were conducted on the entire dataset uploaded to REDCap, i.e. both routine monitoring and specified core measures. All young people referred to Family Support T&R within the recruitment phase were thus captured via secondary analysis of this routine monitoring data and primary analysis of core measure outcome data. There were 89 families originally referred (of 100 intended). Data

on 33 families were provided at three months and for 54 families at six months. The somewhat unusual reported increase in collated measures between three and six months is probably related both to the completion *processes* – without the originally envisaged level of face to face to contact – and the *willingness* of service users to complete the measures. It is probable that young people or their families became more willing to complete measures after a rapport had been established. Practitioners may also have developed their own confidence in implementing measures that were less familiar to them.

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 from T&R as well as the other providers, were also sampled purposively. It was therefore proposed to conduct interviews, individually, jointly or within a group, as appropriate, with up to 15 participants associated with T&R. Recruitment processes were the same as those articulated in the feasibility section above.

Data collection

The evaluation of Family Support T&R 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

The majority of quantitative data collected comprises either data routinely collected within the delivery of the Family Support T&R programme or the specified YEF core dataset. It was uploaded to the REDCap system by members of the grantee team and stored securely on university servers. Data collection, data entry and queries raised by members of the grantee team were managed in line with the Data Management processes as agreed between the grantees and the evaluation team. Follow-ups with the clients were indicated at three (t1) and six (t2) months. Routine monitoring, evaluation and core measures were the same as those outlined for audit in the feasibility phase. Table 7 provides a summary of the data collection schedule.

Table 7: Schedule of planned data collection and assessments

	Referral	Screening	Baseline (t0)	3-month follow-up (t2)	6-month follow-up t3)
Demographics	X				
Programme-specific process	X	X			
SDQ			X	X	X
SCORE 15			X	X	X
IES-R			X	X	X
CRIES-8			X	X	X
ESYTC			X	X	X
End of intervention or engagement form				To have been completed if a client withdraws or when they complete the intervention.	

Data Sources

To simplify description of the data, 'clients' encompasses the young people and/or families being considered for intervention, as appropriate. Data was captured separately for young people and their parents or carers. Please note that each client subset 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 grantees' interventions. For each of the aims articulated in Table 6 above, data source is listed below:

Aim 1: To evaluate the direction and magnitude of change in core outcomes over time.

The key data source was the data collected on the REDCap database.

Aim 2: To evaluate effect size.

The effect size was estimated from the core dataset specified in Aim 1.

Aim 3: To describe the referral and screening process for the Family Support T&R programme.

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

Aim 4: To assess client retention and data completion

Attendance at therapeutic sessions and the client completion record were intended to allow evaluation of engagement in the Family Support T&R intervention, and the database record provides information on data completion.

Aim 5: To evaluate the readiness to deliver 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 the 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; and service users' experiences and views of the intervention. The interviews informed the assessment of acceptability of and engagement with Family Support T&R by the young people and their families. Interviews with practitioners and referrers also helped the evaluators 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 a video conferencing tool. In some instances, these were sound files only to conform to participant preference.

Table 8. Methods overview

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Secondary analysis.	Routine monitoring data collected by Family Support (including core measures).	Those referred, screened, accepted, discharged AND completing Family Support services. Includes progress against outcomes as measured using YEF's core measures.	Descriptive and, where meaningful, 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 Family Support 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 will be assessed. The findings of those assessments will then be presented in subsequent sections of this report.

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

The analysis will consider each of the four YEF core measures independently. 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 (t0) and estimated effect size (with confidence intervals) at three (t1) and six (t2) months.

It was initially intended that a sensitivity analysis would consider the influence of baseline characteristics and missing data. As the dataset is small, any models would have had to constrain the number of variables included. The analysis was intended to seek to demonstrate the gross effects of baseline variability and missing data (by replacement of missing values) and interpret any influence on the observed change over time. However, it was not possible to conduct a sensitivity analysis, as data completion rates were so low, and there was too much missing data to make a sensitivity analysis viable.

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 were not selected for the intervention at each stage. Descriptive analysis will seek to evaluate, through tabulation, the extent to which selection of clients was subject to bias, excluding particular groups of clients. Numbers of clients will be small, but where possible, analysis will use $\chi 2$ to aid in 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 the 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 highlighted. 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 was a significant issue, it could easily be detected and flagged.

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 that makes a judgement about the minimum number of therapeutic sessions that should be attended to achieve a reasonable therapeutic effect. However, this is only informative when clients are required to attend a high proportion of available sessions to achieve the desired clinical outcome.

Aim 5: Evaluation of success criteria.

Readiness to progress to a larger scale efficacy or effectiveness trial will be assessed and estimated following analysis of 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 Family Support are successful in retaining at least 75% of families who start the T&R programme and remain engaged by the end of the programme. This is irrespective of family or young person adherence to specific intervention sessions – set at 66% as the desirable level. Secondary analysis will consider any apparent differences between families who 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 data has been completed for each outcome sufficiently to evaluate a scale score.

4. Whether a trial of sufficient magnitude could be delivered.

   Analysis will proceed by tabulating the assessed outcomes from an 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 could 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 treating centres per year and the total number of treating centres required to achieve the required sample size.

Aim 6 Implementation process.

Interview data were transcribed sufficiently for thematic analysis. Due to the richness of the dataset, the evaluators have also incorporated emerging themes 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 positive outcomes were also incorporated into the qualitative analysis. The evaluation of Family Support T&R was one of four family-based interventions being delivered and evaluated concurrently by this evaluation team. This meant that emerging themes could be developed for each grantee and that it will be possible to conduct a secondary analysis across all four interventions subsequently, drawing on a larger sample size than within this study alone.

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 and children and young people themselves). The themes initially created were shared within the research team to test for consistency and to provide a degree of inter-rater development. This resulted in some shifting of sub-themes and reframing of themes. The analysis then continued, in this reflective way, to develop a thematic map and the findings presented below.

Timeline

Table 9. 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 extension
30.05.22	Completion of all pre-post-pilot focus groups and stakeholder interviews and REDCap data download
30.06.22	Cleaning and preparation of data, data analysis (pilot data)
30.09.22	Submission of draft final reports
31.1.23	Final report drafting, peer review and revision (feasibility and pre-post pilot).

Findings

Participants

Qualitative fieldwork was completed with five young people (four males and one female, aged between 12 and 13 at the time of the interview). Five interviewees had parental responsibility, and seven were professional stakeholders.

From the routine monitoring data, there was no way to tell how many young people had been initially referred, nor was it clear for what reasons some may not have been fully enrolled in the programme. The records indicate that 89 young people were enrolled at baseline (i.e. 89% of the originally intended number of families). Key characteristics of the 89 families enrolled are outlined in Table 10 below.

At six months, 54 families were followed up. This gives a retention rate of 61% to six months. Completion rates were still low throughout on parent measures but better for child measures. By the end of the pilot phase, 48 families had completed the intervention, one had withdrawn and five were continuing. This gives a final retention rate of just under 60%.

Findings

All aims will be considered in this section. The order of the aims is here altered slightly to aid the interpretability of the findings. For each aim, quantitative findings are presented first, and where possible, relevant qualitative themes are considered. The last aim evaluated, Aim 6, is entirely assessed through qualitative analysis.

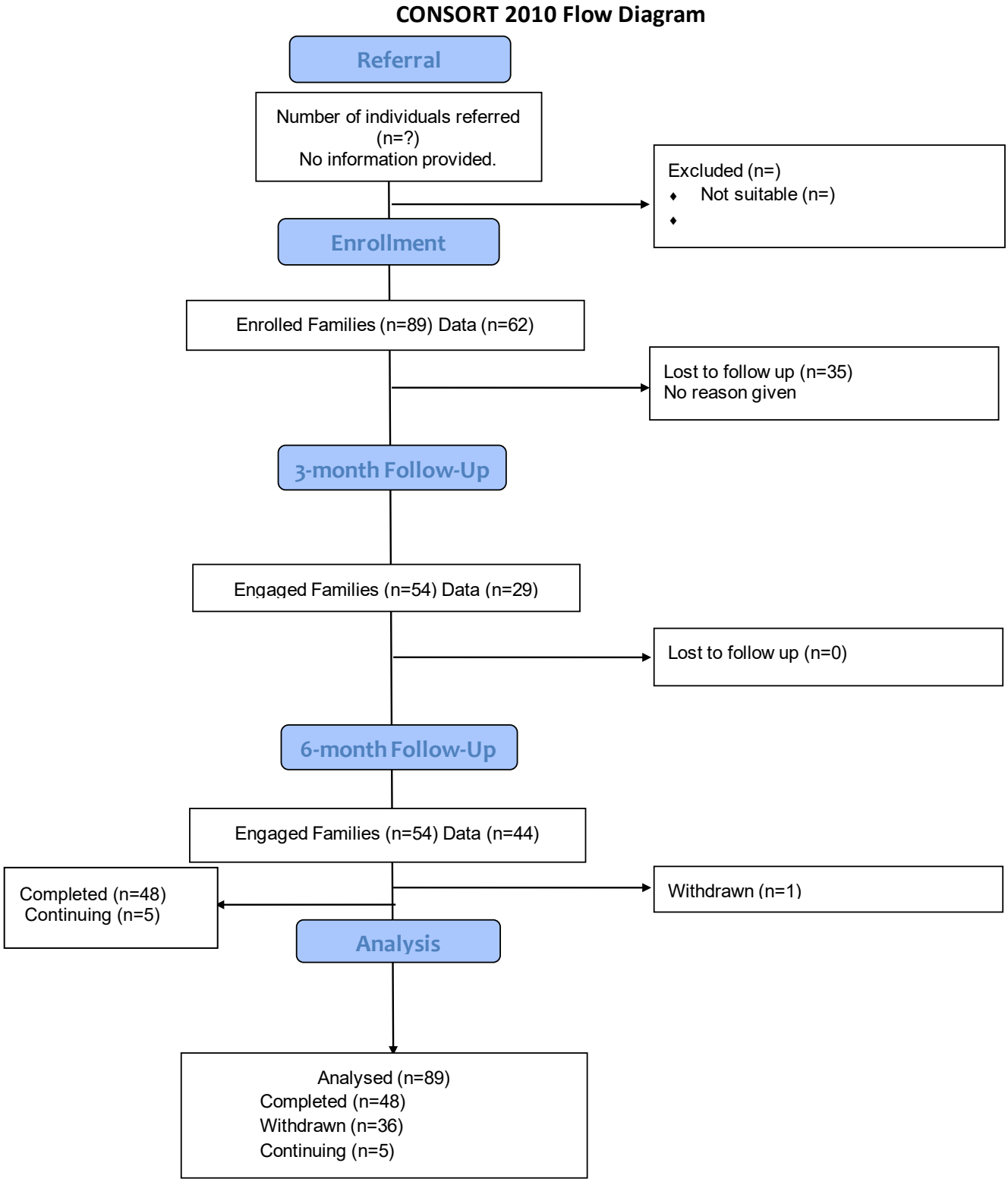
Table 10 summarises the intended data collection schedule for Family Support.

Aim 3: The referral and screening process

Starting with Aim 3, the referral and screening process is evaluated first and is summarised in the flow chart (Figure 4) and Tables 13 and 14. Family Support did not supply any information about families that were

referred to them that were not suitable. The information presented is in relation to the enrolled families only. Eighty-nine families were enrolled in the programme.

Figure 4: CONSORT-type flow chart to summarise the referral and enrolment process



For the majority of the enrolled families, the child was 11 years old, predominantly male (64.04%) and Black (31.46%) or White (22.47%) (see Table 11). In the majority of cases, the referral source was not recorded (64.04%). Of referrals that were reported, the main route was through schools (32.58%). Time from referral to enrolment ranged from two days to 425 days, with COVID-19 lockdown periods severely impacting the recruitment process.

Due to not having information about families who were not eligible, it is not possible to speculate on the risk of bias during the referral and screening process.

Aim 4: Client retention and data completion

Client retention and data completion (Aim 4) are outlined in Table 12. Under the principle of intention-to-treat, data completion is considered here in relation to the proportion of records at each time point in comparison to the number of families enrolled in the programme (n=89). Family Support T&R followed up with clients for six months. It should be noted that they did not record end-of-study information for all families, and 35 families were not followed up at either three months or six months, suggesting they may have been lost to follow-up after baseline. The COVID-19 pandemic may have been a significant disruptive factor.

The number of families remaining on the T&R programme for six months was 54 (60.67%). In general, the children were more likely to provide data than the parents; this was most likely because, once lockdown conditions permitted, more work was conducted in schools than had been initially envisaged. Even so, this was still less than half of those who were enrolled in the study. The maximum number of families providing data at follow-up is 29 (32.58%) at three months and 44 (49.44%) at six months.

This indicates both a very low rate of data completion and the potential for significant bias. Tables 18 and 19 provide a comparison between the families (n=53) at baseline who were recorded as completed or continuing at six months compared to those who were recorded as withdrawn (n=1) at six months or those for whom it is assumed they were lost to follow up with (n=35) due to no data being collected at any of the follow-ups. While the data do not indicate a difference between the demographics of families who completed the programme and those lost to follow-up, and the scores for those who completed data are very similar, the parents of the families who were lost to follow-up did not complete any of the measures, and only a small number of children from families who were lost to follow up completed the SCORE 15 and CRIES-8, with no children completing the ESYTC. Therefore, there remains the potential (outlined below) for significant differences in response to the programme between these groups.

The Family Support T&R programme provided no data on the number of sessions attended by the families and did not provide completion data for all the families enrolled in the programme. Assuming that the 34 families who did not have any follow-up data collected were lost to follow-up, client retention was just under two-thirds or 54 families (60.67%) retained in the programme for six months. Overall, 48 families are reported to have completed the programme, and five are reported as continuing with the programme at six months. Table 10 (below) indicates the planned data collection schedule, table 11 outlines the demographic characteristics of those who enrolled in the programme and table 12 provides summary data collected at each timepoint: baseline (t0), three months (t1) and six months (t2).

Table 10: Data collection schedule at each time point

	Referral	Screening	Baseline (T0)	3 months (T1)	6 months (T2)
ID Number	X				
Date of referral	X				
Age					
Gender					
Ethnicity					
Family background					
Referrer	X				
Therapist		X			
Risk score (0–16)*		X			
Main difficulties	X	X			
Index of Deprivation					
SDQ			X	X	X
SCORE 15			X	X	X
IES/CRIES-8			X	X	X
ESYTC			X	X	X
Study End Form					X

Table 11. Demographic characteristics of families enrolled

		Enrolled
n		89
Child's Age mean (sd)		11.07 (.69)
Child's Gender n (%)	Male	57 (64.04%)
	Female	30 (33.71%)
	Prefer not to say	-
Ethnicity n (%)	White	20 (22.47%)
	Black	28 (31.46%)
	Asian	6 (6.74%)
	Mixed	7 (7.87%)
	Other	14 (15.73%)
	Not provided	14 (15.73%)
Referrer	Social Worker	1 (1.12%)
	School	29 (32.58%)
	Other	2 (2.25%)
	Not Provided	57 (64.04%)

Table 12: Summary of data collected at each time point

	Referral n=?	Screening	Baseline (T0) Enrolled n= 89	3 months (T1) Remaining n= 89	6 months (T2) Remaining n= 89
ID Number	79 (88.76%)				
Date of referral	30 (33.71%)				
Age	30 (33.71%)				
Gender	87 (97.75%)				
Ethnicity	75 (84.27%)				
Family background	MISSING				
Referrer	32 (35.96%)				
Therapist		MISSING			
Risk score (0–16)*		MISSING			
Main difficulties		MISSING			
Index of Deprivation		MISSING			
SDQ			P: 29 (32.58%) C: 62 (69.66%)	P: 12 (13.48%) C: 29 (32.58%)	P: 10 (11.24%) C: 44 (49.44%)
SCORE 15			P: 22 (24.72%) C: 41 (46.07)	P: 10 (11.24%) C: 26 (29.21%)	P: 7 (7.87%) C: 37 (41.57%)
IES			12 (13.48%)	6 (6.74%)	7 (7.87%)
CRIES-8			17 (19.10%)	21 (23.60%)	28 (31.46%)
ESYTC			3 (3.37%)	10 (11.24%)	11 (12.36%)
Study End Form			0	0	Complete 48 (53.93%) Other 1 (1.12%) Continuing 5 (5.62%)

Notes: P – Parent, C – Child. Family background, engagement with other programs, therapist, risk score, main difficulties, index of deprivation not on database.

Additional insight into referral, screening and retention is available from the implementation process interviews, where the importance of relationships built between families and practitioners was a common thread. Such relationships were also strengthened through practitioners' engagement with other agencies on behalf of families:

> *"*[We've] *advocated for the families, we've shared our knowledge, our experiences with other services. We've supported them in building those relationships or may have referred them to external services. So, they have that in place to move forward as well. They know where to go after that support if they need it in the future. So, we've empowered them to sustain that change or know where to go and build those resources for the families"* (Manager #2).

Practitioners would also adapt the length and intensity of support according to the identified needs of families. This would help determine when the support should finish whilst encouraging family and young people's agency in making that decision:

> "[We've] *had some young people who have been really clear that, actually – and their families have been – that they've achieved the outcomes they've wanted to achieve, and that's great, and it's a really clear defined ending point. Some families have found it really beneficial, so actually have wanted to continue with* [mentoring service] *because of the person's voice and aspirations, or would just benefit from continuing to still build that confidence. […] No journey is a straight line, and actually having that extra support is really great. And then for others, there is still a clear need maybe around a certain area ..."* (Practitioner #1).

The relatively poor completion rates of core outcome measures were acknowledged by at least one manager who made reference to not having enough outcome data. They recognised the need for such data to understand the impact of 'early help' interventions. Similarly, other interviewees indicated that the time it took to complete the questionnaires impacted session delivery, as did families' willingness to engage in completing the questionnaires. The core measures were flagged quite early on by T&R staff as being likely to cause a problem, although the evaluators are not aware of discussion they may have had directly with the YEF project management team about the measures.

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

The mean scores for each of the outcome measurements are presented in the following tables for each of the time points: SDQ (Tables 13 and 14), SCORE 15 (Table 15), IES-r, CRIES-8 and ESYTC- Sweep 3 (Table 16).

In general, where data has been reported, the children report a significant improvement, whereas any improvement seen by the parents has not reached a significant level. The SDQ total scores at baseline for both parents and children are slightly higher than average, dropping to within normal ranges by three months. Potentially of interest is that the SDQ total score for the parents is lower at three months than at six months (10.33 cf 12.9), although these are both within the normal ranges for that specific measure. The impact scores also decline but remain high over time.

The children report a significant improvement in the SCORE 15 over time, but it is notable that the parents report an improvement in the score at three months and then a slightly higher score at six months compared to baseline. Similarly, the parents report a considerable improvement in IES-r score at three months but a similar score at six months to the baseline measure. However, comparison of these results is difficult, as only a small number of parents completed the measure at baseline and three months (n=3) and at baseline and six months (n=4).

For the CRIES-8, the scores fall considerably over both three and six months, and the number of reported acts of delinquency and their frequency (ESYTC) also fall slightly over time.

The change in the scores for the outcome measures was evaluated at each time point compared to baseline (see Table 17). For all outcomes, the number of families providing data was well below 75%, making adjustment meaningless. Similarly, no attempt was made to evaluate the effect of missing data (sensitivity analysis), as any attempt to impute missing values would overwhelm the data reported. Further commentary on these issues is reported below.

What is notable is that for most of the outcome measures, the scores fall somewhat by three months and continue to fall at six months, but not to a significant extent. Comparison of the parents' scores is difficult due to the very low number of parents repeating any of the measures at three and six months, and although they indicate a continued improvement across each of the measures over time, **none of these differences reached a significant level**. For the SDQ, the largest difference was between baseline and three months, with a 3.44 point decrease ($t=1.98$, $p=.08$). For the SCORE 15, the largest difference was between baseline and six months, with a 2.6 point decrease in total score ($t=-.92$, $p=.41$). Similarly, the largest difference for the IES-r was also between baseline and six months, with a 7.75 point decrease ($t=1.26$, $p=.30$).

A comparison of the children's scores shows a significant improvement in the SDQ and SCORE 15 at three months, which is continued at six months. The reported effect sizes[3] are medium to large and indicate a fairly robust treatment response (where data is reported).

By three months, a significant improvement in scores for the children is reported, with a 3.21 point decrease in SDQ total score (t=3.57, p<0.01) and a medium effect size of d_z=.66. This is continued over six months, with a 4.5 point decrease in the reported SDQ total score (t=5.79, p<0.01) and a large effect size d_z=.89. Similarly, there is a significant improvement in the SCORE 15 at three months, with a 4.11 point decrease in total score (t=2.92, p=0.01) and a medium effect size of d_z=.69, which is continued at six months with a 5.03 point decrease in the SCORE 15 total score (t=2.93, p<0.01) and a medium effect size d_z= .53.

With the other measures for the children, there is a similar but not significant improvement over three and six months, with a slight reduction in total score (CRIES-8) and the number and frequency of reported delinquent acts (ESYTC). While the reported change over time is notable and statistically reliable for the children, the large proportion of missing data makes interpretation difficult. It should again be acknowledged that the COVID-19 pandemic was a significant factor in preventing the completion of outcome measures during the pilot period.

An analysis of missing data is not helpful, as imputed scores will overwhelm observed scores. The profile of families reporting data compared to those who do not does not show any difference at baseline (as reported above). However, it remains possible that families who have not provided data at follow-up were not responding as well to the programme as those families who did provide data. The outcomes, therefore, need to be treated with caution.

Table 13. Mean score and standard deviation for total SDQ score across each time point

	Baseline n= 29			3 months n= 12			6 months n= 10		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	14.1* (5.35)	4	26	10.33 (6.24)	3	21	12.9 (7.49)	2	25
	Baseline n= 62			**3 months n= 29**			**6 months n= 43**		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
SDQ total	14.53* (6.15)	1	29	11.03 (5.96)	2	22	10.19 (5.61)	0	24

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

[3] It is generally recognised that an effect size d>0.7 is large. However, repeated measures designs, where the evaluation is change over time generally, show larger effects than comparisons between groups in parallel group designs (intervention compared to control groups).

Table 14. Mean SDQ impact score and standard deviation across each time point

	Baseline n= 19			3 months n= 7			6 months n= 7		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	2.79*** (1.87)	0	7	1.57** (1.27)	0	3	1.57** (1.72)	0	4
	Baseline n= 48			**3 months n= 15**			**6 months n= 7**		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Impact	4.52*** (2.36)	0	10	1.6** (1.3)	0	4	1.57** (1.72)	0	4

Note. The range is 0–10 for parent and child scores. The 4-band solution for cut-off scores of SDQ (rounded to nearest whole number) has been used. *=slightly raised than average **=High ***=Very high

Table 15. Mean and standard deviation for the SCORE 15 across each time point

	Baseline n= 22			3 months n= 10			6 months n= 7		
Parent	m (sd)	min	max	m (sd)	min	max	m (sd)	Min	max
Total score	24.59 (7.56)	15	41	19.9 (5.36)	15	31	25.29 (7.02)	16	35
Average	1.64 (.5)	1	2.73	1.33 (.36)	1	2.07	1.69 (.47)	1.07	2.33
	Baseline n= 41			**3 months n= 26**			**6 months n= 37**		
Child	m (sd)	min	max	m (sd)	min	max	m (sd)	Min	max
Total score	29.56 (9.68)	16	56	25.38 (8.24)	15	48	22.05 (6.99)	15	48
Average	1.97 (.65)	1.07	3.73	1.69 (.55)	1	3.2	1.47 (.47)	1	3.2

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

Table 16. Mean and standard deviation of the IES-r, CRIES-8 scores and ESYTC number and frequency of reported acts across each time point

	Baseline n= 12			3 months n= 6			6 months n= 7		
IES-r	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Total score	12.83 (19.23)	0	52	5.33 (6.06)	0	15	12.43 (13.64)	0	31
	Baseline n= 16			**3 months n= 21**			**6 months n= 28**		
CRIES-8	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Total score	15.19 (11.16)	0	34	12.43 (9.17)	0	34	7.89 (8.89)	0	34
	Baseline n= 3			**3 months n= 10**			**6 months n= 11**		
ESYTC	m (sd)	min	max	m (sd)	min	max	m (sd)	min	max
Acts reported	1 (1.73)	0	3	.8 (1.22)	0	3	.27 (.65)	0	2
Frequency	.89 (1.54)	0	2.67	1.03 (1.47)	0	3.33	.27 (.65)	0	2

Note 1. The CRIES-8 produces a total score, with a cut-off of 17 being a reliable indication of possible PTSD.

Table 17. Estimation of outcome and treatment effects (comparison to baseline), 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%)
Parents	**SDQ**	51	29	14.10	5.35	12	10.33	6.24	9	3.44	1.98 (.08)	.66	-.57 – 7.46	10	12.9	7.49	8	2	.95 (.37)	.34	-2.96 – 6.96
	SCORE 15	39	22	24.59	7.56	10	19.9	5.36	6	0	.000 (1.00)	0	-3.11 – 3.11	7	25.29	7.02	5	-2.6	-.92 (.41)	-.41	-10.4 – 5.23
	IES-r	25	12	12.83	19.23	6	5.33	6.06	3	-2.33	-1.61 (.25)	-.93	-8.58 – 3.92	7	12.43	13.64	4	7.75	1.26 (.30)	.63	-11.75 – 27.25
Child	**SDQ**	134	62	14.53	6.15	29	11.03	5.96	29	3.21	3.57 (.001*)	.66	1.36 – 5.05	43	10.19	5.61	42	4.5	5.79 (.001*)	.89	2.93 – 6.07
	SCORE 15	104	41	29.56	9.68	26	25.38	8.24	18	4.11	2.92 (.01*)	.69	1.14 _ 7.08	37	22.05	6.99	30	5.03	2.93 (.007*)	.53	1.52 – 8.55
	CRIES-8	65	16	15.19	11.16	21	12.43	9.17	7	-1.86	-1.49 (.19)	-.56	-4.9 – 1.18	28	7.89	8.89	10	-1.6	-0.78 (0.45)	-.25	-6.21 – 3.01
	ESYTC	25	3	1	1.73	10	.8	1.22	2	0	-	-	-	11	.27	.65	2	.5	1.00 (.50)	.71	-5.85 – 6.85

Note. * indicates a significant difference at a .05 level

Table 18. Comparison of demographics between families who did or did not complete study measures

		Completed	Withdrew	Test of significance
n		53	36	
Child's Age mean (sd)		10.87 (.34)	11.29 (.91)	t= -1.67, p=.11
Child's Gender n (%)	Male	31 (58.49%)	26 (72.22%)	
	Female	21 (39.62%)	9 (25%)	χ^2= 1.99, p= .16
	Prefer not to say	-	-	
Race n (%)	White	13 (24.53%)	7 (19.44%)	
	Black	17 (32.08%)	11 (30.56%)	
	Asian	6 (11.32%)	0	χ^2= 7.17, .13
	Mixed	2 (3.77%)	5 (13.89%)	
	Other	8 (15.09%)	6 (16.67%)	
	Not provided	7 (13.21%)	7 (19.44%)	
	Social Worker	0	1 (2.78%)	
Referrer	School	17 (32.08%)	12 (33.33%)	
	Other	1 (1.89%)	1 (2.78%)	χ^2= 1.38, p= .50
	Not Provided	35 (66.04%)	22 (61.11%)	

Note 1. Thirty-five families did not have any follow-up data collected and were considered lost to follow-up for the purpose of this analysis.
Note 2. Five families continued with the course after the six-month period; they have been included as completed for the purposes of this analysis.

Table 19. Comparison of mean scores between families who did or did not complete study measures

		Completed		Withdrawn		Test of significance
		n	Mean (sd)	n	Mean (sd)	
Parent	SDQ	29	14.10 (5.35)	0	-	-
	SCORE 15	22	24.59 (7.56)	0	-	-
	IES-r	12	12.83 (19.23)	0	-	-
Child	SDQ	48	14.65 (6.09)	14	14.14 (6.57)	t= .27, p=.79
	SCORE 15	38	30.16 (9.76)	3	22 (4.58)	t= 1.42, p= .16
	CRIES-8	15	15.2 (2.98)	1	15.19 (-)	-
	ESYTC	3	1 (1.73)	0	-	-

Note 1. Thirty-five families did not have any follow-up data collected and were considered lost to follow up for the purpose of this analysis.
Note 2. Five families continued with the course after the six-month period; they have been included as completed for the purposes of this analysis.

Qualitative findings indicate that the intervention has helped communication within families, strengthening their relationships. The extracts below are from a parent, practitioner and young person. Together, they show how the intervention may have affected change:

> "[At] *first, he was saying, I'm not going to tell you about what's happening inside the school or with my friend. You're going to go and tell them, or I don't want you to get involved. But since* [the sessions]*, yeah, it's been open, so I know 100 per cent what he's doing*" (Parent #1).

"Families have been able to see some changes within the family for their children. Families would also say that we've supported them in terms of communication and relationship … I think, as well, like the young people have felt listened to and felt, again, supported by the practitioners" (Manager #2).

"[The] *way I behave with siblings* [has changed] *like, not overreacting … I've got some better relationships with people, which are close to me"* (Young person #5).

Improved psychological well-being was another key intended outcome. One manager highlighted that young people's exposure to mentoring and counselling helped build their "resilience and emotional well-being" (Manager #3). A young person also acknowledged that they "feel more confident about talking with friends" and "expressing emotions" (Young person #5). A parent recognised that their child has "more confidence in himself", which was attributed to access to a counsellor: "*When you see that you have a specialist just to talk to, you feel more confident to talk about anything you want to*" (Parent #5). Other parents (#1 and #3) recognised that their child was less withdrawn and better able to communicate their feelings to them. One practitioner described a gradual change in a young person they were working alongside:

"So, one young person had a very challenging home life, had a lot of changes at home. There was mental health within the family, parental alienation and separation, domestic violence, substance misuse and so on. And actually, this young person was really hesitant to work with us at the start because of his perceptions of services. He engaged pretty well, pretty quickly, but then for him, the next thing was there was definitely a stigma culturally around mental health, but also because of his family's own lived experiences. [To] *see a young person's journey from, yeah, not wanting to engage to actually being able to request help when he needs it"* (Practitioner #1).

Another desired longer-term outcome was educational progress, including reduced truancy and exclusion and improved attainment. Practitioners and parents acknowledged children's re-engagement in schooling and their successful transition to secondary school:

"[The] *positive change is an increase in their child's confidence and resilience, and ability to cope in school. And, actually, then I would say quite a few of our young people are then also talking about their aspirations, hopes and dreams"* (Practitioner #1).

"She's settled down back into Year eight very, very good and not getting into trouble. So it did help quite a lot; [...] she doesn't get into trouble anymore at all. Before, I was getting loads of calls home from the teachers" (Parent #2).

Practitioners have observed that bridging individual mentoring and peer group work within the school environment has helped young people re-engage in school, while families and young people also reported changes in school engagement:

"He was more positive about going to school. He was more, I'll just say, comfortable with his homework and being able to do it, and in lessons. So, I think it was just knowing that he had that support in the beginning, and he was able then to flourish afterwards" (Parent #3).

"At first I didn't want to be involved, but when I started doing the sessions, I really liked it. [It changed] *my motivation.* [My] *mentor tells my teachers how I'm getting on and what my goals are so they can achieve with me. It's helped me in the classroom as well, like controlling my behaviour. And it's helped me outside of school"* (Young person #1).

IIPs worked with some parents whose children may have been excluded from school or have additional support needs. Practitioners would support the family to identify and access additional support, which also helped them re-engage in school:

> *"So one parent* [mentioned] *a EHCP* [Education, Health & Care Plan] *application in process* [and had] *been asking for a long time. Or another has an ASD* [Autism Spectrum Disorder] *assessment progressing"* (Practitioner #4).

Aim 5: Evaluation of success criteria

1. Bias in the screening and referral process. [Missing/Red]

Due to not receiving information about the screening and referral process, it is not possible to rule out bias in the process. This would need to be addressed for a larger-scale trial.

2. Retention of families in the programme. [Amber]

The programme did not report the number of sessions attended by children or parents, as originally intended, but did report the number of families completing the programme. The proportion completing the programme was medium (60%). While there is potential bias in reporting by the programme, there was no compelling evidence that this was the case.

3. Sufficiently robust and unbiased data completion. [Red]

Data completion was a significant problem. While it is acknowledged that the COVID-19 pandemic was an issue, the maximum proportion of data completion was 70% at baseline, 33% at three months and 49% at six months, which is very low and compromises the internal reliability of any study design. There was no indication that there was a significant difference between families who did or did not complete the measures; however, it is also possible that families who did not complete measures were not responding to the programme as well. There is no way to evaluate this possibility. This issue remains a significant risk to a future larger-scale trial.

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

The programme produced a significant treatment effect for families who did report outcome data in two of the outcome measures, indicating that there is some evidence that the intervention could be effective in a randomised trial with at least a small effect size. Assuming an effect size of d=0.4 given the before-after effect size for the SDQ at six months (α=0.05, 1-β=0.9), the required sample size per group is n=133 per group. This would need to be considered in the context of the completion of the intervention (68%) and data completion, which would significantly increase the required sample size.

The programme recruited a significant number of families to the intervention over a year (n=89), indicating that families are willing to engage initially. How many of these families would be willing to take part in the randomised trial, with random allocation to the intervention or to a suitable control, is unclear. There remains the potential to complete an appropriately powered trial given the potential to recruit to the programme, but the original programme would need to be reinstated, capacity would need to be increased and/or other sites would need to be identified.

If T&R were to be reinstated, then the primary risk to a trial must be the lack of data completion. The impact of the pandemic needs to be considered, but even under these circumstances, the level of data completion is low. A number of issues would need to be addressed to recommend progression to a full trial.

I. Can sufficient evidence be gathered to indicate non-bias at screening and referral?
II. Can sufficient evidence be gathered to indicate that data completion can be improved?
III. Can a suitable control intervention be identified that is not subject to too much heterogeneity?
IV. Is there evidence that indicates that families would be willing to be randomised?

If these issues can be addressed, it is possible that a trial of sufficient magnitude could be delivered. Scaling up the offer in order to conduct a trial and increase support was also highlighted as being important by participants in the process assessment.

The relationships between mentors and young people are integral to the positive outcomes that have been recognised. However, any continuation or upscaling should also consider additional resources to help mitigate the emotional toll on mentors:

> *"We're a stable factor, and stable factors for young people right now are so far and few in between that they're going to cling onto it. And, respectfully, sometimes we are burnt out; we are tired, we are going through our own personal issues, but we know that there are young people that rely on this meeting, and if we don't communicate effectively or hear them out effectively, that they're going to spiral to another place. And we're going to become another person in authority or another adult that they're going to put on the dump heap to say that, actually, they failed me"* (Practitioner #4).

Aim 6: Implementation process assessment

Implementation fidelity

Although not formally manualised, the ways in which T&R were intended to be delivered were articulated within the logic model. Consideration of the findings under this aim starts by assessing how closely that model was followed.

The logic model promotes flexible and creative delivery, and this was linked to the service being able to maintain the participation of young people:

> *"We do see the young people outside of school, in the community, within the home as well or virtually. So, we have been creative in engagement with our families and our young people, which has obviously helped with that"* (Manager #2).

Practitioner #2 highlighted that it can represent a "loss at the end" when support was retracted. This tied into other challenges related to the level of risk some young people experience, the need for a broader multi-agency approach and a sense that support was needed beyond T&R:

> *"I think the other themes that I'd like to add into that, particularly in that school, was the themes around safeguarding. So, we worked with young people who were at risk of being in gangs. And again, I think one of the things that we would want to say in this forum, as part of the evaluation process, is that there needs to be a more focused approach to all young people in terms of the support that they get. I think part of our journey was being witness to a process in which we could see that there was an imbalance in terms of the support, and that's what made us stay.* [What] *we saw in*

[one school] *was the layers of support that were needed for staff, for parents and carers, for the children, for the young people"* (Manager #3).

The need for allocated space for direct work with young people was a common barrier to delivering the programme as intended:

> *"Being in quite a lot of schools and ... not being able to offer a base room. So sometimes I'm almost hotdesking with the student each week, and I feel that that sometimes mimics maybe the instability they're already having at school and at home"* (Practitioner #2).

> "[The] *impact of not having a room, a space, at times, it sets the young person up. You're walking around trying to find a room; you're losing time. [...] That also has an impact on us, as a staff, who need to go in to be able to support"* (Manager #3).

Service user engagement

Parents described having straightforward access to practitioners, clearly valuing how easy it was for them to reach out or be engaged:

> "[It helped] *me a lot because I have his phone number, so I would contact him anytime if I had any concern"* (Parent #1).

Young people also spoke of how they felt engaged by the mentors and IIPs, describing relationships built and bonds made:

> "[I] *think it's helpful because you can speak to someone as well*. [I] *think it creates a bond with your mentor"* (Young person #1).

> *"I think being able to talk to someone, and then also giving me advice on what to do, kind of helped me* [to] *focus on what I need to change"* (Young person #2).

Interviewees emphasised the merit of a whole-family approach alongside dedicated transitional support for young people. A practitioner highlighted that enabling young people and parents to share their concerns is central to engaging families:

> *"I think for a lot of parents as well, it was something, especially the primary school to secondary school; that's about having someone who travels with their child. So, we get to know their child in primary school and understand the support they need and then* [are] *able to advocate for them and continue that in secondary school. That is something that parents reference a lot.* [Once] *you build that trust,* [they] *do ask for additional support that isn't just school-focused, but as a family system"* (Practitioner #1).

Parents and young people recognised a need for ongoing support for the young people in their care, with several indicating that the direct work did not always feel sufficient:

> "[It's] *been very beneficial,* [but] *it's lasted only six months"* (Parent #1).

"I think it would have definitely been better if it was longer, at least half the year[4] … Because certain things could arise that might not necessarily be something that I can help with, but they could have helped with, within that setting" (Parent #3).

"I think that if it was for longer, maybe, I don't know, but I feel like I enjoyed it very much, and I kind of wanted to do it more" (Young person #2).

"[More] *sessions and more time in the session … Because sometimes we need to rush it through"* (Young person #5).

Overall, parents acknowledged that Family Support practitioners communicated with them well and offered updates on their child's progress. However, one parent highlighted that written feedback would have been useful at the "*beginning, what they've noticed, at the middle of the programme* [and] *at the end"* (Parent #1). Whilst another parent suggested that the service seeks feedback from young people more around *"what can help them more"* (Parent #5).

Intervention responsivity

Direct work with practitioners was delivered in various ways, including one-to-one mentoring or counselling, peer group sessions, VR workshops, showing films within groups and trips out with practitioners and other young people. Project practitioners tailored interventions individually, which is both part of the logic model and encouraged participation:

"When I do the initial assessment, I kind of see what their personality is like. Some are more engaged and kind of just a pure talking therapy, so it's just easier for them to talk about their issues and problems. Whereas others, and particularly mostly, I would say boys, they find that quite hard to just kind of access their deeper emotions straightaway. So, therefore, I might have to bring in some games and some art. [Quite] *often through that, it's just a little bit easier for them to talk about things that are truly affecting them"* (Practitioner #2).

Practitioners worked flexibly with young people and adapted to the challenges that arose from the COVID-19 pandemic and when young people did not respond well to a particular approach:

"[I] *think we can be quite adaptable […]; the pandemic keeps coming back to mind in the different ways that we've met in parks and different places depending on just what's open and what's available. So just listening to their feedback and, yeah, slightly emphasising different bits of the project depending on what they want. And, at the moment, social media is a big thing, so actually, we're doing more workshops on that"* (Practitioner #1).

Group-based sessions were delivered in parallel to individual direct work, providing opportunity to develop relationships with peers and problem-solve around challenges they each faced:

"[Young people] *really value the group work at times. So we do a lot of group workshops where the young people also are problem solving and coming up with solutions, as a whole, together, I don't know, around peer pressure, social media. We did one last week around anxiety, and they really*

[4] Please note that in this case, the in-school element of the intervention had lasted four months, which is the duration being referred to here.

valued that sort of like young person-led and solution-focus[ed] *kind of work together"* (Practitioner #1).

Parents endorsed the variation in activities that raised young people's interest to become involved and kept them engaged. One parent observed that creative delivery helped *"make it fun for the children"*, which was important as they then *"feel that it's not a major thing that you are having* [i.e. receiving] *support"* (Parent #1).

Family Support offered consent-based, targeted support to families who were usually referred by social workers or school leaders for direct work with young people:

> *"*[It is] *a service that are brought in to help, that social workers might identify a family that needs a bit of extra support. Maybe their child is at risk of exclusion, or there's possibly some domestic violence that has occurred* [and] *before escalating it, they come in first as kind of a mediation ... Basically, just to offer the family a lot of robust, caring support without judgement"* (Practitioner #2).

Due to the variety of reasons why families may need additional support, the programme relied on practitioners' understanding of the needs of families and delivering tailored support. This involved carefully matching practitioners to families and choosing what support is required:

> *"*[It's] *so key to have that first assessment through the Family Support practitioner because then they can identify whether a child would engage with further counselling and also whether there is maybe a need for it too. Because quite often, there are some children that just having the Family Support practitioner is enough, and maybe mentoring, so maybe they don't need all three of us*" (Practitioner #2).

This responsiveness was extended to young people, who may be accessing the project in circumstances where their families may not have been involved in the intervention initially:

> *"It is a support system that helps you, depending on your needs, so they tend to cater depending on what you need … So he has a learning disability, and he was struggling with lessons, homework load, because it's obviously being just compared to Year six, where you get bare minimum homework, to getting probably like seven or eight pieces a week.* [They] *offered for me to see if there was anything that Family Support could do"* (Parent #3).

Being responsive to the needs of families also involves practitioners demonstrating flexibility and adaptability in their communication with families. This included the use of email, text or digital platforms that were fitted to families' schedules or preferences. The COVID-19 pandemic clearly demonstrated the importance of this approach when practitioners needed to change their delivery:

> *"*[We] *remodelled to adapt to what would work during the pandemic, so we loaned out some phones with WhatsApp enabled. So, if people were digitally excluded, they could access mentoring sessions via video calls. We helped secure some laptops"* (Practitioner #1).

Even where direct work was focussed on the young person, a network of support was available for the family:

> *"I think hearing the child's voice and also the parent being part of that journey as well is really important just to really understand what's going on for them and how we can support them. So, yeah,*

it goes well, and building those relationships with other services and professionals to make sure that the family are supported" (Manager #2).

One manager described how building a professional network around the family was key to supporting them in meeting the desired outcomes of the intervention:

> *"So within the Transition Resilience project* [T&R programme]*, we complete an assessment, so that looks at the young person's needs. We have Team Around the Family meetings, so that's with the school, with the practitioner, with the family. Again, to go over what are the areas of need and support that's required for the young person and for the family and put together a really clear plan with the school, and other professionals that are involved as well"* (Manager #2).

Interviewees also placed emphasis on the mentor–young person relationship as central to supporting young people:

> *"*[The] *thing about the mentor relationship that benefits young people, that I think we found, is the fact that we mentor holistically ... We mentor looking at all aspects, and we're not there as an advocate for the teachers, we're not there for an advocate for the parents. We're not there for an advocate for the key worker, or the government bodies that you're attached to. We're an advocate for you"* (Practitioner #4).

To Family Support professionals, overcoming family hesitancy to become involved represented a barrier. Although they saw the value that the programme might bring, practitioners highlighted the importance of understanding the reasons why families may express hesitancy:

> *"*[Some] *parents are quite hesitant because for a variety of reasons. So, it's trying to understand what that is and asking the questions to unlock that so we can start the conversation.* [If] *they've had a negative experience or just experience with services previously? If they don't have a good relationship with the school, that can be a bit of a barrier.* [Some] *parents are so really busy. Like, I'm a single parent, I work nine to five, I get five emails from school a day about all these different things. I'm worried about the cost-of-living crisis or I have family members* [in crisis]*; I don't have time for you to be ringing me. So, there's a real mix of reasons"* (Practitioner #1).

Understanding why families are hesitant helps practitioners overcome this type of barrier and try to find a way of relationship building and offering assurance:

> *For some families, […] there's a fear that asking for help; maybe you were perceived that your child has a problem, or is behaving naughtily in school, and so we have to do work around that. I had one child, his parent wanted the help, but I think how they described our help to the young person made them feel like they're in trouble. So, I think it is taking each case as an individual and just trying to establish what it is the family would like and any sort of fears or misconceptions or beliefs they hold, and then going from there"* (Practitioner #1).

It was also noted that families may express hesitancy as they associate Family Support with statutory services. Family Support professionals are able to uphold the consent-based nature of the service and respect families declining to be involved. Where there is a need for lower-tier statutory intervention, the team will make a referral:

"If some people are absolutely adamant, no, I don't want you, and if there aren't any safeguarding concerns, then we're not going to be involved because we have to be proportionate as well. So, forcing ourselves onto people's lives, if they don't want us, [it's] *not going to equate to a positive relationship anyway. But a lot of the times we do change people's views and minds.* [Some] *families, rightly so, will be just like […], 'I don't want to work with you', and that's fine.* [When] *there are safeguarding concerns, we will send it back up and say this potentially needs to be thought of in a different way for social work intervention, given that the family don't want to work with us"* (Manager #1).

The COVID-19 pandemic posed several challenges that affected the delivery of the programme to families. The Family Support T&R programme in schools was delayed, as practitioners were unable to work within schools during lockdown. COVID-19-related restrictions also impacted face-to-face delivery with young people, meaning direct work had to be delivered online, with mixed results:

"We also did trips, and we've had to adapt all of these things, obviously, during the school closures, so we've worked online for a while. Some young people responded to online learning quite well, and counselling and mentoring. Others, there was challenges like digital exclusion or not enough space within the family home […]. I'm thinking about one young person who had no space even to do her learning. Mentoring worked all right, but just counselling within the family home because there wasn't that private space; [it] *just didn't work"* (Practitioner #1).

"[I] *visit the children in the schools. […] So, most of it had to be conducted via Zoom or Teams or WhatsApp. Ninety-five per cent of children, including boys, prefer face to face.* [There] *were two cases where two boys weren't ... engaging so well onscreen, and they actually then decided to terminate early. They felt they had the family support practitioner, so they felt they didn't need the counselling as well.* [Then] *when they saw me in school, and they saw me working with some of their peers, they then wanted to get re-referred and wanted to start the sessions again"* (Practitioner #2).

Online delivery also impacted the relationship between practitioners and young people. One practitioner noted, *"confidentiality and privacy over Zoom was an issue"*, as *"the parent would keep intruding in the session"* (Practitioner #2). A practitioner also recognised that if COVID-19 had personally impacted professionals working with young people, this stressor could have an impact on the relationship.

Another unforeseen consequence related to the sheer amount of different data reporting required of T&R. One manager mentioned various data capture channels to collect outcomes data related to their service. They underlined the complexities at play in determining attribution to various pilot or long-standing family-focussed interventions that may be implemented within the organisation across a given time period:

"It's so individualised to each family; it's not like this is what we do. So, if we're looking at outcomes, there's things such as re-referrals that are looked at and escalation to how many are stepped up. [When] *we're closing, we do have outcome scales, so when we start the work ... we do scaling, and we do the same at closure to see what they look like then.* [We] *are building data for Early Help, which we didn't have initially"* (Manager #1).

Part of this complexity relates to the need to build datasets concerning outcomes for families alongside capturing synonymous outcomes data for other parties:

> "*I don't think I've got enough* [outcomes] *data,* [and] *that's where we know is one of our challenges that we are still building on our dataset. So, I think once I've got more data, I'd be able to really say* [is it] *individualised* [support] *or is there key things, because we look at the Supporting Families' requirements as well? So Supporting Families is a government thing, which we have to report on. So that's also something, so I think it's just really looking at when I get some better data, does that tell us enough about our outcomes, and our intervention, to be able to know whether it's one way or the other?*" (Manager #1).

This raises both a funding and policy implication for family interventions to better consider the competing requirements interventions may have in collating outcomes data.

Evaluation feasibility

Conclusions may be drawn about each of the key aims of the pilot evaluation, 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 the SDQ and SCORE 15, the children report a statistically significant improvement of moderate or large effect size, respectively. Any improvement seen by the parents, however, has not reached a significant level. It is notable that although non-significant on both of these measures, the parents report an improvement in score at three months but a slightly poorer score at six months. Similarly, the parents report a considerable improvement in IES-r score at three months but a similar score at six months to the baseline measure. Further comparison of these results is difficult, as so few parents completed the measures.

For all outcomes, the number of families providing data was well below 75%, making adjustment meaningless. Similarly, no attempt was made to evaluate the effect of missing data (sensitivity analysis), as any attempt to impute missing values would overwhelm the data reported. While the reported change over time is notable and statistically reliable for the children, the large proportion of missing data makes interpretation difficult. We should again acknowledge that the COVID-19 pandemic was a significant factor in preventing the completion of outcome measures during the pilot period.

Aim 3: The referral and screening process

Family Support did not supply any information about families who were referred to the intervention but were not suitable. For the majority of the 89 enrolled families, the child was 11 years old, predominantly male and Black (31.46%) or White (22.47%). Most referral sources were not recorded, but for those that were recorded, the main route was through schools. Time from referral to enrolment ranged from two days to 425 days, with COVID-19 lockdown periods severely impacting the recruitment process.

Due to not having information about families who were not eligible, it is not possible to speculate on the risk of bias during the referral and screening process.

Aim 4: Client retention and data completion

The intervention provided no data on the number of sessions attended by the families and did not provide completion data for all the families enrolled in the programme. Assuming that the 34 families who did not have any follow-up data collected were lost to follow-up, client retention was just under two-thirds or 54 families (60.67%) retained in the programme for six months. Overall, 48 families are reported to have

completed the programme, and five families are reported as continuing with the programme at six months. Data completion rates for those enrolled at baseline were poor overall. Of those who stayed in the programme for six months, children's SDQ measures were completed at an acceptable rate (81.48% of those who completed the programme), the SCORE 15 was slightly lower (68.51% of children who completed), the CRIES-8 was completed by just over half the remaining children and the ESYTC by about a fifth. Data completion rates for the parents were poor.

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 or unsatisfactory (red), and one may be possible to meet (amber). Specifically, we were unable to assess bias in the screening and referral processes. Retention of families in the intervention was good; 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 whether the fourth one could be met – to deliver a trial of sufficient magnitude – would depend firstly on whether data completion could be improved. It would also be necessary to be able to demonstrate no bias in the screening and selection processes. Then, it would depend on the identification of a suitable control intervention and 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

When assessing whether the programme was delivered as intended, it should be noted that the evaluation coincided with when implementation was strongly affected by COVID-19. During feasibility, any engagement with schools was almost impossible during the first lockdown period. This improved as schools and families adjusted to different pandemic-related measures. It is particularly noticeable that the vast majority of parents did not complete the measures. This may be in part because the intervention works most closely with young people. Measures could be completed with an IIP, mentor or counsellor during one-to-one sessions in school with young people.

The intervention is designed to be implemented by practitioners using different approaches and tools. It is unclear from the logic model exactly how long each child is expected to be supported by each of these professionals, particularly the ASE mentors, who come at the end of the process and can be returned to after completion of work with IIPs. It is also unclear from this evaluation if particular criteria are assessed as part of a handover between professionals. However, the implementation process assessment indicates that practitioners felt that transitions between them were handled smoothly. Parents, and potentially young people, were less clear about the different types of professionals offering the intervention, but all seemed to have been greatly appreciated. One common theme in the interviews was how well individual families felt supported by the tailored packages put together for their child. It would seem, therefore, that, in alignment with the logic model, different elements of the potential package were being drawn on according to the assessed needs of the young people.

Service user engagement

As already noted, quantitative assessment of parents' responses was compromised by their low engagement with the core measures. The qualitative interviews and feedback show that families greatly appreciated the support and empowerment facilitated through the intervention. Adults with parental responsibility noted improvements in young people's psychological well-being and engagement in school. There were some indications that they would have appreciated knowing about the programme prior to their child being referred to it. Also, it was not always clear that they knew the criteria on which referrals were based. We do not know exactly the reasons for initial engagement with the programme, nor why some people did not complete it. It is, therefore, hard to speculate about how those who were lost to the intervention may have been better engaged with or if they had been deemed unsuitable for it at some point in the process (either by themselves or the delivery team). The interviews conducted with some families who were retained are extremely positive and show excellent service user engagement.

Programme responsiveness

Relationships between families and practitioners were generally seen as being positive. It was clear that families felt listened to and that they appreciated the support being offered to children and young people in their care. They also appreciated that the young people were being treated as individuals when it came to looking at how to advise them. In a complementary manner, the group work also seems to have been appreciated, not least in helping young people avoid feeling stigmatised and in recognising that there were other children 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 Family Support T&R, the qualitative data from practitioners and managers demonstrate their willingness to respond to the needs of individual families and to assess ongoing development of the intervention. For example, the professionals were able to identify reasons why families may be hesitant to engage initially with the support being offered. There was also some practitioner attempt to consider differences in culture and views that may be prevalent regarding psychological intervention.

The responsiveness extends as well to the intervention's relationship with other agencies. For example, practitioners were concerned that if they tried to push parents to allow their child to engage with the project, against their judgment, intervention would be counteractive. Professionals would try to change families' minds using persuasion and try to help families recognise the potential positive benefits. However, they did not want to appear coercive. There was concomitant recognition that this may risk leaving a safeguarding need unaddressed. In such instances, the team would refer back, making recommendations about the use of potential alternatives to their team to address the outstanding safeguarding matters.

Evidence of promise

Having addressed the research aims above, this section will consider the implications of the findings to the logic model (Figures 2 and 3 above).

Broadly speaking, the findings reinforce the logic model. The Brain in Hand app, in hindsight, was probably always going to be difficult due to the age of the children involved. With that exception, the inputs were delivered as intended and seemed to work in supplementary and complementary manners.

The initial outputs were affected by the pandemic, but where data completion rates were sufficient for analysis, findings are consistent with the theory of change, and it does not seem necessary to change them. The short-term outcomes were largely determined by the core measures being used by YEF. The data do indicate positive changes on some of those measures, but not on all of them. If those measures are to be retained, then a way to build in better data completion would be necessary, particularly from parents.

This is an early-stage intervention designed to engage young people who are not necessarily heavily involved in delinquent activity. Although some of the young people were targeted because of risk of involvement in street gangs, this was not a prerequisite. It may be that the ESYTC could be kept as a potential, but not a required measure, to be deployed according to practitioners' professional judgement. This may also be something to consider with tools specifically aimed at trauma. The mid- to long-term outcomes cannot really be commented on as part of this evaluation, although we do note that both parents and young people reported better engagement in schools and greater willingness from children to go (back) to school.

Overall, we are cautiously optimistic that the logic model was a fair reflection of what was found in the evaluation and that significant modification would not be necessary prior to a randomised trial, should the other conditions for a trial be met.

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 yet. In particular, it would be important to be sure of the following:

1. Whether there was still capacity to deliver the intervention or whether it could be reinstated
2. If sufficient evidence could be gathered to indicate non-bias at screening and referral
3. Whether the current/reinstated programme would be able to increase capacity or if other sites could be identified
4. If sufficient evidence could be gathered to indicate that data completion can be improved
5. Whether a suitable control intervention could be identified that is not subject to too much heterogeneity, and
6. 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	For the children, reported changes over time on the SDQ and SCORE 15 were in the desired directions, sustained over the duration of the evaluation and statistically significant. Although the direction of travel is the same for the rest of the measures, the levels of improvement are not statistically significant. Very few parents completed all of the core measures, and even the most marked adult reported difference (in the SDQ between baseline and three months) did not reach statistical significance. The large proportion of missing data makes interpretation difficult. The COVID-19 pandemic was a significant disruptive factor in preventing the completion of outcome measures during the pilot period as was the significant staffing reorganisation and restructuring for those involved in Family Support.
Effect size	For two of the children's measures, reported effect sizes are moderate (SDQ dz=0.66) and large (Score-15: dz=.89), indicating a robust, positive effect of the intervention. Although scores on the CRIES-8 and the ESYTC scores show a slight downward trend, they are not statistically significant.
Referral and screening	It is not possible to speculate on the risk of bias during the referral and screening process because information was not provided about families who were not enrolled.
Retention and data completion	Retention with the programme was satisfactory; however, data completion rates were low. The maximum number of families providing data at follow-up is 44 (49.44%) at six months.
Potential to move to a randomised trial	At present, we do not think that this intervention is ready to progress to a randomised trial. There remains the potential to complete an appropriately powered trial, but several issues would need to be addressed to recommend progression to a full trial: i. Can sufficient evidence be gathered to indicate a lack of bias at screening and referral? ii. Can sufficient evidence be gathered to indicate that data completion can be improved? iii. Can a suitable control (business as usual) be identified that is not subject to too much heterogeneity? iv. Evidence would need to be gathered to indicate that families would be willing to be randomly allocated to control or intervention. v. If these issues can be addressed, it is likely that a trial of sufficient magnitude can be delivered.
Fidelity of intervention	Despite changes that had to be made for COVID-19, Family Support T&R was broadly implemented as initially intended and in close alignment with the logic model. One change was made during the feasibility phase, which was to remove the Brain in Hand CBT type of mobile phone application.
Service user engagement	The implementation process interviews indicate that, for those interviewed, service user engagement was commendable and sustained. However, it was clearly difficult to gain service user engagement in completing the core measures, particularly from parents/carers.
Intervention responsiveness	The flexibility and responsiveness of the mentors, counsellors and practitioners were noted by interviewees from each key group (children, adults with parental responsibility, referrers and other professionals), although families were not always clear on the role of each professional.

Evaluator judgement of intervention and evaluation feasibility

In this case, there were significant barriers to meeting the success criteria for moving to a larger-scale, randomised trial. These include the responses to the COVID-19 pandemic as well as the reorganisation/restructuring of Family Support. The quantitative and qualitative findings indicate that this early-stage intervention is much appreciated by families and has moderately successful outcomes. If delivery expertise can be retained and the conditions for a trial met, then it would be feasible for additional evaluation. However, as it stands, the intervention is not (yet) ready.

Interpretation

As noted in the background section of this report, Family Support T&R offered a trauma-informed intervention. Rather than providing services to treat one or more particular aspects of trauma, a trauma-informed approach seeks to be engaging and accessible, seeking to avoid worsening trauma by not acting in ways that would be harmful (University of Buffalo, 2019). Although tending to move in the desired direction, the quantitative data on measures of trauma did not show a statistically significant improvement. The qualitative implementation process findings indicate that families find practitioners to be approachable, accessible and trustworthy, all of which are consistent with trauma-informed work, although not unique to that approach. Young people and/or their families are positive about the practitioners, mentors and counsellors and respond positively to the intervention. This would be much harder and less likely to succeed if the intervention itself were triggering or potentially re-traumatising. Hence, if the experience of these service users is representative, it seems fair to conclude that the intention of acting appropriately and accessibly is met.

Similarly, the findings indicate that the team were young-person centred but with a strong emphasis on family needs. There was also some evidence of awareness of the different local communities and cultures and evidence of good relationships with many (if not all) schools. These are all part of delivering effective wraparound support (Bruns and Walker 2008). Mentors in this programme work hard to develop and sustain good relationships with young people and their families. Meetings seem to have occurred when needed, and IIPs were frequently available in the schools. Together, these would seem to demonstrate that meaningful contact was established in ways that might be expected to succeed (Tolan, 2013).

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 before a randomised control trial could be envisaged. Each core measure was used to a different extent, and it would be worth considering each measure separately prior to a wider roll-out (alongside the other conditions already considered). It may be worth noting that although the intervention was designed to improve executive functioning, this was not specifically measured by the T&R nor required by commissioners as part of the core measures. Conversely, given the low completion rates, and relatively low delinquency risks, we think it unnecessary to retain trauma or delinquency measures should a trial be conducted later.

When interpreting the low completion rates, it is also worth considering that IIP familiarity with the core measures would have varied, as would families and young people's potential previous experiences of some of these measures, e.g. through their use in CAMHS. Where completed, core measures seem to have been used appropriately, but the practitioners acknowledged some variability in their comfort with implementing them. Particularly, when so much was in flux during early lockdowns, it is hard to judge whether the

challenge was in the use of the measures themselves or the appropriateness of the ways and context within which they were being implemented.

Another potential limitation relates to the participant implementation process assessment. The similarity and consistency across many of the themes considered are 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.

The data did not allow the evaluation team to consider potential causes of bias in recruitment or retention to the intervention, and some caution needs to be exercised regarding the data completion rates. It is possible that those who did not complete the measures differed in some 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 (business as usual). For most of the referred families, there is no 'treatment as usual'. It would therefore be necessary to consider what a control intervention might look like and who would provide it.

References

asecic.org.uk. (n.d.). Who. [online] Available at: https://www.asecic.org.uk/who [Accessed 10 Feb. 2022]

Asmussen, K., Masterman, T., McBride, T. and Molloy, D. (2022). *Trauma-informed care: Understanding the use of trauma-informed approaches within children's social care.* London: Early Intervention Foundation. Available at: https://www.eif.org.uk/report/trauma-informed-care-understanding-the-use-of-trauma-informed-approaches-within-childrens-social-care

Bell, B., Costa, R. and Machin, S. (2021). Why does education reduce crime? *Journal of Political Economy*. 130(3), pp. 732–765. doi:10.1086/717895

Bruns, E. J., and Walker, J. S. The National Wraparound Initiative Advisory Group. (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health. Available at: https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf [Accessed 10 Feb. 2022]

Buffalo Center for Social Research (2019). *What is trauma-informed care?* University at Buffalo School of Social Work – University at Buffalo. [online] Available at: http://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html. [Accessed 7 Feb. 2022]

CDC (2020). *Adverse childhood experiences* (ACEs). [online] Available at: https://www.cdc.gov/violenceprevention/aces/index.html. [Accessed 7 Feb. 2022]

Crosweller, S., Stafford, M. and Bathgate, H. (2022). *The education and social care background of young people who interact with the criminal justice system*. London: Office for National Statistics. [online] Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/theeducationandsocialcarebackgroundofyoungpeoplewhointeractwiththecriminaljusticesystem/may2022#absence-and-exclusions. [Accessed 25 Nov. 2022]

Department for Education and Ministry of Justice (2022). *Education, children's social care and offending descriptive statistics*. London: Crown. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1059556/Education_children_s_social_care_and_offending_descriptive_stats_FINAL.pdf. [Accessed 24 Nov. 2022]

Eldridge, S.M., Lancaster, G.A., Campbell, M.J., Thabane, L., Hopewell, S., Coleman, C.L. and Bond, C.M. (2016). Defining feasibility and pilot studies in preparation for randomised controlled trials: development of a conceptual framework. *PLOS ONE*, 11(3), p. e0150205. doi:10.1371/journal.pone.0150205. [Accessed 3 Dec. 2022]

Goodman, R. (1997). *Strengths and difficulties questionnaire* (SDQ). APA PsycTests. Available at: https://doi.org/10.1037/t00540-000. Also available from: https://www.sdqinfo.com/

Jolliffe, D. and Farrington, D. (2008). T*he influence of mentoring on re-offending*. Stockholm: The Swedish National Council for Crime Prevention.

London Borough of Hammersmith and Fulham (LBHF) (2022). *Early intervention strategy 2022–2027.* Available at: https://www.lbhf.gov.uk/sites/default/files/section_attachments/cmc_hf_early_intervention_strategy_2022-27_final.pdf. [Accessed 18 Nov. 2022]

McVie, S (2007). Technical Report Sweeps 3 and 4. *Technical report number 2: Edinburgh study of youth transitions and crime*. Available at: https://www.edinstudy.law.ed.ac.uk

Midgley, N., Reynolds, S., Kelvin, R., Loades, M., Calderon, A. and Martin, P., IMPACT Consortium and O'Keeffe, S. (2018). Therapists' techniques in the treatment of adolescent depression. Journal of Psychotherapy Integration, 28(4), pp.413–428. doi:10.1037/int0000119.

NHS England (2019). *The NHS Long Term Plan. [online]* Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf. [Accessed 8 Feb. 2022]

National Institute for Health and Care Excellence (2018). Final Post-traumatic stress disorder: evidence reviews for organisation and delivery of care for people with PTSD. *NICE guideline NG116 Evidence Reviews.* [online] Available at: https://www.nice.org.uk/guidance/ng116/evidence/evidence-review-i-organisation-and-delivery-of-care-for-people-with-ptsd-pdf-6602621013. [Accessed 8 Feb. 2022]

Perrin, S., Meiser-Stedman, R. and Smith, P. (2005). The children's revised impact of event scale (CRIES): validity as a screening instrument for PTSD. *Behavioural and Cognitive Psychotherapy*, 33(4), pp. 487–498. https://doi.org/10.1017/S1352465805002419

Round Midnight. (n.d.). *Virtual_decisions*. [online] Available at: https://www.roundmidnight.org.uk/virtual_decisions/ [Accessed 17 Feb. 2022]

Schulz, K.F., Altman, D.G. and Moher, D. (2010). CONSORT 2010 Statement: updated guidelines for reporting parallel group randomised trials. *BMJ*, 340(1), pp. c332–c332. doi:10.1136/bmj.c332

St James-Roberts, I., Greenlaw, G., Simon, A. and Hurry, J. (2005). *National evaluation of youth justice board mentoring schemes* 2001-2204. [online] Available at: https://core.ac.uk/download/pdf/4157305.pdf. [Accessed 8 Feb. 2022]

Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E. and Peppiatt, A. (2014). Validation of the SCORE-15. Index of family functioning and change in detecting therapeutic improvement early in therapy. *Journal of Family Therapy*. 36, pp. 3–19. doi:10.1111/1467-6427.12022. Also available from: https://www.aft.org.uk/view/score.htm

Tarling, R., Davison, T. and Clarke, A. (2004). T*he national evaluation of the youth justice board's mentoring.* Youth Justice Board: London. Retrieved from http://yjbpublications.justice.gov.uk/en-gb/Resources/Downloads/mentoringfull.pdf. [Accessed 8 Feb. 2022].

Thabane, L., Ma, J., Chu, R., Cheng, J., Ismaila, A., Rios, L.P., Robson, R., Thabane, M., Giangregorio, L. and Goldsmith, C.H. (2010). A tutorial on pilot studies: the what, why and how. *BMC Medical Research Methodology*, [online] 10(1). doi:10.1186/1471-2288-10-1. [Accessed 3 Dec. 2022]

Tic+. (n.d.). *Young Hammersmith & Fulham Foundation*. [online] Available at: https://www.ticplus.org.uk/resources/hammersmith-fulham/. [Accessed 17 Feb. 2022]

Tolan, P., Henry, D., Schoeny, M. and Bass, A. (2008). Mentoring interventions to affect juvenile delinquency and associated problems. *Campbell Systematic Reviews*, 4(1), pp. 1–112.

UNICEF (1989). *UN Convention on the Rights of the Child (UNCRC)*. UNICEF UK. [online] Available at: https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

Washington State Institute for Public Policy (WSIPP) (2020). Available at: https://www.wsipp.wa.gov/ReportFile/1727/Wsipp_Updated-Inventory-of-Evidence-Based-Research-Based-and-Promising-Practices-For-Prevention-and-Intervention-Services-for-Children-and-Juveniles-in-the-Child-Welfare-Juvenile-Justice-and-Mental-Health-Systems_Report.pdf. [Accessed 10 Feb. 2022]

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168–189). New York: Guilford Press. Also available from https://www.ptsd.va.gov/professional/assessment/adult-sr/ies-r.asp

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: Family Support-Transition and Resilience programme

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 – Family Support-Transition and Resilience programme - 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: Family Support-Transition and Resilience programme

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 Family Support-Transition and Resilience programme.

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: Family Support-Transition and Resilience programme

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

Family Support-Transition and Resilience programme

(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 Family Support-Transition and Resilience programme

(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.		

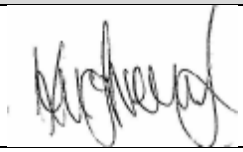
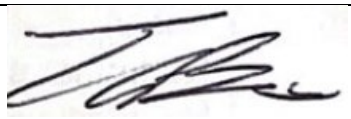
HAZARD ASSESSMENT						
Severity of Consequences	Score	Risk Classification				
No or minor injury/ health disorder Minor Damage or Loss Insignificant Environmental Impact Group 1 Biological agents	1	Trivial (1)	Trivial (2)	Trivial (3)	Trivial (4)	Tolerable (5)
Injury or Health Disorder – resulting in 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 Almost Impossible	2 Unlikely – possible exposure every 1-3 years	3 Harm is possible	4 Harm is likely to occur	5 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: 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: Family Support

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 Family Support-Transition and Resilience programme.

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

Family Support-Transition and Resilience programme

(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

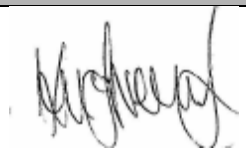
Other hazards not listed above	Vulnerable children (at risk of offending) and their parents/carers. Some respondents may experience distress, feel vulnerable having shared their personal experiences, and be anxious about the use of their accounts to inform the research.

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	All respondents will be debriefed and offered referrals and contact details for additional support (e.g. a range of suitable charities,	Low.	No.	All fieldworkers are experienced, trauma-informed researchers. As

		issues, views or experiences reported during the course of an interview.	ensuring people are not directed again to services in which they have had negative experiences).			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*