EVALUATION PROTOCOL

Cash for families: A randomised controlled trial of a social care intervention

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Principal investigator: Julian Edbrooke-Childs

YOUTH ENDOWMENT FUND

Cash for families: A randomised controlled trial of a social care intervention

Evaluation protocol

Evaluating institution: Anna Freud
Principal investigator(s): Julian Edbrooke-Childs

YEF trial protocol for efficacy and effectiveness studies

Project title	Cash for Families: A randomised controlled trial of a social care intervention
Developer (Institution)	The Policy Unit, King's College London
Evaluator (Institution)	Anna Freud, University College London (UCL), University of Exeter, University of Plymouth
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Protocol author(s)	Julian Edbrooke-Childs, Vashti Berry, Nick Axford, Amy Bond, David Westlake, Matthew Constantinou, Philippa Powell, Abigail Thompson, & Jessica Deighton
Trial design	Two-armed randomised controlled trial with randomisation at the individual index-child level
Trial type	Efficacy
Evaluation setting	Local Authorities
Target group	Families with at least 1 child with a Child in Need (CiN) or Child Protection Plan (CPP) status and who are eligible to receive financial support under Section 17

Number of participants	1,291 children (aged 10-16) recruited from 8-10 Local Authorities
Primary outcome and data source	Child-reported externalising difficulties measured by the conduct + inattention difficulties subscales of the Strengths and Difficulties Questionnaire (SDQ) measured at baseline and 35 weeks post-randomisation.
Secondary outcome and data source	Child-reported outcomes measured at baseline and 35 weeks post-randomisation: • Internalising difficulties measured by the emotional + peer difficulties subscales of the SDQ. • Total difficulties measured by the total difficulties score of the SDQ. • Prosocial behaviour measured by the prosocial behaviour subscale of the SDQ. • Impact of difficulties measured by the impact supplement of the SDQ. • Family functioning measured by the total score of the Systemic Clinical and Routine Outcome Evaluation (SCORE-15). • Substance misuse. • Time spent engaging in activities with parent/carer. Parent/carer-reported outcomes measured at baseline and 35 weeks post-randomisation: • Parent/carer anxiety measured by the total score of the Generalised Anxiety Disorder (GAD-7). • Parent/carer depression measured by the total score of the Patient Health Questionnaire (PHQ-8). • Parent/carer wellbeing measured by the Short Warwick-Edinburgh Mental Wellbeing Scale. • Family functioning measured by the total score of the SCORE-15. • Financial stress/strain measured by the modified Financial Stress Questionnaire.

	Local Authority reported outcomes measured at 35 weeks post-randomisation: • Welfare concerns about the child measured by number of strategy discussions and contacts/referral to the Multi-Agency Safeguarding Hub. • Child's school attendance and fixed-term and permanent exclusions.

Protocol version history

Version	Date	Reason for revision
1.5 [latest]	30/10/2025	Updated ineligibility criteria to clarify that when a participating child enters care, they will not automatically be excluded from the study. Added "child being taken into care" to the list of adverse events. Included "changes to social care status" in the LA-reported outcomes, to capture information on children entering care and the duration of care. Replaced the use of the PHQ-9 with the PHQ-8 to measure parent/carer depression. Removed the process requiring SPOCs to send enrolled families' demographic data to reduce duplication of effort, as families will enter this data themselves. Changed the translation languages of documents from Punjabi and Bengali to Polish and Urdu, following scoping discussions with the LAs.
1.4	23/09/2025	Updated details regarding UCL's involvement and the use of the REDCap database (which has replaced POD).
1.0 – 1.3	30/07/2025	

Any changes to the design or methods need to be discussed with the YEF Evaluation Manager and the developer team prior to any change(s) being finalised. Describe in the table above any agreed changes made to the evaluation design. Please ensure that these changes are also reflected in the SAP (CONSORT 3b, 6b).

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Study rationale and background

Families who are known to Children's Social Care are particularly disadvantaged, and many of them are affected by poverty and low incomes. Children who have a social worker have disproportionately high levels of involvement with the criminal justice system, both as victims and offenders (Children's Commissioner, 2024; Schofield et al., 2015). Recent statistics suggest that more than half of looked after children have a conviction by age 24 and are more likely to be convicted at a younger age than their non-care experienced peers (ONS, 2022). Furthermore, Black and Mixed Race boys with experience of care appear to be at even greater risk of being convicted (Lammy, 2017). Other outcomes for children who have a social worker – from education to mental ill-health – are similarly poor (MacAlister, 2021, 2022). Added to this, new risks such as 'county lines' networks and developing forms of exploitation are drawing vulnerable young people into criminal activity (Maxwell, 2024; Andell & Pitts, 2017).

This is coupled with the withdrawal of traditional forms of support that protected young people from these risks. Since 2010 there have been severe cuts to services designed to support young people and divert them from offending. The Local Government Association estimates that youth services have been cut by around 70% in this period, which is likely to have added pressure on targeted services and removed an important form of community safeguarding (Local Government Association, 2020). This highlights the need for radical approaches to addressing the problems, and cash transfer programmes are a promising solution.

The rise of cash transfers for tacking social problems

There has been a sharp increase in the number of cash transfer programmes being undertaken in recent years, including in the UK. 'Cash transfer' is an umbrella term for a range of interventions which include one off or regular cash payments which may be conditional or unconditional. This includes schemes such as basic income programmes, minimum income guarantees, and negative income tax schemes. There is particular interest in unconditional basic income initiatives, and the intervention in this study – a regular, predictable cash transfer not subject to behavioural conditions – has much in common with these programmes.

At the time of writing, Stanford University logs over 200 active/concluded basic income experiments (Stanford Basic Income Lab, 2025) and we are aware of several other pilots currently underway. Using cash to tackle various social problems has become more mainstream since the Covid-19 pandemic, with many current pilots funded by governments (e.g., Finnish Government), devolved administrations (e.g., Welsh Government; U.S. states), intergovernmental organisations (e.g., the World Bank), and charities or Non-Governmental Organisations (NGOs) (e.g., What Works Centres; Give Directly).

Cash transfers have been targeted at a wide range of social problems, including poverty, physical and mental health, homelessness, unemployment, and transitions from care to independence (Bastagli et al., 2016; Dwyer et al., 2023; Johnson et al., 2023; Watson, 2020). The underlying rationale is that cash may be a more effective, efficient and humane way of alleviating social problems than more traditional forms of support. Indeed, there is growing evidence that cash may be effective in several ways. Positive effects have been reported on wellbeing and mental health, education, poverty, and entrepreneurship, among others (De Wispelaere et al., 2019; McGuire et al., 2022; Ribas, 2014; Sedlmayr et al., 2020).

Notwithstanding this evidence of positive effects, some studies challenge the notion that cash can have a transformative and sustained impact on recipients. In one of the most comprehensive studies to date, where 3,000 participants were given $1000 monthly for 3 years, effects were mixed and overall underwhelming. Large but short-lived improvements in stress and food security were reported alongside an *increase* in hospitalisation and only moderate effects on other outcomes such as employment (Miller et al., 2024).

Evidence for cash transfers in relation to youth crime

Moreover, these interventions have not been extensively used to address youth crime. Cash transfer and basic income schemes are more commonly targeted at health, education and employment rather than child behaviour or youth crime outcomes (Gibson et al., 2018; Hasdell, 2020). Nonetheless, a recent systematic review of the evidence that is available suggested that cash transfer programmes may reduce certain risk factors and act as a protective factor for women and children experiencing violence (Machado et al, 2024). Other pilots do provide evidence about effects on related issues that may be important factors in youth behavioural difficulties and offending. This includes positive impacts on factors that may be related to future involvement in crime, such as child and adolescent mental health, early childhood development, and family relationships (Akeem et al., 2010; Basic Income Canada Network, 2019; Ferdosi et al., 2020; Marinescu, 2018). Moreover, there are associations between behavioural or emotional difficulties among children and later involvement in crime and violence, and this suggests focussing on these outcomes may yield valuable evidence about how to reduce youth violence (Moffit, 1993).

This suggests there may be unrealised potential in cash transfer interventions for tacking youth crime.

Launched in 2018, the Baby's First Years randomised controlled trial (RCT) explored the impact of unconditional cash transfers for mothers in low-income families on early childhood development. Though not explicitly designed to address youth violence, its findings have important implications for early risk factors related to behavioural problems.

The programme provided either $333 per month (treatment group) or $20 per month (control group) to 1,000 low-income mothers in four cities in the USA. Payments started shortly after birth and continued for the first 40 months (just over 3 years) of the child's life. The evaluation team reported reduced behavioural problems among toddlers in families receiving the higher payments, including lower levels of aggression and emotional reactivity. Notably, maternal stress was significantly lower in the treatment group, which researchers linked to improved mother-child interactions. There were also improvements in cognitive functioning in parts of children's brains associated with language, memory, and executive functioning—skills associated with impulse control and reduced risk for later emotional and behavioural difficulties (Noble et al., 2021; Troller-Renfree et al., 2022).

Elsewhere, Ozer et al. (2009) identified indirect effects of child behaviour – a reduction in aggressive behaviour – among young children resident in the poor families who took part in Mexico's *Oportunidades* conditional cash transfer programme in the late 1990s. Similarly, other trials have found positive changes in family wellbeing measures. For example, the SEED programme in Stockton – which tested the effects of $500 monthly payments to families – reported parents spending more time with children and improved parental mental health (Stockton Economic Empowerment Demonstration, 2021).

Potential adverse effects of cash transfer programmes

Alongside the benefits discussed above, several potentially adverse effects of cash transfers have been acknowledged in the literature. These include the possibility for financial exploitation and the exacerbation of problems such as addictions (Holland et al, 2024). This has implications for how the money is distributed and who receives it, especially where a family-level intervention is being delivered. More generally, it underlines the need for policymakers and researchers to consider the potential for harm and assess risks appropriately. Nonetheless, there is also evidence from some studies that theorised adverse effects have not materialised (Evans & Popova, 2017).

Reduction of financial help for children in need

An important context for the current study is that other forms of cash support for families involved with Children's Social Care have always been modest and have been decreasing in recent years. For many decades, the Children Act 1989 (and previous legislation in this area – going back to 1969) has included provision for cash to be given to children and families in need. Local authorities (LAs) can grant financial assistance to families where a child is on a child in need or child protection plan under Section 17 of the Children Act 1989;

> *The services provided by a local authority in the exercise of functions conferred on them by this section may include providing accommodation and giving assistance in kind or… in cash. (Children Act, 1989)*

Yet recent evidence suggests budgets for families under this provision have been under increased pressure (Association of Directors of Children's Services, 2018; 2021) due to austerity and increased demand (Hirsch, 2022; Westlake et al., 2022). As a result, the use of Section 17 has become more targeted, formalised, and crisis-oriented over the past two decades. Researchers and policy makers have repeatedly highlighted the tensions between preventative work and crisis intervention in relation to how Section 17 funds are used (Featherstone, Morris & White, 2014), and the broader issue of professional discretion in financial support pre-dates the Children Act 1989 (Heywood & Allen, 1971).

The amount of financial help currently provided via Section 17 is typically much lower than the cash transfers due to be made in the current study, and one-off assistance is much more common than regular grants. It is also associated with a higher bureaucratic burden for practitioners and managers. In part due to the budgetary pressures discussed above, there are typically strict procedures in place to control and limit the amounts of money distributed. In many LAs, social workers require approval from managers or resource panels (i.e., senior managers) in order to grant any funds from Section 17 (Westlake et al., 2022). Moreover, in a previous study of organisational culture in an LA, a member of our evaluation team observed a convoluted process to obtain management sign off taking to cover the bus fare for a parent (£1.30), which took over an hour (Forrester et al., 2013). This highlights how materially different the intervention in the current study is compared to usual provision.

Two theories that underpin cash transfer programmes

There is a growing body of evidence linking household income to child development, and the research suggests that higher levels of household income facilitate positive child outcomes and that poverty can impede child development. These include cognitive and social-behavioural development and health outcomes (Cooper & Stewart, 2020). In light of this and the evidence above, there are two established theories that help us to understand how the cash transfers might work to support families and reduce the likelihood of children offending: the Family Stress and Family Investment Models.

The Family Stress Model (FSM) focuses on how economic hardship affects child development through parental distress, inter-parental conflict and disrupted parenting – providing an explanation of why poverty exacerbates negative outcomes (Conger et al., 2010). The Resource Investment Model (RIM) explains how socioeconomic resources affect child development through parental investments in their development and future opportunities (Duncan et al., 2014). It provides a framework for understanding how economic advantages translate into positive child outcomes – both as a result of material investments (e.g., higher quality housing, learning materials) and time investments (e.g., more family time, attendance at clubs and extracurricular activities). Other putative mechanisms include enabling families to engage more with other social, health or educational services, or to move to an area with less deprivation or violence. A recent review of studies on the impact of cash transfer studies

on child behaviour and mental health in the US found mixed evidence for the Family Stress Model but stronger evidence for the Resource Investment Model (by increasing child-related expenditures and savings and increasing the time that parents spend with children) (Jaffee et al., 2025). A consistent message in this review and others (e.g., Evans-Lacko et al., 2023) is a need for further investigation of mechanisms of impact of cash transfers.

The cash transfers in the current study are intended to simultaneously reduce family stress caused by poverty and also provide families with an opportunity to invest in their children's wellbeing and development. The intervention has some implicit characteristics that are likely to empower families to achieve change. First, by giving the cash without conditions the message is that they are best placed to decide how to use it. Second, using cash rather than vouchers or other material goods shows families that they are trusted to make good decisions independently. This contrasts with (more common) professionally driven interventions which often have conditions or sanctions attached, and other studies have found that this is likely to increase feelings of autonomy, choice, and motivation (Holland et al, 2024).

Aim of the present research

The aim of the present research is to address the above gaps in the evidence on the impact of unconditional cash transfers on tackling factors associated with youth crime and violence in the long-term. We focus on families who are involved with social care services, where such factors may be overrepresented. To provide robust evidence on the impact of unconditional cash transfers, particularly necessary to justify a high-cost intervention, we will conduct a two-arm RCT: unconditional cash transfer + business as usual vs. business as usual only. We will examine the implementation of the intervention and the processes by which it may affect outcomes through a mixed-methods implementation process evaluation.

Intervention

Intervention description

The intervention is described in detail in the TIDieR document (Appendix 1). It involves providing families with unconditional financial assistance in the form of cash. Payments are unconditional, meaning that no expectation is placed upon recipients (e.g., to seek work or take part in community service). Payments are also unrestricted, meaning that families can choose to spend the money as they wish. Each family receives payments over 45 weeks. Families in London will be given 20% more. Payments are made weekly for 45 weeks. There are fixed dates for starting the intervention and receiving cash, and there is tapering near the end. (The amount of the payments has been removed from this document version to reduce the risk of financial exploitation of participating families.)

Payments are made direct to the designated primary caregiver of the child in question by bank transfer. Unbanked families will be given information about setting up a bank account

by their social worker. The King's College London (KCL) expenses team ('payment agent') makes the payments on behalf of the respective LAs directly into families' bank accounts. The process is overseen by the KCL payment agent. Social workers ('intermediary agent') provide support to enable payments. This includes identifying eligible families, providing information to unbanked families on how to set up a bank account, checking if payments are received (and notifying the payment agent if there are problems with this), monitoring and reporting adverse events (e.g., escalation of substance misuse, financial exploitation), notifying the payment agent of relevant information about the family (e.g., changes to participant eligibility or address). A single point of contact (SPOC) in each LA will provide support with these tasks and pass relevant information about families to the evaluation team to enable recruitment into the study (role detailed below in the section on 'Participants').

Families are eligible to receive the payment if they meet *all* the following inclusion criteria on the census date AND at the point of enrolment:

i. currently engaged with children's services (at least one child who is classed as a Child in Need [CiN] or who is subject to a Child Protection Plan [CPP])
ii. eligible for financial support under Section 17 of the *Children Act* 1989
iii. have at least one child meeting criterion (i) who is aged 10-16 years at the time of enrolment
iv. are open to participating in the study (including providing data at various points)

Families who meet the inclusion criteria will be excluded:

- The sole reason for the CiN status is due to the child having a disability;
- The practitioner identifying the family knows of a risk of financial exploitation for the family or members thereof;
- The practitioner identifying the family knows of a risk of harm that could arise from taking part in the study (i.e., serious, harmful, and persistent parent/child substance use that would be escalated through increased financial resources; a family member is subject to Prevent input; a family member is at imminent risk of serious physical harm requiring sustained hospitalisation from another family member) – this would be agreed on a case-by-case basis by the SPOC/ practitioner with the payment agent;
- There is an imminent escalation of social care/ state input, meaning that the child is likely to be taken into care (e.g., the family is subject to Public Law Outline proceedings) or into the children and young people's secure estate;
- The family or members thereof are under criminal investigation for fraud of financial offences.

There are no specific incentives to encourage families to take up the intervention offer.

Theory of change

The theory of change is set out in detail in Appendix 2 (Version 25.4.25). It may be summarised as follows. Financial hardship is a contributing factor to poor child health and development, involvement in crime and violence, and state intervention in children's lives. An unconditional cash transfer provides a time-limited additional income to families, giving them the agency to direct it towards self-determined needs. The (temporary) increase to net household income improves families' financial security (e.g., through reduced debt or arrears on rent/bills) and reduces financial stress (i.e., improves their ability to afford perceived necessities).

The additional income supports improvements to the material and living conditions of the family and the home environment (including improvements to the quality of housing, where appropriate), and enables the purchase of educational resources, equipment or opportunities for the child. It also enables parents/carers to spend more time with their children *[Resource Investment Model]*. The additional income also improves parent/carer subjective well-being, reduces parenting stress, financial worry/anxiety and finance-related family conflict events *[Family Stress Model]*.

These contribute to improved child outcomes in the *short-term* (improved child behaviour, improved mental health, reduced substance use, improved engagement in education and learning). Long-term *child* outcomes (not measured as part of the study) include reduced offending and involvement in crime/violence, improved educational performance and attainment, and reduced trauma. Long-term outcomes for *parents/carers* (not measured as part of the study) include reduced use of violence and control in family relationships, reduced substance use and increased stability in family relationships and living conditions. Collectively, these changes contribute to families being discharged from social services care or de-escalated (i.e., child no longer classed as a CiN or on a CPP).

Description of business as usual

The nature of business as usual is described in detail in Appendix 3 and summarised here.

Families can receive all forms of service as they would were they not part of the trial. This includes financial or material support provided by local authorities via social workers provision through s.17 of the *Children Act* 1989. It also includes existing community resources and financial capability support (e.g., accessing benefits, money management) provided by a range of statutory and third sector organisations. This is likely to be heterogeneous across participating areas. All families in the trial can access existing financial/material support and financial capability support in line with the respective services' eligibility criteria.

All families in the study will receive a handbook (produced by the payment agent in virtual format, with hard copy available for families without access to a printer or smartphone) signposting them to relevant services that can assist with economic and social challenges.

There will be one handbook only (i.e., not specific to each area), containing a combination of (a) national services and (b) pointers to any local registries of local services.

In two LAs, Impact on Urban Health (IoUH) will offer signposting in the form of community open days to showcase support that they fund. The venue and timing of these is at the discretion of IoUH.

Impact evaluation

Research questions or study objectives

Primary research question:

1. Is providing families with a child aged 10-16 under CiN/CPP with Unconditional Cash Transfers (UCTs), plus Business-as-Usual (BAU) services, more effective than BAU-only in reducing child-reported externalising behavioural difficulties (primary outcome)?

Secondary research questions:

Is providing families with a child under CiN/CPP with UCTs, plus BAU, more effective than BAU-only in improving:

1. Child-reported internalising difficulties?
2. Child-reported prosocial behaviour?
3. Child-reported impact of difficulties?
4. Child-reported family functioning?
5. Child engagement in education?
6. Child-reported substance use?
7. Child-reported time spent with caregivers?
8. Welfare concerns for the child?
9. Parent/carer-reported financial stress?
10. Parent/carer mental health and wellbeing?
11. Parent/carer-reported family functioning?

Is the impact of UCTs on the primary outcome explained (mediated) by changes in financial circumstances and one or more of the theorised pathways:

1. The Family Stress Model (e.g., parent-reported financial stress, parenting stress)?
2. The Resource Investment Model (e.g., housing quality, educational resources and opportunities, parent-child time spent together)?
3. Change in wider living environment (i.e., area-level deprivation)?

Is the impact of UCTs on primary and secondary outcomes, and mediators, different for families (moderated) according to:

1. Baseline level of income?
2. Level of state involvement?
3. Amount of cash received?
4. Number of children in the family?
5. Child gender and ethnicity?

Tertiary aims and objectives

We will examine the extent to which other variables (e.g., child age, completion vs. attrition) affect the impact of UCT plus BAU vs. BAU only on the above outcomes. We will also examine any unintended consequences of UCT and research processes by examining worsening of outcomes over time and reports of negative effects in the implementation and process evaluation and through monitoring safeguarding concerns and (serious) adverse events.

Design

We will conduct a two-arm efficacy RCT: UCT + BAU vs. BAU only. Randomisation will occur at the individual child-level, meaning that if a family has multiple children who meet the inclusion/exclusion criteria one will be selected (the youngest). A 1:3 allocation ratio (UCT + BAU: BAU only) will be used to maximise power whilst keeping the intervention costs as low as possible, to enable the trial to be feasible. The primary endpoint is 35 weeks post-randomisation, which is the end of the mainstage intervention when tapering of cash begins.

Table 1: Trial design

Trial design, including number of arms	**Two-arm efficacy randomised controlled trial: unconditional cash transfer + business as usual vs. business as usual only**
Unit of randomisation	Individual index-child level
Stratification variables (if applicable)	Local authority, social care status (Child in Need vs. Child Protection Plan)

Primary outcome	variable	Behavioural difficulties
	measure (instrument, scale, source)	Child-reported externalising difficulties measured by the conduct + inattention difficulties subscales of the Strengths and Difficulties Questionnaire (SDQ) measured at baseline and 35 weeks post-randomisation.
Secondary outcome(s)	variable(s), measure (instrument, scale, source)	**Child-reported outcomes measured at baseline and 35 weeks post-randomisation:** Internalising difficulties measured by the emotional + peer difficulties subscales of the SDQ. Total difficulties measured by the total score of the SDQ. Prosocial behaviour measured by the prosocial behaviour subscale of the SDQ. Impact of difficulties measured by the impact supplement of the SDQ. Family functioning measured by the total score of the Systemic Clinical and Routine Outcome Evaluation (SCORE-15). Substance misuse. Time spent engaging in activities with parent/carer. **Parent/carer-reported outcomes measured at baseline and 35 weeks post-randomisation:** Parent/carer anxiety measured by the total score of the Generalised Anxiety Disorder (GAD-7). Parent/carer depression measured by the total score of the Patient Health Questionnaire (PHQ-8).

		Parent/carer wellbeing measured by the Short Warick-Edinburgh Mental Wellbeing Scale. Family functioning measured by the total score of the SCORE-15. **Local Authority reported outcomes measured at 35 weeks post-randomisation:** Welfare concerns about the child measured by number of strategy discussions and contacts/referral to the Multi-Agency Safeguarding Hub. Child's school attendance and fixed-term and permanent exclusions.

Randomisation

We will randomize at the individual level (one index child per family, the youngest child within our age bracket) on a rolling basis, following the completion of eligibility, informed consent, and baseline data collection procedures. If there are multiple children with CiN or CPP who meet the inclusion criteria within a family, the youngest child will be selected as the index child.

Randomization will be stratified by LA and social care status (CiN vs. CPP), to ensure equal representation of clinical need within each LA between the UCT+BAU vs. BAU-only. With eight LAs (subject to change), this results in 16 strata (8 LAs x 2 social care groups).

Within each stratum, children will be randomized at a 1:3 allocation ratio to UCT+BAU and BAU-only arms, to maximise statistical power while ensuring adequate representation across the treatment group (see 'Sample Size' section).

Our quantitative researcher–who is independent of participant recruitment and enrolment–will generate a random allocation sequence using the *blockrand* package in R. Researchers blinded to the random allocation sequence will complete the eligibility, consent, and baseline assessment procedures. Researchers will enter baseline data into a centralized system, which will automatically assign index children to the UCT + BAU or BAU only group following the random sequence. Researchers will not be able to view the previous or next treatment assignment. A full audit trail of the randomisation process (e.g., records of the stratification

variables, group assignment, child pseudonymized ID, randomization ID, date and time of randomization) will be securely stored within the trial's electronic data capture system (Research Electronic Data Capture; REDCap), with restricted access to ensure data integrity and participant confidentiality. Randomisation will be conducted once each week during the recruitment periods. The trial manager will notify the primary caregiver, payment agent, and the SPOC at the relevant LA of the allocation outcome; the family's social worker or other relevant practitioners will also be notified either directly by the evaluation team or by the SPOC.

Each participating LA will be funded 0.1 Full Time Equivalent (FTE) for a SPOC for the duration of the study. The role of the SPOC is to:

- Be the primary point of contact for the evaluation team and payment agent;
- Lead on the identification of eligible families for the evaluation, therefore easing the burden on social workers and providing a more systematic approach to identification compared to having a number of different staff in an LA doing this;
- Lead on the screening of eligible families, supported by a relevant practitioner with additional knowledge about the family where necessary;
- Lead on contacting families to provide initial information about the study and gather their interest in taking part (with support from colleagues where necessary);
- Be the safeguarding contact and notify the evaluation team and payment agent of adverse events;
- Manage the LA's participation in the study, including supporting with evaluation data from the LA and helping to address concerns about or barriers to engaging with the evaluation;
- Helping to contact families (e.g., for data collection)

To support the retention to the trial of control group participants, they will receive a substantive material reimbursement at the end of the study in the form of a gift (e.g., an electric blanket).

Participants

The inclusion/exclusion criteria below are the same for the evaluation and intervention.

Inclusion criteria:

- Child aged 10-16 years;
- Child under CiN or CPP;

- Family eligible for financial support under S17 at a minimum for three weeks from time of identification, by which time the intervention would have begun for those assigned to this condition.

Exclusion criteria:

- The sole reason for the CiN status is due to the child having a disability;
- The practitioner identifying the family knows of a risk of financial exploitation for the family or members thereof;
- The practitioner identifying the family knows of a risk of harm that could arise from taking part in the study (i.e., serious, harmful, and persistent parent/child substance use that would be escalated through increased financial resources; a family member is subject to Prevent input; a family member is at imminent risk of serious physical harm requiring sustained hospitalisation from another family member) – this would be agreed on a case-by-case basis by the SPOC/ practitioner with the payment agent;
- There is an imminent escalation of social care/ state input, meaning that the child is likely to be taken into care (e.g., the family is subject to Public Law Outline proceedings) or into the children and young people's secure estate;
- The family or members thereof are under criminal investigation for fraud of financial offences.

SPOCs will notify the evaluation team and payment agent if an included family becomes ineligible during the course of the study because:

- The family moves to a different LA that is not involved in the study;
- The intervention is observed to be increasing harm or risk within the family.

The LA practitioner or SPOC will notify the evaluation team and payment agent if the LA becomes the primary carer for a participating child (e.g., if the child enters care) during the course of the study. In such cases, the family will not be automatically excluded; continuation in the study will be determined on a case-by-case basis by the family, the LA practitioner, and the evaluation team and payment agent.

SPOCs with any questions about whether a family is eligible will be able to consult with the payment agent. This is particularly likely when assessing exclusion due to risk.

Each LA will be allocated to one of the two recruitment periods: cohort 1, September – November 2025; cohort 2: March – April 2026. Families in the intervention group in Cohort 1 will receive the intervention in the period September 2025 to October 2026. Families in Cohort 2 will receive the intervention in the period March 2026 to March 2027. We estimate 1 LA will recruit in September, due to time for LA onboarding, two LAs will recruit in October and two in November, and then three over March and April.

Each LA will be given a census date when families with a child under CiN/CPP are identified. SPOCs will then screen identified families against the inclusion/exclusion criteria. SPOCs will contact eligible families to introduce the study and obtain consent from those interested in taking part to pass their contact details to the evaluation team. If the primary caregiver is interested but does not want the SPOC to pass on their contact details, they will be provided a link to register their interest with the evaluation team and/or they will be provided with the evaluation team's contact details. Prospective participants will then be provided further information about the study and will be able to provide informed consent. They will be able to receive further information and/or support accessing information about the study through information webinars, drop in sessions, and/or booking individual meetings with the evaluation team. Participants will be able to contact us through a study email address and phone number that includes WhatsApp messages and calls. Given the volume of participants and the timescale, we will endeavour to focus the bulk of further information and/or support through resources (e.g., information sheet, video/animation, Q&A) and information webinars.

Participants will be recruited from eight LAs at the time of writing. To reduce the risk of financial exploitation of families, the names of the LAs have been removed from this version of the document.

We will consult with LAs about the most common groups who cannot communicate in English.

Sample size calculations

The sample size was determined a priori, based on a power calculation conducted using the *PowerUp!* tool (Dong & Maynard, 2013). We aim to detect a Minimum Detectable Effect Size (MDES) of 0.19 (standardized mean difference) with 80% power, using a 5% alpha level (two-tailed) and a 1:3 allocation ratio between the UCT+BAU vs. BAU-only arms. Based on these assumptions, and adjusting for 10% attrition in line with YEF guidelines, we require a total of 1,291 children, comprising 323 in the UCT arm and 968 in the BAU arm. We have assumed 75% of referred families will consent to take part, based on families already been screened for eligibility by LAs and having already indicated some level of interest in the study. Therefore, the required number of referrals is 1,721. The conversion rate will be re-assessed after recruitment of cohort 1.

The MDES of 0.19 was informed by Ozer, Fernald, Manley, and Gertler's (2009) findings on the reduction in aggressive and oppositional problems following cash transfers for families living in poor rural communities. We also present MDESs ranging from 0.15 to 0.20 in Appendix 6.

Whilst a 1:1 allocation ratio is more common, where there is a cap on the treatment group size due to budgetary restrictions, a 1:3 allocation ratio produces similar power but with

fewer treated families, hence lower costs (see Appendix 6). We feel a 1:3 is also justified due to our assumption of equipoise for receiving vs. not receiving UCTs. We have also discussed and approved this approach with the funder.

We did not adjust for clustering by LA in the sample size calculation due to the limited number of clusters (currently 8 LAs) and the expectation that LAs will explain a relatively small proportion of the variance in treatment outcomes (e.g., intra-cluster correlation coefficient or *ICC* ≈.05; Duke Clinical Research institute, 2020). Adjusting for clustering with a small number of clusters can lead to inflated sample size estimates. Instead, clustering will be accounted for through stratification in the randomization process and in the analytic plan using random effects models and robust degrees-of-freedom corrections, as recommended by Leyrat, Morgan, Leurent, and Kahan (2018; see statistical analysis below). In Appendix 6, we present different sample sizes based on MDES ranging between 0.15 and 0.2, for 1:3 and 1:1 treatment:control group allocations at 80% power and a 5% alpha level (two-tailed). Sample sizes have been adjusted for 10% attrition.

Table 4: Sample size calculations

		PARAMETER
Minimum Detectable Effect Size (MDES)		0.19
Pre-test/ post-test correlations	level 1 (participant)	N/A
	level 2 (cluster)	N/A
Intracluster correlations (ICCs)	level 1 (participant)	N/A
	level 2 (cluster)	N/A
Alpha		0.05
Power		0.8
One-sided or two-sided?		Two-sided
Average cluster size (if clustered)		N/A

		PARAMETER
Number of clusters	Intervention	N/A
	Control	N/A
	Total	N/A
Number of participants	Intervention	323
	Control	968
	Total	1,291

At this stage, we have assumed equal recruitment targets for each participating LA (i.e., 161 families). We have based recruitment targets for different ethnic groups within each LA using population data for each LA. We expect both of these targets to change following conversations with the LAs and receipt of data from their CiN and CPP records. A recruitment breakdown by study months is shown in Appendix 7.

Outcome measures

At the time of writing, we propose translating study materials into Polish and Urdu following scoping discussions with LAs. We will only include standardised measures that have pre-existing translations into these languages. We will translate demographic questions and non-standardised questions into Polish and Urdu, if needed.

Primary outcome

The primary outcome is **externalising difficulties** measured by the 10-item score, which is the combination of the conduct and inattention difficulties subscales, of the item Strengths and Difficulties Questionnaire (SDQ; Goodman, 1999). The score can range from 0-20. It is a measure in the YEF database and has demonstrated validity and reliability in previous studies; e.g., Cronbach's alpha = 0.65-0.78 (Goodman et al., 2010). It will be measured as baseline and 35 weeks post-randomisation. We have chosen externalising difficulties, rather than a broader total difficulties score, as previous studies of cash transfer interventions show that effects for young people are more pronounced for externalising difficulties than internalising

difficulties (Jaffee et al., 2025). Using the SDQ total difficulties score, combining internalising and externalising difficulties, could reduce our ability to detect change.

Secondary outcomes

All secondary outcomes will be completed at baseline and 35 weeks post-randomisation. The maximum number of items a child will be completing in one survey is 59 including demographics. In similar projects, we have recently consulted young people about the proposed measures, who are of a similar age to the target sample. They completed the measures in 10-15 minutes. Estimating three-to-four items are completed in a minute in the target sample, the survey will take 15-20 minutes. We will review burden during cohort 1 and consider prioritizing secondary outcomes for cohort 2.

Child-reported outcomes

Three outcomes will be measured using 30 items of the (SDQ) (Goodman, 1999), including impact supplement.

2. **Internalising difficulties** comprised of the emotional and peer relationships difficulties subscales (10 items, score 0-20);
3. **Impact of difficulties** (5 items, score 0-10).;
4. **Prosocial behaviour** (5 items, score 0-10);
5. **Total difficulties** (20 items, score 0-40).

The SDQ is a widely used measure of mental health difficulties for children and has demonstrated reliability and validity in previous studies (e.g., Cronbach's alpha: 0.65-0.78) (Goodman et al., 2010). Reduced externalising difficulties, arising from reduced family stress, is the primary outcome in the theory of change. Therefore, we have chosen to measure subscales as secondary outcomes rather than use the SDQ total difficulties score. To assess longer-term outcomes, the SDQ will also be completed at 12-months post endline.

Family relationships is an outcome in the logic model, and one family outcome (**family functioning**) will be measured using the total score of the SCORE-15 (Stratton et al., 2010) (score 15-75) (sample item: "In my family we talk to each other about things which matter to us"), which has demonstrated evidence of reliability and validity in previous studies (e.g., Cronbach's alpha = 0.89-0.90; Hamilton et al., 2015; Stratton et al., 2010). It has been found to be able to differentiate clinical and non-clinical samples and to show change over the course of receiving support. Other measures were considered (e.g., Parenting and Family Adjustment Scale; Sanders et al., 2014) but were not chosen as they did not have child and parent/carer versions and/or they had a greater focus on constructs not represented in the logic model, such as parenting practices, parental wellbeing, and satisfaction with parenting.

Three questions will ask young people how often in the past month they **have drunk alcohol, smoked, and taken non-prescription drugs**. One question will ask young people how many times over the last month have they been intoxicated due to any of the three substance types. To minimise survey burden and intrusion, we have not chosen a measure in the YEF measures database as they are longer and ask very detailed questions about types of substances.

Five questions will ask **how often they have engaged in activities with their primary caregiver** (Dennis & Chestnut Health Systems, 2022): question stem: "During the past 90 days, have you done any of the following things with your (biological, foster, adopted or step) parents?", sample item: "Spent 30 minutes or more playing or doing fun things with them" (response option, yes/no). Although this is a mediator in the theory of change, and parent/carer reported time spent with the child will be analysed as such, we are including the child report as an outcome for three reasons: 1) it is a prosocial outcome, 2) relationship with a trusted adult is an important protective factor for youth crime and violence, and 3) measuring it at midline would be disproportionate as it would be the only survey for children at midline.

Children will be asked to provide **demographic information**.

Parent-reported outcomes

The parent/carer surveys are 56-57 items including demographics. Estimating three-to-four items are completed in a minute in the target sample, the survey will take 15-20 minutes. We will review burden during cohort 1 and consider prioritizing secondary outcomes for cohort 2.

One parent/carer outcome will be measured using the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (Tennant et al., 2007): **wellbeing** (7 items; total score: 7-35) (sample item: "I've been feeling optimistic about the future"). The SWEMWBS is a widely used measure of wellbeing and has demonstrated reliability and validity in previous studies (Ng Fat, Scholes, Boniface, Mindell, & Stewart-Brown, 2017; Tennant et al., 2007). Wellbeing will also be measured at the mid-point survey.

One parent/carer outcome will be measured using the Generalized Anxiety Disorder (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006): **anxiety** (7 items; total score: 0-21) (question stem: "Over the last 2 weeks, how often have you been bothered by any of the following problems?", sample item: "Feeling nervous, anxious or on edge"). The GAD-7 is a widely used measure of anxiety and has demonstrated reliability and validity in previous studies (Löwe et al., 2008).

One parent/carer outcome will be measured using the Patient Health Questionnaire (PHQ-8) (Kroenke et al., 2009): **depression** (8 items; total score: 0-24) (question stem: "Over the last 2 weeks, how often have you been bothered by any of the following problems?", sample item:

"Little interest or pleasure in doing things"). The PHQ-8 is a widely used measure of depression and has demonstrated reliability and validity in previous studies (Kroenke, Spitzer, Williams, & Löwe, 2010).

One family outcome (**family functioning**) will be measured using the total score of the SCORE-15 (Stratton et al., 2010) (score 15-75) (see above).

Parents/carers will be asked to provide **demographic information** and questions on financial circumstances at baseline and endline (i.e., number of jobs, hours worked per week, type of employment, highest level of education, benefits received, and household income). We will ask parents/carers for their full postcode at baseline, midline, and endline. We will link postcode to their Lower-layer Super Output Area (LSOA) and then link the LSOA with the index of multiple deprivation data to facilitate tracking of the extent to which families move to more or less deprived geographical areas over the course of the intervention.

LA data

LAs will be requested to complete data on number of eligible families identified, number of families approached about the study, and numbers families declining on initial approach, with general reasons for exclusion recorded at each stage (i.e., reasons will not be recorded on an individual family basis due to administrative load).

Three outcomes will be captured through practitioner-reported data (e.g., from social worker) either entered by the LA practitioner or collated by the SPOC (baseline and 35-week follow up):

1. **Child's school attendance, fixed-term, and permanent exclusions**. If this is not available, we will ask parents to report it in the endline survey.
2. **Welfare concerns** measured by number of strategy discussions and/or discussions/referrals to the multi-agency safeguarding hub (MASH).
3. **Changes to social care status** (i.e., child entering care and duration) measured only at the 35-week follow-up.

The information will be either entered into the study database through a survey or exported by LAs and securely transferred to Anna Freud and UCL.

Delivery data

The payment agent will be asked to provide the evaluation team information on families in the intervention arm:

- Number of payments successfully transferred;

- Number of payments due but not transferred, with reasons;
- Dates of payments.

The information will be either entered into the study database through a survey or exported by King's and securely transferred to Anna Freud and UCL.

Compliance

Compliance with the intervention will be assessed using routinely collected data from the payment agent on amount of cash successfully transferred to a primary caregiver. A threshold of 80% of cash successfully transferred to each family (i.e., without delay/disruption) will be used to indicate compliance.

Mediators of change (immediate outcomes)

To evaluate how and why any changes in the primary outcome have come about (or to help explain why they have not), it is necessary to measure hypothesised mediators. The theory of change delineates the three main pathways we are testing, namely the Resource Investment Model (RIM), the Family Stress Model (FSM) and change in wider living environment (WLE). Each of these requires that there is first a change in families' financial circumstances (FS). Accordingly, mediator measures have been selected to map onto different elements of these pathways and are described in this order in what follows. As it is not practical to measure all 10 hypothesised mediators identified in the theory of change, we have selected seven (asterisked in the diagram, Appendix 2) to ensure adequate coverage of the three main pathways. Thus, the analysis will investigate the mediating effects of these variables on the primary outcome.

All of these mediator measures will be included in the midpoint survey, which will be administered to parents/carers. Should a mediator measure additionally be included at a different timepoint, this is indicated below. We will review measures with our Experts by Experience and if necessary amend them to ensure they are understandable and make sense in a UK context. We have sought to use validated measures where suitable but if they do not exist or are culturally irrelevant or out of date we propose to develop bespoke measures (again working alongside our Experts by Experience). We indicate where measures are bespoke or validated.

Financial circumstances (FS)

Income: This will be measured by asking parents/carers to indicate the income band that best describes their household income (described above).

Financial stress / perceived ability to afford necessities: This will be measured using an adapted version of the Financial Stress Questionnaire (CPPRG, n.d.), currently a 9-item measure that explores the affordability of spending sources in the household (e.g., home,

clothing, furniture, care, food, leisure) on a 1-5 scale (strongly agree to strongly disagree), the affordability of bills and how much money is left at the end of the month on a 1-4 scale (not enough to more than enough). This will be adapted to remove items that seem less relevant (e.g., affordability of medical care) and to add items that seem relevant (e.g., digital access, leisure and fun activities, community or cultural activities, school supplies, non-school/college related learning, and travel). This will be measured at midline only using parent/carer report.

Debts/arrears: This will be measured using two items in the adapted Financial Stress Questionnaire: "Think back over the past year and tell us how much difficulty you had with paying your bills" (existing question) and "Think back over the past year and tell us how much difficulty you had with paying your rent or mortgage" (new question), 1 to 5 scale (a great deal of difficulty to no difficulty at all). This will be measured at midline only using parent/carer report.

Resource investment model (RIM) pathway

Housing quality: This will be measured using a short series (approximately 6 items) of closed questions about aspects of the family's physical home environment, specifically (i) the adequacy of heating, plumbing and electricity, (ii) internal structural damage and (iii) the presence of damp or mould. This will be derived from a study by the Center for Guaranteed Income Research (CGIR) at the University of Pennsylvania, US. This will be measured at midline only using parent/carer report.

Educational resources and opportunities: This will be measured using a bespoke measure that captures children's access to relevant resources and opportunities. It will be informed in part by items in the HOME-21 that are suitable for young people aged 10-16 years (Lansford et al., 2021, 2023). These include access to books, the internet, a computer and activities such as educational trips/visit or extracurricular lessons. Adaptations will include updating the measure to include recent developments (e.g., the use of language learning apps) and avoid perceived class bias (e.g., regarding the type of extracurricular activities covered). Response options will be selected to fit the questions but are likely to involve Likert scales. This will be measured at midline only using parent/carer report.

Parent time with child: This will be measured using five questions about **how often parents have engaged in activities with their child** (to mirror the questions asked of children – see above). Question stem: "During the past 90 days, have you done any of the following things with your child?", sample item: "Spent 30 minutes or more playing or doing fun things with them" (response option, yes/no). This will be measured at midline only using parent/career report.

Family stress model (FSM) pathway

Parent subjective well-being: This will be measured using the SWEMWBS (described above).

Worry / anxiety about finances: This will be captured through a single bespoke closed question with Likert-style response items: "We worry a lot about money in the house", with a 5-point scale from "Strongly agree" to "Strongly disagree". This will be measured at midline only using parent/carer report.

Conflict in family about finances: This will be captured through a single bespoke closed question with Likert-style response items: "There are often arguments in the house about money", with a 5-point scale from "Strongly agree" to "Strongly disagree". This will be measured at midline only using parent/carer report.

Parenting stress: The Parenting Stress Scale (PSS; Berry et al., 1995) is an 18-item self-report scale used to assess parental stress levels. Sample items include "I enjoy spending time with my child(ren)" and "I feel overwhelmed by the responsibility of being a parent". Each self-report item is rated from strongly disagree (n=1) to strongly agree (n=5). Overall scores can range from 18-90, with a low score signifying low levels of stress and a high score signifying high levels of stress. The PSS is a widely used measure of parenting stress and has demonstrated internal consistency (with Cronbach's alpha values ranging from 0.83 to 0.86), test-retest reliability, and validity in previous studies (Berry et al., 1995; Algarvio et al., 2025; Zelman & Ferro., 2018). This will be measured at midline only using parent/carer report.

Wider living environment (WLE) pathway

Neighbourhood deprivation: This will be measured by linking postcode provided at each time point to data from the index of multiple deprivation (described above). A neighbourhood deprivation score will be calculated at each time point for each family.

Analysis

Ongoing study monitoring

We will routinely monitor the progress of the study through monthly status updates. Although there will not be an internal pilot, the first cohort will give us an opportunity to review progress, identify concerns, and develop mitigation strategies. Table 6 shows the cohort 1 review criteria.

Table 6. Cohort 1 review criteria.

Criterion	Green	Amber	Red
Conversion of referrals to recruitment: This includes numbers of families referred to the evaluation who then meet inclusion/exclusion criteria and provide consent.	75-100% of families referred are consented: 807-1076/1076	55-74% of families referred are consented: 592-806/1076	<55 of families referred are consented: <592/1076
Recruitment: This includes completion of consent, baseline measures, and randomization. The cohort 1 sample recruitment target is 807 for the three-month period. Assuming there are eight included LAs, and the recruitment targets are equally distributed, 807 is the equivalent of four LAs meeting their recruitment targets (one in September 2025, 1 in October 2025, and two in November 2025).	80-100% of target sample recruited: 646-807/807	60-79% of target sample recruited 484-645/807	<60% of target sample recruited: <484/807
Fidelity: This is defined by amount of payments successfully paid out of payments due. Assuming: a) 40 families are allocated to the intervention arm in September 2025, 40 in October 2025, and 80 in November 2025, b) 4 payments are made per family per month, and c) each family is recruited at the start of the month, the maximum total number of cohort 1 payments due at the end of November is 640.	80-100% of payments due are successfully paid: 512-640/640	60-79% of payments due are successfully paid: 384-511/640	<60% of payments due are successfully paid: <384/640
Acceptability: This includes reports from LAs and families about	Few reports that children and parents/ carers	Some reports that children and parents/ carers	Many reports that children and parents/ carers

substantial challenges engaging in evaluation materials and processes.	(<20% of the sample) experience substantial challenges engaging in the evaluation materials and processes.	(20-39% of the sample) experience substantial challenges engaging in the evaluation materials and processes.	(40-100% of the sample) experience substantial challenges engaging in the evaluation materials and processes.
Safety concerns: This includes safety concerns reported by families or practitioners related to taking part in the evaluation/ intervention and number of (serious) adverse events.	Minimal (e.g., 1-3) adverse events reported, none of which are related to the evaluation/ intervention.	Few safety concerns are reported, such as a small number of (serious) adverse events related to the evaluation/ intervention.	Significant safety concerns are reported, which could include a small number of serious adverse events or a large number of adverse events related to the evaluation/ intervention.

Note. Green ratings indicate few concerns about proceeding to cohort 2 and/or minimal changes and mitigations are required. Amber ratings indicate moderate concerns about proceeding to cohort 2 and/or moderate changes and mitigations are required. Red ratings indicate serious concerns about proceeding to cohort 2 and/or substantive changes and mitigations are required.

We will conduct the analysis in three stages:

- Primary analysis: Includes CONSORT flowchart, assessment of selection and randomization bias, and evaluation of treatment differences while adjusting for primary prognostic covariates.
- Secondary analysis: Includes evaluation of treatment differences with additional covariates, moderation analysis, and mediation analysis.
- Tertiary analysis: Includes sensitivity analyses related to attrition, missing data, and engagement with UCT and BAU arms.

Further details for each analysis stage are provided below.

Primary Analysis

First, a CONSORT flowchart will be completed. Bias in selection through the screening process will be considered by comparing families who are not referred, enrolled, or progressed to trial with those who are, using descriptives and standard group comparison methods (t-tests, chi-square tests, and non-parametric equivalents as appropriate depending on the data distribution). Furthermore, balance between UCT and BAU groups following randomization will be checked by comparing covariates using descriptive statistics and group comparison methods (e.g.,t-tests, chi-square tests and non-parametric equivalents). Comparisons will also explore the extent of diversity, with a particular focus on ethnicity and whether recruitment targets are achieved or not.

Next, we will estimate treatment differences using hierarchical generalised linear models, which we refer to as our baseline model. We will examine differences between UCT and BAU arms in our primary outcome (child-reported externalising difficulties) and secondary outcomes (child-reported outcomes, parent-reported outcomes, and LA data; see Secondary Outcomes) at the 35-week primary endpoint. We will use a normal link function for continuous outcomes, logit link function for binary outcomes, and Poisson link function for count outcomes. We will control for baseline scores on the primary or secondary outcome measure to increase power and minimize regression to the mean (Barnett, van der Pols, & Dobson, 2005; van Breukelen, 2006). We will also control for key prognostic covariates, including child age, child gender, social care status (CiN vs. CPP), cohort/time of enrolment (due to staggered starts across LAs), and covariates that might be unbalanced following randomization.

We will include a random intercept to account for clustering of children (level 1) within LAs (level 2). The baseline model can be specified as:

$$Ypost_{ij} = \beta 0 + \beta 1(Baseline)_{ij} + \beta 2(Treatment\ Group)_{ij} + \beta 3(Covariates)_{i} + u0_{j} + \varepsilon_{ij}$$

Where:

$Ypost_{ij}$ is the predicted score on the primary or secondary outcome for child *i* in local authority *j* at 40-weeks (i.e. end of treatment).

$\beta 0$ is the intercept, i.e. the average post-treatment score for the BAU group (i.e. when predictors equal zero).

$\beta 1(\text{Baseline})_{ij}$ is the effect of scores on the primary or secondary outcome at baseline (i.e. week 0) for child *i* in local authority *j*.

$\beta 2(\text{Treatment Group})_{ij}$ is the effect of random assignment to the BAU arm (0) or UCT arm (1).

$\beta 3(\text{Covariates})_i$ is the effect child-level variation in prognostic covariates.

$u0_j$ is the random intercept reflecting variation in the primary or secondary outcome due to local authority *j*.

ε_{ij} is the residual variance for child *i* in local authority *j* which is assumed to be normally distributed, $\varepsilon_{ij} \sim N(0, \sigma^2)$

Estimates will be reported with 95% confidence intervals and *p* values at the 5% level. Effect size indices will include Hedges *g* (based on pre-post differences), Cohen's f^2 and $R^{2.}$ Analyses will include all available data on an intention-to-treat basis. Hierarchical General Linear Models will be conducted in Stata v14.

Secondary Analysis

Secondary analyses will extend the baseline model described above to explore the impact of additional covariates, moderators, and mediators on primary and secondary outcomes.

Additional covariates. In addition to the primary prognostic covariates (e.g., baseline scores, child age and sex, social care status, cohort, unbalanced covariates), we will include additional covariates that could have a confounding or enhancing impact on treatment outcomes, including child ethnicity, parent/carer age, family size, amounts of cash transferred, area-level deprivation, and LA characteristics.

Moderator analysis. We will examine whether the effect of treatment on primary and secondary outcomes varies by moderator variables using an interaction term between treatment group and the individual moderator (e.g., baseline level of income, CiN vs. CPP, amount of cash received, number of children in the family, child gender and ethnicity). This approach avoids the loss of power associated with splitting the sample into subgroups. We will aim to compare individual ethnic categories (e.g., Asian/Asian Britih, Black/Black British, Mixed, White/White British, Other). If numbers are too small, we will collapse categories (e.g., White vs. minoritised ethnic groups). We will also consider descriptive comparisons to aid interpretations of moderation effects.

Mediator analysis. We will use path analysis in Mplus v8 to examine whether our mediator variables (see ***Mediators and immediate outcomes***) measured at six months (mid-treatment) mediate the relationship between treatment assignment at baseline (UCT vs. BAU) and primary outcome (see Implementation and Process Evaluation Research Questions). We will first test each mediator separately and, based on the degree of collinearity (assessed with the Variance Inflation Factor and correlation coefficients), proceed with a parallel or sequential mediation model.

We will run unconditional models without covariates followed by conditional models with primary prognostic covariates (e.g., baseline scores on the primary or secondary outcome

measure and the mediator if available, child age and gender, social care plan, and cohort). If prior moderation analyses indicate that ethnicity moderates treatment effects, we will explore moderated mediation models to examine if and how ethnicity moderates the indirect effects of our mediators.

We will estimate indirect effects using bias-corrected bootstrapped 95% confidence intervals. Furthermore, we will account for clustering at the LA level using the COMPLEX option. We will use maximum likelihood estimation with robust standard errors.

Tertiary Analysis

To assess the robustness of findings in the primary analysis, we will conduct sensitivity analyses based on the baseline model (see above). We will examine differences in treatment outcomes on primary and secondary outcomes by comparing:

- Child age;
- Complete vs. incomplete cases (i.e., excluding attrited participants);
- Intention-to-treat vs. methods for handling missing data (assuming assumptions are met);
- How cash was used.

Longitudinal follow-ups

The SDQ (Goodman, 1999) will be completed at 12-months post-endline.

Implementation and process evaluation

Research Questions

The implementation and process evaluation will address three sets of questions relating respectively to trial procedures, intervention delivery and mechanisms of intervention impact:

1. How successful are trial procedures, specifically recruitment, consent, randomisation and retention?
2. To what extent is the intervention implemented as intended, notably in relation to adherence, fidelity and reach? What factors affect this and how effective are strategies put in place by the payment agent to support effective implementation?
3. To what extent does the intervention improve the primary outcome through hypothesised mediators, for example by reducing financial and family/parenting stress [Family Stress Model] and/or improving the home environment [Resource Investment Model]? Are there any iatrogenic effects and, if so, what is the nature of these and what has contributed to them?

Design

A mixed methods IPE will evaluate trial procedures, assess intervention delivery, and ascertain reasons for the intervention's success or failure. The IPE is underpinned by widely accepted frameworks and models to help ensure it is rigorous, focused and theoretically sound. The MRC Framework for process evaluation sets out the need to investigate context, implementation and mechanisms of impact (Moore et al., 2015). To inform data collection and analysis, we have co-developed: (a) an Implementation Research Logic Model (IRLM; Smith et al., 2020) with the payment agent to map out expected implementation determinants, strategies and outcomes (Appendix 4); (b) an intervention theory of change that integrates both Family Stress Model and Resource Investment Model mechanisms of how financial support for families improves child outcomes (Appendix 2); and (c) a table outlining potential ways in which the intervention could cause harm (e.g., purchasing unhealthy goods or activities) (Appendix 5).

To address the IPE research questions, the IPE team will collect a range of both quantitative and qualitative data throughout the study's timeline. Each data collection method and how it will contribute to answering the IPE research questions is outlined in Table 7. We will work closely with Christal Kihm, the appointed YEF Race Equity Advisor, as well as our recruited peer researchers and expert by lived experience (EbE) group to ensure that all aspects of the IPE adopt a poverty-aware and racially and culturally sensitive approach. The EbE group will also support the development of data collection tools, ensuring they are appropriate for the study population.

Data sharing agreements will be established between each participating LA and the associated universities in the study prior to the intervention delivery start date. The trial team will collect routine data on all parents/carers as part of trial management (i.e., trial procedures, including number of parents/carers recruited, consented, randomised and completing measures at each time point). We will use data collected by the payment agent on intervention delivery, focusing on number of families receiving money, characteristics of those in receipt of money (e.g., ethnicity, SEND status, social service status), dosage (amount received per family) and percentage of funds released.

The trial team will also distribute questionnaires to parents/carers at baseline, midpoint (~20 weeks) and endpoint (i.e., post interventions, ~45 weeks). The outcome and mediator measures that will be explored in the questionnaires at different time points are outlined above in Outcomes section. We will also collect quantitative data in these questionnaires on trial process (e.g. acceptability of recruitment, experience of randomisation), other services received besides cash transfers (e.g., financial, therapeutic, other) and how parents/carers are using the additional money received (intervention arm only). Specifically, we will ask a generic open-ended question about this at mid-point (to avoid influencing parents'/carers' spending choices by forcing them to reflect on specific expenditure categories) and a

checklist-style question at end point (asking if they have used additional money on categories such as rent, bills, food, clothing, goods or opportunities for children, entertainment, savings). Parent/carer questionnaires will be created on REDCap and distributed to parents/carers via email or WhatsApp (according to their preferred method of communication). Parents/carers will be sent up to five automated reminders to complete the questionnaire (those who have withdrawn from the study will not be sent the questionnaire). Alongside automated reminders, social workers will remind parents/carers to complete questionnaires. Parents/carers will be offered a £10 thank you voucher for completion of the baseline survey, a £15 thank you voucher for the completion of the midpoint survey, and a £25 thank you voucher for completion of the endpoint survey, reflecting the length of the respective surveys.

Qualitative interviews will be conducted by the evaluation team and the parent/carer peer researcher. We will conduct qualitative interviews with a sample of parents/carers (n=30: 25 intervention, 5 control) at two points: ~2-3 months and ~7-8 months. Interviews will explore (i) aspects of intervention receipt (intervention arm only), including acceptability, factors affecting engagement and any adaptations needed, and (ii) hypothesised FSM/IM pathways to impact and potential iatrogenic effects, such as escalating substance use or financial exploitation (both arms). A purposive sample will ensure good representation of all LA sites and important case characteristics, including parent/carer ethnicity, age, gender and employment status and child SEND status. We plan to interview the same parents/carers at both timepoints to build a longitudinal picture of their experiences. Parent/carer interviews will normally be online (Zoom, Teams), but by phone if that is not convenient or in-person if necessary (~20%) with interpretation available (~20%).Evaluation team members will support participants to access Zoom or Teams as necessary by guiding them on how to download and use the relevant app on their mobile. Interviews will last approximately 1 hour, and parents/carers will be offered a thank you voucher (£30) for their participation in an interview at each timepoint.

Two sets of online (Zoom, Teams) focus groups will be conducted. First, we will conduct an online focus group with the KCL intervention payment agent (including developer) towards the end of delivery to explore intervention fidelity, factors affecting this (barriers, facilitators) and the nature and success of the implementation strategies they have employed. For instance, the implementation logic model identifies social worker reticence to deal with a family's financial issues as a potential barrier to implementation, so the payment agent is proposing to brief social workers on the potential for cash transfer to improve child outcomes. Second, we will conduct one or two (contingent on number of participants) online focus group with family caseworkers (max. n=20, 2 per site) near the end of delivery. This will explore: (i) their families' experiences of trial processes, (ii) intervention and business as usual delivery (including how it has been for their families to receive the transfers or be in the control arm, the nature of services received besides transfers, considerations for moving cash transfers

into routine practice), (iii) the nature of any change mechanisms in families triggered by the intervention, and (iv) potential harm. We plan for each focus group to last 1 to 1.5 hours. Prior to each focus group, participants will receive an information sheet and be asked to provide informed consent. Unlike parent/carer data collection, we do not propose to provide the KCL team members or family caseworkers with vouchers on the basis that KCL and LAs are project partners and therefore staff should be permitted to take part in data collection as part of their regular roles.

All data collection instruments, including survey questionnaires and interview and focus group schedules, will be finalised in collaboration with the EBE group and peer researcher, with particular attention to language and length. For questions in interviews and focus groups about mechanisms of impact, intervention delivery and potential harms, topic guides will be directly informed by the intervention theory of change, implementation logic model respectively and table of potential harms respectively. In the case of parents/carers, this will include leading them through a simplified version of the theory of change during interviews.

IPE Analysis

Quantitative data on trial process and intervention delivery will be analysed using descriptive statistics, with attention to variation by subgroup (e.g., ethnicity, SEND). Multivariate models using quantitative data will examine explanatory mechanisms of change (mediation, moderation – see above for detail).

Interviews and focus groups will be audio recorded and transcribed using automated transcription for online data collection and via a GDPR-compliant external transcription service for in-person data collection. We will input the qualitative data into the NVivo software package, which will be used to maintain a clear audit trial for the analysis. The data will be analysed using framework analysis (Gale et al., 2013), a form of thematic analysis. This will be informed by the implementation research logic model for intervention delivery, the intervention theory of change and the table of potential harms (Appendices 4, 2, and 5, respectively). Standards for reporting on qualitative research (Levitt et al., 2018) will be adhered to, ensuring credibility and trustworthiness. The peer researchers and study EBE group will support the interpretation of findings.

Table 7: IPE methods overview.

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed	Implementation/ logic model relevance
Quantitative	Routine data collection on trial procedures (i.e., parents/carers recruited, consented, randomised and completion measures)	Parent/ Carers (n=1,291) Data will be collected at baseline, midpoint and endpoint	Descriptive statistics and multivariate analysis	Trial Procedures	Not applicable (focus is on trial procedures)
Quantitative	Routine data collection on intervention delivery (i.e., number and characteristics of families receiving the intervention, amount of money received per family, percentage of funds released)	Intervention payment agent working with sites (n=8-10 sites)	Descriptive statistics	Intervention Delivery	Concerns extent to which intervention is implemented as intended
Quantitative	Parent/carer questionnaires, covering trial process, outcomes, mediators, use of money and other services used	Parents/ Carers (n=1,291) Data will be collected at: Baseline (trial process, outcomes, mediators) Midpoint (mediators, use of money) Endpoint (outcomes, use of	Descriptive statistics and mediation analysis	Intervention Mechanisms	Concerns mechanisms of impact (and potential harms)

		money, other services used)			
Qualitative	Interviews with parents/carers, covering what they have received (inc. acceptability) and if/how it has affected them and their children (inc. potential harm)	Parent/ Carers (n= 60: 50 intervention, 10 control, with 50% of interviews at ~2-3 months and 50% at ~7-8 months) Data will be collected at two time-points (~2-3 months and ~7-8 months)	Framework Analysis	Intervention delivery Intervention mechanisms	Concerns acceptability of intervention, mechanisms of impact, and potential harm
Qualitative	Focus group with intervention payment agent	Intervention Payment agent	Framework Analysis	Trial procedures Intervention delivery	Concerns extent to which intervention was implemented as intended, factors that affected this (including success of implementation strategies)
Qualitative	Focus group(s)	Family case workers (n=20, 2 per site)	Framework Analysis	Trial Procedures Intervention delivery Intervention mechanisms	Concerns acceptability of intervention, mechanisms of impact, and potential harms

Race equity and expert by experience involvement

Race equity and equity, diversity, and inclusion (REDI) has been considered throughout co-design between the evaluation and payment agent, YEF REDI Associate, YEF, and IoUH. It has also been considered during the EbE sessions.

Marginalised and minoritised groups are exposed to higher levels of disadvantage due to current and historic racism and discrimination. Asian and Black young people and those with special educational needs are over-represented in those affected by youth crime and violence. These groups also experience additional barriers to being involved in research. This could potentially result in our target population being over-represented with marginalised and minoritised groups but our participant sample being under-represented.

To address this, we propose four mitigations:

1. Include target recruitment rates for different ethnic groups;
2. Ongoing monitoring of recruitment to identify groups underrepresented, in which case we will work with LAs to iterate our recruitment strategies based on their knowledge;
3. Ensure REDI considerations are included in our communications plans and materials;
4. Translate recruitment materials into locally relevant languages for the participating LAs and use interpreters for interviews;

We are aware that bias could affect who is identified as being eligible by practitioners. In particular, there could be views on who might benefit from the programme or who might be "underserving" of receiving cash. Therefore, we have developed clear inclusion/exclusion criteria for SPOCs to apply when identifying families, making it clear that only those families who do not meet these criteria should not be invited. Practitioners will be trained by the evaluation and payment agent to help ensure consistency. We will also ask LAs to report on an aggregate levels of the reasons why families were not eligible. The funded LA SPOC role will be the primary staff identifying families, which should further mitigate bias.

We will examine other non-intervention factors that might influence intervention outcomes. This will include examining different impacts based on: social care status (CiN vs. CPP), number of children in the family, child gender and ethnicity, baseline levels of deprivation, and area-level deprivation.

A REDI consideration identified by our YEF REDI Associate was that when interviewing families, different members might have different knowledge; e.g., the member who knows about how family finances are used might not be the same member who knows the most about the child's mental health and wellbeing. This has directly informed our recruitment strategy, and when we invite primary caregivers to interview we will ask if there are other family members we should interview for different knowledge.

Another important consideration has been who should receive the cash transfer. Roles in relation to finances might differ for different families. An aim of the intervention is to empower women and mothers through increasing their access to financial resources. On careful consideration, we have decided that the primary caregiver on the LA's records should be the recipient of the cash transfer intervention. This was also agreed by our EbE members.

During co-design, we have used three approaches to involve EbEs:

1. We recruited a parent/carer peer researcher who has been involved in decision making about study plans and leading other EbE work;
2. We have recruited two parent/carer EbEs for ongoing sessions, and we have held three sessions with these members;
3. We have held three one-off sessions for further input with three parent/carer EbEs and two young person EbEs.

In the full study, we will recruit an additional parent/carer peer researcher. We will convene two six-to-eight person advisory group (one for parents/carers (PCAG), one for young people (YPAG)) who will meet quarterly and input on all areas of the evaluation. To ensure we have flexible opportunities for those who might not be able to join the regular advisory groups. We will work with LA SPOCs to identify local advisory groups and organisations we can engage with during the study, including community groups representing groups with whom the evaluation may struggle to otherwise enable to have a voice in the study (e.g., faith-based groups, minoritised ethnic group). We have budgeted to hold individual/group sessions locally and/or online with EbEs from these groups. Sessions will be clustered around (but not limited to): 1) co-design and mobilisation, 2) designing parent/carer/child surveys and interviews with families, and 3) interpreting results and findings.

We hold individual onboarding sessions with all EbEs to ensure they have full information about what is being asked of them, any support needs that they may have, if there are any sensitive topics for them of which we should be aware, and any goals they have for taking part. EbEs will be provided with training about research and the evaluation. We will work with EbEs to identify any additional ways in which they would like to be involved in the operational delivery of the evaluation (with appropriate support and training). The main areas discussed with EbEs during codesign were: regular opportunities to be involved in making decisions about the evaluation and hearing updates, having spaces for EbEs to learn from each other, and being involved in interviews with families such as designing the questions being asked, conducting interviews, transcribing interviews, and being involved in analysis.

The two peer researchers will be to the core research team and contribute to all stages of study development and delivery. As with other members of the research team, they will contribute to discussions and decisions about recruitment, retention, engagement, data collection, analysis, troubleshooting, and management of risks and issues. They will be involved in leading the other EbE activities and sessions conducting elements of the research (e.g., collecting and analysing interview data) similar to the other EbEs.

All of our EbE work is informed by the Lundy model of participation (see https://www.annafreud.org/participation/). This proposes four key elements of meaningful participation:

1. Voice: individuals are facilitated to express their views in ways that work for them;
2. Space: individuals are provided with safe and inclusive opportunities to form and express their views;
3. Audience: individuals' views are listened to by those able to enact change;
4. Influence: individuals' views are acted on where appropriate.

In our work with EbEs, we make it clear that we are interested in hearing all of their views, however there will be some views and suggestions we might not be able to action. These would include a fundamental change to the research questions (e.g., a new question requiring an additional workstream that is not funded) or to the research methods meaning that we would not be able to answer our research questions (e.g., not having a control group,). Still, such views and suggestions would always be reviewed and considered by the evaluation team and funder as appropriate. EbEs can and have inform(ed) the outcomes we examine, the appropriateness of measures, and the questions we ask in interviews. They have and will play an important role in determining our research processes and how we engage parents, carers, and children, including those from marginalised and minoritised groups. They will help us interpret our findings and what these might mean for families but they would not be able to change the findings.

EbE work is important in this project to ensure the approaches used in the study are acceptable to the intended participant group, we do not inadvertently miss asking about topics relevant to the participant group, and ultimately the findings are meaningful to the lives of individuals who are the intended beneficiaries of the research. It is important to gather views and perspectives from individuals who might have different backgrounds and experiences to those represented in the evaluation team. EbE involvement can also help to identify and challenge systemic biases that may be introduced through using existing research methods and tools.

Feedback and input from EbEs will be regularly discussed in evaluation team meetings and with the funder. Summaries of actions taken from feedback and input will be regularly provided to EbEs. Our EbE work will be reported in line with best practice guidelines (Staniszewska et al., 2017). We will evaluate our EbE work through regular discussions in sessions and through anonymous feedback forms. EbEs are regularly given opportunities for briefings and de-briefing meetings for additional support with sessions. We also regularly review with individual EbEs their support needs to see if they have changed or if there is anything else we can do to support them, and we also check in with any goals they may have and how we are helping to achieve them.

The EbE work during codesign has been incredibly valuable and informed a number of changes to the evaluation. We have also been pleased with the levels of diversity of members regarding ethnicity and gender. Key points and actions are summarised below.

- They suggested we name the study that emphasises supporting families' lives. .
- They have informed the outcomes we focus on:
    - They highlighted the importance of understanding how the cash is used and what it is spent on. Parents/carers discussed understanding the use of the cash for the benefit of the child compared to the benefit of the parent/carer would be important. This has informed how we ask about how parents/carers have used the cash.
    - They agreed with the importance of measuring mental health and wellbeing for both children and parents/carers and why we are including measures of depression and anxiety for parents/carers. Parents/carers described that negative emotional impact not being able to provide certain goods/activities for their children, due to financial constraints.
    - Young people emphasised that not being able to buy a certain good, or not being able to go on a school trip, has impacts beyond those goods and activities. They described that missing out on such things their peers have or are doing can lead to feelings of isolation and loneliness. This has informed the questions we ask young people in surveys.
    - Parents/carers described that increased financial resources may create more opportunities for positive interactions with a child, teaching the child about managing finances, and also discussing wider principles (e.g., it is important to try and use the resources one has to support other people). They also mentioned that increased financial resources may create more opportunities for children to engage in prosocial, rather than less prosocial, activities. These points have informed the questions we ask in surveys and in interviews.
- Parents/carers suggested we include a material reimbursement for families in the BAU-only arm as a thank you for taking part. This has directly informed our decision to include a material good reimbursement for families in this arm.
- Related to REDI, EbEs said that for certain communities it would be even more important for participation in the study to remain private. This has directly informed our communications strategy with participants, in which we will give them a choice of their preferred means of communication (e.g., text, email, phone call) and ensuring when we send routine communications they do not go into details of the study. We will not advertise the study on an open website and we will restrict information in the public domain to technical outputs. We are liaising with the payment agent about how payments appear on bank statements, as EbEs said they wanted something vague rather than explicit.
- Parents/carers highlighted that families engaged with social care may have high levels of concern about professionals' views of them. They suggested we make it clear in information sheets that being invited to take part in the study – and choosing to take part

– is by no means an indicator that they are struggling and they have not been individually singled out as requiring extra support.

- They have helped us to think through potential risks and mitigations (see risk register).

Cost data reporting and collecting

The aim of the cost data collection is to examine the resources required for LAs to deliver the intervention, recognising that they are not delivering the payments. We will follow YEF Cost Reporting Guidance. We will work with participating LAs to collect information on their costs of delivering UCT, using a 'bottom-up' approach. These costs will be presented for the whole programme, an average cost per site, and an average cost per family.

We will obtain data on costs through a brief survey completed by the SPOC and finance contact at each site at the midline and endline evaluation periods. It will ask about the amount of time staff have spent delivering UCT (excluding evaluation activities) for different staff roles. For staff costs, the survey will ask about LA staff (e.g., practitioners, social workers) roles and grades, salary bands, and non-wage labour costs. Where salary information is disclosive, sector-wide assumptions will be applied (e.g., Personal Social Services Research Unit database). Data on practitioners' travel and subsistence costs to deliver the intervention will also be included.

The survey will ask about other inputs (i.e., renting additional buildings and facilities, and material and equipment such as printing). There are no anticipated programme procurement costs and there are no incentives for the families taking part in the intervention.

Ethics and registration

Ethical approval will be sought from the UCL Research Ethics Committee (REC), supplemented with any required ethical approval from other evaluating organisations and/or participating LAs. This study will be conducted in accordance with data protection legislation (e.g., UK General Data Protection Regulation (GDPR; Assimilated Regulation (EU) 2016/679) and the Data Protection Act (2018)) and the guidelines of the Declaration of Helsinki (World Medical Association, 2024). The trial will be undertaken according to the principles of Good Clinical Practice and all relevant ethics and governance processes. The Principle Investigator (PI) will notify the REC of the end of the trial and if the trial is ended prematurely, the PI will notify the REC, including the reasons for the premature termination. Within one year after the end of the trial, the PI will submit a final report to the REC.

Voluntary and fully informed written consent will be obtained from all participants before they take part in any study activities. On enrolment, the primary caregiver will be required to

provide consent as will the identified index child; if the child is 10-15 years, the primary caregiver will also have to provide consent for their child to take part. Clear and accessible information sheets and consent forms will explain to participants why we need the data, what we will hold, how it will be used, and give them the opportunity to ask questions or raise objections. There will be two versions of the informed consent materials for young people: 10-15 years and 16+ years. Participants will be made aware of their right to withdraw from the trial at any point, whilst being clear that participants can only receive the intervention as part of the trial (i.e., families not taking part in the trial cannot receive the money). Information sheets and recruitment materials will make it clear to participants there may be situations in which there is an obligation to share information that reveals a safeguarding risk. We will attempt to notify a participant that we will share information due to a safeguarding risk before doing so. Information sheets and recruitment materials will also make it clear that by consenting to take part, participants are consenting to the YEF Data Archiving and that this is a condition of taking part.

Interviews with families are the most likely source of the evaluation team identifying safeguarding concerns. When arranging interviews, the interviewer will identify a senior member of the team available during and after the interview to address safeguarding concerns. Safeguarding concerns will be immediately raised with a senior member of the research team and the PI and Safeguarding Lead will be notified. Interviews with parents/carers will be followed by a debrief between the interviewer and a senior member of the research team within one business day to ensure timely identification of safeguarding issues. Our PI and Safeguarding Lead will ensure staff understand best practice guidance for identification and management of safeguarding risks. At each LA, we will identify a named safeguarding lead (i.e., the SPOC) who will be contacted in the event a safeguarding risk is identified for a family.

The evaluation team will be notified of adverse events that become known to the LA. The adverse events are listed below, with serious adverse events indicated in bold with an asterisk:

- Involvement in violent behaviour that results in physical harm.
- **Hospitalisation due to violence, drugs, alcohol, self-harm, or psychiatric reasons*** (including in-patient hospitalisation or significant disability/incapacity).
- Self-harm.
- Suicidal ideation: a preoccupation with suicide/thoughts about suicide, with no clear plans to take own life.
- **Suicidal intent***: concrete and deliberate plans to end own life, with a conscious desire to escape from the world and a resolve to act purposively in this regard (e.g., a suicide attempt). This may be a deliberate action or disclosing of a deliberate action.
- **Exploitation (e.g., financial, criminal, sexual), extremism, and criminal activity*.**

- **Death*.**
- **Involvement in serious criminal activity (e.g., sexual assault, murder)*.**
- **Child being taken into care***

Alongside usual site safeguarding procedures, local LA staff will be required to fill out an adverse events form within two days of becoming aware of a serious adverse event or five days of an adverse event. All adverse events and safeguarding concerns will be recorded by the study team on the database, along with a log of action taken.

The evaluators will be notified when an adverse event form is completed. Serious adverse events will be immediately reported to the PI and Safeguarding Lead. They will consult with senior members of the research team to determine whether or not the event was related to the study and expected. Serious adverse events deemed related to the study and unexpected will be reported to the REC within 15 days of the PI being notified, with a copy sent to UCL, as the sponsor, along with a copy of the REC receipt. All adverse events will be monitored on a regular basis in team meetings and at least quarterly in meetings of the Trial Management Group. Serious adverse events will be reported to the Trial Steering Committee (TSC) and, if there are significant concerns, the TSC will be asked to convene immediately.

Adverse events will be reported in the annual progress report to the REC and copied to UCL as the sponsor. The Youth Endowment Fund risk register will be updated accordingly and submitted with each quarterly monitoring report.

The trial will be registered with the ISRCTN Registry. The team will ensure that trial registry is updated with outcomes at the end of the trial.

Data protection

Anna Freud, UCL, University of Exeter, and University of Plymouth operate with strict information governance policies, complying with relevant legislation, and all staff receive annual data protection training. We anticipate that the three institutions may act as data controllers/processors by signing joint controller or data sharing agreements as appropriate.

Ahead of ethical approval, we will create privacy notices, a data protection impact assessment (DPIA), and record of data processing activities. We anticipate the legal bases being legitimate interest (Article 6(1)(f)) and archiving for research purposes (Article 9(2)(j)) for special category data.

Collection and processing of participants' personal information will be limited to what is necessary to ensure the study's scientific practicability, and in line with relevant legislation e.g., UK GDPR (Assimilated Regulation (EU) 2016/679).

Survey management and administration will be provided on UCL's Data Safe Haven REDCap platform. Data protection on the server meets the highest standards (ISO 27001) and conforms to NHS Digital's Information Governance Toolkit. Access to the database will be restricted to relevant staff and necessary areas, with full access audit.

Interviews will be securely recorded (e.g., Encrypted Dictaphone, University of Plymouth Zoom or Teams) and will be stored securely on University servers. The reporting of results (including quotations) will be fully anonymised.

We will put in place data sharing agreements with individual LAs and King's for sharing families' information and for routine data collection. Data collection and transfer across all strands of the evaluation will only take place via approved secure mechanisms; e.g., use of encrypted Dictaphones for qualitative data. All data will be stored securely and kept strictly confidential. An external company - with an existing non-disclosure agreement - will be used for interview transcription.

Information on the YEF Data Archive will be included in these agreements, privacy notices, participant information sheets and consent forms, in line with YEF guidance. Data obtained from the study, including names, will be securely transferred to the Department of Education who will match data with that held by the Ministry of Justice. Anonymised data will be securely transferred to the Office of National Statistics who will deposit data in the YEF archive indefinitely. Further, anonymised data will be retained by Anna Freud and UCL for a period up to 10 years for the purposes of secondary analysis, publications, and queries that may arise through these processes.

Stakeholders and interests

Evaluation team:

Prof. Julian Edbrooke-Childs

Affiliation(s): Head of Evaluation at Anna Freud; Professor of Evidence Based Child and Adolescent Mental Health at UCL, Co-Director of the Evidence Based Practice Unit at Anna Freud and UCL.

Role on project: Principal Investigator (PI)

Responsibilities: Overall leadership of the project, including budget, timeline and risk management; strategic point of contact for YEF and delivery sites.

Dr Abigail Thompson (maternity leave)

Affiliation(s): Trials Manager at Anna Freud; PhD, Institute of Psychiatry, Psychology & Neuroscience at King's College London.

Role on project: Trial Manager

Responsibilities: Operational management of the RCT including research ethics procedures, day-to-day management, and managing relationships with sites and partners.

Dr Matthew Constantinou

Affiliation(s): Clinical Psychologist and Senior Research Fellow at Anna Freud; PhD, Mental Health at UCL.

Role on project: Quantitative Research Fellow, Safeguarding Lead.

Responsibilities: Conduct statistical design and analysis of the trial. Managing safeguarding concerns, adverse events, and monitoring of harms from a clinical perspective.

Research Officer x 2 (to be recruited)

Affiliation(s): To be recruited by Anna Freud

Responsibilities: Contribute to the operational conduct and delivery of the project, working across all elements but particularly within the RCT and participatory strands.

Philipa Power and Peer Researchers x 1 (parent/carer)

Affiliation(s): To be recruited by Anna Freud

Responsibilities: Contribute to the operational conduct and delivery of the project, working across all elements but particularly within the IPE and qualitative strands.

Prof. Jessica Deighton

Affiliation(s): Director of Applied Research and Evaluation at Anna Freud; Professor of Child Mental Health and Wellbeing at UCL; Co-Director of the Evidence Based Practice Unit at Anna Freud and UCL.

Role on project: Critical Friend.

Bernadette Martin

Affiliation(s): Head of Participation at Anna Freud.

Role on project: Participation Oversight.

Responsibilities: Support planning and delivery of the three participation strands – Peer Researchers, Young People's and Parent/Carer Advisory Groups, and Local Advisory Groups

– ensuring experts by experience are well supported.

Charli Atkinson-Ryan
Affiliation(s): Head of Equality, Diversity and Inclusion (EDI) at Anna Freud.

Role on project: EDI Oversight.

Responsibilities: Provide specialist input and strategic oversight on EDI to ensure that consideration of EDI is at the heart of the project.

David Westlake

Affiliation(s): Principal Research Fellow at the School of Social Sciences, Cardiff University, Director of Rubric Social Research Ltd.

Role on project: Expert Consultant

Responsibilities: Expert input on the design, conduct, and analysis of cash transfer evaluation studies, regular advice, support, and recommendations provided through the Trial Management Group and ad hoc consultations (e.g., troubleshooting).

Prof. Vashti Berry
Affiliation(s): PenARC Co-Director, Professor of Prevention Science at University of Exeter.

Role on project: IPE Co-Lead.

Responsibilities: Contribute to all strands of study design and conduct including co-design, protocol development and the trial group; Strategic management of IPE strand, including IPE design, data collection, analysis, and reporting, with a focus on quantitative arm e.g. mediators and routine data; Line management of IPE Manager and IPE Research Fellow.

Dr Nick Axford

Affiliation(s): PenARC Implementation Lead, Associate Professor at University of Plymouth.

Role: IPE Co-Lead.

Responsibilities: Contribute to all strands of study design and conduct including co-design, protocol development and the trial group; Strategic management of IPE strand, including IPE design, data collection, analysis, and reporting, with a focus on qualitative arm.

Dr Amy Bond

Affiliation(s): Research Fellow at University of Exeter.

Role: IPE Manager.

Responsibilities: Operational management of the IPE, including managing recruitment, day-to-day management of activities (including quantitative and qualitative data collection and analysis) and managing relationships with sites and partners; Contribute to report-writing.

Dr Georgia Smith – IPE Research Fellow
Affiliation(s): Research Fellow at University of Exeter.

Role: IPE Research Fellow.

Responsibilities: Oversight of methodological conduct of the IPE, with a focus on recruitment for interview and focus groups and qualitative data collection and analysis; Support the IPE Research Assistant; Contribute to report-writing.

Eleanor Bryant – IPE Research Assistant

Affiliation(s): Research Assistant at University of Exeter

Role: IPE Research Assistant

Responsibilities: Contribute to the operational conduct and delivery of the project, working across all elements of the project but particularly within the IPE and participatory strands;

There is one declaration (rather than conflict) of interest: David Westlake works closely with The Policy Institute at King's College London on various projects, including the ongoing YEF-funded Police in Schools trial. We will manage this by having clear roles and responsibilities and declaring interests in any outputs/reports.

Risks

The top five risks to the study are detailed below (please see Risk Register, Appendix 8) for all risks.

Table 8: Top five evaluation risks.

Risk description	Impact	Likelihood	Risk rating	Mitigations

There is a relatively narrow recruitment period of 5 months (September-November 2025, March-April 2026). This is primarily to avoid families starting the intervention at such a time that they would end the intervention in December 2026/ January 2027, which is generally already a financially difficult time. Some LAs have said this would be a deal breaker for their involvement. However, it results in a heavy administrative burden for LAs, the delivery team, and the evaluation team. Based on a sample size of 1,291 and a 75% conversion from referral to consent, 1,721 referrals would need to be made within 5 months.	5	5	25	Additional researcher capacity has been included in the evaluation budget to manage the volume of communication with participants (at the outset and throughout the project). We are working on technical solutions to help manage communication with participants. We are also exploring options for a wider staff pool to support with the recruitment and consent stage. With support of the funders, we are prosing funding for a 0.1FTE manager in each LA to be funded to support with identifying, onboarding, and referring families into the study. We have included a budget option with other researchers over the five month recruitment period. We envisage the local authority (LA) single point of contact (SPOC) will be managing the local evaluation activities, including supporting practitioners to identify families and contact families to provide initial information about the study. The SPOC will (with permission) transfer the parent's or carer's contact details to the evaluation team or they will contact the evaluation team directly. The evaluation team will need to communicate with parents/carers to go over the study information, collect informed consent, and support the completion of baseline measures. The evaluation team will need to communicate with the delivery team and parents/carers about the allocation outcome. We are struggling to provide a justification for why these 2 additional Research Officer will not be needed to manage these activities for the intended number of participants. We see 4 staff managing this for the 5 month recruitment period as being commensurate with what is required. Without these 2 roles, the risk to recruitment is

				significantly increased due to a lack of evaluation team capacity.
Retaining families allocated to the control condition could be difficult because they perceive they have lost out and have nothing to gain from involvement. This could also result in lower baseline scores (resentful demoralisation).	5	4	20	An engagement strategy is being developed (including with experts by experience or EBEs) to ensure engagement of the control group. During co-design, different options have been considered, such as whether both groups could receive larger sums for completing the final questionnaires. All families will be reimbursed equally for taking part in evaluation activities (e.g., £10 for baseline and midpoint surveys, £25 for endline surveys). Based on feedback from EBEs and with support of the funders, we are implementing a substantive material reimbursement for families in the control group (e.g., a gift at the end of the project such as an electric blanket). Baseline differences will be examined as part of testing imbalances.
Perception of the BAU-only condition - there may be an impression by practitioners that families are 'missing out' on care. This could impact adversely on practitioners' willingness to include families in the study or introduce the study to them, and it could impact adversely on families' willingness to participate in the study. Similarly, practitioners may have objections to the study (e.g., randomisation). Either could have a negative impact the ability of the study to achieve its intended sample size and power requirements.	5	4	20	We are co-producing our communications materials with the delivery team and EBEs. See also engagement of families in the control condition. We are not planning to advertise the amount of cash received in material (e.g., information sheets) but will need to be prepared to answer direct questions about it. These communication plans will also need to be adhered to by LAs when interacting with families. Communications with practitioners and LAs will be clear about the importance of the study (e.g., equipoise).

Families in the intervention arm may experience stress and a worsening of outcomes towards the end of the intervention due to the cash being terminated. As our primary endpoint is the end of the intervention, there could be a risk that any improvements in outcomes that families experience whilst receiving the cash are not observed by the evaluation; it could be that families experience a worsening of outcomes at the end of the intervention.	4	4	16	It is challenging to mitigate this risk. On the one hand, measuring outcome at the end of the intervention period could disadvantage the intervention by reducing the likelihood of detecting change. On the other hand, as it is a time-limited intervention, it could be advantage (and/or be disingenuous) to measure outcomes at, for example, the start of the intervention tapering period. However, this could be conceived of as the end of the mainstage intervention. Alternative approaches could be to have the primary endpoint be the end of the mainstage intervention, with a follow up (e.g., three months after completion of tapering) for the intervention group only to see if effects are sustained. The opposite could also be employed, to examine if there is an improvement in outcomes at the end of the mainstage intervention for families in the intervention group, even if these do not result in a difference in outcomes across the two arms by the end of the intervention. An end-of-mainstage-intervention follow up and one three-to-six months after the end of the tapering period for both arms could be another option.
Heterogeneity in support offered through BAU in LAs.	5	3	15	We expect there to be heterogeneity in BAU, and there is little we can do to alter it given the applied nature of this research. BAU has been discussed in co-design and it has been decided that no additions/changes to business as usual will be provided. We will take LA into account in the analysis. As part of the IPE, we are planning a midpoint parent/carer survey, asking about types of support received as part of BAU and how families have spent any additional money received.

Timeline

Table 9: Timeline.

Full timeline is shown in Appendix 9.

Activity	Owner	Start date	End date
Evaluator drafts protocol	02/04/25	02/04/25	Evaluator
YEF to review protocol and provide feedback. In some cases an external peer reviewer will also provide feedback.	03/04/25	09/04/25	YEF
Evaluator incorporates feedback and submits final protocol for Grants and Evaluation Committee (GECo) meeting	10/04/25	28/04/25	Evaluator
GECo meeting	21/05/25	21/05/25	YEF
Final protocol submitted addressing GECo feedback	20/08/25	20/08/25	Evaluator
Protocol published	01/10/25	31/10/25	YEF
Evaluator drafts information sheets and privacy notices	01/05/25	21/05/25	Evaluator
YEF to review information sheets and privacy notices	22/05/25	31/05/25	YEF
Evaluator incorporates feedback and submits final information sheets and privacy notices	01/06/25	14/06/25	Evaluator
Evaluator drafts statistical analysis plan	01/10/25	30/11/25	Evaluator
YEF to review statistical analysis plan	01/12/25	31/01/26	YEF
Final statistical analysis plan submitted	31/03/26	31/03/26	Evaluation
Ethics submission deadline	25/06/25	25/06/25	Evaluator
Evaluator obtains ethical approval and provides confirmation to YEF	22/08/25	31/08/25	Evaluator
LA governance approvals	01/06/25	31/10/25	Evaluator
Translation of study documents	01/06/25	31/07/25	Evaluator
Information governance approval	01/02/25	31/03/25	Evaluator
Set up oversight groups	01/03/25	30/04/25	Evaluator
Development of study database	01/05/25	30/06/25	Evaluator
Set up of trial (e.g., pre-registration)	01/04/25	31/08/25	Evaluator
LAs set up (including signing of MoU and DSA)	01/03/25	28/02/26	Eval. & project
Identification and recruitment of families	01/08/25	30/04/26	Project team
Start receiving referrals	01/09/25	30/09/25	Project team
Delivery of intervention	01/09/25	31/03/27	Project team
Tapering stage 1: payments reduced for 5 weeks at 35 weeks	01/05/26	31/01/27	Project team
Tapering stage 2: payments reduced again for weeks 41-45	14/06/26	31/03/27	Project team
First LAs start referring	01/09/25	30/09/25	Evaluator
Baseline data collection	01/09/25	30/04/26	Evaluator
Randomisation	01/09/25	30/04/26	Evaluator
Last LAs go live	01/03/26	31/03/26	Evaluator
Referrals stop	30/11/25	30/04/26	Project team
Routine delivery data recording	01/09/25	31/03/27	Project team
Follow up data collection	01/05/26	28/02/27	Evaluator
12 months follow up	01/05/27	28/02/28	Evaluator
Submission of draft final evaluation report	01/06/27	07/06/27	Evaluator
Submission of final, peer reviewed evaluation report	14/06/27	21/06/27	Evaluator
Submission of draft follow up report	05/07/28	09/07/28	Evaluator
Submission of final, peer reviewed follow up report	26/07/28	30/07/28	Evaluator
Evaluator supports with YEF publication process + follow up report	01/07/27	31/10/28	Evaluator
Data archived	30/06/27	30/06/27	Evaluator
Mid-point parent/carer survey	01/02/26	30/09/26	Evaluator
Qualitative interviews with parents/carers	01/02/26	31/01/27	Evaluator
Focus group with delivery staff	01/02/26	31/01/27	Evaluator
Focus group with social workers	01/02/26	31/01/27	Evaluator

Receipt and validation of routine delivery data	01/02/27	30/04/27	Evaluator
Quantitative data analysis	01/01/26	31/05/27	Evaluator
Follow up analysis	01/03/28	30/06/28	Evaluator
Interview transcription	04/01/2026	28/02/27	Evaluator
Qualitative data coding and analysis	01/07/26	30/04/27	Evaluator
Main report	01/12/26	30/06/27	Evaluator
Final report	01/05/28	31/07/28	Evaluator
YPAG and PCAG	01/05/25	31/05/27	Evaluator
Local advisory groups	01/04/25	31/05/27	Evaluator
Liaison and coordination with sites	01/04/25	30/03/27	Evaluator
Core team (including liaison with YEF)	01/04/25	30/06/27	Evaluator
Trial Management Group	01/04/25	30/04/27	Evaluator
Data Monitoring and Ethics Committee	01/11/25	13/11/26	Evaluator
Trial Steering Committee	14/11/25	30/11/26	Evaluator
EDI mentoring & guidance	01/04/25	30/06/27	Evaluator

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List of Appendices

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Appendix 1: Intervention description

1. Name
Unconditional Cash Transfers for Families OR Basic Income for Families

2. Rationale
The theory of change (see diagram) may be summarised as follows.

Financial hardship is a contributing factor to poor child health and development, involvement in crime and violence, and state intervention in children's lives.

An unconditional cash transfer provides a time-limited additional income to families, giving them the agency to direct it towards self-determined needs.

The increase to net household income improves families' financial security (e.g., reduced debt or arrears on rent/bills), reduces financial stressors and conflict events and reduces parent/carer perception of economic strain.

The additional income supports improvements to the material and living conditions of the family and the home environment, and enables the purchase of improved educational resources, equipment or opportunities for the child. It also enables parents to spend more time with their children. [Resource Investment Model]

The additional income also improves parent/carer subjective well-being, reduces parenting stress, improves parent/carer mental health, improves family relationships and family functioning, and reduces family conflict and use of violence and control in relationships. [Family Stress Model]

These contribute to improved child outcomes in the *short-term* (improved child behaviour, improved mental health, reduced substance use, improved engagement in education and learning).

Long-term *child* outcomes include reduced offending and involvement in crime/violence, improved educational performance and attainment, and reduced trauma. Long-term outcomes for *parents* include reduced use of violence and control in family relationships, reduced substance use and stability in family relationships and living conditions.

Collectively, these changes contribute to families being discharged from social services care or de-escalated (i.e., child no longer classed as a Child in Need or on a Child Protection Plan).

3. What is provided
Unconditional financial assistance in the form of cash.

Support to enable payments includes:

- identifying and recruiting eligible families
- providing information to unbanked families on how to set up a bank account

- ensuring that payments are received
- monitoring any possible harm
- keeping track of address changes to facilitate ongoing payment
- monitoring changes to participant eligibility

Financial capability support is part of BAU (see separate TIDieR document) and therefore not part of the intervention, but it is possible that those receiving the payment (i.e., the intervention) may be more likely to take it up.

4. To whom is it provided

Families who meet *all* of the following inclusion criteria on the census date AND at the point of enrolment:[1]

(i) currently engaged with children's services (at least one child who is classed as a Child in Need [CiN; excluding disability as the sole basis for CiN status] or who is subject to a Child Protection Plan [CPP])
(ii) eligible for financial support under Section 17 of the *Children Act* 1989
(iii) have at least one child meeting criterion (i) who is aged 10-16 years at the time of enrolment[2]
(iv) are open to participating in the study (including providing data at various points)

Families who meet the inclusion criteria will be excluded if the family's social worker assesses that:

- there is known financial exploitation (or a risk) for the family or members thereof
- the family or members thereof are under criminal investigation for fraud or financial offences
- there is an imminent escalation of social care / state input, meaning that the child is likely to be taken into care or into the children and young people's secure estate
- there are other safeguarding issues that should prohibit participation *and* this is agreed on a case-by-case basis with the delivery team[3]

Payment is made to the primary caregiver of the child in question.

[1] If the case closes after the census date but *before* the point of enrolment then the family is not eligible for the cash transfers because they are no longer eligible for s.17 funding.

[2] For example, a family where the child in need is 8 years old but has a sibling aged 12 who is not a CiN or subject to a CPP then the family is *not* eligible.

[3] Examples (not exhaustive): (i) serious, harmful and persistent parent/child substance use that would be escalated through increased financial resources (e.g., to the point that overdose is likely because the risk is only mitigated by financial constraints); (ii) a family member is subject to Prevent input; or (iii) a family member is at imminent risk from another family member of serious physical harm requiring sustained hospitalisation.

Payments are unconditional, meaning no expectation is placed upon recipients (e.g., to seek work or take part in community service). Payments are also unrestricted, meaning that families can choose to spend the money as they wish.

If a family becomes ineligible due to safeguarding risks (see above), payments will be discontinued.

Changes to location (i.e., if the child moves to a new local authority) or status (i.e., CiN/CPP or going into care) after enrolment will *not* affect payments.

5. Who provides it
Intermediary agent: Social workers in participating local authorities.

Payment agent: King's College London (KCL) makes payment on behalf of the respective local authorities direct into families' bank accounts.

The process is overseen by KCL, in partnership with Impact on Urban Health (IoUH).

6. How it is provided
Payments are made direct to the designated primary caregiver by bank transfer.

7. Where it is provided
Intermediary agent: Social work support is provided in the usual settings.

Payment agent: There is no physical location for the payments as they are by bank transfer.

The intervention is provided in X local authorities.

8. When it is provided
Weekly for 45 weeks. There are fixed dates for starting the intervention and receiving cash.

9. How much is provided
Each family receives payments over 45 weeks. Families in London will be given 20% more. Payments are made weekly for 45 weeks. There are fixed dates for starting the intervention and receiving cash, and there is tapering near the end. (The amount of the payments has been removed from this document version to reduce the risk of financial exploitation of participating families.)

10. How it can be adapted
No adaptations are envisaged.

11. How is fidelity supported
See Implementation Logic Model.

12. How is fidelity monitored
See Implementation Logic Model.

Appendix 2: Theory of change

Evidence-based observation	Evidence-based need	Target population	Intervention inputs & activities that will address the need	Immediate outcomes (hypothesised mediators of change)	Intermediary (short-term) outcomes – by 12 months	Primary (long-term) outcomes – by24-48 months
Financial hardship is a contributing factor to poor child health and development, involvement in youth violence and crime, and state intervention in children's lives. Existing financial support mechanisms,	An unconditional cash transfer (UCT) provides a time-limited additional income to families with the agency to direct the income towards self-determined needs. This reduces parent/carer stress associated with financial insecurity and improves the	Families with a social worker/family support worker, where there is at least one child in need (CiN) OR at least one child who is subject to a Child Protection Plan (CPP) Families who are eligible for financial support	A social/family support worker to act as intermediary agent to check eligibility of families and refer for the cash transfer. A payment agent to confirm eligibility and distribute payments weekly.	* (Temporarily) increased net income *Reduced debt or financial arrears on bills/rent *Reduced financial stress/strain (ability to afford necessities)	Children/young people: *Improved child behaviour / reduced behavioural difficulties *Improved mental health	Children/young people: Reduced offending/ involvement in violence and crime Reduced trauma Reduced substance use

where they exist, often deny agency to recipients or involve burdensome conditionality. [This ToC draws on evidence generated in the context of varied UCT/CCT studies in both HICs and LMICs, with mixed findings. As such, outcome constructs are best hypotheses].	material conditions of the family, in turn leading to increased parenting capacity, improved health and educational opportunities for the children. The receipt of the UCT does not disrupt/alter existing welfare or benefits paid to families.	under S.17 of the Children Act. Families with at least one child in the age range 10-16 years meeting the above criteria.	Treated families receive cash payments unconditionally for 45 weeks irrespective of the number of children in the family. Families in London will be given 20% more. Payments are made weekly for 45 weeks. There are fixed dates for starting the intervention and receiving cash, and there is tapering near the end. (The amount of the payments has been removed	*Reduced financial worry/anxiety * Reduced family conflict events related to finances *Improved parent/carer subjective wellbeing *Reduced parenting stress *Improvement in the material and living conditions	*Reduced substance use Improved nutrition and physical health Improved concentration and focus *Improved engagement in education and learning (including improved attendance and reduced exclusions)	Improved educational performance and attainment Family/parent-carer: Reduced use of violence and control in family relationships Reduced parental substance use

			from this document version to reduce the risk of financial exploitation of participating families. Social workers may provide information to eligible families who do not have a bank account, to facilitate them to receive the cash transfer.	of the family and home environment (housing quality) *Improved educational resources, equipment or opportunities for the child *Increased time available for parent/s and children/young people to spend together *Improved neighbourhood/	Family/parent-carer: *Reduced financial stress/strain (ability to afford necessities) *Improved parent/carer subjective wellbeing *Improved parent/carer mental health *Improved family relationships and	Stability in family relationships and living conditions Discharge and/or de-escalation of social care case

				community environment Increased (financial) agency for families Increased empowerment of women in target families	family functioning Improved parent/carer cognitive capacity/mental bandwidth Improved parenting capacity Improved parent-child relationship Increased locus of control in parents/carers	

Appendix 3: Business as usual: Intervention description

1. Name
BAU for Unconditional Cash Transfers

2. Rationale
N/A

3. What is provided
Families can receive all forms of service as they would were they not part of the trial.

This includes financial or material provision through s.17 of the *Children Act* 1989.

It also includes existing community resources and financial capability support (e.g., accessing benefits, money management). This is likely to be heterogeneous across participating areas.

Families in the study will receive a handbook (produced by the delivery team in virtual format[4]) signposting them to relevant services that can assist with economic and social challenges.

There will be one handbook only (i.e., not specific to each area), containing a combination of (a) national services and (b) pointers to any local registries of local services.

In two local authorities, Impact on Urban Health (IoUH) will offer signposting in the form of community open days to showcase support that they fund.

4. To whom is it provided
Families who meet eligibility criteria for the intervention (see intervention TIDieR document), in both intervention and control arms, will receive the handbook.

Those who meet the criteria in the two local authorities will additionally be invited to community open days convened by IoUH (tbc).

All families in the trial can access existing financial/material support financial capability support in line with the respective services' eligibility criteria.

5. Who provides it
Financial or material provision through s.17 of the *Children Act* 1989 is provided by local authorities via social workers.

[4] Available in hard copy if a family does not have access to a computer or smartphone.

Financial capability support is provided by a range of statutory and third sector organisations in respective areas.

The handbook is written and produced by the delivery team. It will be given to families by social workers (hard copy in person, link virtual copy by email or text).

The community open days in the two local authorities will be convened by IoUH and attended by relevant organisations they fund (tbc).

6. How it is provided
Financial or material provision through s.17 of the *Children Act* 1989 will be provided in the usual ways.

The means of providing regular financial capability support is likely to be varied (e.g., group and 1:1, in-person/virtual/phone)

A link to the handbook will be sent to families by email or text.[5]

Community events in the two local authorities will be in-person and open to the wider community but with invitations to trial participants.

7. Where it is provided
Financial or material provision through s.17 of the *Children Act* 1989 will be provided in the usual ways.

Regular financial capability support is provided in a variety of ways – in-person (home, community), virtual, phone.

Families will be given the handbook in settings where they regularly meet their social worker. A link to the virtual copy will be sent by email or text.

The community events in the two local authorities will take place in local accessible community venues.

All support is provided in eight local authorities.

8. When it is provided
Financial or material provision through s.17 of the *Children Act* 1989 will be provided in the usual ways.

Regular financial capability support is provided throughout the study period.

[5] The hard copy format would be given to families in person or posted to them.

Families will receive the handbook at the point of enrolment and up to two subsequent points (tbc).

The timing of the community events at the two local authorities will be determined by IoUH.

9. How much is provided
Regular financial/material provision (inc. s.17) and financial capability support will be provided in differing quantities depending on the nature and capacity of the service and the degree of family need and engagement.

Each family will receive one handbook.

There will be a minimum of one IoUH-convened community event in each of the two local authorities.

10. How it can be adapted
Families can be sent a link to the handbook at other points in the project besides those listed above, according to their needs.

The venues and timing of IoUH-convened community events are subject to IoUH discretion (tbc).

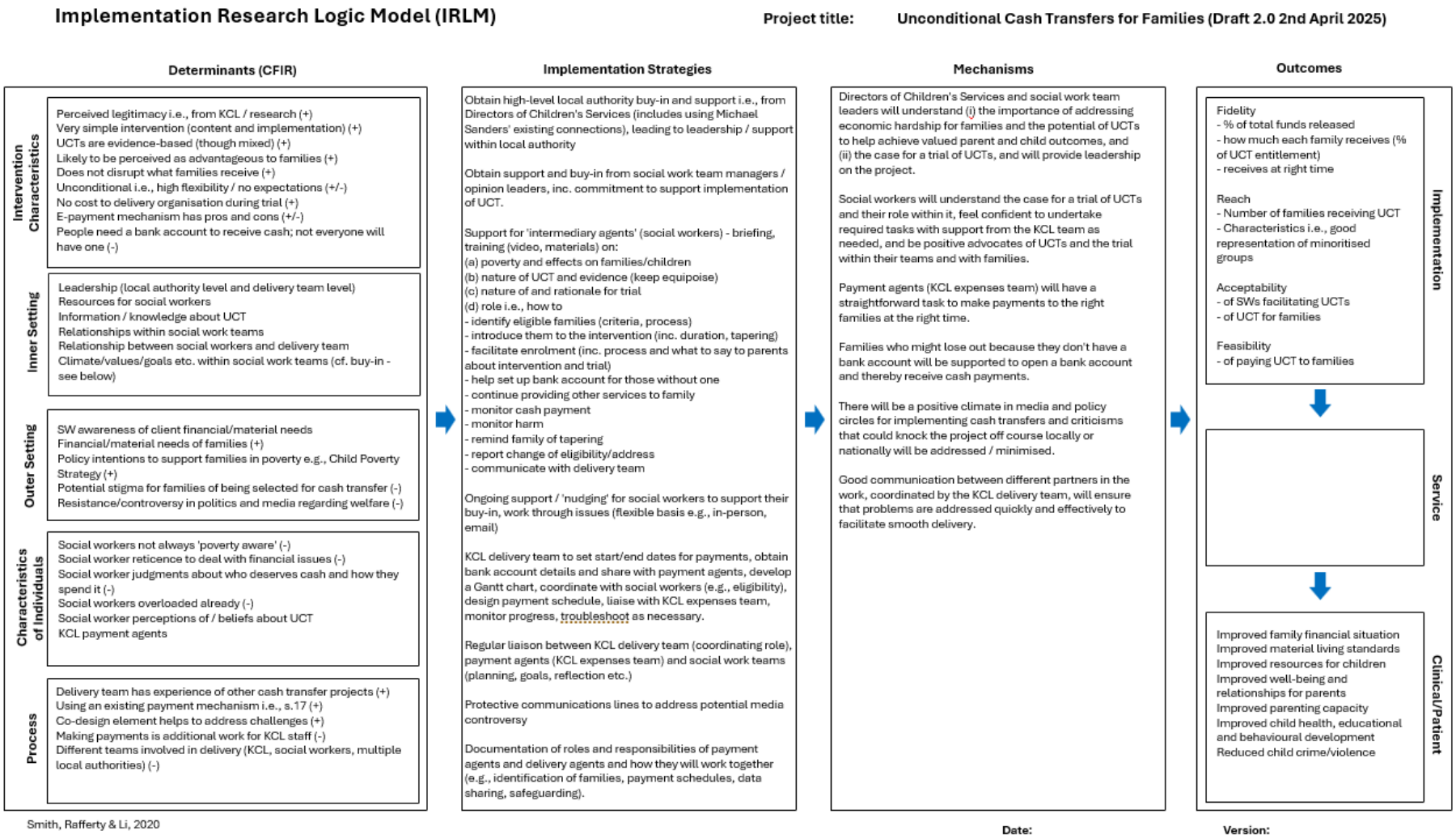
The intervention delivery and evaluation teams have no control over the actual financial/material or financial capability support that is provided or how it is adapted for family needs.

11. How is fidelity supported
The delivery team will ensure that each family receives the handbook and that families in the two local authorities are invited to the IoUH open days (tbc).

12. How is fidelity monitored
Provision of the handbook and the convening of IoUH community events will be monitored by the intervention delivery team (tbc).

The amount/nature of s.17 provision *besides the unconditional cash transfer* and the nature of regular financial capability support accessed by families will be captured by the evaluation team in the mid-point survey and parent/carer interviews. There is no fidelity metric for either.

Appendix 4: Implementation logic model



Appendix 5: List of potential harms

UCT study – potential harms to explore

Draft 1.0 2nd April 2025

This is a living document based on a combination of (i) evaluation and delivery team discussions during co-design, (ii) ongoing reading of evidence on cash transfers and (iii) discussions with other colleagues working in this space. It will inform qualitative data collection in the UCT study.

Short description	Longer description	Notes / evidence[6]
1. Harmful spending	Families spend more on so-called 'temptation goods' (alcohol, cigarettes, recreational drugs etc.). This has an adverse effect on health and means that the money is not spent on other things that would be beneficial for parents/carers and children (e.g., rent, clothes, food, opportunities).	Shah & Gennetian – little evidence in studies in LMICs that cash transfers increase expenditure on temptation goods such as alcohol and tobacco; in BFY study in US parents spend more money on child-focused items. Jaffee – doesn't address directly but suggests that extra money allows parents to increase child-related expenditures (e.g., toys, clothing, food, education-related activities). Evans-Lacko notes that a theorised mediator is decreasing the need to call upon negative coping strategies such as alcohol consumption.

[6] Blanks cells indicate that the issue has not obviously been explored in cash transfer evaluations.

		Jaroszewicz – no evidence of increased spending on recreational drugs or alcohol
2. Dependence	Families take on new financial commitments that are unsustainable beyond the end of the additional money (e.g., subscriptions, hire purchase, membership). This creates financial problems and associated stress when the UCT payments end.	
3. Partner conflict	Additional money contributes to arguments with partnership about how the money should be spent.	Jaffee – evidence that cash transfers contribute to reduced partner conflict and violence Evans-Lacko notes that this may be affected by gender norms and dynamics in the community or household i.e., if the male head of household feels their role or control of finances is threatened.
4. Declining relationships	Additional money contributes to conflict with extended family and friends, for example because of changed lifestyle or perception that recipient is not fairly sharing enough of their funds (may be particularly the case with larger sums of money). Alternatively, recipients may distance themselves from friends and family to avoid being asked or help they cannot or do not want to provide. Finally, the additional resource may enable families to move house/neighbourhood but in so doing isolate themselves from informal sources of support.	Jaroszewicz – explored this mechanism and found no evidence
5. Financial exploitation	If it becomes known that the parent/carer is receiving extra money they may be more vulnerable to people (family, friends, others) seeking to control their finances or deceiving or coercing them into handing over money or assets (e.g., blackmail, fraud, stealing	

	money or property). This would have an adverse effect on the family's finances, living standards and mental and physical health.	
6. Service displacement	If service providers become aware that the family is receiving extra money it may cause them to reduce, withdraw or deny other support on the basis that the family does not need it (or does not need it as much as families who are not receiving extra money). Equally, the family may decide to disengage from or not seek other non-cash forms of support because they feel that they do not need them, even though those supports may still be beneficial.	Some evidence generally (not specific to cash transfers) that in intervention arms of trials service providers and service users may change what they do regarding usual care.
7. Income offset (reduced labour market participation)	The extra money enables parents/carers who are in employment either to stop working or to reduce their hours / number of jobs, meaning that they lose income through paid work. This means that net income does not increase by the same amount as the cash transfer, and may mean that families are actually worse-off than they were at the start once the cash transfers end. Equally, the additional money means that parents/carers have less incentive to seek other more sustainable forms of income e.g., work (if unemployed) or better paid work (if employed).	Shah & Gennetian – research in LMICs generally finds cash transfers to parents have minimal labour supply effects among parents; studies in higher-income countries (inc. US) also don't seem to show marked reduction in labour market participation Jaffee – doesn't address directly but finds largely consistent evidence that cash transfer programmes increase the amount of time parent/carers spend with their children (a positive outcome). This issue is likely to be moderated by the type of employment parents are engaged in. For example, it may be relatively easy to 'dial up' some types of work (e.g. zero hours, gig economy) once cash transfers end.

8. Income offset (reduced other income sources)	The extra money means that families lose other non-employment sources of money, for instance in the form of benefits, one-off payments made by charities, or informal support (e.g. from family).	Assumption of the project is that s.17 payments should not affect benefit entitlements.
9. Heightened financial awareness	As parents/carers consider how to spend the additional cash they think more deeply about their existing financial obligations and potentially uncover new ones (their own and other's e.g., friends/family). This causes them distress/overwhelm because they discover these obligations are larger than they previously thought and that the extra cash is insufficient to address these.	Jaroszewicz finds evidence in support of this mechanism – "focusing attention on one's bad financial state can be unpleasant" (NB. talking about comparatively small amounts $500 or $2000)
10. Spending decision stress	Parents/carers have more choice over how to spend their money, which leads to stress	Jaroszewicz finds evidence in support of this and suggests it is consistent with work on negative effects of choice (e.g., choice overload and regret of options not chosen)

References

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Evans-Lacko, S,. Araya, R., Bauer, A., Garman, E., Álvarez-Iglesias, A., McDaid, D., Hessel, P., Matijasevich, A., Paula, C. S., Park, A-L., & Lund, C. (2023). Potential mechanisms by which cash transfer programmes could improve the mental health and life chances of young people: A conceptual framework and lines of enquiry for research and policy. *Cambridge Prisms: Global Mental Health*, 10, e13, 1–11.

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SSRN: https://ssrn.com/abstract=4154000 or http://dx.doi.org/10.2139/ssrn.4154000

Appendix 6: Sample size calculations

Sample size calculations at different Minimum Detectable Effect Sizes (MDES) and allocation ratios.

MDES	1:3 Allocation Ratio ($n_{adjusted}$)			1:1 Allocation Ratio ($n_{adjusted}$)		
	Treatment	Control	Total	Treatment	Control	Total
0.15	518	1553	2070	776	776	1553
0.16	455	1364	1819	682	682	1365
0.17	403	1209	1612	605	605	1209
0.18	359	1078	1438	539	539	1079
0.19	323	968	1291	484	484	969
0.20	291	874	1166	437	437	874

Appendix 7: Referral and recruitment table

Months (e.g. Oct-Dec 23):	Q1 Apr-Jun 25	Q2 Jul-Sept 25 (1 recruitment month, 1 Local Authority recruiting)	Q3 Oct-Dec 25 (2 recruitment months, 4 Local Authorities recruiting)	Q4 Jan-Mar 26 (1 recruitment month, 1.5 Local Authorities recruiting)	Q5 Apr-Jun 26 (1 recruitment month, 1.5 Local Authorities recruiting)	Q6 Jul-Sept 26
Target number of young people **referred into the project**		215	861	323	323	
Target number of young people **recruited to the project and evaluation (75% onboarded and randomised)**		161	645	242	242	
Target number of young people who **withdraw/drop out (10% attrition rate)**			16	65	24	24

Appendix 8: Risk register

Risk Register

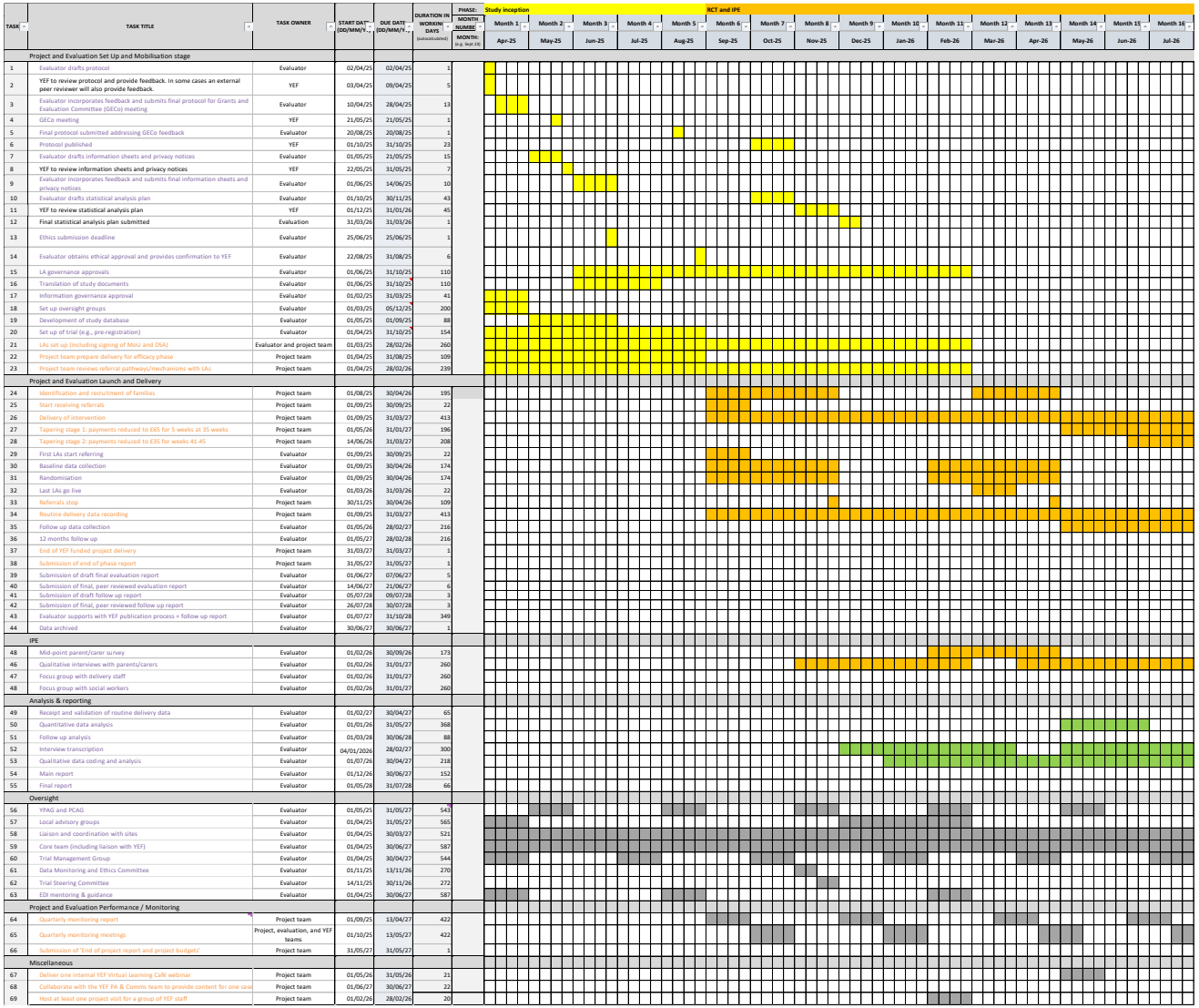
PROJECT NAME	CREATED BY	DATE CREATED	REVIEWED BY	DATE REVIEWED	NEXT REVIEW D
Unconditional Cash Transfers	Abigail Thompson	03/07/2025	Ping San	02/10/2025	03/11/2025

REF ID	RISK TITLE	RISK DESCRIPTION AND IMPACT	DATE IDENTIFIED	RISK CATEGORY	RISK SUB-CATEGORY	IMPACT LEVEL	PROBABILITY LEVEL	PRIORITY LEVEL / RISK RATING	STATUS	OWNER	MITIGATIONS	DATE CLOSED
1	Recruitment: screening	Families will need to be systematically screened from those with Child in Need or Child Protection Plan status. Practitioners will likely have information about the family (e.g. financial hardship, substance use issues), meaning additional criteria beyond the inclusion/exclusion criteria may be applied, resulting in eligible families not being included.	01/01/2025	Evaluation	Avoiding bias	3	2	6	Open	Julian	Eligibility criteria has been discussed and refined during the co-design process. Eligibility criteria will be broad (only requiring child in need status or a child protection plan). We will provide guidance to sites for introducing the study to families in a consistent manner.	
2	Recruitment: increased sample size	It has been agreed that the sample size will be 1291, which is larger than originally proposed. This has implications for the delivery team in terms of recruiting additional local authorities. It also requires participating LAs to have sufficient numbers of families on their caseloads.	03/03/2025	Delivery	Sample size	4	3	12	Open	Michael	The delivery team have already been in contact with additional local authorities and have been received positively. The delivery team is obtaining data from LAs meaning we will have a clearer picture about potential population size. To mitigate this risk, one potential option is to increase the target age range to go beyond 14 years, which is currently proposed.	
3	Retention	Retaining families allocated to the control condition could be difficult because they perceive they have lost out and have nothing to gain from involvement. This could also result in lower baseline scores (resentful demoralisation).	01/01/2025	Evaluation	Attrition	5	4	20	Open	Julian	An engagement strategy is being developed (including with experts by experience or EBEs) to ensure engagement of the control group. During co-design, different options have been considered, such as whether both groups could receive larger sums for completing the final questionnaires. All families will be reimbursed equally for taking part in evaluation activities (e.g., £10 for baseline and midpoint surveys, £25 for endline surveys). Based on feedback from EBEs and with support of the funders, we are implementing a substantive material reimbursement for families in the control group (e.g., a gift at the end of the project such as an electric blanket). Baseline differences will be examined as part of testing imbalances.	
4	Retention	Retaining families allocated to the intervention condition in evaluation activities.	02/28/2025	Evaluation	Attrition	2	4	8	Open	Julian	Taking part in the evaluation is necessary to receive the intervention. Families will be required to complete midline and endling surveys to receive cash, whilst still having the opportunity to not answer specific questions (as participation is voluntary).	
5	Exit strategy	An appropriate exit strategy will be required to ensure there are no unintended consequences of taking the transfers away towards the end of the study (e.g., because families make financial commitments they cannot sustain).	01/01/2025	Ethics	Unintended consequences	3	2	6	Open	Julian	Exit strategies have been discussed during co-design, including different options for tapering off the amounts towards the end of the project. The plan is to taper payments and reduce them for five weeks at week 35 and then reduce further for four weeks from week 40. This will also be examined in the IPE (e.g., if families take on unsustainable commitments).	
6	Delivery to timescales	Delivery of the project within set timescales.	01/01/2025	Evaluation	Timelines	3	3	9	Open	Julian	LAs will sign a Memorandum of Understanding at the outset of the project, ensuring there are clear expectations. The delivery team is being clear about the parameters of the study in preliminary conversations. We are proposing a plan to give LAs as much time to identify and onboard families as possible - up to 8 weeks based on a census date 4 weeks ahead of their 4 week recruitment period. We are planning on allocated each LA a recruitment month, but LAs will not be constrained to only recruiting in that month if more time is needed.	
7	Lack of expert by experience input	Lack of co-production and participation from EBEs in research design and delivery, and lack of input from (a) parents with a CiN or CPP and/or (b) diverse groups (ethnicity etc.), which could result in less relevant insights to inform evaluation design.	01/01/2025	Evaluation	PPIE	3	3	9	Open	Julian	We have planned both ongoing and flexible methods of EbE input to mitigate this risk. EbE input comprises x 2 peer researchers, quarterly YPAG and PCAG meetings, and rolling input from local advisory groups. The local advisory groups will help us to achieve representation from diverse groups and parents with a child with a CiN/CPP status. Peer researchers will form part of the core research team and receive research training. EBE work supported by Anna Freud's dedicated Participation Team, including the Head of Participation, and Anna Freud's wider pool of young person and parent/carer champions if required.	
8	Cross-contamination	Open events showcasing Impact of Urban Health support, where families in the intervention arm may interact with those in the control arm, potentially affecting attrition (because control arm families become aware of what they are not receiving - especially the amount - and feel aggrieved).	01/01/2025	Evaluation	Attrition	1	3	3	Open	Julian	We will work with Impact on Urban Health about communications strategies for participants for these events. We are working with EBEs on messaging to use with participants if potentially sensitive questions arise (e.g., why someone else is receiving money and they are not).	
9	Uptake of BAU	Heterogeneity in support offered through BAU in LAs.	01/01/2025	Evaluation	Business as usual	5	3	15	Open	Julian	We expect there to be heterogeneity in BAU, and there is little we can do to alter it given the applied nature of this research. BAU has been discussed in co-design and it has been decided that no additions/changes to business as usual will be provided. We will take LA into account in the analysis. As part of the IPE, we are planning a midpoint parent/carer survey, asking about types of support received as part of BAU and how families have spent any additional money received.	

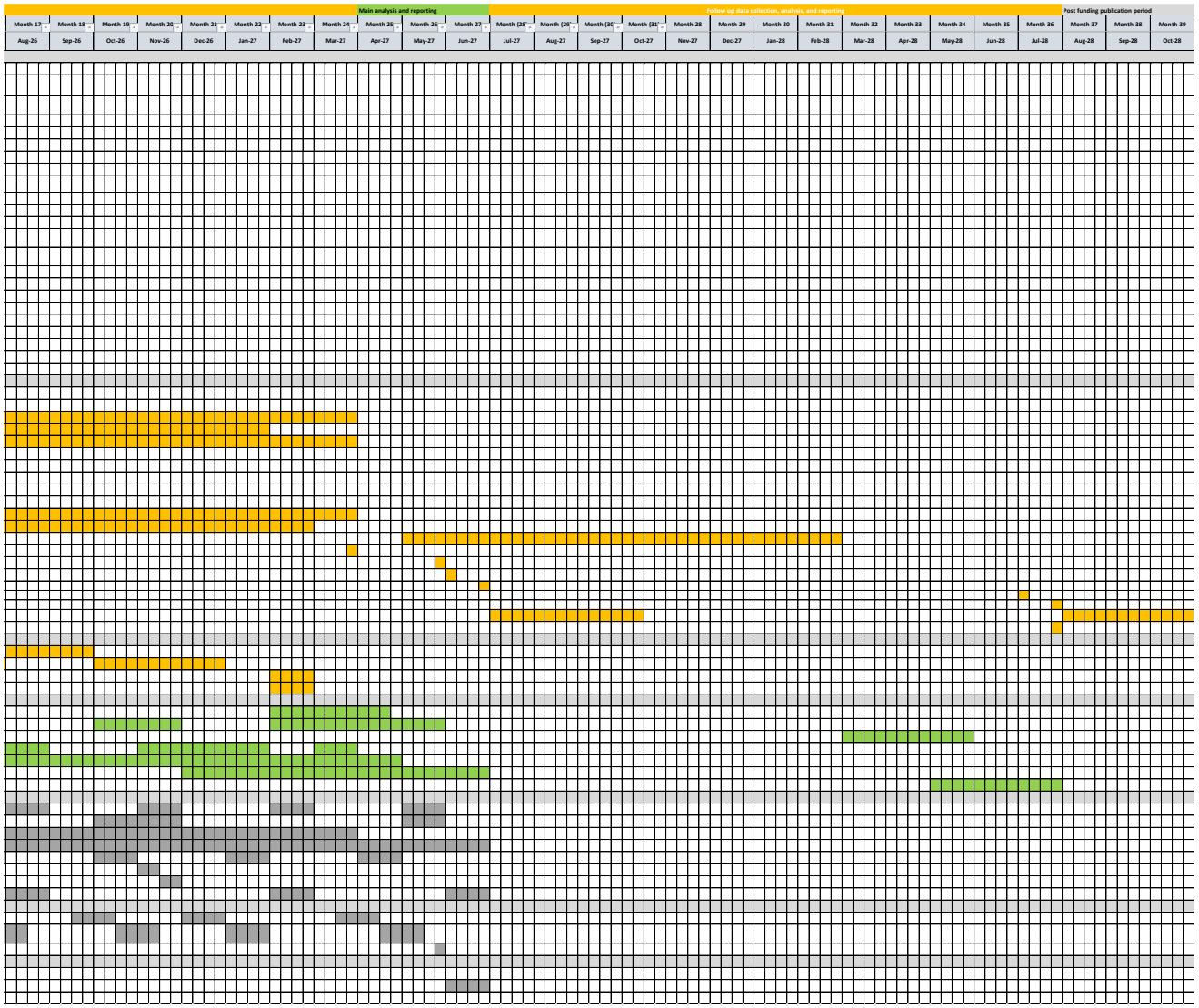
10	Safety: financial exploitation	There is a risk that individuals/families may be at increased risk of financial exploitation for the intervention arm and control arm (if others assume they receiving additional income due to taking part in the trial). If social workers are supporting multiple families within the same community, there could be a risk that social workers/ practitioners inadvertently disclose allocation beyond the families.	03/06/2025	Evaluation	Unintended consequences	3	2	6	Open	Julian	We will not include families where there is known financial exploitation. We are working on a strategy to ensure that communication with participants is kept private. We will monitor safeguarding and adverse events for increases in financial exploitation, which will also be explored in the IPE. We have agreed that the cash recipient will be the primary caregiver as per the LAs records. Social workers and practitioners will be reminded about the need for absolute discretion and confidentiality in terms of identities of families recruited in the trial to be protected.	
11	Financial exploitation is an exclusion criterion	There is a risk that (a) this may be applied subjectively, (b) families may be excluded due to unsubstantiated claims they are being financially exploited, or (c) financial exploitation is not known meaning this criterion is incorrectly not applied.	02/17/2025	Evaluation	Avoiding bias	3	2	6	Open	Julian	Although the mechanism (i.e., information available to the practitioner at the time of screening/referral) for identifying financial exploitation is acknowledged to be not ideal, it has been concluded that it would be unacceptable to include a family where there is known financial exploitation as we could be increasing that exploitation.	
12	Media attention	This project might attract more (negative) media attention than other projects; e.g., spending money on people who "don't deserve it", parents wasting money, families who do deserve it missing out (e.g., CiN for disability), the Government's aim to reduce spend on benefits. There is a risk that the study could be politicised in the media due to broader political and social issues surrounding anti-immigration sentiment. In turn, this could present risk of reputation and possibly harm to the institutions and individuals in the study team.	02/28/2025	Evaluation and delivery	Media	3	3	9	Open	Julian	We will start putting together some communication plans including "protective messages" so that we are prepared in advance should there be some media attention. Also, we will join up the comms teams of the various organisations involved to ensure there is a coordinated approach. We'll also produce guidance for staff on managing any direct correspondence should they receive it from media and/or external people.	
13	Staff sickness and turnover	Staff sickness and turnover impact our ability to delivery to time.	01/01/2025	Evaluation and delivery	Staff	3	3	9	Open	Julian and Michael	During co-design we will work with the delivery teams and LAs to inform plans for capacity planning and ensuring continuity. The evaluators (both AF and PenARC) have a large pool of experts that could be called upon in the case of loss or absence of project staff. Strong project management would ensure a smooth transition. Staff will keep ongoing handover documentation and ensure that different team members (including those not directly involved in a project) understand a project and the status to facilitate handover.	
14	Project poorly managed and/or not keeping to budget and timelines	The evaluation will need to be delivered to set costs and strict timescales, with a particular focus on completing certain activities (e.g., evaluation protocol, recruitment) by the agreed date.	01/01/2025	Evaluation and delivery	Timelines	3	3	9	Open	Julian and Michael	The budget is a realistic projection of project costs, which has been developed in conjunction with a clear and realistic project schedule. The PI and Trial Manager will routinely monitor project expenditure and progress. The project timeline includes a breakdown of phases, activities and milestones, as well as regular meetings between relevant teams to ensure risks to delivery are flagged and addressed quickly. Ethical approval will be sought from University College London Research Ethics Committee, with which the evaluators are very familiar.	
15	Conflicting priorities and/or lack of buy-in	Conflicting priorities between the evaluation and delivery teams, and a lack of buy-in to the evaluation by the delivery team.	01/01/2025	Evaluation and delivery	Priorities	3	2	6	Open	Julian and Michael	We will be transparent about our expectations at an early stage to quickly identify and mitigate any conflicts, and the co-design period will provide a helpful platform to do so. We will be in constant communication with the delivery team from the outset of the project, with regular meetings scheduled. There has been a high level of buy-in with the evaluation. Although a small risk, it is possible the delivery team and evaluators have conflicting views on the evaluation design and/or approach. At the outset, we have ensured there is a shared understanding of teams' roles and responsibilities.	
16	Safeguarding	Families are exposed to additional risks as safeguarding procedures are not followed.	01/01/2025	Evaluation	Safeguarding	2	2	4	Open	Julian	This is important as families participating in the evaluation are highly vulnerable with complex needs and may be involved or likely to become involved in the Youth Justice System. All members of the evaluation team adhere to strict safeguarding policy and procedures. All staff must complete appropriate safeguarding training. We will detail in the protocol a clear process for safeguarding (including reporting concerns), that can be implemented across the study and within each LA site. It will involve identifying a safeguarding lead at each LA, whom we will contact if the evaluation/delivery team becomes aware of safeguarding issues from participating families. We will have an adverse events procedures for LAs to report issues that they become aware of, which will include a process for managing serious adverse events and those deemed related to the trial (intervention or evaluation).	
17	Perception of the BAU-only condition	Perception of the BAU-only condition - there may be an impression by practitioners that families are 'missing out' on care. This could impact adversely on practitioners' willingness to include families in the study or introduce the study to them, and it could impact adversely on families' willingness to participate in the study. Similarly, practitnes may have objections to the study (e.g., randomisation). Either could have a negative impact the ability of the study to achieve its intended sample size and power requirements.	01/01/2025	Evaluation	Power	5	4	20	Open	Julian and Michael	We are co-producing our communications materials with the delivery team and EBEs. See also engagement of families in the control condition. We are not planning to advertise the amount of cash received in material (e.g., information sheets) but will need to be prepared to answer direct questions about it. These communication plans will also need to be adhered to by LAs when interacting with families. Communications with practitioners and LAs will be clear about the importance of the study (e.g., equipoise).	
18	Safety: communications with families	EBEs have identified the importance of keeping a family's participation in the study as private. This is to address potential stigma from members of the community. It may also affect the risk of families being financially exploited.	03/11/2025	Evaluation	Safeguarding	5	2	10	Open	Julian	We are considering our communications about the study; e.g., having an innocuous study title, asking participants how best to contact them to ensure privacy (e.g., in case of shared email accounts), whether a two stage communication process is needed to "validate" we are liaising with the intended individual. Public information about the study (e.g., website) will need to be carefully considered. Some information sources, like the study protocol, will be disclosive however it is unlikely that these material will readily be accessed by members of the public.	
19	Equity, diversity, and inclusion	Failure to recruit and retain a diverse sample, in particular participants from minoritised and marginalised groups	02/28/2025	Evaluation	EDI	5	3	15	Open	Julian	We are co-producing our communications materials and processes with EBEs and race equity advisors to maximise our ability to include families from marginalised and minoritised groups. We will identify recruitment targets based on the ethnic composition of each LA to monitor during recruitment. We will liaise with LAs for advice on engaging the marginalised groups with whom they work and if they work with any specific organisations locally to support them engage with marginalised groups.	
20	Intervention and evaluation delivery	Limited engagement with practitioners and/or LAs. This could delay intervention delivery and evaluation processes.	03/12/2025	Evaluation and delivery	Timelines	3	3	9	Open	Julian and Michael	Director-level buy in for the project has been/ is being established with each participating LA. LAs will sign a Memorandum of Understanding at the outset. The evaluation team will have a named single point of contact (including back up) at each LA. As part of our communications plan with LAs, this will include how we escalate communications within an LA as necessary. The SPOC will be managing the local evaluation activities, including supporting practitioners to identify families and contact families to provide initial information about the study. The evaluation will also organise drop-in sessions for LAs to discuss any issues that may arise.	

21	Fidelity	Families in the intervention arm do not receive the cash as intended.	03/12/2025	Delivery	Fidelity	4	2	8	Open	Michael	This is a low risk as the cash is being administered directly by the delivery team (not by LAs). Although this places a large administrative burden on the delivery team. The delivery team are working with King's finance teams to ensure efficient delivery of cash.	
22	Equity, diversity, and inclusion	Family members may have different roles; for example, the individual receiving the cash may not have as much information on the wellbeing of the child as another member of the family, the individual receiving the cash may not be the one determining how the family's money is being used. This may make it difficult to obtain all necessary data from parent/carer participants in interviews.	02/28/2025	Evaluation	EDI	3	2	6	Open	Vashti and Nick	We are planning in the IPE how to include other interviewees should more than one family member be required to report on relevant aspects.	
23	Intervention delivery	Families may not have a bank account, meaning they are not able to receive the cash.	02/03/2025	Delivery	EDI	3	3	9	Open	Michael	There will be guidance for LAs on supporting families to set up a bank account, which can be easily done with online banks.	
24	Unintended consequences	There are unintended harmful consequences of the intervention (e.g., increasing domestic violence due to financial exploitation).	02/03/2025	Evaluation and delivery	Safety	5	3	15	Open	Julian and Michael	In addition to the safeguarding and adverse events monitoring processes, we will be developing a logic model of unintended harmful consequences to make sure we are capturing the right information to identify this. It should be noted that previous cash transfer intervention have not reported serious concerns; for example, they have found that cash transfer intervention have not increased violence towards women or that the cash was used for potentially harmful activities such as substance use. The cash recipient will be the primary caregiver on social care records. Whilst this may be more likely to be a female, we cannot guarantee it and, on careful discussion, there is little rationale we can give to argue it should always be a female (e.g., if the father is the biological parent and the female is the step parent). Still, it is recognised that an aim of the intervention is to increase female empowerment.	
25	Recruitment	There is a relatively narrow recruitment period of 5 months (September-November 2025, March-April 2026). This is primarily to avoid families starting the intervention at such a time that they would end the intervention in December 2026/ January 2027, which is generally already a financially difficult time. Some LAs have said this would be a deal breaker for their involvement. However, it results in a heavy administrative burden for LAs, the delivery team, and the evaluation team. Based on a sample size of 1,291 and a 75% conversion from referral to consent, 1,721 referrals would need to be made within 5 months.	03/12/2025	Evaluation and delivery	Timelines	5	5	25	Open	Julian and Michael	Additional researcher capacity has been included in the evaluation budget to manage the volume of communication with participants (at the outset and throughout the project). We are working on technical solutions to help manage communication with participants. We are also exploring options for a wider staff pool to support with the recruitment and consent stage. With support of the funders, we are prosing funding for a 0.1FTE manager (SPOC) in each LA to be funded to support with identifying, onboarding, and referring families into the study. In the early stages of recruitment, we also intend to assess referral rates of recruitment and review reruitment stategies with each LA.	
26	Recruitment: pressure to participate	Families may perceive trial participation as a requirement imposed on them by LAs/support workers. It will be important to ensure that families do not feel under pressure to participate in the research.	03/18/2025	Evaluation and delivery	Ethics	3	3	9	Open	Julian and Michael	Recruitment materials for LAs, practitioners, and families will make it clear that participation is voluntary for families and that they have the right to withdraw at any time without a reason. These messages will also make it clear to families that their being identified as eligible - or their decision to take part - has no bearing on their social care status or their access to support.	
27	Recruitment: reluctance to refer due to liability concerns	Practitioners may be reluctant to refer due to concerns about their liability; e.g., if a family uses the cash for harmful activities.	3/31/25	Evaluation and delivery	Power	3	3	9	Open	Julian and Michael	We will remind practitioners that the provision of financial aid - such as cash - is already within their remit as part of S. 17. We have mechanisms in place to minimise the likelihood of harm. We will also reiterate that there is little state control over how individuals generally spend their money, meaning an additional responsibility in this instance could be perceived as imbalanced.	
28	End of treatment stress	Families in the intervention arm may experience stress and a worsening of outcomes towards the end of the intervention due to the cash being terminated. As our primary endpoint is the end of the intervention, there could be a risk that any improvements in outcomes that families experience whilst receiving the cash are not observed by the evaluation; it could be that families experience a worsening of outcomes at the end of the intervention.	3/31/25	Ability to detect change	Quality	4	4	16	Open	Julian/ YEF	It is challenging to mitigate this risk. On the one hand, measuring outcome at the end of the intervention period could disadvantage the intervention by reducing the likelihood of detecting change. On the other hand, as it is a time-limited intervention, it could be advantage (and/or be disingenuous) to measure outcomes at, for example, the start of the intervention tapering period. However, this could be conceived of as the end of the mainstage intervention. Alternative approaches could be to have the primary endpoint be the end of the mainstage intervention, with a follow up (e.g., three months after completion of tapering) for the intervention group only to see if effects are sustained. The opposite could also be employed, to examine if there is an improvement in outcomes at the end of the mainstage intervention for families in the intervention group, even if these do not result in a difference in outcomes across the two arms by the end of the intervention. An end-of-mainstage-intervention follow up and one three-to-six months after the end of the tapering period for both arms could be another option.	

Appendix 9: Timeline



TASK	TASK TITLE	TASK OWNER	START DATE (DD/MM/YY)	DUE DATE (DD/MM/YY)	DURATION IN WORKING DAYS (autocalculated)
	PHASE:				
	MONTH NUMBER:				
	MONTH: (e.g. Sept 23)				
	Project and Evaluation Set Up and Mobilisation stage				
1	Evaluator drafts protocol	Evaluator	02/04/25	02/04/25	1
2	YEF to review protocol and provide feedback. In some cases an external peer reviewer will also provide feedback.	YEF	03/04/25	09/04/25	5
3	Evaluator incorporates feedback and submits final protocol for Grants and Evaluation Committee (GECo) meeting	Evaluator	10/04/25	28/04/25	13
4	GECo meeting	YEF	21/05/25	21/05/25	1
5	Final protocol submitted addressing GECo feedback	Evaluator	20/08/25	20/08/25	1
6	Protocol published	YEF	01/10/25	31/10/25	23
7	Evaluator drafts information sheets and privacy notices	Evaluator	01/05/25	21/05/25	15
8	YEF to review information sheets and privacy notices	YEF	22/05/25	31/05/25	7
9	Evaluator incorporates feedback and submits final information sheets and privacy notices	Evaluator	01/06/25	14/06/25	10
10	Evaluator drafts statistical analysis plan	Evaluator	01/10/25	30/11/25	43
11	YEF to review statistical analysis plan	YEF	01/12/25	31/01/26	45
12	Final statistical analysis plan submitted	Evaluation	31/03/26	31/03/26	1
13	Ethics submission deadline	Evaluator	25/06/25	25/06/25	1
14	Evaluator obtains ethical approval and provides confirmation to YEF	Evaluator	22/08/25	31/08/25	6
15	LA governance approvals	Evaluator	01/06/25	31/10/25	110
16	Translation of study documents	Evaluator	01/06/25	31/10/25	110
17	Information governance approval	Evaluator	01/02/25	31/03/25	41
18	Set up oversight groups	Evaluator	01/03/25	05/12/25	200
19	Development of study database	Evaluator	01/05/25	01/09/25	88
20	Set up of trial (e.g., pre-registration)	Evaluator	01/04/25	31/10/25	154
21	LAs set up (including signing of MoU and DSA)	Evaluator and project team	01/03/25	28/02/26	260
22	Project team prepare delivery for efficacy phase	Project team	01/04/25	31/08/25	109
23	Project team reviews referral pathways/mechanisms with LAs	Project team	01/04/25	28/02/26	239
	Project and Evaluation Launch and Delivery				
24	Identification and recruitment of families	Project team	01/08/25	30/04/26	195
25	Start receiving referrals	Project team	01/09/25	30/09/25	22
26	Delivery of intervention	Project team	01/09/25	31/03/27	413
27	Tapering stage 1: payments reduced to £65 for 5 weeks at 35 weeks	Project team	01/05/26	31/01/27	196
28	Tapering stage 2: payments reduced to £35 for weeks 41-45	Project team	14/06/26	31/03/27	208
29	First LAs start referring	Evaluator	01/09/25	30/09/25	22
30	Baseline data collection	Evaluator	01/09/25	30/04/26	174
31	Randomisation	Evaluator	01/09/25	30/04/26	174
32	Last LAs go live	Evaluator	01/03/26	31/03/26	22
33	Referrals stop	Project team	30/11/25	30/04/26	109
34	Routine delivery data recording	Project team	01/09/25	31/03/27	413
35	Follow up data collection	Evaluator	01/05/26	28/02/27	216
36	12 months follow up	Evaluator	01/05/27	28/02/28	216
37	End of YEF funded project delivery	Project team	31/03/27	31/03/27	1
38	Submission of end of phase report	Project team	31/05/27	31/05/27	1
39	Submission of draft final evaluation report	Evaluator	01/06/27	07/06/27	5
40	Submission of final, peer reviewed evaluation report	Evaluator	14/06/27	21/06/27	6
41	Submission of draft follow up report	Evaluator	05/07/28	09/07/28	3
42	Submission of final, peer reviewed follow up report	Evaluator	26/07/28	30/07/28	3
43	Evaluator supports with YEF publication process + follow up report	Evaluator	01/07/27	31/10/28	349
44	Data archived	Evaluator	30/06/27	30/06/27	1
	IPE				
48	Mid-point parent/carer survey	Evaluator	01/02/26	30/09/26	173
46	Qualitative interviews with parents/carers	Evaluator	01/02/26	31/01/27	260
47	Focus group with delivery staff	Evaluator	01/02/26	31/01/27	260
48	Focus group with social workers	Evaluator	01/02/26	31/01/27	260
	Analysis & reporting				
49	Receipt and validation of routine delivery data	Evaluator	01/02/27	30/04/27	65
50	Quantitative data analysis	Evaluator	01/01/26	31/05/27	368
51	Follow up analysis	Evaluator	01/03/28	30/06/28	88
52	Interview transcription	Evaluator	04/01/2026	28/02/27	300
53	Qualitative data coding and analysis	Evaluator	01/07/26	30/04/27	218
54	Main report	Evaluator	01/12/26	30/06/27	152
55	Final report	Evaluator	01/05/28	31/07/28	66
	Oversight				
56	YPAG and PCAG	Evaluator	01/05/25	31/05/27	543
57	Local advisory groups	Evaluator	01/04/25	31/05/27	565
58	Liaison and coordination with sites	Evaluator	01/04/25	30/03/27	521
59	Core team (including liaison with YEF)	Evaluator	01/04/25	30/06/27	587
60	Trial Management Group	Evaluator	01/04/25	30/04/27	544
61	Data Monitoring and Ethics Committee	Evaluator	01/11/25	13/11/26	270
62	Trial Steering Committee	Evaluator	14/11/25	30/11/26	272
63	EDI mentoring & guidance	Evaluator	01/04/25	30/06/27	587
	Project and Evaluation Performance / Monitoring				
64	Quarterly monitoring report	Project team	01/09/25	13/04/27	422
65	Quarterly monitoring meetings	Project, evaluation, and YEF teams	01/10/25	13/05/27	422
66	Submission of 'End of project report and project budgets'	Project team	31/05/27	31/05/27	1
	Miscellaneous				
67	Deliver one internal YEF Virtual Learning Café webinar	Project team	01/05/26	31/05/26	21
68	Collaborate with the YEF PA & Comms team to provide content for one case	Project team	01/06/27	30/06/27	22
69	Host at least one project visit for a group of YEF staff	Project team	01/02/26	28/02/26	20


Main analysis and reporting
Follow up data collection, analysis, and reporting
Post funding publication period
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Month 19
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