Foundations
What Works Centre for Children & Families

WEMATTER: EVALUATION PROTOCOL

Intervention developer	Victim Support
Delivery organisations	Victim Support
Evaluator	Verian (Verian Group UK Ltd.)
Principal investigator	Prof. Natalie Gold
Protocol author(s)	Dr James Thom, Dr Shi Zhuo, Varvara Kuz, Ben Toombs, Penny Stothard, Pieter Cornel, Dr Kelda Henderson, Paul Fenton Villar, Prof. Natalie Gold
Type of trial	Two-arm blocked partially nested randomised controlled trial.
Age or status of participants	8-17 years old.
Number of participating Local Authorities	All areas in England.
Number of children and families	752 children and young people.
Primary outcome(s)	Child/Young person mental wellbeing at Week 1 and Week 10 post randomisation.
Secondary outcome(s)	N/A. We will consider adding secondary outcome(s) based on facilitator and CYP feedback about the demands of the data collection.
Contextual factors	-

Summary

Background

Domestic abuse is estimated to affect 1 in 5 children (Radford et al., 2011). It has a negative impact on a wide range of physical, emotional, behavioural, cognitive, and social outcomes for children (Lloyd, 2018), but research suggests that providing timely support can mitigate or avoid negative outcomes (Mullender et al., 2002, p. 121). However, a recent report found that only 29% of parent victim-survivors in England and Wales who wanted support for their children were able to access it (Domestic Abuse Commissioner, 2022). A major barrier to improving services is that there is very little evidence about which services improve outcomes for children in families at risk of, or experiencing, domestic abuse.

Intervention

WeMatter is a digital, group-based support service for children and young people (CYP) who are victimsof domestic abuse. As part of the eligibility criteria for the service, CYP and their victim-survivor parent should not be in contact with the abusive parent. The service lasts 10 weeks in total, comprising eight weekly group sessions and a one-to-one session at the beginning and end of the service. Developed by Victim Support (a specialist independent charity service provider), the WeMatter service provides digital group support based on trauma-informed cognitive behavioural therapy (CBT) techniques utilising the Rock Pool CYP Domestic Abuse Recovery Toolkit. It enables CYP to access support either from their home or school, allowing them to choose a location that feels more comfortable to them.

The digital-group delivery of WeMatter provides an important social component to this support service, enabling CYP to engage with peers who have been through similar experiences in a way intends to make it easier to open up and share, compared to if the service was delivered in person with CYP who participants may know in real life. The digital-group format of the WeMatter service also enables Victim Support to expand access widely as the home-based facilitators can deliver the service across different local areas. This facilitates more timely access to support than alternative one-to-one support services offered in some areas of the UK, which can have waiting lists spanning several months.

Aims

In this pilot evaluation of the WeMatter service we aim to:

- Assess and practically test approaches to evaluate the effects of the WeMatter service using a randomised control trial design
- Provide preliminary evidence of the impacts of WeMatter on CYP's mental wellbeing
- Examine how the WeMatter service works and whether it works as intended
- Review the costs of running the WeMatter service and, for illustrative purposes, compare this with the costs of running a one-to-one in-person support service.

Methods

This pilot evaluation will include a pilot impact evaluation of the effects of WeMatter on improving CYP mental wellbeing, an implementation and process evaluation considering how and whether WeMatter works as intended and exploring unintended consequences, and an analysis of the service's costs.

Pilot impact evaluation

The pilot impact evaluation will consist of a blocked partially nested randomised control trial design. 47 blocks of up to 20 CYP between the ages of 8 and 17 years old will be randomised using split randomisation (we expect most blocks to consist of 16 CYP, with an extra 4 spots for oversubscription). Each block will be split into two groups, with 8-10 CYP randomised to a treatment group which receives access to WeMatter's support services, and 8-10 CYP to a waitlist control group where they will receive WeMatter after the treatment group have completed the service CYP will be recruited for the randomised trial from referrals to Victim Support from all areas in England. The blocks of CYP will be organised according to age group and their preference for the setting in which sessions are delivered (home- or school-based). For the treatment group, CYP mental wellbeing will be measured using the Stirling Children's Wellbeing Scale and collected by Victim Support's trained professionals during one-to-one Zoom calls with the CYP before and after the support sessions. Outcome data will be collected at the same timepoints (both pre-intervention) for the control waitlist group.

Implementation and process evaluation

We will use a combination of administrative service data and interviews with WeMatter facilitators, CYP beneficiaries, and their non-abuser parents/carers. We will interview CYP and their parents/carers across a range of demographic characteristics, from both treatment and control groups, to get rich insights into how they experienced the trial and the impact of the implementation of the intervention.

Iterative testing approach

We will conduct two reviews with Victim Support and Foundations during which Victim Support will provide feedback about the research design and the evaluation team will review the progress of the evaluation. At these meetings, we will consider changing elements of the research processes or design, to address any issues that arise during the pilot. This may include, for example, introducing additional outcome measures or approaches that may encourage CYP to participate in the trial and limit attrition (such as financial incentives), or changing who administers the outcome measures (known vs unknown facilitators).

Cost evaluation

The analysis of WeMatter's costs will include the costs of running the service and the average cost per individual. The analysis will report prerequisites and start-up costs, as well as the recurring costs for running the service. The reported costs will be based on Victim Support cost estimates; and the cost items informed by interviews with key stakeholders at Victim Support conducted

during the implementation and process evaluation. In addition, for illustrative purposes, we will also capture and compare the costs of WeMatter to running a one-to-one in-person support service if data are available from Victim Support or other sources.

Timeline

The design and planning for this evaluation were completed between January and May 2024. The recruitment into the trial will begin on 3 June 2024 following the peer review of the evaluation protocol, agreement from the Verian ethics panel for the project, and the creation of a randomised sequence determining trial participants' allocation to the treatment or waitlist control group. The evaluation protocol will be published on the Foundations and Open Science Framework (OSF) websites. Victim Support will implement the 94 planned WeMatter groups and participant outcome data collection across a 43-week period. Each participant in the treatment group will complete the WeMatter service over a period of 10 weeks during the 43-week delivery period, with the final treatment group completing the service in December 2024 (to allow their paired waitlist group to receive the service by 31 March 2025). The evaluation team will conduct two reviews of the evaluation approach with Foundations and Victim Support, with an initial review in July 2024 and an in-depth review in September 2024. An interim evaluation progress report is due 14 March 2025 and the final evaluation report 8 September 2025. Analysis code and pseudonymised data will be available on GitHub and Foundations' data archive from 12 September 2025.

Contents

Background

Domestic abuse is estimated to affect one in five children (Radford et al., 2011) and is the most common reason for referral to children's social care (Foundations, 2023b). It has a negative impact on a wide range of outcomes, including: emotional outcomes, such as feelings of guilt, depression, and low self-esteem (Calder & Regan, 2008); behavioural outcomes, such as substance abuse and risk-taking behaviour (Children's Commissioner, 2018); social outcomes, such as poor social networks and disaffection with education (Children's Commissioner, 2018); and physical outcomes, such as eating problems and stress-related conditions (Calder & Regan, 2008).

Research suggests that providing timely support for CYP who are victims of domestic abuse can mitigate or avoid negative outcomes (Mullender et al., 2002). This can help CYP recover from the impact of trauma, achieve positive relationships, and lead healthy and happy lives. Without support, CYP may carry the impact of their experiences into the future (Holt et al., 2008). Section 3 of the Domestic Abuse Act 2021 now recognises CYP who witness, experience or are exposed to the effects of domestic abuse as victims, granting them improved access to crucial support services.

However, a recent report found that only 29% of parents who are victim-survivors in England and Wales, and who wanted support for their children were able to access that support (Domestic Abuse Commissioner, 2022). There is a postcode lottery of support and a patchwork of different services across different local authorities. Further, existing domestic abuse support services tend to focus on CYP who are at high risk of harm, underserving CYP who have experienced abuse but are not classified as high-risk, who would also benefit from support. Support services are often oversubscribed and can have waiting lists spanning several months. Out of the 317 service providers surveyed for a Domestic Abuse Commissioner report, 26% of those had waiting lists exceeding one month, with 4% of the services having waiting times in excess of six months (Commissioner, 2022).

A major barrier to improving services is that there is very little evidence about which services improve outcomes for children in families at risk of – or experiencing – domestic abuse. A report by the Early Intervention Foundation (2021) identified more than 100 domestic abuse services operating across the UK, but less than a third of these have been evaluated, so we do not know robustly if they improve outcomes. Where published evidence does exist, it is often based on small sample sizes, does not include a control group, or uses inconsistent and non-validated outcome measures (Foundations, 2023a). This limits our ability to make generalisable causal inferences about which interventions improve outcomes.

WeMatter is a digital, group support service for CYP who have been affected by domestic abuse but are not classified as high-risk of harm. It was launched as a pilot in Devon, Cornwall, Staffordshire, Warwickshire, and Brent (London) in September 2022 and will end in March 2024. The service utilises Rock Pool[1] Domestic Abuse Recovery CYP Toolkit (the UK's leading trauma-informed

[1] Rock Pool support organisations that want to improve practice, share knowledge and expertise, and enable their workforce to inspire hope, promote resilience, and aid recovery for people affected by trauma. Their innovative, practical solutions

recovery services for adult and children and young people that have experienced or witnessed domestic abuse) and applies it digitally in a group context. Distinctive features include that it is:

- Digital – enabling CYP to seek support regardless of their location
- Group-based (social) – incorporating activities, games, and discussions.

Victim Support anticipate that the WeMatter service will improve the wellbeing of CYP victims. As well as any potential therapeutic advantages, these features of the service may help to alleviate the high demand for services, as it provides support that can be delivered to a larger group and could present a cost-effective solution for CYP who are not classified as high-risk. Further details on the pilot of WeMatter can be found in the WeMatter Intervention Protocol, which will be published on Foundations website.

Therefore, supported by the Evaluation Accelerator Fund, which is managed by the UK's Evaluation Task Force, Foundations has commissioned Verian to conduct an independent pilot evaluation of the WeMatter service. The main aims of the pilot evaluation are:

1. To evaluate the service's theory of change in a pilot context, i.e. small cohorts, with a relatively high level of implementation support and commitment to the intervention and evaluation.
2. To evaluate the viability of a full-scale impact evaluation (likely an RCT).

In order to do this, we will conduct a pilot impact evaluation (IE), a full implementation and process evaluation (IPE), and a cost evaluation. We will randomise participants into treatment and control groups, and will answer Foundations' pilot evaluation questions:

1. Does the intervention work?
2. Does the intervention work differently in certain conditions?
3. Does the intervention work as intended?
4. To what extent was the intervention implemented as intended?
5. How much does it cost to deliver the intervention?
6. How can the intervention be improved?

How can the evaluation be improved?

Given that the evaluation is a pilot, the focus will not be on providing robust estimates to answer Questions 1, 2, 3, and 5, but rather to trial methods that aim to answer those questions and to gather data that would help inform the design of a full-scale RCT. Elements of the design will be monitored and reviewed throughout the evaluation and recommendations for a full-scale RCT will be provided in the final report.

---

and training opportunities are informed by lived experience and what is known to work. Their services include programmes for adult victims and survivors and a domestic abuse (DA) recovery toolkit designed specifically for CYP that was adopted by WeMatter as the programme delivered in this project.

Intervention and theory of change

WeMatter service

WeMatter is a digital group support service designed and delivered via video-conferencing (Zoom) by Victim Support to support CYP who have been affected by domestic abuse and are between the ages of 8 and 17 at the time of referral. This includes those who have witnessed domestic abuse or experienced domestic abuse directly. WeMatter is a recovery service and is only able to support those who are no longer experiencing domestic abuse and no longer live with the alleged perpetrator of the abuse. To qualify for the service, CYP must be proficient in English. CYP also need to have digital access and competency (with support from a trusted adult if needed), though there is a small pot of funding available from Victim Support to purchase IT equipment for families.

CYP can be referred to Victim Support by various sources, such as the police, GPs, schools, social services, charities, parents/carers or self-referrals from CYP themselves (however, parent/carer and self-referrals will not be included in this evaluation). Following a referral each CYP's safe parent/carer or CYP themselves receives a triage phone call, usually within 48 hours, where a triage officer records details about the CYP and other services the CYP is engaging with (to ensure that there is not duplication of therapeutic interventions and to consider professional overload), assesses the risks and needs, confirms their eligibility for WeMatter, provides the parents/carers and CYP with details about Victim Support's services.

The risks and needs are assessed via Victim Support's CYP Critical Discussion Tool, which considers factors such as exposure to domestic abuse, suicidal thoughts, environment, and impacts of experiences to determine whether the risk of harm is standard or high. Parents/carers and CYP are asked to update any changes regarding risks in a timely manner throughout the service. Facilitators also review the risk assessment for CYP every four weeks, and liaise with social care and early help partners to keep abreast of risks. More details about the referral and triage process (e.g. what will happen for CYP not wanting to take part or not suitable for a digital service) as well as the risk assessment and safeguarding measures can be found in the WeMatter Intervention Protocol.

The 10-week service was designed based on Rock Pool CYP Domestic Abuse Recovery Toolkit[2] and is entirely operated by Victim Support. The service makes use of trauma-informed cognitive behavioural therapy (CBT) techniques, incorporating activities, games and discussions that could be adapted to accommodate CYP's support needs (e.g. autism, reading difficulty). The service was designed to help CYP understand their own experiences of domestic abuse, develop healthy coping strategies and increase their feelings of safety.

[2] See https://rockpool.life/course/combined-adult-children-and-young-people-domestic-abuse-recovery-toolkit/

The service consists of one introductory and one concluding one-to-one session between a CYP and the facilitator, with eight weekly one-hour group sessions attended online between these. The eight one-hour group sessions follow a pre-determined order and structure:

1. Introductions
2. Abuse and early warning signs
3. Self-esteem and negative automatic thoughts
4. Gender roles and relationships with parents and carers
5. Self-affirmations and safety planning
6. How to explore anger and other emotions
7. Healthy relationships
8. Celebrations and goodbyes.

Each of the group sessions is facilitated by two specialist facilitators and can accommodate eight participants, with capacity to allow up to 10 participants per group in case of oversubscription. All facilitators are educated to degree level or higher and they are all experienced and accredited by Rock Pool in the delivery of trauma-informed support services for CYP. All Victim Support staff have completed mandatory Safeguarding training, and the WeMatter team have also received internal CYP training which highlights the risk of engaging in digital support and online harms, as well as additional training on neuro-divergence and on gathering insights from CYP focus groups. Groups are formed based on age groups (8–12, 13–15, and 16–17) to take into account the differences in the development stage of the CYP and allow the content and activities in the group sessions to be tailored to age. The entire service is delivered digitally through Zoom. This allows CYP to join from school or their home, ensuring a safe environment for participation (see the summary of the intervention service in Table 1 and the Intervention Protocol for more detail).[3]

The WeMatter Intervention Protocol will include further detail on the service and its delivery (including how Victim Support work with schools to facilitate school-based sessions), as well as the service's policy on data protection and safeguarding (e.g. how Victim Support work with wider multi-agency teams to ensure there is a joined-up approach to support for CYP in and dropping out from the service).

[3] Measures taken to ensure safety environment includes the CYP Video Call Approval Form used during the triage call, as well as requirements for camera to be on at all times, private/confidential space for CYP to engage in support independently, and no home-based sessions to take place if alleged perpetrator is residing/present in the family home.

Table 1: TIDieR description of WeMatter service

Name	WeMatter: a digital group service designed to support CYP who have been affected by domestic abuse
Why (theory/rationale)	To provide a safe, peer-supported environment via group sessions led by accredited facilitators for CYP, to help them process their experiences of domestic abuse in a timely way, and equip them with coping strategies to aid in their recovery.
Who (recipients)	Children and young people (CYP) between the ages of 8 and 17 who have experienced or witnessed abuse within parent's/caregiver's home but are no longer experiencing abuse or living with the alleged perpetrator.
What (materials)	Trauma-informed CBT techniques, activities, games, discussions that could be adapted to accommodate CYP's support needs (e.g. autism, reading difficulty). Non-mandatory take home activities are also included as part of the service.
What (procedures)	10-week digital intervention service: two (introduction and conclusion) one-to-one sessions and eight group sessions each targeting a different domestic abuse-related topic. Facilitators also correspond with CYP outside of the sessions to check in and encourage engagement in following sessions.
Who (provider)	Victim Support
How (format)	One-to-one introduction and conclusion sessions bookending eight digital group sessions (eight participants per group and the group members remain the same throughout the whole service). Led by two facilitators.
Where (location)	Digital sessions delivered in school or home settings for CYP referred from all local authorities across England
When and how much (dosage)	one-hour weekly meeting over 10 weeks.
Tailoring (adaptation)	Groups are adjusted according to age groups (8–12, 13–15, and 16–17), and disability and additional needs. Facilitators make adaptions to session materials based on the results of the 'all about me' assessment in the introduction one-to-one session to accommodate CYP's support needs (e.g. reading difficulty, autism). Group dynamics are taken into consideration from the initial point of risk assessment during the triage call and are also considered following the 'all about me' assessment. Facilitators manage group dynamics initially by establishing a group contract which sets out expectations throughout the sessions. During the delivery of the service, break out rooms can be used to managed CYP's behaviour throughout and facilitators are mindful of how and which activities are delivered according to the dynamics within the group.

Theory of change

The initial theory of change (ToC) was developed during two workshops and a series of follow-up communications with input from Victim Support, Verian, Foundations and our domestic abuse expert advisers (Dr Kelda Henderson and Professor Nicole Westmarland). The ToC sought to establish the mechanisms, the outputs of these mechanisms and the related outcomes, and the eventual long-term impacts of the intervention. Based on input from Victim Support, the ToC also established the contextual factors that may impact the outcomes of the intervention alongside the intended mechanisms as well as the assumptions necessary for the intended outputs. This ToC helped inform the design of the evaluation, specifically in terms of the outputs, mechanisms and outcomes that should be evaluated.

View the theory of change here.

Inputs

To deliver the intervention Victim Support needs the following inputs:

- Referral of CYP in need of support from appropriate referral sources e.g. Police, GPs, schools, social services etc.
- WeMatter staff: qualified and accredited WeMatter facilitators, triage and early intervention officers, management team, governance board
- Service resources: Rock Pool CYP Domestic Abuse Recovery Toolkit, tailored service, and Zoom access
- CYP resources: digital access (to Wi-Fi, hardware, and software) from home or school, support from parents, carers, or trusted adults, and time available to engage with the service.

Activities

There are a range of activities performed by WeMatter staff and the CYP before, during and after the intervention:

- Pre-intervention engagement includes the initial triage call to assess CYP's suitability, needs and risks, to collect relevant personal and Equality, Diversity, Inclusion, and Equity (EDIE) data, and a follow-up call by the WeMatter facilitator to obtain parental/guardian consent for their CYP to take part in the service and evaluation and to do the randomisation.
- The introductory one-to-one session between CYP and the facilitator to complete digital competency assessment, familiarise the CYP with the platform, build the CYP-facilitator relationship, and collect Week 1 outcome data.
- Eight one-hour digital group sessions based on Rock Pool CYP Domestic Abuse Recovery Toolkit, each session covering a domestic abuse related topic.
- During the intervention CYP also complete non-mandatory home tasks before and after each session. Facilitators also provide one-to-one support when needed during the group sessions and correspond with CYP outside of sessions to check in and encourage CYP's engagement in following sessions.

- After the intervention facilitators have a concluding one-to-one session with each CYP where they will collect Week 10 outcome data and provide referral for further support if needed.

There is also a range of activities throughout the entire intervention:

- Facilitators engage with delivery sites (school, carer) to share information about support and planned sessions.
- Facilitators/other Victim Support staff provide support to parent/carer to give reassurance, advice and/or formal referral to specialist support.
- Facilitators/other Victim Support staff engage with multi-agency meetings (e.g. safeguarding/professionals' meetings) on behalf of the CYP.
- Victim Support staff provide ongoing support for the delivery of the service, including one-to-one supervision, case reviews, service audits, or safeguarding audits.
- WeMatter facilitators receive ongoing training on domestic abuse, GDPR, continued professional development from both Victim Support and Rock Pool. They also engage in team-building activities.

Mechanisms, outputs and outcomes

The evaluation team sought to answer the following questions regarding the mechanisms and outcomes of the WeMatter service.

- What are the inputs that need to be in place to produce change?
- What outcomes were considered as a priority and why?
- What are the mechanisms that lead to identified outcomes?
- What are the contextual factors that may have a moderating and/or direct effect on the outcomes?

The ToC work identified three key mechanisms for the service to successfully achieve the desired outputs and outcomes:

- **CYP can successfully engage with support:** the digital delivery mode of the service allows more flexibility in terms of when and where a CYP can access the service, resulting in a shorter waiting time between the referral and the start of the support, which also minimises disengagement from support. The research-based service design aim to ensure CYP find the content relevant, so they want to attend the sessions. The service also ensures CYP with special needs can engage successfully by tailoring the support based on the results of initial assessment of individual needs. Furthermore, facilitators engage with safe parents/carers/schools outside of the sessions and carry out other activities to make sure CYP can stay safe and have support to avoid CYP dropping out of the service.
- **CYP feel supported and validated by peers in WeMatter groups:** the digital delivery mode allows CYP to join a group from different geographic areas, reducing the likelihood that CYP in a group know each other offline. This increased anonymity aim to make it easier for CYP to share and explore their trauma experiences in a group setting. In addition, the facilitators are trained to establish safe practices around tech-facilitated

support in the groups, and pick up on dynamics and issues, so CYP can feel safe in the group environment and feel supported and validated by their peers.
- **CYP have trusting relationships with the facilitators:** the accredited facilitators have sufficient expertise, along with ongoing training and support from the wider team, to build trusting relationship with the CYP in a short timeframe, assessing risks and individual needs and issues in a timely way to make sure CYP feel safe and supported throughout the service.

All three mechanisms contribute to a series of outputs relating to the attendance of and engagement with the service, including: number of eligible CYP who attend the service, number of sessions attended, number of eligible CYP who complete the service, time spent on home tasks by CYP before and after sessions, sharing and discussion by CYP in sessions, number and quality of action plans, safety plans, and other materials created as part of the service that could be used by CYP in the future. Most of these outputs will be captured through service monitoring data. Attendance and engagement with the service then result in a set of outcomes and impacts. Together with Victim Support, we identified priority outcomes that were the focus of the evaluation (outcomes identified as priority outcomes in **bold**):

- **'Improved CYP wellbeing'** was identified as a key aim of the service by Victim Support, following from outcomes that are direct results of increased awareness and knowledge of session content and the skills and tools covered. This is split out in the ToC as mental and physical wellbeing, although we anticipate the greatest (immediate) impact of the service will be on 'mental wellbeing'.
- **'Improved awareness and understanding of domestic abuse risks'** was highlighted as a priority outcome that directly led to another priority outcome of 'improved ability to identify domestic abuse risks'.
- **'Improved understanding of healthy and unhealthy relationships'** was another key outcome as it led to the other relevant (non-priority) outcomes 'improved ability to recognise abusive behaviours in their own future relationships' and 'improved ability to assert rights related to relationships'.

In addition to this we identified a further two priority outcomes that are not only results of attending and engaging with the service in general, but also their relationships built during WeMatter:

- **'Increased feelings of safety'**, resulting from attending and engaging with the service content but also from having trusting relationships with the facilitators.
- **'Increased feelings of being supported'**, resulting from attending and engaging with the WeMatter content but also from feeling supported and trusted by the peers in their groups.

There were also other, non-priority outcomes. 'Improved understanding of the difficulties they/their family went through' led to an 'improved understanding of their rights as a CYP and young victim'. 'Improved awareness and/or understanding of healthy coping strategies' led to an 'increased ability to manage and cope with difficult emotions'. And finally, 'improved awareness/knowledge of the support and services available to them' led to a 'better ability to ask for help for domestic abuse issues as well as an improved support network'.

Collectively, all of the aforementioned outcomes led to the following outcomes: 'increased confidence', 'self-esteem and resilience', 'improved ability to manage daily life', 'increased ability to cope with problems', 'improved mental and physical wellbeing', 'improved relationships with peers and family members' and 'improved social network'.

Contextual factors

Based on the Foundations' Programme Promise and Evaluation Feasibility (2023) report, and with input from Victim Support, we identified the following contextual factors that may affect the intervention outcomes:

- **Individual circumstances** such as past experiences of domestic abuse, past experiences of other forms of child abuse, levels of assessed risk at referral, how CYP are referred to Victim Support, ongoing coercion and control from abuser, and changes in domestic abuse circumstances during the service.
- **Demographic characteristics** such as age, gender, ethnicity, language ability, special education needs and disabilities (SEND), and family income/socio-economic status.
- **Local environmental factors** such as referral rate/existing demand for domestic abuse intervention services, socio-economic makeup, Victim Support's organisational capacity, other non-domestic abuse specific activities that might produce an impact on CYP, and local authority support. One important factor is availability of alternative domestic abuse intervention services in the area and the waiting time to access the service. The WeMatter Intervention Protocol will include more details about alternative services existed, including the one-to-one support offered by Victim Support in some areas.
- **Experiences during the service** such as parental engagement and support, delivery setting (school vs home), group composition and dynamic, gender and other characteristics of the facilitators, expertise and wellbeing of facilitators, and whether there is a match between CYP and facilitator characteristics (e.g. gender).

Assumptions

Alongside the contextual factors, the ToC also established assumptions of the service that may contribute to its success based on the Foundations' Programme Promise and Evaluation Feasibility (2023) report. First, the intervention programme should be delivered as intended – 'the programme protocol should stay consistent' with 'facilitators not deviating from the programme protocol unduly'. Second, there should also be 'no changes of facilitators during a given CYP's experience of the programme'. Third, at the same time the programme delivery should not be rigid with 'facilitators having the time to reflect and respond to individual needs and issues dynamically'. Furthermore, 'the facilitators should have access to wider support in the organisation for things like digital infrastructure, further training or safeguarding practices'. In addition, it is required that 'parents/carers and CYP update any changes regarding risks timely, with facilitators completing risk assessments review for CYP every four weeks and liaising with social care and early help partners to keep abreast of risks'. Finally, it is important that 'referrers understand and believe in the service'.

Impact evaluation

Aims

Pilot impact evaluations (IEs) investigate an intervention's potential for improving outcomes, and they may also provide preliminary evidence of their effects (Early Intervention Foundation, 2024). The aims of this pilot IE are:

1. To evaluate the viability of a full-scale RCT and recommend an evaluation design.
2. To provide preliminary evidence of whether the WeMatter service improves outcomes for CYP.

Research questions

The research questions that the pilot IE seeks to answer are:

1. Can the impact evaluation design be improved?
2. What effect does the WeMatter service have on CYP's mental wellbeing at Week 10 of the service (final week after the completion of all eight group sessions) measured using the Stirling Children's Wellbeing scale, compared to those who are allocated to no intervention (a waitlist control)?
3. Does the effect of the WeMatter service on CYP's mental wellbeing at Week 10 of the service measured using the Stirling Children's Wellbeing scale compared to no intervention (a waitlist control) vary by age group and preferred setting of WeMatter delivery (school vs home)?

Given this evaluation is a pilot, there are several practical design factors that require testing with Victim Support, such as the processes for obtaining consent, randomisation and the collection of outcomes from the evaluation's participants. Similarly, there are several potential factors that pose risks to the evaluation design and require further investigation. For example, whether eligible CYP referred to WeMatter will consent to participating in a randomised trial, particularly in areas where other one-to-one local support services are available (or there are short waiting lists for alternative local services).

We will conduct a progress review in July 2024 to consider amends to the evaluation to improve or enhance it. One consideration discussed at this point will be whether there is scope to include a secondary outcome measure in the data collection. For more information about these reviews, please see section 5.

Planning quantitative evaluations of intervention effects also requires ex-ante sample size and power calculations. Inaccurate sample size estimates can result in studies either being underpowered (or unable to detect the desired minimum effect size) or data collection being more expensive than necessary, which is wasteful of research funding. Our research will consider and report any information that could usefully inform future planning and sample size calculations for large-scale evaluations of WeMatter (e.g. distributions of outcomes, preliminary effect sizes, and

intracluster correlations) and potentially other interventions that involve CYP affected by domestic abuse.

Design

The pilot IE will consist of a blocked, partially nested, waitlist randomised control trial design. A partially nested randomised control trial refers to trials where participants in the treatment group receive intervention services in groups, causing clustering of outcomes, but where this same clustering does not occur for those in the control group (Lohr et al., 2014). Participating CYP will be organised into blocks of 20 CYP each consisting of a control and an intervention group of equal sizes and matched for age and programme delivery setting. The CYP within each block will be randomised between an intervention group that receives access to WeMatter's group-based support services and a no-intervention waitlist control group. Those CYP randomised to the waitlist (control group) will receive access to WeMatter following the completion of the treatment groups' initial programme of support sessions (so after ~10 weeks).

The trial will run WeMatter groups across a 43-week period. The delivery setting and number of groups have been pre-planned based on Victim Support's estimated number of referrals and demand. The age group will be determined by demand and, once a block of 20 CYP has formed, an age-specific group will be arranged for the next available start date given the groups preferred delivery setting. Victim Support will review the number of referrals during the delivery period and adjust the delivery plan accordingly. If needed, Victim Support will also implement targeted communications to encourage referrals.

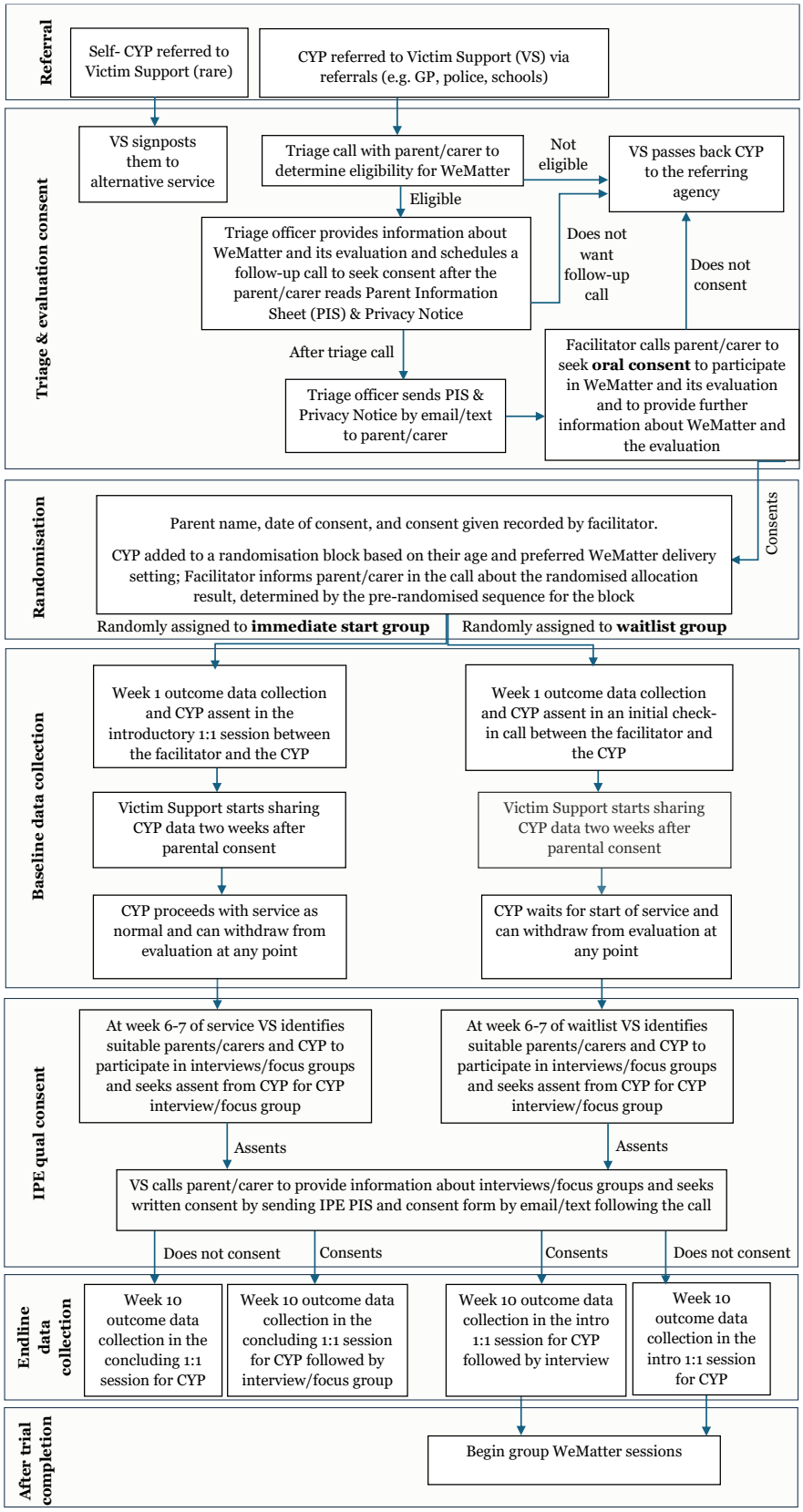
Table 2 has a summary of the trial design and Figure 1 provides an illustration of the evaluation process, including the consent process and data collection points.

Table 2: Summary of pilot impact evaluation trial design

Trial type and number of arms		Two-arm blocked partially nested randomised controlled trial, with individuals randomised to a treatment or waitlist control group.
Unit of randomisation		Individual
Stratification variables (if applicable)		The sample is stratified by age group (8–12, 13–15, and 16–17) and individuals' preference for the setting of delivery of the sessions (home- or school-based).
Primary outcome	Variable	Mental Wellbeing

	measure (instrument, scale)	Stirling Children's Wellbeing Scale (12-item questionnaire, each item a Likert scale from 1-5, resulting in aggregated scores between 12 and 60) Collected in Week 1 and Week 10.
Secondary outcome	Variable	N/A We will consider adding secondary outcome(s) based on facilitator and CYP feedback about the demands of the data collection. Secondary outcomes we could consider adding later are self-esteem or 'feeling of being supported'.
	measure (instrument, scale)	TBC

Figure 1: Illustration of trial process



Referral, eligibility, and consent

Referrals into Victim Support are managed by a triage team, members of which contact the safe parent/carer of the referred CYP for an initial triage call. The triage team will provide information about the service and a short summary of its evaluation and will enquire about the CYP's needs and parents'/carers' potential consent to participate in the WeMatter service and its evaluation during the initial triage call. They will be informed that participation in the service is conditional on participation in its evaluation. At this stage, if parents/carers don't want their child to participate in WeMatter or the evaluation, Victim Support will signpost them to an alternative service or re-refer them to their original referrer.

Before parents/carers can consent to the service and its evaluation, they will need to read the Participant Information Sheet and Privacy Notice that detail the evaluation, its purpose and the associated data sharing arrangements and agreements. These will clearly inform the parent/carer that they are able to opt out of the evaluation at any point, with CYP receiving the same information before they can assent during their first one-to-one meeting with their facilitator. The documents will be sent to the parents/carers via email or text message following the initial triage call. The triage team will arrange a follow-up call between the service facilitator assigned to their child and the parent/carer to seek their informed oral consent. During the follow-up call, the facilitator will confirm that the parent/carer has read and understood all of the written materials and record their oral consent. Once their consent is confirmed the facilitator will randomly allocate their child to a pre-randomised group and inform them of the randomisation outcome.

For parents/carers who are not sure whether to give consent during the follow-up call, the facilitator will ask to arrange another call with them to discuss participation again. No data sharing will happen with evaluators until two weeks after consent is given, to allow a cooling-off period for parents/carers to consider their involvement. The parents/carers will be informed that if they wish to withdraw their child from the evaluation after they have started the service, the child can finish the service without any further evaluation data collected and their data will be withdrawn from the evaluation. However, if they decide to withdraw from both the evaluation and the intervention after already having started the service, Victim Support will first explore the reasons for this with the CYP or their safe parent/carer. They will also assess whether there are any outstanding needs for the CYP and if so, will signpost or refer them to a local one-to-one service or another agency.

Those referrals who are not eligible to participate in the WeMatter service, or who do not consent to participate in the evaluation, will be referred back to the original referral source to explore options offered by other available services. In some areas in England, local services can offer one-to-one support for CYP but waiting times to access this support also vary considerably across the country. For CYP in areas where Victim Support provides alternative support, the triage officer will provide information about the alternative support (including information on waiting list); in other cases, the triage officer will signpost the safe parent/carer to other organisations, refer/advise on local options available, or liaise with the referrer on alternative options. In the rare cases where a CYP or their parent/carer self-refer to WeMatter, they will not be invited to participate in the trial and Victim Support will support them making a referral or signposting to an alternative support service.

The script of the informed consent process, along with the participant information sheet, has been carefully designed to make sure the language is neutral and clear, and sufficient information is provided to make sure parents/carers are fully informed. Participation in the service is conditional on participation in the evaluation, which may create pressure to participate in the evaluation. To mitigate this, we will provide every parent/carer with detailed information about the evaluation to help them make an informed decision and – if they are happy for their child to participate – provide informed consent. The script and the participant information sheet were reviewed by two lived experience experts and Verian's research ethics panel. The evaluation team also provided a training session on the informed consent to relevant staff at Victim Support before the trial started and will help Victim Support set up internal quality assurance measures to make sure the proper consent process will be followed.

Randomisation

Referred CYP who are eligible for the service and have received parental consent will be organised into blocks that consist of a waitlist-control and an immediate-start intervention group. These will be matched according to their age group and preference for the setting of the delivery of the sessions (home- or school-based). We expect an average of eight CYP per group (i.e. 16 CYP per block). However, to allow for larger group sizes in case of oversubscription, we will provide randomisation blocks with 20 slots using split randomisation (see below for details). Within each block, 8–10 CYP will be randomised to either an intervention group that receives access to the WeMatter service, and 8–10 CYP to a waitlist control group that will receive access to WeMatter following the completion of the treatment groups initial programme of support sessions (~10 weeks after they would have otherwise started WeMatter had they not been part of the trial).

Because WeMatter is delivered at the group-level, and groups are filled based on CYP's age groups (8–12, 13–15, and 16–17) and their preference for the setting of delivery (home- or school-based), the sample will be stratified by age group and delivery preference.

To ensure participants are engaged with the service, Victim Support need to be able to tell parents/carers during the follow-up consent call which service their child will receive, and when this will start. This means the outcomes of the randomisation need to be known to the facilitator during the call, as this is when eligibility for WeMatter is confirmed. To allow for this, we will provide the WeMatter facilitators with a pre-generated list for each 'type' of group they run (three age cohorts, each either at home or in school) to which every new referral will be added *in order of referral*. When the facilitator has taken consent and added the CYP's details to the list, they will be able to see if the CYP is in the intervention or the control group.

To generate this list for each block of 20, we will number the order of referral chronologically, from 1st (earliest) to 20th (last). We will randomly sample 10 positions to be assigned to the intervention group. However, given that we expect most blocks to include 16 CYP, we need to separately sample 8 and 2 positions within 'sub-blocks' of 16 and 4 to keep balanced group sizes in case the remaining 4 positions do not get filled. We will use the *sample* function in the *base* package within the R statistical programming software to randomly select eight and then another two positions in each block to be assigned to the intervention group. The random number seeds (i.e. the starting numbers used for the pseudorandom number generator) will be different for each block, with each

seed number equal to the block number. In this way, we can replicate the results of (pseudo)randomisation.

Victim Support will conduct quality checks to confirm that CYP are assigned to their respective block (age cohort and delivery setting) in chronological order of referral. This means the date of consent for the first CYP in each block should be the earliest date, and so on. The facilitators will not be blinded to the randomisation outcome, but they will be asked not to look at the randomisation allocation until after consent to participate in the trial has been granted. They will also be instructed not to influence or reveal the outcome of randomisation before the parent has consented to their child being part of the trial and the child has been assigned to a block. Once consent has been granted, facilitators can communicate the outcome of the randomisation (i.e. whether the CYP will be in the treatment or control group) to the parent, but they cannot alter the allocation at this stage. If parents/carers are unhappy about their allocation, they may choose to opt out of (or withdraw from) the trial but they cannot be provided another allocation. Training for the facilitators on the allocation process will emphasise the importance of ensuring fidelity to the randomised allocation process for the trial.

Due to the evaluation being a pilot, the evaluators will not be blinded to the outcomes of randomisation, regardless of the randomisation approach used as this will also help to inform our assessment of the design for the rapid design testing aspect of the trial.

Participants

Victim Support had originally envisaged conducting the trial in four areas. They have since expanded the scope of the areas where the trial will recruit participants from to ensure demand for services during the trial. The CYP will be recruited for the randomised trial from referrals to Victim Support and partners from all areas in England.

The trial will include children and young people who:

- Have been referred to Victim Support and witnessed or directly experienced domestic abuse, but no longer experience it and no longer live with the alleged perpetrator of the abuse.
- Are between the ages of 8 and 17 years old at the time of referral.
- Are residing in participating local authorities, i.e. all areas in England.
- Speak proficient English to participate.
- Are eligible to participate in the WeMatter service based on a risk assessment conducted during the triage call. This omits individuals whose risk is considered too high to participate in WeMatter sessions, i.e. CYP witnessing ongoing domestic abuse, and/or with alleged perpetrator living in the family home. This also omits CYP whose parents/carers have not given consent for their participation.[4]

[4] Risks are assessed in the triage call using Victim Support's CYP Critical Discussion Tool to determine if the risk is standard or high for a CYP. This tool considers factors such as exposure to domestic abuse, suicidal thoughts, environment and impacts. Parents/carers and CYP are asked at the start of the programme to update any changes in risks and the risk

- Have digital access and competency (with support from a trusted adult if needed, and/or with support from the pot of funding available from Victim Support to purchase IT equipment).
- Are not engaging in any other support in relation to their experience of domestic abuse.
- Have consented (via their safe parent/carer) to participating in the trial and sharing relevant information (see further details in section 7).

In some areas alternative one-to-one support sessions are provided by local services, including support delivered by Victim Support, and the waiting time to access this support is less than the time individuals will wait if they are assigned to the trial's waitlist group. For example, waiting times for access to one-to-one support in Warwickshire is currently one week and in Pan-London it is approximately five weeks. In these areas, it is likely that the participants who agree to join the trial will have a strong preference for the format of WeMatter service (since they could access one-to-one support relatively quickly), and this group may not represent the broader population of referrals from these areas. This issue may impact the representativeness of the participants in this study. However, it is worth noting that under usual practice (without the trial), where one-to-one support by Victim Support is available in the area, referrals are not able to choose between WeMatter and the one-to-one support; one-to-one support is allocated based on needs, with a focus on CYP with higher risks, and information about waiting time for the one-to-one support is not normally provided with the referral. Therefore, the extent of the selection issue is uncertain and requires examination. We will ask Victim Support to monitor and report the characteristics of those that do and do not agree to participate in the trial (anonymised aggregate data), and to record information about the reasons why people do not wish to participate for those individuals that consent to sharing this data.

Sample size/MDES calculations

Summary

Table 3 provides indicative indicative estimates of the trial's minimum detectable effect size (MDES). Overall, the estimates show that with a total sample size of 752 individuals, the trial is powered to detect a minimum standardised mean difference of 0.11 to 0.21, depending on the assumptions made about the variance in the outcome explained by control variables, intracluster correlations, and variability in standardised treatment effects across blocks. This is a very reasonable MDES to detect meaningful sized effects during a pilot IE and compares favourably to many other commissioned trials. The estimated range is also reasonably tight across estimates scenarios. All estimates assume the parameter for alpha is 0.05 and power is 0.8 and are contingent of the levels of attrition from the trial.

assessment will be reviewed every four weeks by the facilitators for all CYP in the programme. Victim Support also links with social care and early help partners to keep abreast of risk.

Table 3: Minimum Detectable Effect Size (MDES) calculations

	A	B	C	D	E	F
MDES (no attrition)	0.17	0.11	0.16	0.11	0.12	0.2
MDES (10% attrition)	0.18	0.12	0.17	0.11	0.12	0.21
MDES (20% attrition)	0.19	0.13	0.18	0.12	0.13	0.21
Proportion of variance in outcome explained by Level 1 covariates [5]	0.3	0.7	0.3	0.7	0.7	0.3
Intracluster correlations	0.01	0.01	0.15	0.15	0.01	0.15
Variability in standardised treatment effects across blocks	0.0	0.0	0.0	0.0	0.5	0.5
Alpha	0.05	0.05	0.05	0.05	0.05	0.05
Power	0.8	0.8	0.8	0.8	0.8	0.8
One-sided or two-sided?	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided
Average block size	16	16	16	16	16	16
Number of blocks	47	47	47	47	47	47

[5] This includes, and will most likely be most influenced by, the pre-test measure of the outcome variable.

Sample size	**Intervention**	376	376	376	376	376	376
	Control	376	376	376	376	376	376
	Total	752	752	752	752	752	752

MDES calculations and assumptions

The estimates in Table 3 are calculated using the PowerUp tool for Blocked Randomised Control Trials with 2-level random effects (see Dong & Maynard, 2013). The partially nested aspect of this trial's design means that the variance will differ between the WeMatter treatment group and the control group, with the treatment group having a source of variability not found in the control group. However, for simplicity, here we assume that the larger treatment-group variance also applies to the control group. This means our calculations using the PowerUp Tool will provide a conservative estimate of the design's expected statistical power (Lohr et al., 2014).

In the specifications in Table 3, the study sample size was previously determined by the resources and funding available to deliver the WeMatter service for this pilot evaluation. Our estimates are based on the trial including 47 blocks, with 16 CYP included in each block, the same number of WeMatter groups and control groups, and each group consisting of eight CYP. This equates to a total study sample of 752 CYP, 376 in the treatment group and 376 assigned to the waitlist control group. The different specifications in the table reflect that there is a very high degree of uncertainty about several aspects of the trial design. This includes a high degree of uncertainty about the level of clustering of outcomes we should expect within the treatment group in each block, and the likely correlation between the Week 1 and Week 10 outcome measures, particularly since the outcome measure will also be applied to an older age group it is not validated for. The degree of variability in the treatment effects across blocks is also unknown.

Reflecting the uncertainties about key aspects of the design, Table 3 reports different specifications of our estimates based on reasonable lower and upper range values we expect to observe within social experiments given the type of primary outcome included in this evaluation. For the intracluster correlation (ICC), which is a measure of the extent of outcome clustering (or the correlation in outcomes among participants within each group in a block), we report estimates assuming an ICC of between 0.01 and 0.15. We provide estimates assuming the proportion of variance in the outcome explained by control variables, such as the initial measure of the outcome, is between 0.3 and 0.7. We also report specifications according to different degrees of variability in the standardised treatment effects across blocks, assuming values between 0 and 0.5.

Description of MDES calculation results

The results in Table 3 show that assuming a scenario with low levels of clustering (0.01), where control variables explain a relatively low levels of the variance in the outcome (0.3), and no variability in the treatment effects across blocks, the trial is powered to detect an effect of 0.17, or larger (Column A). A more optimistic scenario where the control variables explain a higher degree of the variance in the outcome (0.7) would improve the precision of the trial, providing a smaller MDES of 0.11 (Column B).

Columns C and D show estimates for the MDES if the level of clustering turns out to be reasonably high (0.15). Depending on the assumed proportion of the variance explained by the control variables, the MDES ranges between 0.16 and 0.11. This is not very different to the estimates discussed above from Column A and B.

Columns E and F provide estimates assuming a reasonably high degree of variability in the standardised treatment effects across blocks (0.5). These provide the most pessimistic and optimistic scenarios under the range of values for assumptions previously discussed. Increasing the variance in standardised treatment effects across blocks increases the estimated MDES to between 0.12 and 0.2, but again these estimates do not significantly change our previous findings.

Overall, these results show that the trial design is reasonably well powered, particularly given this is a pilot IE. The range of estimates are also quite tight under more and less optimistic assumptions. This reflects the reasonably high precision of the trial. However, these results illustrate an indicative range of estimates for the MDES that we expect given negligible levels of attrition. The rate of attrition is positively related to the estimated MDES. For example, assuming equal rates of attrition across the treatment and control group, attrition rates of 10% and 20% will increase the MDES for specification A in Table 4 to 0.18 and 0.19, respectively. The outcomes of this pilot will help to provide more specific information that can suitably inform our assumptions about likely levels of attrition in this type of evaluation.

Outcome measures

Primary outcomes

The primary outcome measure will be the Stirling Children's Wellbeing Scale (Stirling scale) (Liddle & Carter, 2010). This is a measure of mental wellbeing and therefore is a measure of the WeMatter service's outcome relating to improving the mental wellbeing of CYP victims.

The outcome measure will be collected for all individuals in Week 10, which is the last week of the WeMatter service for the individuals in the intervention group and the first week of the service for those in the control group. It will be collected via a Zoom call between the CYP and a WeMatter facilitator. We will also collect an initial outcome measure using the same scale in Week 1 (the first week of the 10-week service for those in the intervention group) to be used as a covariate in the analysis, also via a Zoom call between the CYP and a WeMatter facilitator.

The Stirling scale is an established measure of wellbeing, validated for use with children between the ages of 8–15 years old (Liddle & Carter, 2015). We expect this age range to include the large

majority of participants in the trial. (In the last quarter of 2024, 53% of beneficiaries of WeMatter were aged between 8–11 years, 27% aged between 12–14 years, and 20% aged between 15–17 years.).

It consists of 12 items, each with 5-point Likert response scales, with response options that range between 'Never' (1) to 'All of the time' (5) (for full list of items covered see Appendix A). Wellbeing is assessed using the aggregate score (summing the scores for each item), with a minimum possible score of 12 and a maximum score of 60. The scale is free-to-use and can be administered electronically, with research showing that electronic administration increased accessibility to younger children and children with reading difficulties (Liddle & Carter, 2010).

CYP's group facilitator will collect outcomes at the start of the introductory and concluding one-to-one call by sharing their screen with the 12 Stirling scale questions displayed alongside the 5 Likert scale response options. The facilitator will provide verbal instructions to the child which will also be written out at the top of the screen before the questions. This set-up minimises any differences with the self-administered version of the scale. Following this, the facilitator will read out each question one-by-one, while noting down the child's responses.

The outcomes will be collected by the CYP's group facilitator for pragmatic reasons. However, this creates a risk of bias in measurement of the outcome (because the person assessing the outcome knows the CYP's treatment group) and a potential confound (because CYP in the intervention group will have participated in an eight-week service led by the person assessing their outcomes and the control group will not). We hope to be able to vary the person assessing the outcomes in subsequent iterations of the trial.

It is not possible to blind the scale administrators to treatment allocation, since the scale will be administered by WeMatter facilitators. We will provide training to the facilitators to make sure the scale administration will follow consistent procedures and minimise potential biases, in line with the Child Outcomes Research Consortium (CORC) Best Practice Framework.[6] The aggregate score will be calculated by a member of the IE team from Verian who will be blinded to the treatment allocation.

Secondary outcomes

We will conduct an initial progress review in July 2024 to consider amends to the evaluation to improve or enhance it. One consideration discussed at this point will be whether there is scope to include a secondary outcome measure in the data collection. This will depend on CYP and facilitator feedback about the time needed to administer the primary (and any secondary) outcome measures and the risk of CYP fatigue if this is extended. We will review whether a secondary outcome measure could be added for older CYP groups if we find this is feasible for them but not for younger groups due to cognitive load.

[6] https://www.corc.uk.net/about-corc/what-we-do/best-practice-framework/#:~:text=The%20Child%20Outcomes%20Research%20Consortium%20%28CORC%29%20Best%20Practice,organisations%20supporting%20children%20and%20young%20people%E2%80%99s%20mental%20health

Analysis plan

Primary analysis

The primary analysis will be an Intention-To-Treat (ITT) analysis examining the effects of WeMatter on mental wellbeing. This analysis includes all individuals that participated in the trial according to the group they were assigned (treatment or control).[7] We will perform a partially nested heteroscedastic mixed-effects linear regression model that adjusts for the initial outcome measure and a random effect controlling for the trial's blocked design (Candlish et al., 2018):

$$y_{ijh} = \beta_0 + \beta_1 T_{ijh} + \beta_2 X_{ijh} + \theta_{jh} T_{ijh} + \gamma_{ih}(1 - T_{ih}) + \varepsilon_{ijh} T_{ijh}$$

We define y as the aggregate score of the Stirling Children's Wellbeing Scale collected in Week 10, i as the indicator for individual participants, j as the cluster indicator, and h as the block indicator. The clusters refer to the WeMatter groups so participants in the same WeMatter group will belong to the same cluster. T is the treatment variable (0 = control group, 1 = treatment group) and X is a vector of control variables (including only the outcome measure collected in Week 1 in the parsimonious specifications). The parameter β_0 is an intercept, β_1 is the treatment effect and β_2 is a vector of the coefficients of the control variables. The error terms $\theta_{jh} \sim N(0, \sigma_\theta^2)$, $\gamma_{ih} \sim N(0, \sigma_\gamma^2)$, and $\varepsilon_{ijh} \sim N(0, \sigma_\varepsilon^2)$ are respectively the random effects representing the between cluster variation in the treatment group, the individual variation in the control group, and the individual variation in the treatment group. A simple explanation for the intuition underpinning this estimation approach is that it estimates the overall effect of the treatment by averaging the H separate block treatment effects. In essence, we have H independent replications of a basic partially nested randomised controlled trial (each block represents a basic partially nested randomised controlled trial), and the approach averages their results to estimate WeMatter's treatment effect (Lohr et al., 2014).

We will report the estimated coefficients, standard errors, 95% confidence intervals and report the effect size of the intervention in both the absolute terms and as a proportion of the standard deviation in the control group (Glass's Delta). The standard threshold of 0.05 will be used to determine statistical significance, and we will not adjust for multiple hypotheses (following Foundations' requirements in their statistical guidance).

Secondary analysis

Secondary outcome

The effects of WeMatter on any secondary outcome(s) agreed in July 2024 will be estimated using the same model described above for the primary analysis.

[7] Where there is missing outcome data for some trial participants, we will perform a modified intention-to-treat analysis discussed below.

Subgroup effects

The sample is stratified by age group and individuals' preferred setting for WeMatter delivery. Therefore, we will conduct sub-group analysis according to these two factors by including an interaction term with the treatment variable. However, it is likely that the pilot is not powered to detect meaningful differences in subgroup effects, therefore results of the subgroup analysis (e.g. statistical significance) need to be interpreted with caution (e.g. the results could be statistically insignificant even if there exists a subgroup effect; when results are statistically significant, the magnitude of the subgroup effect could be inflated). We will conduct descriptive analysis in terms of other characteristics where data is available, such as gender and ethnicity. The sample size of the pilot does not allow us to stratify the sample further according to these factors, therefore we will not perform regression analysis on these additional subgroups. The descriptive analysis can provide a sense of potential direction of any subgroup effects.

Local effects

The trial will include participants from all areas in England and the pilot is not sufficiently powered to detect meaningful differences in local effects or according to aggregate level characteristics, such as level of deprivation within a local authority, etc. It is also not possible to stratify the sample by local authority as there will be few participants from each local authority for each randomisation. We will report descriptively participants' outcomes according to aggregate level local characteristics of interest, where data is available. The IPE will be able to explore the influence of key local factors further and provide nuances about the experience of participants with the programme's services in different local authorities.

Analysis of harms

We will assess potential harms in our qualitative data, see section 5.

Exploratory analysis

Additional specifications

Additional specifications of the regression model will consider further regression adjustments, for example, controlling for imbalances in baseline characteristics (collected by Victim Support during the referral and triage stage) such as year of birth, gender, sex at birth, public care status e.g. looked after child or care leaver, disability/additional needs, ethnicity, English as Alternative Language (EAL), free school meal status, source of referral, other needs captured by Victim Support systems (Lin, 2013). We will also examine more conservative estimators that include block fixed effects in the regression specification as a robustness test and include interaction terms between the treatment and blocks, allowing treatment effects to vary between blocks (Lohr et al., 2014).

Sensitivity analysis

We will also perform a sensitivity analysis, excluding any sibling groups, in case this relationship between evaluation participants affects their outcomes.

Missing data

If there is missing data, we will need to consider the likely reason for this missingness. In line with the statistical guidance from Foundations, the full sample baseline characteristics, the baseline characteristics of those lost to follow up, and the baseline of those analysed will be reported in a table side by side.

If the levels of missingness and differential attrition are low, then we can reasonably estimate the ITT, or more precisely a modified ITT where we include all participants that we have outcome data in the analysis according to their randomised group (treatment or control). We will also report estimates for a complete-case analysis where missing data varies according to outcome, which will indicate estimates using a common sample across outcomes.

However, a key threat to the validity of a randomised trial is attrition and missing participant outcome data. These issues can severely impact the reported estimates' risk of bias. There are several measures in place to minimise the issue of missing outcome data:

- When a CYP in the treatment group indicates they would like to stop attending the WeMatter programme, the facilitator will ask if they would still be happy to arrange a follow-up call to check in and ask them a few questions on their mental wellbeing as in the initial one-to-one call.
- If a CYP does not attend the final group session, the facilitator will try to get in touch with the CYP to encourage them to still attend the concluding one-to-one call.
- If a CYP does not attend the one-to-one call, the facilitator will try to get in touch with the CYP to arrange another call in the same week or as soon as possible.

We aim to regularly review and, if required, potentially test approaches to minimise these issues during the evaluation using the rapid testing approach discussed in more details in section 5.

If missingness in outcome data turns out to be severe, depending on the type or reason for missing outcome data, we will follow best practice to try to address these issues. For example, in the scenario where there are missing item responses, we will explore using multiple imputation models to impute the missing outcome responses. Otherwise, if there is evidence of differential attrition between the treatment and control group, we will construct weights that balance these groups according to individuals' characteristics (e.g. age, gender, special education needs status, ethnicity, English as additional language status, free school meal status).

While these practices can provide reasonable adjustments to address issues related to missing data, their use is controversial and is also associated with an increased risk of bias of trial estimates (e.g. see Higgins et al., 2019). Overall, this highlights the importance of monitoring attrition and finding methods to address it. Section 5 will provide more details on how we will do this.

Compliance

The main estimates above will report ITT estimates of effects of WeMatter. The ITT estimate reflects the effects of offering CYP the WeMatter services rather than the effects of actually receiving the WeMatter services. This is because it is possible that some CYP who are offered access to the WeMatter service decide not to participate in the sessions (i.e. there maybe be non-

compliers). Non-compliance will dilute the estimated effects of actually participating in WeMatter. Initially we will assess the prevalence of participant compliance by examining descriptively attendance at the provided support sessions. We will then also consider conducting two types of analyses to estimate the effects of the intervention on compliers:

1. Estimation of Treatment on the Treated (TOT) effects[8]

The Treatment on the Treated effects will provide estimates of the effects of the service on CYP that actually participated in the WeMatter sessions. The Treatment on the Treated effects will be estimated by scaling (weighting) the ITT estimates and standard errors according to the prevalence rate of non-compliance in the treatment group, as shown in Bloom (2008).[9] The prevalence rate of non-compliance will be defined by whether CYP attended any group sessions.[10]

2. Estimation of dosage-type model examining heterogeneity in experimental effects

We will also run dosage-type models examining the heterogeneity in the estimated treatment effects according to the number of WeMatter sessions individuals attend. These models will use the same estimation approach described in the primary analysis section, except that the treatment the binary treatment variable will be interacted with a count variable representing the number of sessions attended. However, statistical power may limit what we can infer from this analysis, due to the limited sample size. Furthermore, the method above does require assumptions about the functional form of the relationship between number of sessions attended and outcomes. Alternative explorative specifications might include adding a vector of interaction terms using binary variables that represent different levels of attendance (e.g. 1–2 sessions, 3–6 sessions, 7–8 sessions, or similar). Another illustrative option we may explore includes replacing the binary treatment variable altogether and assessing the association between attending sessions and the outcome variable. However, the results from this approach will need to be heavily caveated.

Assessment of data collection efficacy and reporting of statistical measures

We will examine the efficacy of the data collection procedures, considering data quality and reliability (such as levels of missingness, variable distributions, etc.). We will also report information that can help inform power calculations in future work, such as measures of variance, auto-correlation, response rates, ICCs.

---

[8] Another key assumption of this method is the exclusion restriction principle, as specified by Angrist et al. (1996), which requires that those who are randomised to the WeMatter treatment group but do not comply are not affected by the WeMatter programme. This definition of non-compliance will allow us to meet this principle.

[9] The key assumption of this method is satisfied in our case because CYP randomised to the waitlist control group condition are unable to obtain access to the treatment condition (i.e. there are not crossovers).

[10] Another key assumption of this method is the exclusion restriction principle, as specified by Angrist et al. (1996), which requires that those who are randomised to the WeMatter treatment group but do not comply are not affected by the WeMatter programme. This definition of non-compliance will allow us to meet this principle.

Contextual factors

Other contextual factors in this trial – beyond the characteristics of the CYP, their circumstances and their local area – concern the nature of the delivery of the WeMatter service. This may include, for example, the level of experience of the facilitator, how the activities are planned and organised, whether there are commonalities between child and facilitator (e.g. same sex), etc. However, this pilot study is not powered to examine variation in estimated effects according to these factors. The qualitative research described below may provide insights into the experience of participants within the service according to these aspects.

Implementation and process evaluation

Aims

The implementation and process evaluation (IPE) will complement the IE by providing contextual evidence about how the intervention was delivered, and its perceived impact on participating CYP and WeMatter facilitators. It will also inform periodic discussions about how the trial design might be iterated during the evaluation period.

The aims of the IPE for this project are:

1. To assess the extent to which the WeMatter service was implemented according to the intervention protocol, and the perceptions of staff, stakeholders, parents/carers and CYP with regard to the implementation of the WeMatter service to inform how the intervention can be improved.
2. To assess the extent to which the WeMatter service was perceived to achieve the expected outcomes.
3. To assess the theory of change underpinning the WeMatter service.
4. To assess the extent to which the trial was carried out as planned in the evaluation protocol.
5. To assess how the implementation of the trial was perceived by staff, stakeholders, parents and CYP, to inform how the evaluation design can be improved and scaled up.

Research questions

The research questions for our IPE are outlined below in Table 4, structured following the five aims for the IPE as set out above. The domains we have used to structure these questions are common to IPEs of interventions aimed at children and young people, for example for the Education Endowment Foundation.

Table 4: Implementation and Process Evaluation Research Questions

Aspects of IPE	IPE Research Questions	Method(s) for collection
Aim 1: Implementation of the intervention		
Fidelity to the Intervention Protocol	Was the approach delivered as intended (e.g., 8 x one-hour weekly group digital sessions, with a pre- and post-group one-to-one session)? Were the facilitators able to deliver the intervention as planned? Were there any key enablers or barriers to implementation (e.g. external stakeholder relationships, CYP access to fund	Service data Interviews with triage team and facilitators Feedback from Victim Support managers

	for digital devices, facilitator access to training and support)?	
Reach	What was the level of take-up of the intervention? How did it vary by key EDIE characteristics? To what extent did the intervention reach the intended target population? Why did parents/carers/CYP decide to take part? What were the reasons eligible parents/carers and CYP declined to participate in the intervention? To what extent were CYP retained in the intervention and were there any patterns to retention/dropout rates? How did Victim Support work with schools to ensure they were on board and were able to provide safe space for CYP to access the service? Did CYP who accessed the intervention from schools receive any support from the schools after participating in sessions in relation to managing interactions with other pupils as well as emotional impacts? How did this affect their participation in the intervention?	Service data on participation and opt-out reasons Interviews with facilitators and triage team Interview with beneficiaries and parents and carers Interviews with local authority (LA) representatives and referral partners
Dosage	How much of the intervention were CYP exposed to? How did this vary by key EDIE characteristics? Did CYP attend enough sessions for the intervention to have an effect, according to facilitators/CYP themselves? What level of support did facilitators provide to CYP, parents or carers outside the group sessions?	Service data Interviews with facilitators Interview with beneficiaries and parents and carers

Adaptation	Did the intervention delivery format, setting or content vary? To what extent was delivery adapted, why and how was this done, and what effect did this have on implementation and perceived impact?	Interviews with facilitators and beneficiaries
Responsiveness	To what extent did beneficiaries engage with WeMatter (including individual and group activities, home tasks, or additional support from facilitators)? How did this vary by key EDIE characteristics? What was the quality of the materials produced in the sessions by beneficiaries? How acceptable was the service to beneficiaries and their parents/carers?	Interviews with facilitators, beneficiaries, and parents and carers
Quality	How well was the service delivered? How could the intervention be improved?	Interviews with facilitators, beneficiaries, and parents and carers
Aims 2 & 3: Perceived impact and theory of change		
Perceived impact	How well was the intervention seen to be working? Did this vary by key EDIE characteristics? If so, how? To what extent did the outcomes emerge as anticipated? Were there missing and/or mis-specified outcomes in the ToC?	Interviews with facilitators, beneficiaries, and parents and carers Interview with Rock Pool representative
Mechanisms	To what extent did the mechanisms work as expected? To what extent did CYP find the content of the intervention relevant and engaging? How did CYP feel about their relationships with the facilitators and peers in the WeMatter group? To what extent did CYP feel they received sufficient support from	Interviews with facilitators, beneficiaries, and parents and carers Interview with Rock Pool representative

	parents/carers and/or schools for participating in the intervention? Were there missing and/or mis-specified mechanisms in the ToC?	
Moderators	What influenced whether the service worked, and for whom? (e.g. how did perceived outcomes vary by delivery setting, participant demographic, etc.) What factors may have influenced whether and how WeMatter affected the outcome measures? How did differences in context, timing/ seasonality or individual circumstances (e.g. duration of previous exposure to domestic abuse) affect how well the intervention worked?	Interviews with facilitators, beneficiaries, and parents and carers Interview with Rock Pool representative
Unintended consequences	Were there any perceived positive or negative effects, including possible risks or harms, relating to local authorities, facilitators, beneficiaries or their families?	Interviews with triage team, facilitators, beneficiaries, and parents and carers Feedback from Victim Support managers Interviews with LA representatives and referral partners Interview with Rock Pool representative
Differentiation	How was this intervention different from the alternative service(s) available for similar CYP who have experienced domestic abuse? How did beneficiaries, parents and carers feel about this intervention compared with alternative services available? What is the perceived added value of this intervention?	Interviews with the triage team Interviews with LA representatives and referral partners Feedback from Victim Support's management team Interview with beneficiaries and parents and carers Interview with Rock Pool representative
Aims 4 & 5: Implementation of the evaluation		

Fidelity to the Evaluation Protocol	Was randomisation conducted according to the protocol? Were there any factors that enabled or prevented successful randomisation as intended? Were the outcome measures collected reliably? Were there any enablers and barriers for delivery partners to provide required data?	Interviews with the triage team and facilitators Feedback from Victim Support managers
Uptake	Was the rate of consent to take part in the trial satisfactory? What were the reasons for refusing to take part in the trial, not related to the intervention itself? Did it vary by key EDIE characteristics? If so, how? Was there any variation in take-up across referring LAs depending on availability of alternative services?	Service data on participation and opt-out reasons Interviews with the triage team Interviews with beneficiaries and parents and carers Interviews with LA representatives and referral partners
Monitoring of the control group	How was the waitlist experienced by those in the control group? Did beneficiaries, parents, and carers seek additional support while being on the waitlist?	Interviews with the triage team, facilitators, beneficiaries, and parents and carers in the control group Interviews with LA representatives and referral partners Feedback from Victim Support managers
Acceptability	Was randomisation acceptable to delivery partners and participants? What would make participating in the evaluation more acceptable to parents and CYP? What would make participating in the evaluation more acceptable to Victim Support staff, referrals and wider stakeholders such as local authorities?	Interviews with the triage team and facilitators Feedback from Victim Support managers Interviews with LA representatives and referral partners Interviews with beneficiaries and parents and carers

Improvements to the evaluation	What procedures and timings were optimal from Victim Support's point of view? How could bias due to attrition during the trial correlating with lack of outcome data be minimised (e.g. reducing attrition or collecting outcome data from those who were not retained in the service)? How could we increase rates of consent to be part of the trial and have data used for the evaluation (to track non-consent)? How could recruitment for qualitative research be improved?	Interviews with the triage team and facilitators Feedback from Victim Support managers Interviews with beneficiaries and parents and carers Interviews with LA representatives and referral partners Interview with Rock Pool representative

Design and methods

The IPE will utilise a combination of qualitative interviews, group discussions, and administrative information provided by Victim Support. Triangulating between different methods and data sources will increase our ability to answer the wide-ranging IPE research questions, and to engage stakeholders in the most appropriate manner. Below we describe the methods that will be used; how we will sample and recruit participants; how we will aim for and maintain diversity and inclusion; and how fieldwork will be scheduled so that findings can inform iteration of the trial design during the evaluation period as well as assess implementation and impact overall.

Methods

In-depth interviews and group discussions with the Victim Support triage team, WeMatter facilitators, and WeMatter beneficiaries and their families will provide the majority of the IPE data, alongside administrative data (e.g. attendance) from Victim Support. We will also have interviews with representatives from local authorities and referrals and a representative from Rock Pool. In addition, we will liaise with the WeMatter managers (who manage the facilitator team and are part of the project delivery team) before the review meetings.

The majority of participants will be **WeMatter beneficiaries or their family members**. As recipients of the intervention, they are the focus of interest. However, we will also interview some **participants in the control group** to understand the impact of being on a waitlist, and actions taken during that period, as well as whether any variance in situation influences how the waitlist affects them.

In-depth interviews with CYP and parents and carers will provide a supportive, confidential environment in which to understand their circumstances and characteristics in detail, and how the intervention is affecting them individually. The interviews with CYP will last for 30 minutes and be conducted online (via Zoom). The interview process will be adapted for the younger group (aged 8–12 years old) to better suit their needs. For instance, the interviewer will make sure to use age-

appropriate language, speak at a slower rate with a more emphasised intonation, and use more leading questions than with older children. These one-to-one interviews with CYP will be conducted as part of the final one-to-one facilitator session following receipt of the 10-week intervention or at the end of the 10-week waitlist period for CYP in the control group. The WeMatter facilitator (and a safe parent/carer/adult in close proximity as per Victim Support's safeguarding policy) will be present during the interview. Interviews with the safe parent/carer will be arranged directly with the participant after gaining consent (following the consent process as outlined below). These online or phone interviews will last 30–45 minutes.

We will also conduct digital group discussions with WeMatter beneficiaries to explore the dynamics and engagement within the group intervention setting. We will recruit three age-specific groups of WeMatter beneficiaries from the recently formed WeMatter Youth Advisory Board to capture a range of experiences from a number of WeMatter groups. Group discussions will last 45 minutes and will be arranged via the Victim Support Project Leads at a convenient time and setting for the participants. A Project Lead from Victim Support will also attend the group, to support.

Alongside beneficiaries, we will interview **WeMatter facilitators** and **members of the triage team** to examine their experiences of the process of recruitment and delivering the service (and the evaluation of the service, including the randomisation and the collection of outcome measures). We will also investigate reasons why CYP may drop out, why parents/carers may not consent to participate and may withdraw their CYP from the evaluation, and any ways they believe the service could be improved. We will also examine support available to the Victim Support staff (e.g. training and continuing professional development). We will discuss with Victim Support what the reasons are for CYP/parents/carers declining to participate in the service (or in the trial) and the reasons for CYP dropping out. Moreover, we will request Victim Support to provide **data on attendance at the sessions**. This will be important for dosage analysis and for understanding and combatting attrition – for example, if there are patterns in when CYP drop out of the service.

In addition, we will interview **representatives from a referral agency and local authority** to examine more closely the referral process, and to get a more comprehensive picture of alternative services available, how they differ from the WeMatter service, and how they might have affected uptake of the trial and intervention, as well as wider implications of the intervention and the trial.

Finally, we will conduct an interview with a **representative from Rock Pool** who was involved in the development of the toolkit underpinning the design of the WeMatter service, to input into the validation of the theory-of-change and outcome measures.

Sensitivity in research

In recognition of the specific histories of the participants in this study, we will take steps to ensure we are sensitive to their needs and preferences:

- We will adopt a trauma-informed approach[11] to designing our research materials. We understand that an individual's responses in interviews may be a way of adapting and coping with symptoms of trauma.
- We will create safe spaces for sharing experiences during the interviews by ensuring a familiar face (the WeMatter facilitator) is present during the interview. Pseudonyms can be used if requested by the participant.
- We will pilot the topic guide with Lived Experience Advisors, and will also monitor participant responses during the first interviews to assess if any changes are needed. We utilise two experts by experience who work with Durham University's Centre for Research into Violence and Abuse. We will remain open to developing materials over time.
- Interviews will be carried out by researchers who have received guidance and instruction in how to interview trauma victim-survivors, including how to handle disclosure and safeguarding during the interview, to ensure a robust understanding of domestic abuse and its impacts.

Data collection

Victim Support administrative data collection

Before the intervention period, Victim Support will collect information about CYP, parents/carers via the referring bodies and from parents/carers and CYP themselves. This will include eligibility information, which will be used to randomise participants. As the randomisation is ex-ante, Verian will not receive any information about participants during their first period of interaction with Victim Support.

During the project, Victim Support will routinely collect administrative data including CYP characteristics and demographic data, eligibility data, attendance data and other agreed metrics as well as data about the rates of consent and drop-outs from the evaluation/service, and the reasons for non-consent. Victim Support will follow the standard data collection procedure for the data they already collect by recording it on their case management system. In addition to the data they already collect, Victim Support will also collect data for primary and secondary outcomes, free school meal status and whether a CYP has previously been referred to the service. Victim Support will pseudonymise this data before sending it to Verian by replacing child names with a unique ID created for this trial. Victim Support will share data with Verian at pre-agreed intervals to balance the need to minimise data transfers and administrative requirements with the need to analyse data on an ongoing basis to monitor for issues and adjust the approach if needed.

Qualitative data collection

The intervention period will consist of numerous overlapping groups of WeMatter beneficiaries (and corresponding waitlists). For this reason, for the majority of the project at any given time

[11] See https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice

there will be CYP who are just starting their journey with Victim Support all the way through to those finishing their WeMatter groups. Though fieldwork could be conducted at any point during this period, CYP and parents/carers will be sampled for interviews at two points during the year of the intervention for two 'waves' of qualitative research (see Table 5 for details). This approach aims to account for possible timing or seasonality effects, reduces the burden on Victim Support staff and allows qualitative feedback to feed into the review cycles.

Table 5: Qualitative data collection waves

Quantity	Duration	Method	Sample	Treatment/ Control
Wave 1: June–August 2024				
3x	45-minute	Online focus group, supported by WeMatter Project Leads (approx. 8 participants).	CYP	Treatment
1x	45-minute	Online focus group (3–4 participants)	WeMatter triage team members	N/A
2x	60-minute	Online interviews	WeMatter facilitators (individual or pairs)	N/A
1x	60-90-minute	Online interview	Representative from Rock Pool	N/A
8x	30-minute	Online interviews	CYP	Treatment
2x	30-minute	Online interviews	CYP	Control
3x	30–45-minute	Online interviews	Safe parent of CYP	Treatment
2x	30–45-minute	Online interviews	Safe parent of CYP	Control
Wave 2: October–December 2024				
1x	45-minute	Online focus group, supported by WeMatter Project Leads (approx. 8 participants).	CYP	Treatment

1x	45-minute	Online focus group (3–4 participants)	WeMatter triage team members	N/A
1x	60-minute	Online interview	WeMatter facilitators (individual or pairs)	N/A
4x	30-minute	Online interviews	CYP	Treatment
1x	30-minute	Online interview	CYP	Control
1x	30–45-minute	Online interview	Safe parent of CYP	Treatment
1x	30–45-minute	Online interview	Safe parent of CYP	Control
1x	60–90 minute	Online interview	Representatives from referrals	N/A
1x	60–90 minute	Online interview	Representatives from local authorities	N/A
Total				
4x	45-minute	Online focus group, supported by WeMatter facilitators (approx. 8 participants).	CYP	Treatment
2x	45-minute	Online focus group (3–4 participants)	WeMatter triage team members	N/A
3x	60-minute	Online interviews	WeMatter facilitators (individual or pairs)	N/A
1x	60–90 minute	Online interview	Representative from Rock Pool	N/A
12x	30–45-minute	Online interviews	CYP	Treatment
3x	30–45-minute	Online interviews	CYP	Control
4x	30–45-minute	Online interviews	Safe parent of CYP	Treatment

3x	30–45-minute	Online interviews	Safe parent of CYP	Control
1x	60–90 minute	Online interview	Representatives from referrals	N/A
1x	60–90 minute	Online interview	Representatives from local authorities	N/A

This schedule is designed to allow fieldwork in the IPE to inform evaluation progress review meetings with Foundations and Victim Support, so that comprehensive decisions about the evaluation approach and any iterations required can be made (see below).

CYP will be invited to participate in qualitative fieldwork by Victim Support, who will seek their assent to participate in an interview or a focus group (and/or for their parent to participate in an interview). This will follow Market Research Society (MRS) guidance in getting consent for interviewing minors. Victims Support will then send an information sheet and privacy notice detailing the purpose and nature of this qualitative research to parents/carers of CYP who have provided assent via email or text. Parents will be asked to provide their consent for CYP or themselves to participate in an interview or focus group in writing by completing the online consent form. We believe this is the most suitable approach to recruitment in this context, although we are aware of the risks of selection bias. Once parental consent is received for CYP to take part in an interview or focus group, Victim Support will inform Verian of the scheduled one-to-one facilitator session which will include the 30-minute interview and the 45-minute focus groups.

To facilitate this process, in partnership with Foundations and Victim Support and supported by Lived Experience Experts, we will develop information materials that clearly explain the relevance of the research, who we as evaluators are, and what the research will involve.

For parent/carer interviews, Verian will contact parents/carers who have been identified by Victim Support and given consent via the online consent form to schedule one-to-one 30-minute online interviews.

Following all interviews with parents/carers and CYP we will provide parents) £30 vouchers/PayPal transfers to acknowledge and thank them for their time.

We will review this process, Victim Support feedback, and rates of consent to participate in evaluation progress meetings with Foundations and Victim Support. During these meetings, we will discuss whether we need to improve the information materials, the way these are presented to CYP or parents, the incentives we offer for participation, or other factors that could improve uptake (particularly of participants with minority EDIE characteristics).

Sampling approach

We will take a purposive sampling approach for CYP and parents/carers so that we include a range of different characteristics across the sample, including:

- Gender

- Age
- The setting where the CYP received WeMatter sessions (home or school)
- Area (location)
- Ethnicity
- Free School Meal status
- English as an Additional Language
- Progress in WeMatter service at time of interview.

We will monitor these as the evaluation progresses and adapt our approach as appropriate in partnership with Foundations and WeMatter, to reflect the mix of beneficiaries who are being referred to WeMatter.

We will also aim to cover two sensitive characteristics for which data will not be collected formally by Victim Support nor shared with Verian:

- Sexual orientation
- Long-term health condition, impairment, or neurodiversity.

However, we will not be able to recruit on this basis, since these are not observable characteristics and it may not be appropriate to ask CYP or parents/carers in this context, so this will be pragmatic and we may not achieve the aim.

Our overall sample frame is described in Table 6.

Table 6: Sampling frame for qualitative research

Format/Participant	Criteria	Treatment/Control
4 x 45-minute group discussions with CYP beneficiaries	Natural mix of participants in service	Treatment only
2 x 45-minute group discussions with WeMatter triage team members (3-4), and 3x interviews with WeMatter facilitators (individual or paired)	Mix of areas	NA
15 x 30-minute interviews with CYP	Mix of areas Representation of those home-based vs school-based Representation of those aged 8–10, 11–12, 13–14 and 15–17 Mix of length of time on WM/waiting list	3 control, 12 treatment

	Aim for at least 4 participants from a minority ethnic background Mix of gender, aim for at least 2 LGBTQIA+ beneficiaries Aim for at least 2 participants with a long-term health condition, impairment or neurodiversity	
7 x 30–45-minute interviews with parents/carers	Mix of areas Representing those caring for beneficiaries of a range of ages, having experienced a range of lengths of time on a waiting list Aiming for parents and carers of at least 2 beneficiaries from a minority ethnic background, 1 LGBTQIA+ beneficiary and at least 1 with a long-term health condition, impairment or neurodiversity	3 control, 4 treatment
3 x 30–45-minute interviews with wider stakeholders	Representatives from a referral agency, local authority and Rock Pool	NA

Analysis

For the **qualitative research**, the procedure we will use for the analysis is as follows:

- Prior to the first wave of qualitative research, the researchers will develop an initial thematic framework to organise the data gathered, in the form of a searchable Excel document, informed by the evaluation's key aims and IPE research questions. The framework will be based on the main questions in the topic guide, the research questions (which will also be covered in the guide), and the key assumptions of the theory of change.
- As interviews take place these will be transcribed. This will include notes and recordings from group discussions. We will record and transcribe all interviews and focus groups.
- Based on these transcriptions, the content from each fieldwork unit will be recorded within the framework, which is updated iteratively if new factors emerge as important. Analysis will take place after each wave, as a part of the iterative testing approach.
- Once the data are charted, researchers will review to identify emerging findings and areas for improvement. This will involve discussion and workshops in which researchers bring together findings and clearly establish the key themes and sub-themes arising, and draw out the implications of the research. The process is supervised by a Senior Director and outputs are double-tested and signed off by a Senior Director (or above).

Iterative testing approach

The aim of the pilot is to present recommendations for a scale up to a full RCT, as well as a preliminary evaluation of the intervention. Therefore, we will report findings on the:

- Acceptability of the intervention to service users
- Adherence to the intervention by service users
- Acceptability of a trial to service users, including representativeness of recruitment
- Acceptability of a trial to practitioners
- Feasibility of implementing the randomisation
- Feasibility and reliability of collecting outcome measures
- Discrepancy of the evaluation's assumptions (e.g. on sampling, recruitment, attrition, outcomes) and actual data/findings
- Appropriateness of the outcome measures and the analysis approach
- Safety of the intervention (and any unintended harms)
- Estimates for key parameters needed for power calculations.

Based on these findings, we will make recommendations for:

- Trial design for a scaled-up RCT, including what the control group(s) should be
- Outcome measures
- Approach to randomisation
- Approach to communicating with participants and practitioners
- Approach to minimising attrition
- Appropriate analysis for a scaled-up RCT.

We will **triangulate qualitative, quantitative, and administrative data** such as rates of consent, level of attrition, and quantitative demographic comparisons to provide a full understanding of what we have learned from the pilot and the limitations of our results. We will use this to draw conclusions about future trials or improvement of the intervention.

We will conduct regular reviews with Victim Support and Foundations during which Victim Support will provide feedback about the research design and the evaluation team will review its progress. At these meetings, we will discuss the design in its entirety, and the merits and potential implications of changes to the approach. The meeting times are likely to be at the following times:

- July 2024
- September 2024.

During and following each review meeting we will consider changing elements of the research processes or design based on the outcomes of these meetings. Similarly, if any specific risks to participants or the fidelity of the project are highlighted, we will implement any necessary changes.

The review in July 2024 will explore whether there is scope to include a secondary outcome measure in the data collection. This will depend on CYP and facilitator feedback about the time needed to administer the primary (and any secondary) outcome measures and the risk of CYP fatigue if this is extended. We will review whether a secondary outcome measure could be added

for older CYP groups if we find this is feasible for them but not for younger groups. If we include a secondary outcome measure, this is likely to be a measure of feeling like they are being supported.

Moreover, in both review meetings we will cover:

- Recruitment (including consent and randomisation processes)
- Retention
- Quantitative outcome measures (both data collection and distribution of the data)
- Qualitative data collection
- Risks to participants.

For each item, we will:

1. Inspect the data
2. Assess the data against the risk table
3. Where risks to the trial or the participants are identified as emerging, we will discuss mitigations, including potential changes to the trial design
4. Any changes to the design of the trial will be posted as an amendment to the evaluation protocol.

The outcomes of these design reviews will be reported in the interim and final reports, along with a summary of the project's progress or outcomes.

One key challenge to the evaluation is recruitment and retention. Besides reviewing the qualitative, quantitative and administrative data around consent and attrition in the review meetings, we will ask Victim Support to flag to us if they see a low consent rate or high attrition rate at any point throughout the trial. We will use any data available up to the point and discuss with Victim Support to identify potential reasons for low consent rate/high attrition, and we will arrange meetings with Victim Support and Foundations to discuss measures to combat the challenges.

Depending on the plausible causes identified, we could consider taking mitigation strategies such as:

- Modifying the consent script during the triage stage to address barriers
- Providing more information to and having more follow-up calls with parents/carers who are not sure about participating
- Providing more support for participants randomised to the waitlist condition, including developing better communication channels between participants on the waitlist and Victim Support
- Providing incentives to take part in the trial
- Adjusting the data collection methods
- (Victim Support to) provide more support to potential participants and participants in the trial in terms of digital access and safe space to make sure they can engage with the service successfully
- (Victim Support to) engage more in relationship building with the parents/carers/schools of participants and potential participants

- Sending reminders to participants in both the treatment and waitlist groups using appropriate channel (e.g. texts/emails/schools)
- Developing systems so that participants (or their parents/carers/schools) can better communicate with the facilitators/Victim Support if they see any concerns or issues that might affect their attendance in the service or participation in the trial so the facilitators/Victim Support can address the concerns/issues in a timely way, and encourage participants to stay in the trial even if they have to miss a session
- Developing better feedback mechanisms after each WeMatter session to capture participants' responses (e.g. emojis on an online chat) to the session, with follow-up to understand reasons why afterwards to address negative beneficiary responses to the service in a timely way
- Recontacting participants dropping out of the trial to encourage them to rejoin the trial or to arrange calls to collect outcome measures in Week 10.

We will discuss with Victim Support and Foundations the possibility of implementing the mitigation strategies, taking into account the resources and timeline. Recruitment and delivery are continuous throughout the evaluation until the beginning of the last cohort. Therefore, in principle, the changes can be implemented at any point. We will estimate the time it will take to implement a particular mitigation strategy to decide whether it is worthwhile to implemented it, given the potential effects it could have for the rest of the trial.

Challenges related to outcomes include who collects the outcome measure and whether that can be de-coupled from the CYP's group facilitator, the feasibility of collecting the measures in the fixed time period, the reliable delivery of the outcome measure, the distribution of the outcome measure, e.g. ceiling or floor effects, and (specifically for the secondary measure) whether it is measuring the relevant increase in support provided by the service. Adaptations could include changes to the data collection procedure or the secondary outcome measure.

There will also be an iterative testing approach for the IPE. The researchers will consider after the first wave of interviews if and how the recruitment process and/or materials, the discussion guides, and/or the thematic framework(s) should be adapted. This will be discussed during the review meetings with Foundations and Victim Support. This iterative process means that in the final reporting we will be able to set out the challenges we have encountered, any limitations that may affect the research findings, and how we have responded to these issues, to underpin the validity of the findings. These may include reference to:

- The data collected – e.g. what the interview data in isolation can tell us and how to interpret it.
- The sample – e.g. that the qualitative sampling may have some aspects of bias due to the type of people who opted into the research.
- Methods of data collection – e.g. that the facilitators collection of outcome measures may bias the results.

Cost evaluation

The cost evaluation will provide an analysis of:

- The total cost of running the WeMatter service for a year
- The average cost per CYP accepted to receive WeMatter
- Costs of introducing WeMatter to a new local authority (start-up costs)
- Estimated values of the prerequisites for running WeMatter.

In addition, we will also review the process of collecting, recording, and analysing cost data and identify useful learnings for the value for money evaluation in a full-scale RCT.

Table 7 below provides an overview of cost items broken down between recurring costs, prerequisites, and start-up costs. New cost items might be identified during the delivery period and the process and implementation evaluation, and we will update the list accordingly. We will collect costs data for delivering the service from May 2024 until March 2025 from Victim Support in April 2025, as well as any available data/estimates on the start-up costs and valuation of the prerequisites. Items under *Costs to other public services* and *Costs to wider society* will be estimated using information gathered during the interviews with the relevant stakeholders. All costs will be projected to April 2025.

Following the Cost Analysis Guidance from Foundations' legacy organisation What Works for Children's Social Care,[12] for cases where no actual cost was incurred during the evaluation period, we will use the market price at local level. Any parent, volunteer, and/or CYP's time will be presented separately as units of time. We will make adjustments for overlapping uses and life use of equipment and materials, and apply the 3.5% discount rate and the GDP Price Deflator Index rate to account for time preference and inflation. Where relevant, we will conduct sensitivity analysis on key assumptions made in the cost analysis, and consider broader risks and uncertainty around the costs, exploring any cost items that are not incurred during the evaluation but might occur in the future when the service is further rolled out.

Although WeMatter is run nationally, there might be heterogeneity in the costs of introducing and/or providing the service to different local authorities depending on their existing conditions. We will provide an assessment of local differences if relevant. We would also compare the costs to the costs of providing the in person one-to-one business-as-usual service, if data are available from Victim Support or other sources.

[12] See https://whatworks-csc.org.uk/wp-content/uploads/WWCSC-Cost-analysis-guidance-SEND.pdf

Table 7: Overview of cost analysis items

Category	Type	Item	Data Source(s)
Recurring costs	Staff costs to Victim Support	Salary of WeMatter facilitators	Victim Support
	Staff costs to Victim Support	Time costs of other Victim Support staff (e.g. triage officers, management team, governance board) on activities related to WeMatter (e.g. undertaking community engagement and promotion activities, handling referrals, arranging and completing triage calls, completing admin tasks, data monitoring and reporting, providing staff support and training, completing case reviews and service audits, conducting victim and stakeholder involvement activities, managing the WeMatter Youth Advisory Board, etc.)	Victim Support
	Facilities, equipment and materials costs to Victim Support	Expenses incurred by Victim Support on WeMatter related activities	Victim Support
	Facilities, equipment and materials costs to Victim Support	Funds from Victim Support to help CYP get digital access to WeMatter	Victim Support
	Costs to wider society (quantifiable but unmonetisable)	Time of CYP on WeMatter related activities	Interviews with CYP Interviews with parents/carers

			Interviews with facilitators
	Costs to wider society (presented separately as units of time)	Time costs of parents/carers on WeMatter related activities	Interviews with CYP Interviews with parents/carers
	Costs to wider society	Expenses incurred by CYP and their families on WeMatter related activities	Interviews with CYP Interviews with parents/carers
	Costs to other public services	Time costs of staff at schools, community centres, and referrers on WeMatter related activities	Interviews with parents/carers Interviews with facilitators Interviews with representatives from LA and referral agency
	Costs to other public services	Expenses incurred by schools, community centres, and referrers on WeMatter related activities	Interviews with facilitators Interviews with representatives from LA and referral agency
Prerequisites ***(listed and valued but not included in the cost estimates)***	Other intervention costs to Victim Support	Licence to use the Rock Pool CYP Domestic Abuse Recovery Toolkit	N/A
	Staff costs to Victim Support Costs to other public services	Existing referral pathways	N/A
	Costs to other public services Costs to wider society	Existing access to IT equipment and Zoom	N/A

Start-up costs	Staff costs to Victim Support	Assessing demand and other preparation work before introducing WeMatter to a new local authority	Victim Support
	Staff costs to Victim Support Costs to other public services	Introducing WeMatter to the established referral pathways and setting up new referral pathways where required	Victim Support
	Staff costs to Victim Support	Administrative costs associated with hiring and training new staff	Victim Support
	Staff costs to Victim Support Facilities, equipment and materials costs to Victim Support	Setting up the required operational infrastructure and procedures	Victim Support

Ethics & participation

Verian is the independent evaluator for this research, and as such is responsible for securing ethical approval. During the project planning and design phases, we followed Verian's internal research ethics review process to ensure the proposed project approach met ethical standards and represented a balanced and responsible approach to achieve the aims of this evaluation. The ethics panel selected for this project consisted of three Directors all external to the project team and to Verian's Behavioural Practice team. Their entire role on this project is to ensure it meets the organisation's high ethical standards.

Potential harms associated with this project will be considered and embedded in Verian's safeguarding approach. The relevant considerations and risks will also be written into the ethical approval process.

Participants' parents/carers will be provided information in writing on their right to withdraw from the trial, in the form of a Parent Information Sheet and a project Privacy Notice. The Privacy Notice will detail what data Verian process, how Verian does so, the legal basis and purpose(s) for processing data, and participants' rights. The document will also provide contact information to raise concerns, exercise their rights, or escalate issues if needed. It will also inform participants that we will disclose to authorities if they say anything that raises concern about their safety or wellbeing. See Figure 1 for the detailed flow of the consent process.

The recruitment materials the ethics panel reviewed and signed off were:

- The Evaluation Protocol
- The triage call and follow-up consent call scripts
- The Participant Information Sheet.

Ethics clearance and input regarding these materials and the overall trial was granted by Verian's internal Research Ethics Committee on 28 May 2024. The ethics reference is VERIAN REC (24/B001/04).

Participant consent

As described in more detail in section 3, in the subsection 'Referral, eligibility, and consent', this project relies on the parent/carer of a CYP referred for WeMatter to actively consent and opt into participating in the evaluation of the WeMatter service. The parent/carer of the CYP will be given the opportunity for their child to participate in the service and its evaluation during the initial triage call with Victim Support and will be informed that participating in the service is conditional on participating in the evaluation. Following the initial triage call, the parents/carer will receive a Participant Information Sheet and Privacy Notice that provides further detail about the evaluation and how their data will be handled. The parents/carers will then have a follow-up call with the WeMatter facilitator assigned to their child to seek their informed oral consent.

Participants who are not eligible for WeMatter or whose parents/carers do not consent to participate in the evaluation will be passed back to the referrer or will be signposted/referred to/advised on alternative provision following Victim Support's standard processes. Parents/carers

of CYP participating in the evaluation may also withdraw their consent to be part of the evaluation at any time by informing Victim Support and/or Verian. If this happens after the follow-up call and randomisation, the CYP will continue to receive WeMatter as planned but their data will not be shared with Verian. See Figure 1 for the visualisation of the consent process.

Approach to ensuring confidentiality

Our data protocols and data security procedures are designed to minimise the risk of data loss and data breaches and protect respondents' confidentiality. We have well-established policies and procedures in place to transfer, store, process, analyse, and dispose of data securely in line with the 2018 Data Protection Act and UK GDPR requirements. We are certified to ISO 27001 and hold a valid Cyber Essentials certificate.

Safeguarding approach

Verian's Senior Safeguarding Committee (SSC) has overall responsibility for safeguarding policy and compliance.

Verian field interviewers may, through their work, observe or encounter safeguarding concerns or have these disclosed to them, they must follow the procedure set out in this policy to recognise, respond to, report and adequately record those concerns. The Head of UK Data & Operations will be responsible for ensuring compliance of this policy by field interviewers. Verian interviewers and contractors are to follow the procedure as set out in this policy, and the Project Director for the project is responsible for compliance and escalation.

In the context of the WeMatter evaluation, we will include all participants (including those who turn 18 during the intervention period) as children from a safeguarding perspective. In the context of child protection, children and young people refers to anyone under 18 years of age. The Market Research Society (MRS) Code of Conduct defines a 'child' to be under 16, 'young people' as those aged 16 and 17, and an 'adult' as 18 and over. As signatories to the Convention of the Rights of the Child (UNCRC), the UK has an obligation under law to protect children from all forms of violence, abuse and harm. Whilst we recognise that Verian is bound by MRS' Code of Conduct for how we approach and uphold consent standards in research for the purposes of safeguarding children, we must disclose any concern we have around risk of harm for those under the age of 18. Whilst those aged between 16 and 18 have the right to consent to taking part in the research, for this project we are seeking consent from parents/carers for all participants as agreed with Foundations and Victim Support. Please note that it is Verian practice to escalate all cases where we have a concern without or without consent if the person is under 18.

If a field researcher becomes concerned about the safety or wellbeing of a participant meeting the definition of requiring safeguarding as above, they are to:

- If the concern is a threat to life or significant threat to the participant's immediate health or wellbeing, call the relevant emergency services (Police, Ambulance, Fire).
- Ask the participant if the participant is OK.
- Ascertain if the field researcher knows how to help themselves (where possible).

- Inform the participant (or the parent, if the participant is a CYP and the concern does not seem caused or exacerbated by the parent) that they have become concerned about their safety or wellbeing, and immediately end the interview (and recording) and consider the participant fully withdrawn from the research process.
- Provide information relating to help that may be available to the participant (e.g. support organisations) or their parent.
- Ensure as far as is possible that the participant receives promised incentive before they leave.
- As soon as possible (within 24 hours), inform the project safeguarding lead (Pieter Cornel) responsible for providing support to the end user about the expressed concern. Researchers are not to reveal any unnecessary details about the content of the interview.
- If they have cause for concern that the participant is at risk of harms, complete the safeguarding escalation template (within 24 hours). Share the completed template with the project safeguarding lead (Pieter Cornel) and the Verian Chief Safeguarding Officer (CSO).
- The CSO will assess the case (including information provided to help ascertain if the participant can help themselves). The CSO will contact Victim Support and Foundations to outline that there has been a safeguarding event and that Verian has taken appropriate action.
- Record the incident in the project incident log and review, jointly with Pieter Cornel, if any research materials or processes need to be amended to prevent further incidents.

Registration

The trial was preregistered with, and the evaluation protocol uploaded to, the Open Science Framework (OSF) on 20/06/2024. The OSF registration of the project, and the Evaluation Protocol as uploaded, can be found here: https://osf.io/mbp49/.

Data protection

Verian (trading as Verian Group UK Ltd.) will serve as data processor for the data used for the project evaluation, with Foundations as data controller for this data (jointly with Victim Support). Any personal data shared with Verian will be pseudonymised by replacing names/contact details with a unique ID.

Verian is registered with the Information Commissioner's Office for all our research and other activities, holding ISO27001 accreditation which certifies the legal, physical, and technical controls involved in our information risk management process. We also hold the Cyber Essentials Certificate, and abide by the Data Protection Act 2018, and embed Data Protection by design in all our work. We have a GDPR champion and Quality and Information Security team who consult on all data privacy issues.

Data protection laws require us to meet certain conditions before we are allowed to use data in the manner described in this notice, including having a lawful basis for the processing.

For all information collected for this project Verian is relying on the lawful basis of LEGITIMATE INTERESTS, as instructed by the data controller, Foundations.

Verian's lawful basis for processing CYP's, and WeMatter facilitators' personal data is legitimate interests (as per Article 6 (1) (f) of the UK GDPR) and we have considered that your interests and fundamental rights do not override those legitimate interests). It is necessary in Verian's 'legitimate interests' to process the personal data identified above in order to deliver a meaningful randomised controlled trial (RCT) that has been commissioned by Foundations and the Evaluation Accelerator Fund.

We will process special category data related to health in the form of disability and additional needs (SEN), public care status, sexual orientation, ethnicity and gender identity We will collect this data to provide descriptive statistics about the sample for this project to Foundations, as individuals with disability and additional needs and public care status are likely to be especially vulnerable and it is therefore imperative to understand their role and presence in this evaluation. For the processing of this special category data Verian is also relying on LEGITIMATE INTERESTS.

Verian takes reasonable steps to protect personal information and follow procedures designed to minimise unauthorised access, alteration, loss or disclosure of personal data. Data will be accessed by a limited number of researchers and advisors in Verian's project team working on this project. Taking into account the technological developments, the costs of implementation and the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of natural persons, we implement appropriate technical and organisational measures to ensure a level of security appropriate to the risk of processing.

We ensure that those who have permanent or regular access to personal data, or that are involved in the processing of personal data, are trained and informed of their rights and responsibilities when processing personal data. We provide such access on a need-to-know basis, and have measures in place which are designed to remove that access once it is no longer required.

Verian (the evaluation team) may deal with and share personal data in accordance with a data sharing agreement between Victim Support and Foundations. Such an agreement would need to set out the purposes for which we may process and share personal data and our agreement to cooperate to protect personal data and deal with any requests CYP and their parents/carers may have.

Finally, following the completion of the project, the data shared with us as part of this project (excluding any qualitative research data or contact information) will be provided to Foundations to be stored in their data archive in an anonymised form.

Personnel

Delivery team

- Sue Sanders – Assistant Director and Victim Support lead for Programme
- Michaela Clare Addison – CYP National Lead
- Emma Tinsley – Operations Manager
- Jessica Cressey – Senior Triage and Early Interventions Officer
- Elijah Giraudel – Project lead
- Vanessa Rowland – Project lead
- Mandy Wilcox - CYP Programme Facilitator
- Grace Mac Neela – CYP Programme Facilitator
- Lucy Bishop - CYP Programme Facilitator
- Sammy Jo Costa - CYP Programme Facilitator
- Lucy Smith - CYP Programme Facilitator
- Lucy Belbin – CYP Programme Facilitators

Evaluation team

- Prof. Natalie Gold: Programme Director
- Dr Paul Fenton Villar: Impact Evaluation Lead (until April 22nd 2024)
- Dr James Thom: Impact Evaluation Lead (from April 22nd 2024)
- Ben Toombs: IPE Lead
- Pieter Cornel: Trial Delivery Lead
- Penny Stothard: IPE Project Manager
- Dr Shi Zhuo: Impact Evaluation Manager
- Varvara Kuz: Executive Support
- Prof. Nicole Westmarland: Expert Advisor
- Dr Kelda Henderson: Expert Advisor
- Dr Susan Alderson: Expert Advisor
- Laura Thurman: Lived Experience Expert
- Kate Woodley: Lived Experience Expert

Timeline

Dates	Activity	Staff responsible/ Leading
20/06/2024	Foundations sign off the final version of the evaluation protocol with ethics approval obtained from Verian's ethics panel.	Charlotte Goujon
03/06/2024	Victim Support start processing referrals for the trial, i.e. recruitment and randomisation for the trial starts .	Emma Tinsley
20/06/2024	Evaluation protocol published on Foundations website and the Open Science Framework (OSF).	Pieter Cornel
17/06/2024	First cohort of WeMatter groups in the trial start.	Emma Tinsley
July 2024	First evaluation progress review meeting with Foundations and Victim Support. This meeting will consider: 1. If there is capacity to increase the data collection requirements to include secondary outcome measure (or to do so for older cohort(s))? And, if there is capacity, which secondary outcome(s) should be collected? 2. Who should administer the outcome assessments, 'familiar' or 'unfamiliar' facilitators?	Pieter Cornel
September	Mid-project evaluation in-depth review meeting with Foundations and Victim Support.	Pieter Cornel
Late-September 2024	Recruitment into the trial stops. The last scheduled paired Treatment/Control cohort commences early October, to allow recruited participants in the Control group to complete a 10-12 week waiting period and then a 10-week	Emma Tinsley

	WeMatter programme, with data collection at the end of the programme completed by 31 March 2025.	
December 2024	Final data collection for impact evaluation.	Emma Tinsley
31/03/2025	Interim evaluation report completed.	Prof. Natalie Gold
31/03/2025	WeMatter delivery completes (final Control groups have received WeMatter).	Emma Tinsley
08/09/2025	Final evaluation report completed.	Prof. Natalie Gold
12/09/2025	Analysis code and pseudonymised data published on GitHub and Foundations' data archive.	Dr. James Thom

References

Angrist, J. D., Imbens, G. W. & Rubin, D. B. (1996). Identification of causal effects using instrumental variables. *Journal of the American Statistical Association*. 91 (434), 444–455. https://doi.org/10.1080/01621459.1996.10476902

Bloom, H. S. (2008). The core analytics of randomized experiments for social research. In *The SAGE Handbook of Social Research Methods* (p. 648). SAGE Publications Ltd. https://doi.org/10.4135/9781446212165

Calder, M. C. & Regan, L. (2008). Working with mothers in situations of sexual and domestic abuse: Reframing resistance as restricted choices. In M. C. Calder (Ed.), *The Carrot or the Stick* (pp. 249–276). Russell House Publishing.

Candlish, J., Teare, M. D., Dimairo, M., Flight, L., Mandefield, L. & Walters, S. J. (2018). Appropriate statistical methods for analysing partially nested randomised controlled trials with continuous outcomes: A simulation study. *BMC Medical Research Methodology*. 18 (1), 105. https://doi.org/10.1186/s12874-018-0559-x

Children's Commissioner. (2018). *'Are they shouting because of me?' Voices of children living in households with domestic abuse, parental substance misuse and mental health issues*. Children's Commissioner for England.

Domestic Abuse Commissioner. (2022). *A patchwork of provision: How to meet the need s of victims and survivors across England and Wales*. The Domestic Abuse Commissioner for England and Wales, London.

Dong, N. and Maynard, R., (2013). PowerUp!: A tool for calculating minimum detectable effect sizes and minimum required sample sizes for experimental and quasi-experimental design studies. *Journal of Research on Educational Effectiveness*, *6*(1), pp.24-67.

Early Intervention Foundation. (2024). EIF Evaluation Hub. https://evaluationhub.eif.org.uk/

Early Intervention Foundation. (2021, April 2). *Improving services for children affected by domestic abuse*. https://www.eif.org.uk/report/improving-services-for-children-affected-by-domestic-abuse

Foundations. (2023a). *Improving outcomes for children with child protection concerns who have been exposed to domestic abuse*. Foundations.

Foundations. (2023b, December 18). *Over 827,000 children estimated to have experienced domestic abuse this year, with concerns of increase at Christmas underscoring urgent need for stronger support* (press release). Foundations. https://foundations.org.uk/press-release/over-827000-children-estimated-to-have-experienced-domestic-abuse-this-year-with-concerns-of-increase-at-christmas-underscoring-urgent-need-for-stronger-support/

Higgins, J.P., Savović, J., Page, M.J., Elbers, R.G. and Sterne, J.A., (2019). Assessing risk of bias in a randomized trial. *Cochrane handbook for systematic reviews of interventions*, pp.205-228.

Holt, S., Buckley, H. & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect*. 32(8), 797–810. https://doi.org/10.1016/j.chiabu.2008.02.004

Liddle, I. & Carter, G. (2010). *Emotional and psychological wellbeing in children: The standardisation of the Stirling Children's Wellbeing Scale*. Stirling Council Educational Psychology Service.

Liddle, I. & Carter, G. F. A. (2015). Emotional and psychological well-being in children: The development and validation of the Stirling Children's Well-being Scale. *Educational Psychology in Practice*. 31 (2), 174–185. https://doi.org/10.1080/02667363.2015.1008409

Lin, W. (2013). Agnostic notes on regression adjustments to experimental data: Reexamining Freedman's critique. *The Annals of Applied Statistics*. 7 (1). https://doi.org/10.1214/12-AOAS583

Lloyd, M. (2018). Domestic violence and education: Examining the impact of domestic violence on young children, children, and young people and the potential role of schools. *Frontiers in Psychology*. 9. https://doi.org/10.3389/fpsyg.2018.02094

Lohr, S., Schochet, P. Z. & Sanders, E. (2014). *Partially nested randomized controlled trials in education research: a guide to design and analysis*. National Center for Education Research.

Mullender, A., Hague, G., Imam, U., Kelly, L., Malos, E. & Regan, L. (2002). *Children's perspectives on domestic violence*. SAGE Publications Ltd. https://doi.org/10.4135/9781446220795

Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. & Collishaw, S. (2011). *Child abuse and neglect in the UK today*. University of Central Lancashire and National Society for the Prevention of Cruelty to Children. http://www.nspcc.org.uk/childstudy

Appendix A: The Stirling Children's Wellbeing Scale

Here are some statements or descriptions about how you might have been feeling or thinking about things over the past couple of weeks. For each one please put a tick in the box which best describes your thoughts and feelings; there are no right or wrong answers.

Item	Statements	Never	Not much of the time	Some of the time	Quite a lot of the time	All of the time
1	I think good things will happen in my life	1	2	3	4	5
2	I have always told the truth	1	2	3	4	5
3	I've been able to make choices easily	1	2	3	4	5
4	I can find lots of fun things to do	1	2	3	4	5
5	I feel that I am good at some things	1	2	3	4	5
6	I think lots of people care about me	1	2	3	4	5
7	I like everyone I have met	1	2	3	4	5
8	I think there are many things I can be proud of	1	2	3	4	5
9	I've been feeling calm	1	2	3	4	5

10	I've been in a good mood	1	2	3	4	5
11	I enjoy what each new day brings	1	2	3	4	5
12	I've been getting on well with people	1	2	3	4	5
13	I always share my sweets	1	2	3	4	5
14	I've been cheerful about things	1	2	3	4	5
15	I've been feeling relaxed	1	2	3	4	5

The Stirling Scale Key

Wellbeing Sub-components and Related Items

Wellbeing sub-component	Item	Related item on the Stirling Scale
Positive Emotional State	9	I've been feeling calm
	14	I've been feeling cheerful about things
	15	I've been feeling relaxed
	10	I've been in a good mood
	12	I've been getting on well with people
	11	I enjoy what each new day brings

Positive Outlook	8	I think there are many things I can be proud of
	5	I feel that I am good at some things
	1	I think good things will happen in my life
	4	I can find lots of fun things to do
	6	I think lots of people care about me
	3	I've been able to make choices easily
Social Desirability	2	I have always told the truth
	7	I like everyone I have met
	13	I always share my sweets

Each Item is scored 1 to 5.

Overall scores of 3 or 14/15 on the **Social Desirability Sub-Scale** would indicate that the participant's wellbeing scores should be treated with caution (Liddle & Carter, 2015). However, please note that the social desirability sub-scale is not a necessary part of administering the scale and will not be used in the current study.