November 2025 | **Report**

A pilot randomised controlled trial

WEMATTER

Foundations
What Works Centre for Children & Families

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About Foundations – What Works Centre for Children & Families

Foundations, the national What Works Centre for Children & Families, believes all children should have the foundational relationships they need to thrive in life. By researching and evaluating the effectiveness of family support services and interventions, we're generating the actionable evidence needed to improve them, so more vulnerable children can live safely and happily at home with the foundations they need to reach their full potential.

About Verian

Verian is a world leading, independent research, evidence, evaluation, and communications agency, providing services to government and the public realm. We work with our clients to help solve the next generation of public policy challenges.

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TERMS/ABBREVIATIONS & ACRONYMS

Table 1. Summary of terms, abbreviations, and acronyms used in the report

Abbreviation/acronym/term	Description
CBT	Cognitive behavioural therapy
CI	Confidence interval
CYP	Children and young people
FSM status	Free school meal status
ICC	Intracluster correlation
IE	Impact evaluation
IPE	Implementation and process evaluation
ITT	Intention to treat
RCT	Randomised controlled trial
SE	Standard error
ToC	Theory of change
TOT	Treatment on the treated

EXECUTIVE SUMMARY

Introduction

Domestic abuse is estimated to affect one in five children and is the most common reason for referral to children's social care. It has a negative impact on a wide range of outcomes, which can be mitigated by timely support for children and young people (CYP) who are victim-survivors.

WeMatter is a digital, group-based support service for CYP who have been affected by domestic abuse, but are not classified as at high risk of harm and are not currently experiencing harm or living with the alleged perpetrator. It is run by the charity Victim Support. As well as the potential therapeutic advantages of a digital group-based intervention, these features may help to alleviate the high demand for services and could present a cost-effective solution for CYP who are not classified as at high risk.

Therefore, supported by the Evaluation Accelerator Fund, which is managed by the UK Cabinet Office's Evaluation Task Force, Foundations commissioned Verian to conduct an independent pilot evaluation of WeMatter.

Impact evaluation

Objectives

The pilot impact evaluation (IE) sought to answer the following research questions:

1. Can the impact evaluation design be improved?
2. What effect did WeMatter have on CYP's mental wellbeing compared to those who were allocated to no intervention (a waitlist control)?
3. Did the effect of WeMatter on CYP's mental wellbeing at Week 10 of the intervention vary by age group and preferred setting of WeMatter delivery (school vs home)?

Protocol overview

The evaluation was a two-armed partially nested randomised controlled trial (RCT) comparing WeMatter provision (treatment) to no intervention (waitlist control). It was 'partially nested' because participants in the treatment arm received the intervention in groups or 'clusters', whereas the control participants were not clustered. The treatment arm began WeMatter immediately (two to four weeks after referral), and the waitlist control arm received WeMatter approximately 12 to 14 weeks after referral.

Recruitment through pre-existing referral pathways started in April 2024 and the first CYP were randomised on 5 June 2024. WeMatter sessions for the treatment arm ran from 17 June 2024 to 9 May 2025, and for the control arm from 26 August 2024 to 18 June 2025. The last endline data was collected on 3 June 2025.

The primary outcome was mental wellbeing, as measured by the Stirling Children's Wellbeing Scale (Stirling Scale). Victim Support collected this measure at two time points, which corresponded to the beginning and end of the 10-week period in which the treatment arm received the intervention. The first served as a baseline and the second timepoint was the primary outcome.

The primary analysis was an intention to treat (ITT) analysis examining the effects of WeMatter on participants' Stirling Scale score. Our analytical strategy reflected the design of the trial, using partially nested heteroscedastic mixed-effects linear regression models for RCTs with clustering in the treatment arm but not in the control.

The trial was granted ethical approval by Verian's Research Ethics Panel, which is independent from the project team. Consent was taken from parents and then again (using age-appropriate materials) from CYP.

Key findings

Evaluation design

The referral pipeline was insufficient to achieve the target sample size of 752 CYP. There was a need to (re-)establish referral networks, which hampered recruitment early in the trial. Attrition was high, with only 53% of those randomised being eligible for analysis. The main reasons for attrition were missing endline data, complications with the blocked design arising from the need to move CYP between groups, and critical deviations from the evaluation protocol on randomisation and data collection.

Missing endline data was particularly concerning, because it appeared to occur more often in the treatment arm than in the control, and particularly for those CYP who were least engaged with the intervention. It therefore presents a serious risk of bias.

As a result, we recommend a number of measures aimed at making trial procedures simpler and shifting the burden of the evaluation from the intervention delivery partner to the evaluator.

Effects of the intervention

Among CYP eligible for analysis, the Stirling score at endline was 45.93 (SD: 7.30) in the treatment arm, compared with 42.07 (SD: 7.35) in the control arm.

The primary ITT analysis found a statistically significant effect of WeMatter on endline Stirling scores, when accounting for baseline (fixed-effect coefficient: 4.62; SE: 1.07; 95% CI: 2.49 to 6.76; $p < .001$). This is equivalent to a standardised effect size of 0.74, expressed as Glass's Delta, which is a moderate effect. However, the patterns of missing data in this trial give good cause for caution about the robustness of its headline estimates of impact.

In both school and home settings, mean endline Stirling scores were numerically greater in the treatment arm (school mean: 46.24, SD: 6.73; home mean: 44.53, SD: 9.59) than in the control arm (school mean: 42.14, SD: 7.22; home mean: 41.67, SD: 8.40).

Implementation and process evaluation

Objectives

The implementation and process evaluation (IPE) had the following aims:

1. To assess the extent to which WeMatter was implemented according to the intervention protocol, and the perceptions of staff, stakeholders (e.g. schools, local authorities), parents/carers, and CYP with regard to the implementation of WeMatter to inform how the intervention can be improved.
2. To assess the extent to which WeMatter was perceived to achieve the expected outcomes.
3. To assess the theory of change (ToC) underpinning WeMatter.
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/carers, and CYP, to inform how the evaluation design can be improved and scaled up.

Protocol overview

The IPE involved a mix of in-depth interviews and group discussions, with: CYP who took part in WeMatter, parents/carers of CYP who attended WeMatter, CYP who were on the waitlist, parents/carers of control arm CYP, WeMatter facilitators, WeMatter triage staff, WeMatter project leaders and Victim Support leaders, and stakeholders (Rock Pool representative, local school, local authority). A total of 47 participants were included across the interviews and group discussions. Qualitative data was complemented by administrative data – for example, to assess dosage of the intervention based on session attendance data.

A purposive sampling approach was used for interviews with CYP and parents/carers to ensure representation of a range of characteristics, including gender, age, course setting (i.e. home or school), ethnicity, free school meal status, and area. Interviews with CYP used a trauma-informed approach to ensure they were sensitive to CYP needs and preferences. Topic guides were adapted depending on the age of the CYP. Consent materials were age-appropriate and parents consented as well as CYP.

Qualitative analysis used a flexible deductive-inductive framework approach, which involved summarising data from the interviews in a thematic framework, whose structure was updated as analysis progressed to accommodate emerging themes and patterns. Administrative data was analysed using descriptive statistics.

Key findings

WeMatter was mostly delivered with fidelity: pre-engagement activities and the main 10-session block were delivered as planned in terms of the number and frequency of sessions, the content covered in those sessions, and the approach used. Where there were any deviations, they were due to challenges in terms of securing certain service inputs – for example, sufficient referrals, CYP's digital access to the service, or stable facilitator staff resource. To ensure that the service works as

intended, it will be critical that these inputs are consistently available, as otherwise key service mechanisms could be weakened.

WeMatter was perceived to be effective in achieving its intended outcomes, including all priority outcomes. Key outcome areas where improvements were reported by CYP, parents/carers, and facilitators concerned CYP's understanding of healthy and unhealthy relationships, their ability to manage their emotions, feeling supported, and overall improved mental wellbeing. These findings suggest that most priority outcomes are well defined in the ToC and adequately reflect the perceived impact of WeMatter, although a few minor adjustments to a couple of outcomes were also suggested.

Certain aspects of the evaluation were conducted as intended and perceived to work well, while others involved deviations from the planned approach and posed challenges. Most notably, the waitlist design was felt to be acceptable to parents/carers and CYP, and outcome questionnaires easy and relevant to complete. The main challenges concerned the 'blocked' randomisation approach, which staff felt undermined service flexibility in scheduling WeMatter groups, as well as service delivery staff being responsible for data collection and management, which posed significant workload pressures. The main deviations and issues resulting from these challenges included: CYP being randomised more than once or re-allocated across WeMatter groups; no endline data being collected from CYP who withdrew from the service; and difficulties ensuring data quality.

Cost evaluation

Objectives

The cost evaluation aimed to answer the following research questions:

1. What was the total cost of running the WeMatter service for a year?
2. What was the average cost per CYP accepted to receive WeMatter during the trial?
3. What is the cost of introducing WeMatter to a new local authority (start-up costs)?
4. What are the estimated values of the prerequisites for running WeMatter?

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

Protocol overview

We collected cost data for delivering the service from 3 June 2024 until 3 June 2025 from Victim Support. We broke cost items down between recurring costs, prerequisites, and start-up costs. New cost items that were identified during the delivery period and the process and implementation evaluation were categorised and added. Items categorised as costs to other public services and costs to wider society were estimated using information gathered during the interviews with the relevant stakeholders.

Key findings

The total estimated cost of running the WeMatter service for a year during the pilot trial was £329,075, and the overall cost including activities needed for the evaluation was £430,323. The estimated delivery costs are not expected to change after the trial, apart from increases in staff costs due to increases in National Insurance.

The average cost per CYP randomised during the trial period (excluding the costs associated with the evaluation) was £329,075 / 312 = £1,054.73. The complexity of the trial, staff turnover (possibly linked to trial requirements), and the lower number of referrals especially in the first months of the trial meant that the cost per CYP randomised into the trial was higher than Victim Support's original estimate of £500 per CYP. That estimate was based on Victim Support's planned capacity to delivery the service to 752 CYP during the trial period.

Although it is difficult to assess the cost of introducing WeMatter to a new local area (including building referral pathways), we estimate this to be approximately £22,000. There are no major prerequisites for Victim Support to deliver WeMatter, other than referral pathways. However, Victim Support already has established referral pathways for other services that it provides, which could also be used for WeMatter.

Synthesis

Both the IE and the IPE found evidence of promise that WeMatter has the potential to improve mental wellbeing. These results are also supported by the results of Victim Support's previous internal pilot, which found a 'large' effect on mental wellbeing, as measured by the Short Warwick–Edinburgh Mental Wellbeing Scale. However, although triangulating these data sources shows that they reinforce each other, all three sources are biased towards those who stayed engaged with the WeMatter programme and completed the intervention (including providing endline data).

The most crucial thing for increasing the likelihood of effectiveness of the intervention in the future will be to make sure that the inputs are all available:

- **Sufficient recruitment to support the formation of age-banded groups:** Group size was often smaller than the target of eight CYP. The service recruited most participants in the youngest age band (8–12) and few CYP in the older age band (16–17), and the older CYP were also less likely to be retained.
- **Continuity of facilitators:** There was high turnover of facilitators.
- **Availability of settings (especially during the school holidays):** The school setting was more popular than home, which may reflect more referrals from schools. In a scaled-up trial, it will be important to investigate whether there is a differential impact in school and home settings, as well as any differential attrition.

Pragmatic recommendations and next steps

WeMatter showed evidence of promise: it has the potential to be effective. It would be feasible to conduct a full-scale trial. To test the intervention in a full trial, we recommend the following changes:

- **Recruitment:** Implement a funded period of at least three months before the trial starts, to allow Victim Support time to set up referral pipelines.
- **Sample size/power:** Victim Support will need to recruit 992 CYP if aiming for a standardised effect size of 0.2 (conventionally considered 'small').
- **Timings and settings:** Take into account the fact that school-based groups are only able to operate during term time, when triaging and allocating CYP; school availability is likely to be a key constraint on future research.
- **Randomisation:** Simplify the randomisation by removing the blocking, and set baseline and endline collection to occur a fixed number of days after consent or randomisation.
- **Data management and monitoring:** Establish a 'trial manager' role dedicated to managing the trial's processes, including responsibility for all data management; wherever possible, data management should be automated and centralised.
- **Collection of outcome measures:** Have the outcomes taken by independent assessors, who are not involved in delivery of the intervention; explore the possibility of offering a cash or voucher incentive for completing the baseline and endline measures; establish a clear procedure for staying in touch with participants who drop out of the intervention but who do not withdraw consent for follow-up.

INTRODUCTION

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; Hughes et al., 2017); social outcomes, such as poor social networks and disaffection with education (Children's Commissioner, 2018; Kitzmann et al., 2003); and physical outcomes, such as eating problems and stress-related conditions (Calder & Regan, 2008; Hughes et al., 2017).

Research suggests that providing timely support for children and young people (CYP) who are victim-survivors of domestic abuse can mitigate or avert negative outcomes (Mullender et al., 2002). It 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 victim-survivors, 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, leaving CYP who have experienced abuse but are not classified as at high risk unable to benefit from support. Support services are often oversubscribed and can have waiting lists spanning several months. Out of the 317 service providers surveyed for the 'A Patchwork of Provision: how to meet the needs of victims and survivors across England and Wales' report for the Domestic Abuse Commissioner, 26% had waiting lists exceeding one month, with 4% of services having waiting times in excess of six months (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. 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 if they improve outcomes. Where published evidence does exist, it is often not rigorous because it is 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-based support service for CYP who have been affected by domestic abuse, but are not classified as at high risk of harm and are not currently experiencing harm or living with the alleged perpetrator. Developed by Victim Support (a specialist independent charity service provider), it was launched as a pilot in Devon, Cornwall, Staffordshire, Warwickshire, and

Brent (London) in September 2022, ending in March 2024.[1] The service utilises the CYP Domestic Abuse Recovery Toolkit developed by Rock Pool, the UK's leading trauma-informed recovery service for adults and CYP that have experienced or witnessed domestic abuse.[2] WeMatter applies the Rock Pool Toolkit digitally in a group context. Distinctive features include that it is:

- Group-based (social) – incorporating specific targeted activities, games, and discussions that use simple cognitive behavioural therapy (CBT); and allowing CYP to access peer support.
- Digital – enabling CYP to obtain support regardless of their location.

There is a wealth of evidence that CBT is effective at improving the psychological wellbeing of adult victim-survivors of domestic abuse (Guillermo-Anasicha et al., 2022; Tirado-Muñoz et al., 2014; Trabold et al., 2020). There is some preliminary evidence that it is an effective and cost-effective intervention to treat children and adolescents, albeit with a large degree of uncertainty and a significant heterogeneity of study results, with studies often having a high or unclear risk of bias (Spencer et al., 2023).

There is less evidence about the group-based and digital elements of WeMatter, and little that directly relates to CYP. One study in the review of CBT for children and adolescents showed that group therapy had a positive effect, but the study had a small sample size and short follow-up period (McWhirter, 2011). There is some evidence for digital interventions in adults, but it is hard to interpret because the interventions being compared can be very different and the comparison groups vary. One meta-analysis that compared digital interventions for intimate partner violence to no-intervention controls found no effect, but that only covered five trials, which had high heterogeneity (Linde et al., 2020).

As well as any potential therapeutic advantages, the group-based and digital nature of the intervention may help to alleviate the high demand for services, because 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 at high risk.

Therefore, supported by the Evaluation Accelerator Fund, which is managed by the UK Cabinet Office's Evaluation Task Force, Foundations commissioned Verian to conduct an independent pilot evaluation of WeMatter, consisting of a pilot randomised controlled trial (RCT) and an implementation and process evaluation (IPE). The main aims of the pilot evaluation were:

[1] Further details on pilot of the WeMatter service can be found in the WeMatter Intervention Protocol, published on Foundations' website: https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-intervention-protocol.pdf

[2] Rock Pool supports 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. Its innovative, practical solutions and training opportunities are informed by lived experience and what is known to work. The services include programmes for adult victim-survivors and a domestic abuse recovery toolkit designed specifically for CYP that was adopted by Victim Support for the WeMatter service.

1. To evaluate the intervention's theory of change (ToC) 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 (probably an RCT).

To do this, Verian conducted a pilot impact evaluation (IE), a full IPE, and a cost evaluation. We randomised participants into treatment and control arms to help 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?
7. How can the evaluation be improved?

These evaluation questions were adapted to be more specific to WeMatter and to reflect the aims of the pilot trial. The focus of the pilot was not on providing robust estimates to answer Questions 1, 2, 3, and 5, but rather on trialling 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 were monitored and reviewed by Verian, Victim Support, and Foundations throughout the evaluation, including at progress review meetings in July and September 2024, and recommendations for a full-scale RCT are provided in this report.

Foundations provided further 'bridge funding' to cover further delivery and evaluation of WeMatter from 8 May to 30 September 2025. Findings from the evaluation activities during this bridge funding period are in 'Appendix H: Learnings from the bridge funding test and learn period'.

WHAT IS WEMATTER?

WeMatter is a recovery service for children and young people affected by domestic abuse. The intervention was designed by Victim Support in consultation with Rock Pool and its key characteristics are outlined in this section. A more detailed description of the intervention can be found in the Intervention Protocol.[3]

Why?

WeMatter aims to improve the wellbeing of CYP who have been affected by domestic abuse but are not classified as being at high risk of harm from the perpetrator or due to neglect, and are between the ages of 8 and 17 at the time of referral to Victim Support (by e.g. police, social workers, or schools). WeMatter was designed to help CYP understand their own experiences of domestic abuse, develop healthy coping strategies, increase their feelings of safety, and improve their wellbeing.

Research suggests that providing timely support for CYP who are victim-survivors of domestic abuse can mitigate or avert negative outcomes (Mullender et al., 2002) and that CBT is effective for both adults and children (Guillermo-Anasicha et al., 2022; Spencer et al., 2023; Tirado-Muñoz et al., 2014; Trabold et al., 2020; Warshaw et al., 2013). WeMatter is distinctive in being group-based, and therefore offering peer support; and in being digital, enabling CYP to obtain support regardless of their location. There is little evidence specifically on these features, especially for CYP.

WeMatter was a recovery service and was therefore only able to support CYP who were no longer experiencing domestic abuse and no longer living with the alleged perpetrator of the abuse.

What? (Materials and procedures)

The 10-week intervention was developed based on Rock Pool's CYP Domestic Abuse Recovery Toolkit.[4] It made use of trauma-informed cognitive behavioural therapy techniques, incorporating specific targeted activities, games, and discussions.

The intervention consisted of eight weekly one-hour group sessions, delivered by two specialist facilitators, with an introductory and concluding one-to-one session for each CYP and their facilitator. CYP were triaged within 48 hours of referral, and then began the 10-week programme (ideally within the next two weeks). CYP who engaged with at least five sessions (excluding the introductory and concluding sessions) were considered to have completed the programme.

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[3] The WeMatter Intervention Protocol includes further detail on the intervention and its delivery (including how Victim Support works with schools to facilitate school-based sessions), and can be found at: https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-intervention-protocol.pdf.

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

The CYP toolkit sessions followed a pre-determined order and modular 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.

Facilitators also provided one-to-one support whenever needed, and corresponded with CYP outside sessions to check in and encourage CYP's engagement in the following sessions. During the intervention CYP also completed non-mandatory home tasks before and after each session.

To qualify for the intervention CYP needed to have digital access and competency (with support from a trusted adult if needed), though during the pilot RCT there was a small pot of funding available from Victim Support to purchase IT equipment for families. As the intervention was delivered in English, the CYP also had to be proficient in English (which was assessed with the safe parent/carer in the triage call).

Who provided?

The intervention was delivered by Victim Support, an independent charity in England and Wales that provided specialist practical and emotional support to victim-survivors and witnesses of crime. The WeMatter team consisted of managers, triage officers, and a group of WeMatter facilitators who engaged with CYP and parents/carers, and who delivered the sessions:

- CYP National Lead – acted as the programme's lead and subject matter expert
- Operations Manager – was responsible for the operational delivery of WeMatter
- Triage and Early Interventions Officers – were responsible for assessing suitability of referrals, completing initial needs and risk assessments, and engaging CYP and parents in the evaluation
- Project Leads – were responsible for managing facilitators, service development, partner relationships, and referral pathways
- CYP Programme Facilitators – delivered the programme sessions with support from project leads.

All facilitators were accredited by Rock Pool in the delivery of the trauma-informed psycho-educational CYP Domestic Abuse toolkit. All Victim Support staff had completed mandatory safeguarding training, and the WeMatter team had also received internal CYP training, which highlighted the risk of engaging in digital support and potential online harms, as well as additional training on neuro-divergence and on gathering insights from CYP focus groups.

How?

The intervention was delivered digitally through Zoom. The target group size was eight CYP, but there could be groups of up to 12.

Where?

CYP could join from school or from their home. CYP and parents/carers indicated their preferred setting, which correlated with the timing of the sessions (during or outside the school day), and Victim Support worked with schools (and sometimes social workers) to help CYP attend sessions in private locations and on time.

Where? (Local areas)

Victim Support operated WeMatter in five areas between 2022 and 2024: Devon, Cornwall, Staffordshire, Warwickshire, and the London Borough of Brent. For the evaluation, the service was expanded to be England-wide, in order to increase the potential sample and widen the pipeline with a much wider referral network.

When?

The intervention consisted of eight weekly one-hour group sessions, delivered by two specialist facilitators trained to deliver the Rock Pool Toolkit, with an introductory and concluding one-to-one session for each CYP and their facilitator (in the week or two before and after the group sessions).

Tailoring?

Groups were formed based on CYP's preferred delivery setting (school or home) as well as their age (8–12, 13–15, or 16–17), to account for differences in the developmental stages of the CYP, and allow the content and activities in the group sessions to be tailored to age.

The activities, games, and discussions could be adapted to accommodate CYP's support needs (e.g. neurodiversity, reading difficulty). The facilitators could also tailor and personalise elements of the delivery based on CYP needs and preferences.

Modifications?

The intended duration of each group, which should start within two weeks of CYP referral, was 10 weeks. Due to a lower number of referrals than expected in the first three months of the trial, during the project review meeting between Verian, Victim Support, and Foundations in September 2024, we agreed with Victim Support to increase the waiting time from referral to start of the

group sessions from two weeks to four weeks. No other modifications of the intervention occurred during the study.

How well?

The groups were supposed to consist of eight participants in order to offer the peer support that is part of this intervention. Verian monitored this using administrative data collected by Victim Support, including on randomisation, group allocations, and attendance. We found that groups were often smaller (the mean group size was 4.7 CYP for those randomised). The age cohorts of the groups were sometimes altered, depending on demand – for instance, having groups of 13–16 year olds.

When we investigated fidelity in the IPE, we found that CYP' sometimes did not have concluding one-to-one sessions if they were difficult to schedule, and it is not clear how widely home tasks were used. More details are in the section on 'Implementation and process evaluation'.

PARTICIPANTS

Trial flow

The projected data in Table 2 was provided by Victim Support and covers England. The actual data is from the current evaluation. For more information about the trial participant journey, see Figure 6.

Table 2. Trial flow

	Projected	Actual
1. Estimated size of the eligible population	481,400	Unknown
→ 2. Of those, estimated number of CYP from a minority ethnic background	120,350 (25.0%)	Unknown
3. Estimated number of referrals	1,500 (0.3%)	453
→ 4. Of those, estimated number of CYP from a minority ethnic background	450 (30.0%)	This data is not available for the whole referred sample (only for those who consented to participate in the trial)
5. Estimated number of CYP who consented to be randomised	1,008 (67.2%)	312 (68.9%)
→ 6. Of those, estimated number of CYP who were marked 'yes' for disability or had ethnicity other than 'White'/'prefer not to say'	302 (30.0%)	170 (54.5%)
7. Estimated number of CYP across treatment and control arms who completed at least five sessions	736 (73.0%)	167 (53.5%)
→ 8. Of those, estimated number of CYP who were marked 'yes' for disability or had ethnicity other than 'White'/'prefer not to say' from the subset of CYP who completed at least five sessions	221 (30.0%)	85 (50.1%)

	Projected	Actual
9. Estimated number of CYP across treatment and control for whom we have outcome data that is included in the analysis	721 (71.5%)	165 (51.4%)
10. Of those, estimated number of CYP who were marked 'yes' for disability or had ethnicity other than 'White'/'prefer not to say'	261 (36.2%)	60 (36.4%)

Note. Projected figures were provided by Victim Support in its proposal for funding to Foundations.

Descriptive statistics

Participants randomised into the trial (n = 312) were roughly evenly split between male (49.7%) and female (50.0%), with one transgender participant. They were mainly from the youngest age groups (born from 2012 to 2016: 61.9%), with few from the older age group (born from 2007 to 2008: 8.0%). The majority of participants were White (74.7%), but there was a sizeable proportion of Asian (10.6%) and Mixed participants (10.9%); 35.9% had a disability and 67.3% were eligible for free school meals (FSM). Referrals were from all over England, with most coming from the West Midlands (50.5%), followed by the south-west (23.7%). The referral forms were most often completed by staff from other Victim Support services (following the same process as external agencies) (34.0%), followed by staff from local authorities (28.2%), and then schools (15.7%). The main delivery setting was in school (71.5%). The full breakdown of participant demographics and other characteristics is in Table 3.

Table 3. Breakdown of characteristics for the CYP whose parents/carers consented to taking part in WeMatter

Participant characteristic	Randomised CYP (n = 312)
Gender	
Female	156 (50.0%)
Male	156 (50.0%)
Sex	

Participant characteristic	Randomised CYP (n = 312)
Female	157 (50.3%)
Male	153 (49.0%)
Missing	2 (0.6%)
Year of birth	
2007–2008	25 (8.0%)
2009–2011	94 (30.1%)
2012–2016	193 (61.9%)
Ethnicity	
Asian	33 (10.6%)
Black	8 (2.6%)
Mixed	34 (10.9%)
White	233 (74.7%)
Other ethnic group	3 (1.0%)
Prefer not to say	1 (0.3%)
Disability	
Has one or more disabilities[a]	112 (35.9%)

Participant characteristic	Randomised CYP (n = 312)
FSM status	
Has FSM status	210 (67.3%)
Does not have FSM status	95 (30.4%)
Prefer not to say	1 (0.3%)
Missing	6 (1.9%)
Public care status	
Looked-after child	4 (1.3%)
Main language	
English	308 (98.7%)
Other	4 (1.3%)
Engagement with other support	
Engaged with other support	202 (64.7%)
Referral source	
School	49 (15.7%)
GP/health	11 (3.5%)
Internal Victim Support	106 (34.0%)

Participant characteristic	Randomised CYP (n = 312)
Local authority	88 (28.2%)
Other agency	30 (9.6%)
Police	2 (0.6%)
Referral by parent/guardian	26 (8.3%)
Delivery setting	
Home	88 (28.2%)
School	223 (71.5%)
Home/school	1 (0.3%)
Region of England	
North-east	4 (1.3%)
North-west	26 (8.3%)
Yorkshire and The Humber	16 (5.1%)
East Midlands	12 (3.8%)
West Midlands	156 (50.0%)
East of England	13 (4.2%)
London	7 (2.2%)

Participant characteristic	Randomised CYP (n = 312)
South-east	4 (1.3%)
South-west	74 (23.7%)

[a.] A CYP would be marked as having a disability if they fell into one of the following categories: blind or partially sighted, deaf (Sign Language user), disclosed mental health problem, hearing impaired, ill health, physical frailty, learning difficulty, neurodiverse condition (e.g. autism, dyslexia), other long-term health condition, physical disability, other vulnerability.

Implications for the evaluation

The achieved sample size was lower than planned, so the main analysis may be underpowered. This is especially true of sub-group analyses. Foundations and Verian therefore agreed to reduce the number of exploratory inferential analyses from those planned in the evaluation protocol[5] and instead to report descriptive statistics for sub-group comparisons. The trial is a pilot and was not intended to produce a sample that is representative of the target population. Therefore, we do not consider the sample's demographic breakdown except when considering balance between trial arms, or descriptively exploring sub-group differences including the features of completers and non-completers (see Table 4).

The high rate of attrition (see Figure 6) between randomisation and analysis means there is a risk of bias in headline impact estimates. We address this risk in our discussion of the robustness of the impact evaluation's findings.

[5] See: https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-evaluation-protocol.pdf

IMPACT EVALUATION

Evaluation questions

The research questions that the pilot IE sought to answer were:

1. Can the impact evaluation design be improved?
2. What effect did WeMatter have on CYP's mental wellbeing at Week 10 of the intervention (final week after the completion of all eight group sessions) measured using the Stirling Children's Wellbeing Scale, compared to those who were allocated to no intervention (a waitlist control)?
3. Did the effect of WeMatter on CYP's mental wellbeing at Week 10 of the intervention 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)?

Evaluation design overview

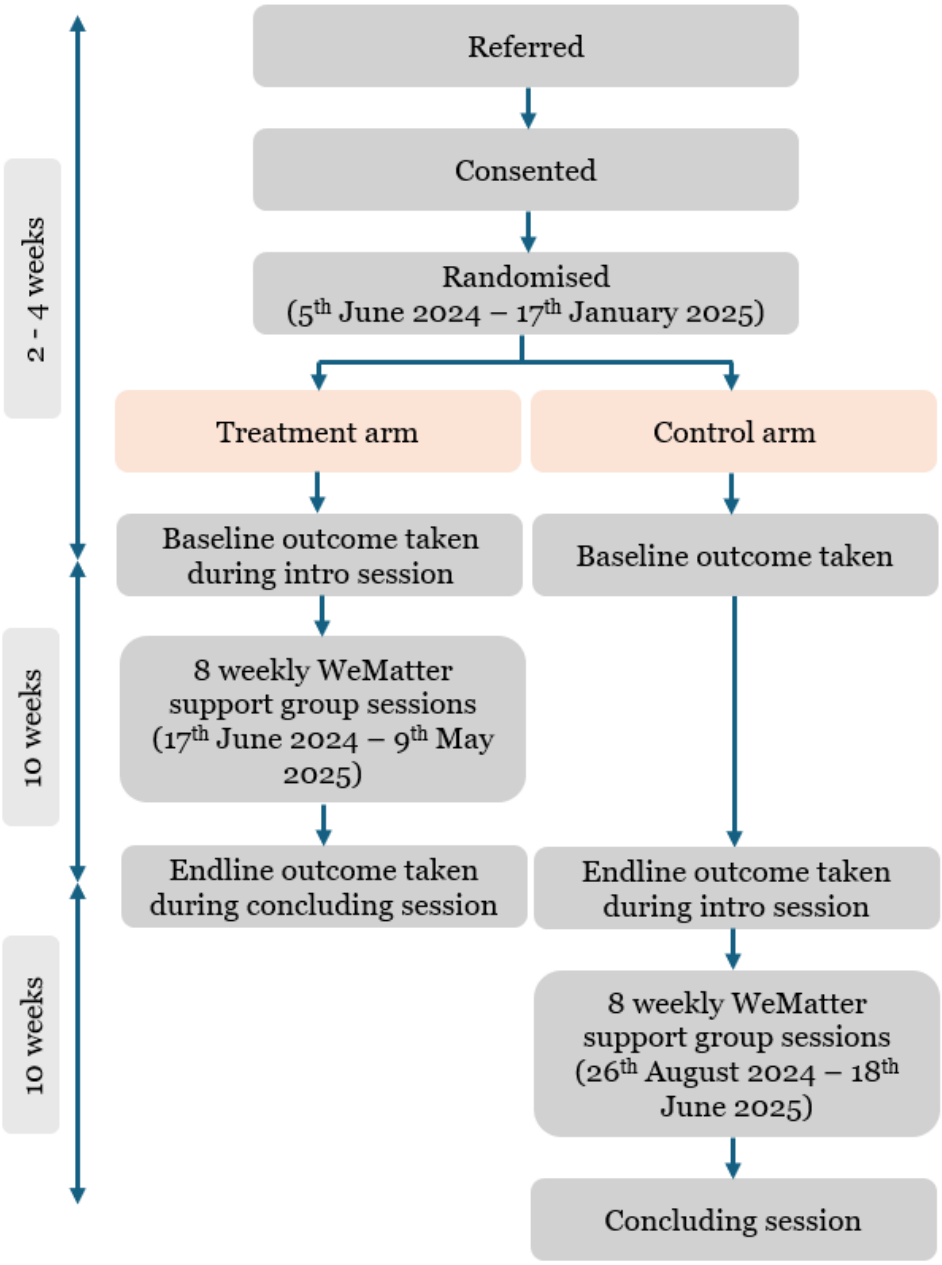
The evaluation was a two-armed partially nested RCT comparing WeMatter provision ('treatment') to no intervention using a waitlist control ('control'). It was 'partially nested' because participants in the treatment arm received the intervention in groups, causing clustering of outcomes, but there was no clustering for those in the control arm (Lohr et al., 2014). The treatment arm began WeMatter immediately (two to four weeks after referral), and the control arm received WeMatter approximately 12 to 14 weeks after referral. Victim Support collected a questionnaire measure of wellbeing at two time points, which corresponded to the beginning and end of the 10-week period in which the treatment arm received the intervention (the introductory and concluding one-to-one sessions for the treatment arm). The control arm attended a specific baseline data collection call with Victim Support, with endline data being collected during their introductory one-to-one session (after they completed the waitlist and as they were about to start WeMatter). The trial's primary outcome was CYP wellbeing in the two arms at the second timepoint ('endline') (Figure 1).

Recruitment through pre-existing referral pathways started in April 2024 and the first CYP were randomised on 5 June 2024. WeMatter sessions for the treatment arm ran from 17 June 2024 to 9 May 2025 and for the control arm from 26 August 2024 to 18 June 2025. The last endline data was collected on 3 June 2025 (Figure 1).

A full description of the evaluation design and methodology is available in the evaluation protocol.[6]

[6] See: https://foundations.org.uk/our-work/current-projects/a-pilot-randomised-controlled-trial-of-wematter

Figure 1. Participant journey for consented CYP in treatment and control arms (go to accessibility text)



Recruitment and consent

We adapted Victim Support's usual triage process to allow enough time for parents/carers to understand the requirements of the trial and give informed consent. Recruitment began when the CYP was referred to Victim Support. CYP could be referred to Victim Support by various sources,

such as the police, GPs, schools, social services, or charities. Detail of the source of referrals during this trial are in Table 3.

Within 48 hours of a referral, a Victim Support triage officer conducted a triage call with the CYP's safe parent/carer or the CYP themselves. The triage officer recorded details about the CYP and other services the CYP was engaging with, assessed their risks and needs, confirmed their eligibility for WeMatter, and provided the parents/carers and CYP with details about Victim Support's services.

After the triage call, Victim Support shared written materials about the intervention and trial with the parent/carer, including associated data collection and processing. A few days later, a Victim Support facilitator re-contacted the parent/carer by phone to confirm that they had read and understood the written materials, and to collect consent. CYP whose parents/carers consented were then randomised immediately on the call.

The process from initial referral to randomisation is shown in Figure 2.

Figure 2. Process from referral to randomisation (go to accessibility text)

More details about the referral and triage process (e.g. what happened for CYP not wanting to take part or not suitable for a digital service) as well as the risk assessment and safeguarding measures are in the WeMatter intervention protocol.[7]

Randomisation

The trial used a blocked randomisation design, which assigned CYP to 'blocks' according to their age cohort and preferred delivery setting, and allocated them to treatment or control arms with equal probability within their block. Under this design, all the treatment arm CYP in a given block would join the same WeMatter sessions, and the whole block (i.e. both arms) would have baseline and endline measures taken at/around the same points in time. We planned for each block to contain 16 CYP (i.e. eight in each trial arm), with an expected minimum block size of 12 so that WeMatter groups would always have at least six members.

There were two practical challenges the randomisation process needed to address: (i) participants were recruited one by one as referrals came in, so it was not possible to randomise the whole sample all at once, pre-trial, and (ii) Victim Support needed to carry out the randomisation during the second call, after obtaining parental consent (see Figure 2).

[7] See: https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-intervention-protocol.pdf

To solve these issues, we devised an Excel randomisation sheet containing 47 blocks of 20 pre-generated participant IDs that we had pre-randomised. We randomised the first 16 IDs independently of the last four, so that a block of 16 CYP would always contain exactly eight CYP in each trial arm. Figure 3 shows an example of an unfilled randomisation block.

Figure 3. Example of an unfilled block from our randomisation sheet. Number, CYP ID, and group assigned were pre-generated by Verian. The group ID was the block number plus a letter indicating allocation to trial arm (go to accessibility text)

Block number 46					
Facilitator 1				Immediate group	TBC
Facilitator 2				Waitlist group	TBC
Setting				Bookings closing	TBC
Age					
Number	CYP ID	Group assigned	Group ID	Time of call	Date of call
1	8739	immediate_start			
2	2435	immediate_start			
3	5013	waitlist			
4	5900	immediate_start			
5	7386	waitlist			
6	5102	immediate_start			
7	9711	immediate_start			
8	5894	waitlist			
9	5813	immediate_start			
10	8798	waitlist			
11	9983	waitlist			
12	2653	immediate_start			
13	1426	waitlist			
14	1862	immediate_start			
15	9353	waitlist			
16	4198	waitlist			
17	5361	waitlist			
18	8879	immediate_start			
19	2715	waitlist			
20	9503	immediate_start			

Before recruiting any CYP into a new block, Victim Support decided the setting (school/home) and age cohort for that block. This meant they could vary the blocking to conform to delivery considerations. For example, the number of blocks for each age cohort would reflect the ages of

CYP being referred to them; and they could recruit into multiple blocks with the same age cohort and delivery setting, for WeMatter groups on different days of the week.

During the second call with the parent/carer, Victim Support determined which block the CYP was suitable for based on their age and preferred WeMatter delivery setting. Then, if they obtained consent, they entered the participant into that block in the randomisation sheet, using the first unfilled row.

Recruitment into a block closed either when the block was full or after approximately two weeks had elapsed since the first CYP had been entered into it. This was to ensure that CYP in the treatment arm began their WeMatter sessions promptly. Following the September 2024 review, this interval was extended to approximately four weeks to accommodate slower-than-expected recruitment.

Primary outcome

The primary outcome measure was the Stirling Children's Wellbeing Scale (Stirling Scale), which was chosen to measure the priority outcome in the ToC of 'improving CYP wellbeing' (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. It is validated for use with children aged 8–15 years old (Liddle & Carter, 2015). We expected this age range to cover most participants in the trial, since according to data supplied by Victim Support, in the last quarter of 2023, 53% of WeMatter beneficiaries were aged 8–11 years, 27% aged 12–14 years and 20% aged 15–17 years.

The Stirling Scale consists of 12 items, each with 5-point Likert response scales, with response options that range from 'Never' (1) to 'All of the time' (5) (for the full list of items covered see 'Appendix A: The Stirling Children's Wellbeing Scale'). 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 (Liddle & Carter, 2010).

Victim Support collected the primary outcome on a one-to-one Zoom call with the CYP. To ensure the measures were sensible for participants and could be delivered via Zoom, we tested the primary outcome measure and materials with the WeMatter youth advisory group prior to their implementation.

At the outset of the trial, we planned for the data collection calls to be led by the CYP's assigned group facilitator, at Victim Support's request. The rationale for this was that the facilitator would be well placed to create a safe environment for the CYP. Victim Support stressed the importance of building rapport and making risk assessments, the sensitive nature of the questions, and the Rock Pool guidance that individual assessments should be done by a facilitator. It was also logistically challenging to arrange for an additional person to join the individual assessments, or liaise with CYP and parents to set up a separate data collection session.

However, this meant it was impossible to blind the person collecting the data to the CYP's trial arm. See the 'Deviations from the protocol' section for more information. It also created a difference between the trial arms that could cause bias in any impact estimates because, by the end

of the trial, CYP in the treatment arm will have been more familiar with the facilitator after attending (up to) eight WeMatter sessions with them.

We instructed the facilitators to collect outcomes by sharing their screen with the 12 Stirling Scale questions displayed alongside the 5 Likert scale response options. There was a short set of instructions at the top of the screen, which the facilitator read aloud to the child before asking the questions. Then, they read out each question one by one, and recorded the CYP's answers. We provided training to the facilitators to make sure the scale administration followed consistent procedures and minimised potential biases, in line with the Child Outcomes Research Consortium (CORC) Best Practice Framework.[8]

Secondary outcome

Following an evaluation review in September 2024, Foundations, Victim Support, and Verian agreed to introduce a secondary outcome measure for CYP aged 13 years and over, the Social Support Scale to measure 'feelings of being supported' as outlined in the ToC. Building trusted relationships with facilitators and feeling supported by their peers is supposed to impact CYP's feeling of being supported. The Social Support Scale was developed for the 'Mental health of children and young people in Great Britain 2004' survey (Green et al., 2005) and the 2017 version of the survey was cognitively tested (Vizard et al., 2018). It consists of three items probing the extent of the child's social networks (with response options ranging from 'None' (0) to 'Two or more' (2)) and a further seven items probing the availability of social support (with response options ranging from 'Not true' (0) to 'Certainly true' (2)) (see 'Appendix B: Social Support Scale' for the full list of items). Social support is assessed using the aggregate score (summing the scores for each item), with a minimum possible score of 0 and a maximum score of 20.

Data collection processes and timings

Victim Support collected outcome measures at two time points: when CYP entered the trial after randomisation but before any CYP in the treatment arm for that block had their first WeMatter session ('baseline'), and at the end of the (approximately) 10-week delivery period in which all eight treatment arm WeMatter sessions (and the introduction and concluding sessions) took place ('endline'). For treatment participants, data collection was conducted in their introductory and concluding one-to-one sessions. For control participants, Victim Support conducted a separate data collection call around the time the treatment participants in their block were having their introductory one-to-one sessions. Endline data was collected for the control group during their introductory one-to-one sessions, when they started WeMatter.

Victim Support collated outcome data and combined it with Excel sheets recording the randomisation of CYP into trial arms, and an overall monitoring sheet conveying demographic information and information about WeMatter session attendance.

[8] See: https://www.corc.uk.net/what-we-do/how-we-support-you/best-practice-framework

A member of the IE team at Verian calculated the aggregate scores for the Stirling and (where applicable) Social Support Scales at baseline and endline.

Analysis

The primary analysis was an intention to treat (ITT) analysis examining the effects of WeMatter on mental wellbeing, as measured by aggregate scores on the Stirling Scale. Our analysis design follows a simulation study that recommended running partially nested heteroscedastic mixed-effects linear regression models for RCTs with clustering in the treatment arm but not in the control (Candlish et al., 2018).

The primary analysis model specification is as follows:

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

We define y as the aggregate score of the Stirling Scale collected at endline, 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 baseline Stirling score). 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 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 RCT), and the approach averages their results to estimate WeMatter's treatment effect (Lohr et al., 2014). We report effect sizes (Glass's Delta) and estimates of the intracluster correlation (ICC) alongside the model's output.

During the trial, Victim Support pooled some of the smaller blocks into larger groups for intervention delivery, to ensure the WeMatter sessions included enough CYP. The analysis needed to account for clustering in the delivery of the intervention, so where the WeMatter group assigned at randomisation was different from the group actually offered to the CYP, we used the delivery group.

We also ran several exploratory and secondary analyses to evaluate the statistical robustness of the main ITT estimates of impact. Because sample and cluster (WeMatter group) sizes were much smaller than anticipated, Foundations and Verian agreed not to carry out some of the secondary analyses listed in the evaluation protocol. In those instances, we report the relevant descriptives instead.

The ITT estimates derived from the primary analysis indicate the impact of offering CYP WeMatter rather than of them actually receiving it. To determine the impact of attending WeMatter, we estimated the effect of treatment on the treated (TOT), following the process set out in Bloom (2008).

We ran all inferential analyses presented in this report using Stata 18.0, using the *mixed* command for the primary analysis model with approximated degrees of freedom following the Satterthwaite method, as recommended by Candlish et al. (2018).

Deviations from the protocol

The evaluation protocol outlined an iterative testing approach where we would conduct regular reviews with Foundations and Victim Support and consider changes to the trial's design. During the trial's delivery, we agreed the following amendments:

- To introduce a secondary outcome measure for 13–17 year olds (the Social Support Scale), once Victim Support reported they were confident it would be feasible and not unduly burdensome to do so.
- To increase the waiting time from referral to start of the group sessions from two to four weeks, to allow each randomisation block to fill up more completely. We agreed this change after slower-than-expected recruitment led to small block sizes.
- To allow Victim Support to pool the WeMatter groups for blocks that were beginning around the same time if they considered them to be underfilled, in order to have sufficient CYP for the 'group-based' aspect of the intervention. In these cases, we used an indicator for the pooled group to represent clustering in the treatment arm in our analysis.

In addition, Victim Support implemented the following:

- Varied the age ranges covered by blocks and introduced some mixed settings (i.e. combining home and school delivery) to match demand at referral. This did not affect the main analysis, but meant it was not possible to carry out the planned analysis exploring how impact varies across age cohorts and settings.
- Moved CYP (n = 33) between WeMatter groups so that intervention delivery was no longer aligned with their block, sometimes with multiple baseline or endline measures being collected. Victim Support reported that these changes were made when practical constraints made (prompt) intervention delivery within that CYP's block impractical – for example, in the case of conflicting commitments not known at the time of triage. It was difficult to discern from the data exactly what had happened in each of these cases. We therefore agreed with Foundations to exclude these cases from our main analysis, but have also run a sensitivity analysis that includes them.

On reviewing the data, we also found evidence that in some cases the design set out in the evaluation protocol had not been adhered to properly:

- A facilitator changed the trial arm that 11 CYP were randomised into, leading to their exclusion from the analysis. The exact reason for this is unclear as the facilitator subsequently left the WeMatter team.
- Two CYP in the treatment arm had their baseline data taken after their first WeMatter session, leading to their exclusion from the analysis.
- Eight CYP in the waitlist control arm had their endline data taken after their first WeMatter session, leading to their exclusion from the analysis.

- The number of days between baseline and endline measures varied between CYP and appeared to be systematically different between the two trial arms. For further details see 'Evaluation question 1: Can the impact evaluation design be improved?'
- Victim Support confirmed it did not collect endline data from those CYP who withdrew from WeMatter (which is not a part of its usual process, but was added specifically for the evaluation), leading to higher levels of attrition in the treatment arm than in the control arm. For further details see 'Evaluation question 1: Can the impact evaluation design be improved?'
- In some instances, after the Social Support Scale was introduced as a secondary outcome, facilitators did not collect it from eligible CYP aged 13 years or over.[9] Post hoc, Victim Support suggests that these CYP may have had additional support or learning needs that influenced the decision, but there is no record of why facilitators did not collect data in particular instances.

Lastly, as stated above, Foundations and Verian agreed to reduce the number of secondary/ exploratory analyses to be carried out where those planned in the evaluation protocol would not yield useful insights given the lower-than-planned sample size.

Findings

Evaluation question 1: Can the impact evaluation design be improved?

What did we expect?

The evaluation protocol set out an evaluation design (described above and in greater detail in the evaluation protocol), with the potential to vary the design during fieldwork as required, in order to report on the design's feasibility and recommend a design for a full trial.

What did we find?

Recruitment and consent

The n = 312 CYP randomised fell below the planned sample size of 752. This is largely attributable to a lower-than-expected number of referrals: a total of 453 CYP were referred to Victim Support during the trial, against a projected 1,500 in the intervention protocol.

Victim Support identified three key challenges that particularly impacted recruitment during the first three months of the trial:

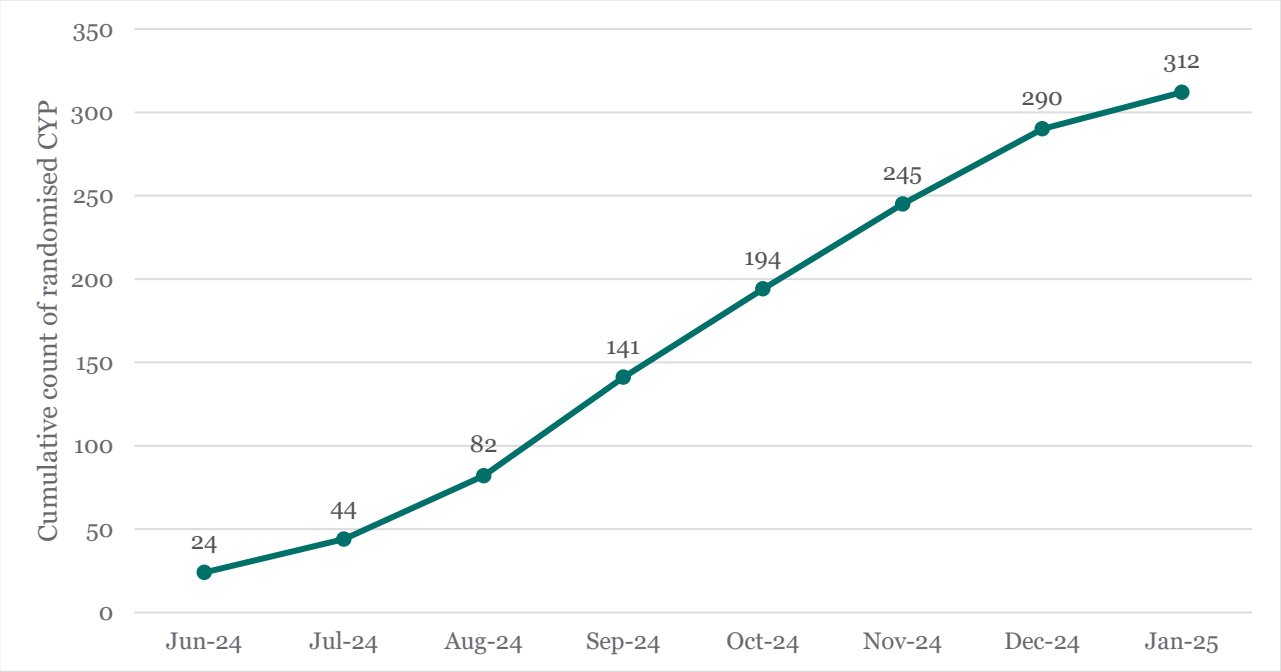
[9] We cannot give an exact figure because we do not have participants' ages at the time of data collection, just their year of birth.

- Victim Support was unable to start (re)building referral networks/recruiting CYP into the intervention until the start of the trial, due to a condition of the trial's funding. They estimate it takes at least three months to build a sufficient pipeline of CYP to enable recruitment on the scale seen later in the trial.
- The pre-election period for the 2024 UK general election exacerbated the problem of low referrals early in the trial because Victim Support was prohibited from advertising the intervention during the pre-election period between 25 May 2024 and 4 July 2024.
- School summer holidays started shortly after the trial's start (and the election), complicating enrolment for CYP who opted for a school-based group.

In addition to challenges early in the trial period, it was agreed that recruitment into the trial would need to stop before the end of the trial period in order to deliver the intervention to the full cohort of waitlist participants, per the evaluation design.

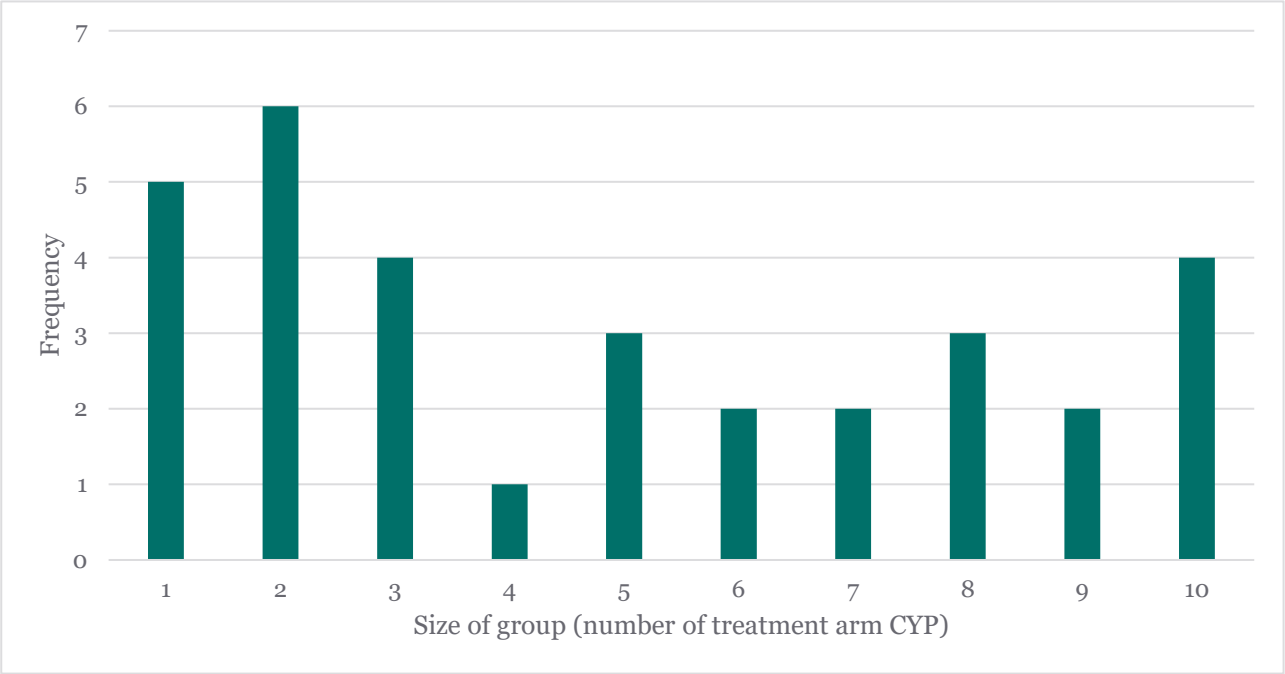
These challenges are borne out in the recruitment figures, with fewer CYP randomised in the first three months of the trial than in subsequent months, and with recruitment tailing off in the final month (Figure 4). During those middle months when the referral process was fully set up, Victim Support was able to recruit and randomise between 45 and 59 CYP each month.

Figure 4. Cumulative count of CYP randomised by month (go to accessibility text)



Of the 453 CYP referred to Victim Support, 312 consented to take part and 51 did not give consent. A further 49 could not be reached and 24 did not meet the intervention's eligibility criteria (also see the participant flow diagram in Figure 6). Lastly, 17 CYP were recruited before the trial's start (i.e. before the consent process was launched), and so were not randomised into the trial – these CYP were not considered trial participants and have not been included in any subsequent analyses.

Figure 5. Intervention group sizes at randomisation (n of groups = 32)
(go to accessibility text)



One consequence of referrals being slower than expected was that individual blocks did not fill up within the two-week window before baseline. (Later in the trial, we amended this window to four weeks to allow more time for blocks to fill.) Figure 5 gives a breakdown of group sizes for the treatment arm at randomisation, showing most blocks contained fewer than the 8–12 treatment CYP anticipated by the evaluation protocol.

Attrition and exclusions

Of the 312 CYP who consented to take part and were randomised into trial arms, only 165 (53%) could be included in the final sample. This was a higher attrition rate than we had expected, and it poses a risk of bias to any estimates of impact. For a discussion, see 'Risk of error'.

Between randomisation and baseline collection, 56 CYP were lost from the trial. Most of these (n = 43) were cases who did not provide a baseline measure. We saw no evidence of differences between the trial arms at this stage (treatment arm no baseline n = 22, control arm no baseline = 21). A further 13 had to be excluded because the facilitator changed the trial arm they were randomised to (n = 11) or conducted their first treatment group session before taking a baseline measure (n = 2).

Figure 6 shows the numbers of CYP recruited into the trial, randomised into each arm, and analysed, along with reasons for attrition and exclusion.

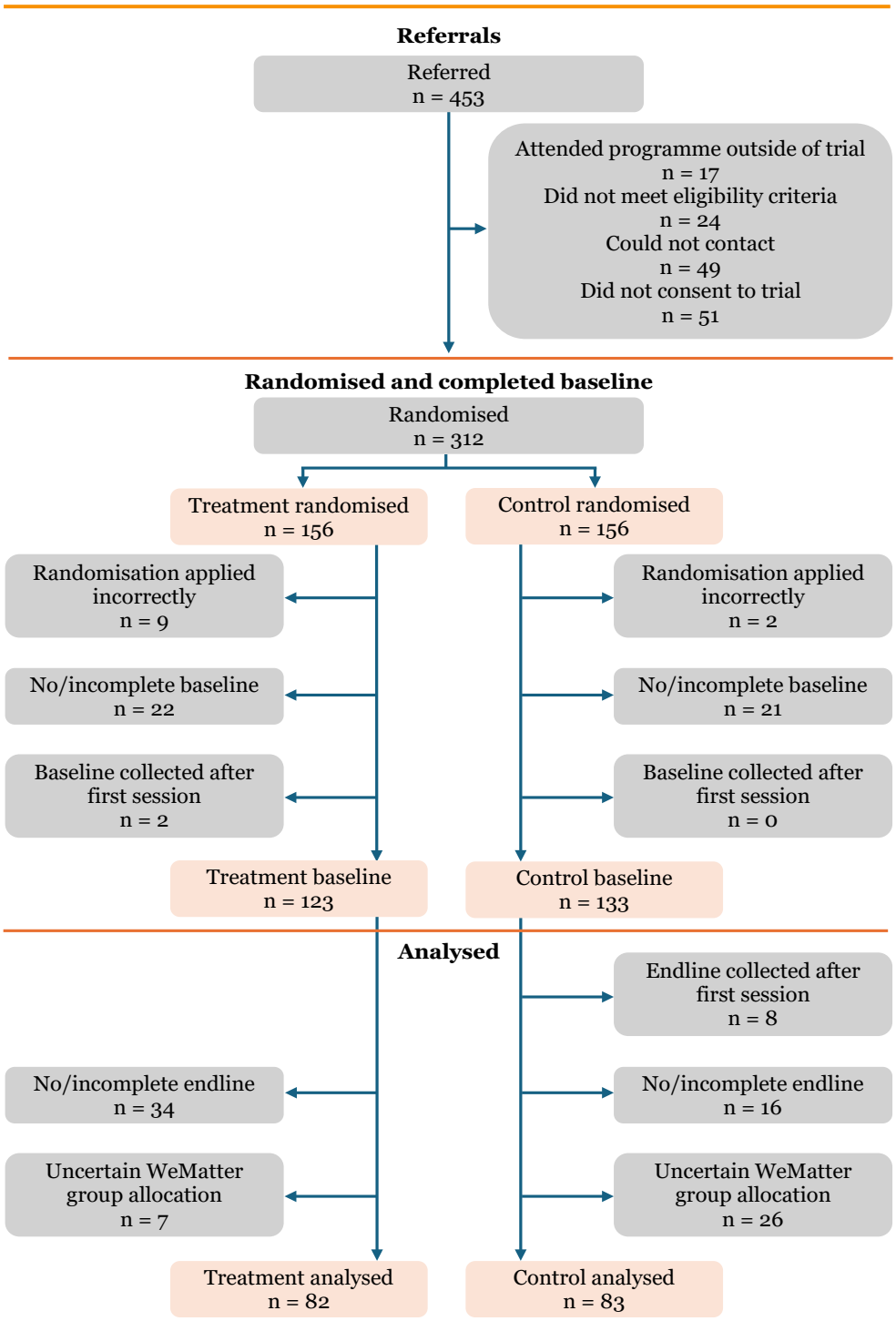
That left a baseline sample of 256 CYP, of whom 50 did not complete the endline outcome measure. This stage of attrition occurred at a higher rate in the treatment arm (n = 34, 27.6% of those with baseline) than in the control (n = 16, 12% of those with baseline). One plausible explanation for this difference is that participants in the treatment arm who stopped attending

their WeMatter sessions did not attend a concluding one-to-one session, in which endline measures were taken. Consistent with that account: CYP in the treatment arm who did not complete their endline measure attended a mean of 2.03 sessions (of a maximum eight), compared with 6.49 by those who did complete the endline measure. Victim Support confirmed it did not obtain endline data collection from those CYP who withdrew from WeMatter during the pilot trial.

A further eight CYP in the control arm were excluded because their first WeMatter group session took place before they provided an endline measure.

Lastly, 33 CYP had their allocated WeMatter groups changed at some point following randomisation, and it was not clear from the data which CYP they had attended sessions with to inform clustering in the analysis. The reasons given for group changes were practical in nature, including changes to the day that the CYP was available for sessions, availability of schools as a venue (which could lead to all CYP in that group being moved), or combining multiple small groups that were too small to operate alone (especially when referral numbers were low). Because this information was used in the clustering of the main analysis model, we excluded these cases from the main analysis. However, we also conducted a sensitivity analysis that included them.

Figure 6. Participant flow diagram for treatment and control arms (go to accessibility text)



Between randomisation and analysis, the sample profile shifted to include a greater proportion of CYP allocated to a WeMatter group in a school setting (71.5% to 83.6%) and towards younger CYP (those born in 2012–2016 made up 61.9% of the sample at randomisation vs 75.2% at analysis). On other characteristics, however, the sample profile did not appear to change greatly throughout the course of the trial (see Table 4).

Table 4. Summary of participant characteristics at randomisation and after attrition/exclusions. Percentages show column proportions within that characteristic

	Randomised sample (n = 312)	Sample with completed baseline (n = 256)	Analysed sample (n = 165)
Mean baseline Stirling score	-	42.48	42.53
Gender			
Woman	156 (50.0%)	127 (49.6%)	83 (50.3%)
Man	155 (49.7%)	128 (50.0%)	81 (49.1%)
Trans-man	1 (0.3%)	1 (0.4%)	1 (0.6%)
Year of birth			
2007–2008	25 (8.0%)	17 (6.6%)	9 (5.5%)
2009–2011	94 (30.1%)	73 (28.5%)	32 (19.4%)
2012–2016	193 (61.9%)	166 (64.8%)	124 (75.2%)
Ethnicity			
Asian	33 (10.6%)	27 (10.5%)	16 (9.7%)

	Randomised sample (n = 312)	Sample with completed baseline (n = 256)	Analysed sample (n = 165)
Black	8 (2.6%)	4 (1.6%)	3 (1.8%)
Mixed	34 (10.9%)	29 (11.3%)	16 (9.7%)
White	233 (74.7%)	192 (75.0%)	129 (78.2%)
Other ethnic group	3 (1.0%)	3 (1.2%)	1 (0.6%)
Prefer not to say	1 (0.3%)	1 (0.4%)	-
Disability			
Has one or more disabilities[a]	112 (35.9%)	92 (35.9%)	59 (35.8%)
FSM status			
Has FSM status	210 (67.3%)	170 (66.4%)	109 (66.1%)
Does not have FSM status	95 (30.4%)	80 (31.3%)	52 (31.5%)
Prefer not to say	1 (0.3%)	1 (0.4%)	-
Missing	6 (1.9%)	5 (2.0%)	4 (2.4%)
Public care status			
Looked-after child	4 (1.3%)	3 (1.2%)	2 (1.2%)

	Randomised sample (n = 312)	Sample with completed baseline (n = 256)	Analysed sample (n = 165)
Main language			
English	308 (98.7%)	252 (98.4%)	164 (99.4%)
Other	4 (1.3%)	4 (1.6%)	1 (0.6%)
Referral source			
School	49 (15.7%)	40 (15.6%)	32 (19.4%)
GP/health	11 (3.5%)	10 (3.9%)	8 (4.8%)
Internal Victim Support	106 (34.0%)	88 (34.4%)	52 (31.5%)
Local authority	88 (28.2%)	68 (26.6%)	41 (24.8%)
Other agency	30 (9.6%)	26 (10.2%)	16 (9.7%)
Police	2 (0.6%)	1 (0.4%)	1 (0.6%)
Referral by parent/guardian	26 (8.3%)	23 (9.0%)	15 (9.1%)
Delivery setting			
Home	88 (28.2%)	63 (24.6%)	27 (16.4%)
School	223 (71.5%)	193 (75.4%)	138 (83.6%)

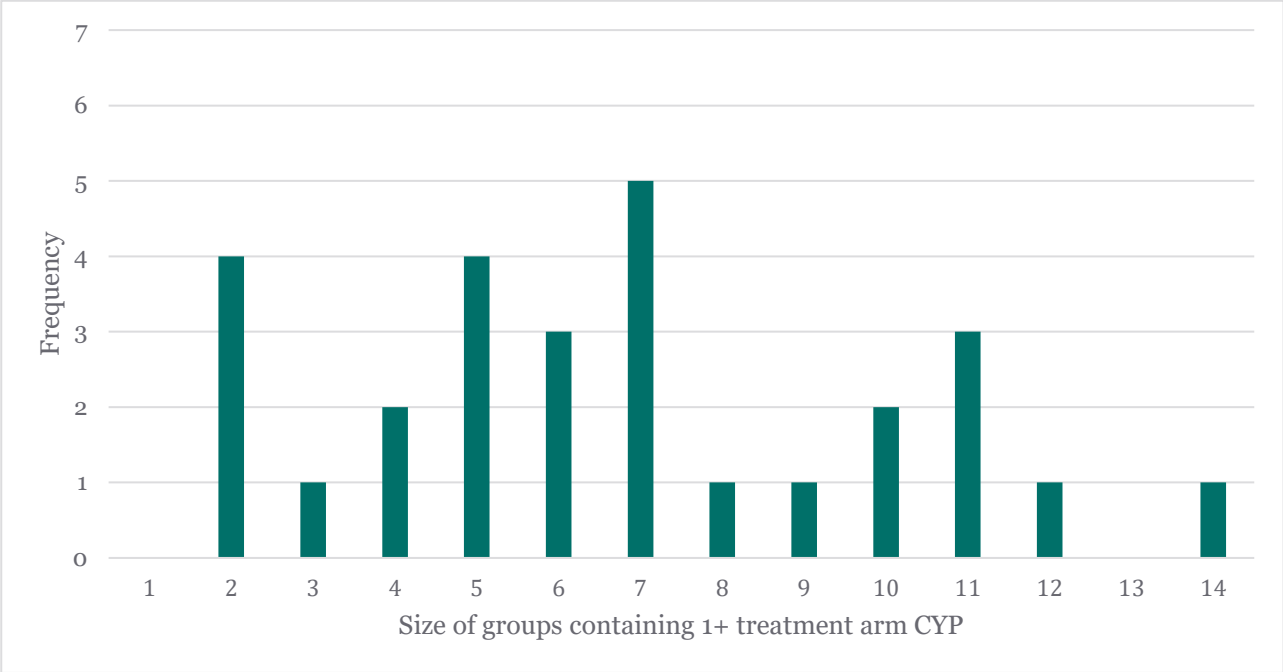
	Randomised sample (n = 312)	Sample with completed baseline (n = 256)	Analysed sample (n = 165)
Home/school[b]	1 (0.3%)	-	-

[a] A CYP would be marked as having a disability if they fell into one of the following categories: blind or partially sighted, deaf (Sign Language user), disclosed mental health problem, hearing impaired, ill health, physical frailty, learning difficulty, neurodiverse condition (e.g. autism, dyslexia), other long-term health condition, physical disability, other vulnerability.

[b] CYP in this group accessed support from home but during school hours.

During the course of the trial, Victim Support began conducting intervention delivery in 'pooled' groups containing CYP in the treatment arm from multiple small blocks and some control CYP from blocks that had already finished the trial and had entered their intervention delivery under the waitlist design. This pooling, combined with some attrition of CYP assigned to smaller groups, led to higher group sizes on average in the final, analysable sample of treatment CYP than we saw in the randomised sample of treatment CYP at randomisation (Figure 7). Nonetheless, most group sizes remained smaller than the 8–12 size anticipated by the evaluation protocol.

Figure 7. Intervention group sizes at analysis (n of groups = 28) (go to accessibility text)



Data collection and monitoring

Although Victim Support initially expressed a preference for facilitators to collect the outcome measures, that proved to be more burdensome than anticipated (see 'Implementation and process evaluation'). Consequently, later in the trial some endline data was collected by other Victim Support staff (see the 'Deviations from the protocol' section for further information).

For the 165 CYP entered into the main analysis, there was a longer time between collection of baseline and endline data in the treatment arm (mean: 86.93 days, SD: 22.16) than in the control arm (mean: 61.90 days, SD: 12.34). This is a deviation from what we expected in the evaluation protocol, which anticipated an approximately 10-week interval between baseline and endline in both arms. An unequal intervention interval between the two arms presents a risk of bias because CYP wellbeing may improve or get worse over time on its own; and there was more time for that in the treatment arm.

Victim Support regularly collated trial data for us to review throughout the course of the trial. None of the team had experience in data collection and management in the context of an evaluation. On review, the data contained errors and internal inconsistencies that affected a large number of cases. Despite multiple rounds of review and revision work by both Victim Support and Verian, we were unable to satisfactorily resolve all issues identified. The data was stored in multiple separate Excel sheets filled out by different facilitators, which Victim Support combined manually. This meant that errors that had been previously identified and fixed often reappeared in subsequent months. In addition to the process being burdensome for Victim Support, the poor quality of data combined with the low sample sizes made it difficult to discern problems arising with attrition and timeliness of data collection.

Summary of feasibility findings and possible improvements to the evaluation design

Below, we discuss key recommendations arising from the findings of Evaluation question 1. We highlight the **key points in bold**. Later in this report, we provide a more comprehensive set of feasibility findings and recommendations, drawing from all strands of the evaluation.

The referral pipeline was insufficient to achieve the target sample size of 752 CYP. There was a need to (re-)establish referral networks, which hampered recruitment early in the trial. Dedicated funding for establishing and refreshing networks pre-trial might have increased the final sample size. However, even if 59 CYP had been randomised each month (the maximum achieved in any one month in this pilot), the pilot would not have met the target sample size envisioned in the evaluation protocol. **If the observed rate of recruitment cannot be improved upon, extending the period over which the trial runs is the best way to recruit a larger sample of CYP overall.** Attrition was high, with only 53% of those randomised being eligible for analysis. The main reasons for attrition were missing endline data, complications with the blocked design arising from the need to move CYP between groups, and critical deviations from the evaluation protocol on randomisation or data collection.

Missing endline data was particularly concerning, because it appeared to occur more often in the treatment arm than in the control, and particularly for those CYP who were least engaged with the

intervention. It therefore presents a serious risk of bias. Victim Support did not contact these cases for endline measures after they withdrew from the intervention, but they would need to be contacted for data in a full trial. **We recommend implementing a formal contact strategy that sets out how and when to contact CYP for endline measures, alongside a call log to monitor what has been done and what has worked.** Offering CYP an incentive for completing the endline measures may also reduce missingness. Victim Support reported that all withdrawals seen in the pilot were explicitly withdrawals from the intervention rather than from the evaluation, but it is worth noting that the proposed change would not be appropriate for CYP who did wish to withdraw from the trial.

Moving CYP between WeMatter groups presented a challenge for the evaluation because assignment to groups was connected to the blocked randomisation. In principle, the blocked design should have produced well-matched trial arms without affecting how the delivery partner operated the intervention. In practice, Victim Support found it restrictive (see 'Implementation and process evaluation' for more detail). **A simpler randomisation design without up-front blocking would be less well powered but would allow the delivery partner greater flexibility.**

We identified a number of cases in which the evaluation protocol was not adhered to, or where poor data quality made it more difficult to identify problems as they arose. As discussed in the 'Implementation and process evaluation', Victim Support found some of the trial processes very burdensome, especially manually consolidating the data collected by various facilitators and resolving problems with that data. There are **several possible improvements** one might make to mitigate these issues:

1. Embed a dedicated trial manager from the evaluation team within Victim Support, whose chief responsibility is to ensure the trial is implemented properly (e.g. baseline and endline measures collected at the right times), and to collate and monitor trial data as it comes in.
2. Reduce the need for Victim Support to manually collate outcome data by recording it in a secure online form that goes straight to the evaluator.
3. Separate delivery of the trial from the intervention entirely by having the evaluator collect baseline and endline outcome data, rather than Victim Support. During trial design, Victim Support felt strongly that it needed to be the facilitators who conducted data collection calls, but there were no obvious problems when they moved away from facilitators collecting endline data partway into the pilot. For further evidence on the feasibility of using independent assessors to collect outcome measures, see 'Appendix H: Learnings from the bridge funding period'.

Evaluation question 2: What effect did WeMatter have on CYP's mental wellbeing at Week 10 of the intervention?

What did we expect?

We expected that the intervention would improve CYP's mental wellbeing compared with that of CYP in the control arm, as measured by the Stirling Scale.

What did we find?

Primary outcome – the Stirling Children's Wellbeing Scale

Among CYP eligible for analysis, the Stirling score at endline was 45.93 (SD: 7.30) in the treatment arm, compared with 42.07 (SD: 7.35) in the control arm. The corresponding Stirling scores at baseline were 41.99 (SD: 7.04) and 43.07 (SD: 6.59), respectively.

The primary ITT analysis found a statistically significant effect of WeMatter on endline Stirling scores, when accounting for baseline (fixed-effect coefficient: 4.62; SE: 1.07; 95% CI: 2.49 to 6.76; $p < .001$). This is equivalent to a standardised effect size of 0.74, expressed as Glass's Delta, which is a moderate effect. See Table 5 for the full results of the main analysis model.

Table 5. Mixed-effects linear regression model for the primary ITT analysis

	Coefficient	Standard error	*p*-value	95% confidence intervals
Treatment	4.62	1.07	< .001	[2.49–6.76]
Baseline Stirling score	0.61	0.07	< .001	[0.47–0.74]

Note. The dependent variable is the endline Stirling score (ranging from 12 to 60). The treatment effect estimates the effect of being randomised into the WeMatter treatment arm. Baseline Stirling score was included as a control variable for any baseline differences.

The estimated ICC for the treatment was 0.19, which was higher than the upper bound of the ranges used in the power calculations presented in the evaluation protocol (0.15). However, it should be noted that ICC estimation may not be wholly accurate when dealing with small cluster sizes (Candlish et al., 2018).

Secondary outcome – the Social Support Scale

In total, 31 CYP who were eligible for the main analysis completed the Social Support Scale at endline (14 in the treatment arm; 17 in the control arm). The mean Social Support Scale score at endline was 17.57 (SD: 2.62) in the treatment arm, compared with 17.24 (SD: 2.25) in the control arm. The corresponding Social Support Scale scores at baseline were 19.00 (SD: 1.84) and 15.88 (SD: 3.53), respectively. Foundations and Verian agreed not to carry out inferential analysis on this outcome because the achieved sample size was so low.

How robust is this finding?

Impact of missing data

The final analysis only included 165 of the 312 CYP who were randomised (52.9%), so nearly half of those initially randomised are not accounted for in the estimates of impact presented above. There is therefore the potential for considerable bias in these estimates.

One way to explore the risk of bias from missingness is to look at aggregate descriptive statistics on key participant characteristics to see if the sample used in the final analysis is measurably different from the sample originally randomised. Reassuringly, mean baseline Stirling scores for everyone who gave one (42.48; SD: 7.16) were very similar to those just in the analysed sample (42.53; SD: 6.82). This was also the case in both trial arms, as shown in Table 6.

Table 6. Comparison of mean baseline Stirling scores between everyone who provided baseline and those who were included in the analysis

	Control arm mean (SD)	Treatment arm mean (SD)	Total mean (SD)
CYP with baseline Stirling scores (n = 256)	42.91 (7.42)	42.01 (6.86)	42.48 (7.16)
CYP included in the analysis (n = 165)	43.06 (6.59)	41.99 (7.04)	42.53 (6.82)

We also explored variation in other key participant characteristics collected by Victim Support and saw no clear signs of bias as a result of missing endline measures, except the shift towards the school setting and younger CYP, noted earlier (Table 4). Foundations and Verian agreed not to attempt any imputation of missing observations, since the number of cases to be imputed was large as a proportion of the whole sample, and the achieved sample offered little from which to generalise.

It is important to note that the above analyses only consider bias as indicated on *observable* characteristics. This does not rule out the possibility that CYP who gave endline measures were systematically different from those who did not on some characteristic that was not measurable, and which is correlated with either the endline measure or sensitivity to treatment.

Differential attrition between trial arms poses a particularly acute risk of bias. In this trial, 34 CYP in the treatment arm (27.6%) provided a valid baseline score but no endline measure, compared with 16 CYP in the control arm (12.0%). We know that Victim Support did not seek endline measures from CYP who had stopped attending their WeMatter sessions, and that this will only

have affected the treatment arm (because control CYP had endline measures taken before they started the programme). Indeed, 29 of the 34 treatment CYP who did not provide endline measures attended fewer than five sessions, with 19 attending either none or one.

Taken together, the patterns of missing data in this trial pilot give good cause for caution about the robustness of its headline estimates of impact. Our recommendations for a future efficacy trial therefore have a strong emphasis on reducing missingness to produce findings that can be reported with greater confidence.

Robustness to varying cases included

We ran three sensitivity analyses varying the cases included in the primary model, and in each the main effect of treatment remained positive and statistically significant. Full statistical outputs for each of these models can be found in 'Appendix C: Sensitivity analysis'.

First, we excluded two control CYP who examination of Q-Q plots of residuals suggested might be outliers (fixed-effect coefficient: 4.67; 95% CI: 2.65 to 6.70; $p < .001$).

Second, we re-ran the primary analysis model after excluding any CYP who had siblings also enrolled in the trial, since this posed a potential risk of contamination (fixed-effect coefficient: 4.45; 95% CI: 1.89 to 7.01; $p = .001$).

And third, we re-ran the primary analysis model, but this time did not exclude CYP where we cannot be certain which WeMatter group they attended (where we had multiple group identifiers for a CYP). For each of those CYP, we used the group identifier on a tab in the spreadsheet called 'CYP info', which was the one that Victim Support was updating during the trial. That gave a total of n = 198 CYP (treatment: n = 89; control: n = 109). The results replicated those found in the primary analysis (fixed-effect coefficient: 4.65; 95% CI: 2.70 to 6.61; $p < .001$). This finding should be treated with extreme caution, because the assumed group informs the clustered error terms in the treatment arm.

Exploratory statistical analyses

The planned robustness test with block fixed effects and treatment by block interaction terms was not viable with the achieved sample, because the low overall sample size combined with some clusters (WeMatter groups) that were much smaller than planned meant the model did not converge. This was also true if we only included blocks containing at least six CYP (the minimum expected in the evaluation protocol).

Given the relatively good balance between trial arms and the danger of overfitting when working with low sample sizes, Foundations and Verian agreed not to run further models with additional demographic predictor variables.

Effect of non-compliance

The above estimates are all on an ITT basis, which reflect the impact of offering CYP WeMatter rather than of them actually receiving it. Of the 82 CYP in the treatment arm who were eligible for analysis, only n = 28 attended all eight WeMatter group sessions. Victim Support advised that a CYP who had engaged with at least five sessions (excluding introductory and concluding sessions)

would be considered to have completed the programme. A total of n = 74 CYP in the treatment arm who were eligible for analysis met this threshold, with eight attending four or fewer sessions. The protocol gave an alternative definition of compliance, which is that a CYP attended any WeMatter group sessions. Only one analysable CYP in the treatment arm failed to meet this threshold, having attended no sessions before completing their endline measures.

Using these two definitions of compliance, we estimated the effect of treatment on the treated (TOT), following the process set out in Bloom (2008). This process divides the ITT estimate of impact by the observed rate of compliance, effectively dividing the effect of WeMatter among those who attended the sessions. The estimated TOT effect is 5.12 (SE: 1.19), where compliance is defined as attending 5+ sessions, or 4.68 (SE: 1.08) using the protocol's definition of compliance.

The TOT estimate for those who attended 5+ sessions assumes those who attended 1–4 WeMatter sessions derived no benefit from doing so. It is unclear whether this is the case because the non-compliant treatment CYP gave lower mean Stirling scores at both baseline (non-compliant mean: 39.00, SE: 6.87; compliant mean: 42.31, SE: 7.03) and endline (non-compliant mean: 43.00, SE: 6.12; compliant mean: 45.93, SE: 7.30). Table 7 summarises baseline and endline scores by dosage. Because of the low achieved sample sizes in each band, Foundations and Verian agreed not to conduct further dosage analyses.

Table 7. Mean baseline and endline Stirling scores for CYP in the treatment arm, by dosage

Number of sessions attended	N of CYP	Mean baseline score	Mean endline score
0 sessions	1	39.00	45.00
1 session	0	-	-
2 sessions	1	34.00	43.00
3 sessions	1	51.00	53.00
4 sessions	5	37.60	40.60
5 sessions	13	42.38	49.77
6 sessions	12	38.58	42.25
7 sessions	21	43.76	46.76
8 sessions	28	42.79	45.90

It should be noted that compliance in this pilot was confounded with missingness because Victim Support did not collect endline data from most of those who stopped attending WeMatter sessions (discussed above). Furthermore, one participant interviewed as part of the IPE indicated that their child – who was in the control arm – received an additional support call from a facilitator during the waitlist period. We do not know how extensive this contamination was. However, taken together, the missingness and potential contamination mean the above TOT estimates should be treated with caution.

Evaluation question 3: Did the effect of WeMatter on CYP's mental wellbeing vary by age group and preferred setting of WeMatter delivery (school vs home)?

What did we expect?

This research question was exploratory, so the evaluation protocol did not set out any hypotheses as to how the impact of WeMatter would vary between CYP sub-groups.

We expected to use the age groups and preferred settings associated with randomisation blocks to support these analyses but deviations from the planned delivery protocol meant that this information was not reliable. Victim Support varied the age ranges covered by the groups so that there were multiple overlapping age ranges for each delivery setting. Additionally, the data received from the delivery partner indicated that some CYP changed their preference for delivery setting following randomisation. We have therefore focused our analyses on two variables: the setting used for WeMatter delivery and CYP year of birth (in three bands).[10]

The evaluation protocol anticipated that sub-group analyses would be underpowered. Because the achieved sample size was much lower than we had originally planned, Foundations agreed to restrict these exploratory sub-group comparisons to descriptive analysis.

What did we find?

Variation by setting

Of the 165 CYP analysed, 138 were assigned to WeMatter groups in a school setting (treatment n = 67, control n = 71), and the remaining 27 were assigned to sessions in a home setting (treatment n = 15, control n = 12).

In both settings, mean endline Stirling scores were numerically greater in the treatment arm (school mean: 46.24, SD: 6.73; home mean: 44.53, SD: 9.59) than in the control arm (school mean: 42.14, SD: 7.22; home mean: 41.67, SD: 8.40).

[10] The trial did not collect more granular information on participant age for data protection reasons. The three bands chosen for year of birth approximately align to the age groups originally intended to be used for intervention delivery.

In the school setting, Stirling scores increased by an average (mean) of 4.16 points in the treatment arm, and they decreased by 1.20 points in the control arm. In the home setting, the corresponding changes were +2.93 points (treatment) and +0.25 points (control).

See Table 8 for a full summary of endline scores by setting, including change from baseline.

Table 8. Summary of endline Stirling scores and the change from baseline Stirling scores broken down by delivery setting

	Control arm mean endline (change from baseline)	Treatment arm mean endline (change from baseline)	Total mean endline (change from baseline)
Total	42.07 (−0.99)	45.93 (+3.94)	43.99 (+1.46)
Delivery setting			
Home	41.67 (+0.25)	44.53 (+2.93)	43.26 (+1.74)
School	42.14 (−1.20)	46.24 (+4.16)	44.13 (+1.41)

Variation by banded year of birth

Of the 165 CYP analysed, nine were born in 2007–2008 (treatment n = 4, control n = 5), 32 were born in 2009–2011 (treatment n = 17, control n = 15), and 124 were born in 2012–2016 (treatment n = 61, control n = 63).

In each of these three groups, mean endline Stirling scores were numerically greater in the treatment arm (2007–2008 mean: 47.25, SD: 8.10; 2009–2011 mean: 43.71, SD: 6.70; 2012–2016 mean: 46.46, SD: 7.41) than in the control arm (2007–2008 mean: 42.40, SD: 8.11; 2009–11 mean: 39.33, SD: 7.01; 2012–16 mean: 42.70, SD: 7.34).

For those born in 2007–2008, Stirling scores increased by an average (mean) of 3.50 points in the treatment arm and by 4.00 points in the control arm. For those born in 2009–2011, the corresponding changes were: +5.29 points (treatment) and −0.20 points (control), and for those born in 2012–2016: +3.59 points (treatment) and −1.57 points (control).

See Table 9 for a full summary of endline scores by banded year of birth, including change from baseline.

Table 9. Summary of endline Stirling scores and the change from baseline Stirling scores broken down by year of birth

	Control arm mean endline (change from baseline)	Treatment arm mean endline (change from baseline)	Total mean endline (change from baseline)
Total	42.07 (−0.99)	45.93 (+3.94)	43.99 (+1.46)
Year of birth			
2007–2008	42.40 (+4.00)	47.25 (+3.50)	44.56 (+3.78)
2009–2011	39.33 (−0.20)	43.71 (+5.29)	41.66 (+2.72)
2012–2016	42.70 (−1.57)	46.46 (+3.59)	44.55 (+0.97)

Variation by other participant characteristics

We also carried out exploratory descriptive analysis of endline Stirling scores. In each sub-group considered (gender, banded year of birth, ethnicity, disability status, FSM status, public care status, main language spoken, referral source, and delivery setting), mean endline Stirling scores were always numerically greater in the treatment arm than in the control arm (see Table 18 in 'Appendix E: Stirling scores by CYP characteristics').

How robust is this finding?

The descriptive analyses presented in this section are purely exploratory so their results should not be treated as robust standalone findings. Additionally, the achieved sample sizes for the home setting (n = 27) and for those born in 2007–2008 (n = 9) or 2009–2011 were small (n = 32), so any estimates coming from these groups would be subject to a considerable degree of random error, even if unbiased.

Discussion

Risk of error

The risk of error in the trial's results is high. In our responses to evaluation questions 1–3, we have identified two major risk factors for bias:

1. High levels of missingness with evidence of differential attrition between the trial arms and selective loss of CYP in the treatment arm who were least engaged with the intervention.
2. Low fidelity in implementation of the trial design, most notably a systematically shorter interval between baseline and endline measurements in the control arm than in the treatment arm.

In addition to these two major risks of bias, the low sample size achieved combined with exclusions mean all trial estimates are imprecise, as indicated by the large confidence intervals shown in the responses to evaluation questions 2–3.

Consistency of findings with previous studies

This is the first RCT of a domestic abuse recovery intervention for children and young people conducted by an independent evaluator in the UK. The headline result of this trial is similar to that of a previous non-randomised, internal pilot evaluation of WeMatter, carried out by Victim Support. That study collected the Short Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS) as a measure of wellbeing and compared scores before and after treatment (Chappell, 2023). Victim Support found a statistically significant improvement in wellbeing post-intervention. However, that study found an effect size conventionally considered 'large' (Cohen's $d > 0.7$), whereas our ITT estimate is conventionally considered 'moderate' ($0.5 >$ Glass's Delta < 0.8).

Generalisability

As a pilot study, this trial was not designed to produce estimates that could be robustly generalised to the target population. The sample sizes involved were low, so all estimates of impact are subject to considerable uncertainty.

We had similar rates of consent to those seen prior to the pilot RCT, suggesting that the trial itself is not causing a drop-off and that the sample may be externally valid, albeit for the population of CYP that are referred to Victim Support.

We are not aware of robust population statistics describing the target population for the intervention, which means it is difficult to judge the extent to which the study's sample is representative of that population. We compared the change in sample profile between randomisation and endline, and found that at endline the sample was increasingly skewed towards younger participants and those joining WeMatter sessions in school settings. These were the largest sub-groups even at recruitment, with older participants and those taking part at home present in small numbers.

IMPLEMENTATION AND PROCESS EVALUATION

Evaluation questions

The aims of the implementation and process evaluation (IPE) of the WeMatter service were:

1. To assess the extent to which WeMatter was implemented according to the intervention protocol, and the perceptions of staff, stakeholders (e.g. schools, local authorities), parents/carers, and CYP with regard to the implementation of WeMatter to inform how the intervention can be improved.
2. To assess the extent to which WeMatter was perceived to achieve the expected outcomes.
3. To assess the theory of change (ToC) underpinning WeMatter.
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/carers, and CYP, to inform how the evaluation design can be improved and scaled up.

See 'Appendix G: Implementation and process evaluation research questions' for detailed research questions and dimensions explored in the IPE.

Evaluation design overview

The IPE involved a mix of in-depth interviews and group discussions. The number of interviews and group discussions proposed in the trial protocol was achieved, as follows:

- 12x depth interviews and 4 group discussions with CYP who took part in WeMatter
- 4x depth interviews with parents/carers of CYP who attended WeMatter
- 4x depth interviews with CYP who were on the waitlist
- 3x depth interviews with parents/carers of control arm CYP
- 1x paired depth interview and 2 group discussions with WeMatter facilitators
- 2x paired depth interviews with WeMatter triage staff
- 1x group discussion with WeMatter project leaders and Victim Support leaders
- 3x depth interviews with stakeholders (1x Rock Pool representative, 1x local school, 1x local authority).

A total of 47 participants were included across the interviews and group discussions. Qualitative data was complemented by administrative data – for example, to assess dosage of the intervention based on session attendance data.

Interviews with CYP used a trauma-informed approach to ensure they were sensitive to CYP needs and preferences. Topic guides were also adapted depending on the age of CYP, with separate guides

used for CYP in 8–12 and 13–17-year-old groups. CYP were interviewed at the end of the service, directly following the final one-to-one session with the facilitator, unless interviewed as part of a focus group discussion.

A purposive sampling approach was used for interviews with CYP and parents/carers to ensure representation of a range of characteristics, including gender, age, course setting (i.e. home or school), ethnicity, free school meal status, and area. The sampling frame for qualitative research is available in the evaluation protocol[11] and a more detailed sample breakdown for CYP and parents/carers is provided in 'Appendix D: IPE sample'.

Qualitative analysis used a flexible deductive-inductive framework approach, which involved summarising data from the interviews in a thematic framework, whose structure was updated as analysis progressed to accommodate emerging themes and patterns. Administrative data was analysed using descriptive statistics.

A full description of the WeMatter IPE evaluation methodology is available in the evaluation protocol.[12]

Deviations from the protocol

The IPE was delivered as planned and the proposed number of depth interviews and group discussions was achieved. The CYP depth interviews followed directly after their final one-to-one sessions. However, that meant that their timing was affected by any delays in scheduling these sessions. At least five CYP were interviewed several weeks after the group sessions ended rather than a week later as planned (and likely more than five, but we cannot establish the exact number from the data that was collected). This typically occurred where school holidays meant that concluding one-to-one sessions were postponed or due to facilitator turnover. The delay potentially affected participant recall, as some provided less detail around their involvement in WeMatter activities. However, this deviation did not impact data quality significantly, as most interviews were conducted closely after the end of the intervention as planned.

In addition, minor adaptations were made in terms of the methods used with certain participants – for example, using in-depth interviews and group discussions flexibly with facilitators and triage staff depending on staff availability.

[11] See https://foundations.org.uk/our-work/current-projects/a-pilot-randomised-controlled-trial-of-wematter

[12] See https://foundations.org.uk/our-work/current-projects/a-pilot-randomised-controlled-trial-of-wematter

Findings

Evaluation aim 1: Implementation of the intervention

What did we expect?

WeMatter is an online 10-week intervention for 8–17-year-old CYP who have experienced domestic abuse. It aims to improve the wellbeing of CYP by helping them understand their own experiences of domestic abuse, develop healthy coping strategies, and increase their feelings of safety and being supported.

Following an introductory one-to-one call with the CYP, WeMatter facilitators lead groups of up to eight participants through a curriculum based on Rock Pool's CYP Domestic Abuse Recovery Toolkit, over the course of eight weekly sessions. Each of the group sessions is led by two specialist facilitators who are educated to degree level or higher and experienced in the delivery of trauma-informed support services for CYP, including being accredited by Rock Pool. During the intervention, participants also complete non-mandatory home tasks and facilitators provide additional one-to-one support during and between sessions where needed. The intervention ends with a concluding one-to-one session with the facilitator.

For the intervention to be delivered as intended, the following service inputs needed to be in place: programme resources (i.e. Rock Pool's CYP Domestic Abuse Recovery Toolkit), staff resources, and CYP resources (e.g. digital access).

Fidelity to the intervention protocol

WeMatter was mostly delivered as intended in terms of pre- and post-engagement activities, and content covered in the eight-week intervention. However, the IPE found some variations and departures from the intended approach

As discussed in the section below, participant numbers were lower than intended in some groups, facilitators were sometimes not consistent over the 10 sessions, activities between sessions were not delivered consistently, and digital access was at times disrupted for CYP. These deviations were due to challenges in terms of securing certain service inputs that were required to deliver the intervention as planned.

WeMatter service inputs

Most service inputs were in place and delivered as intended. Successful intervention delivery was supported by service inputs such as programme resources, local referral networks, staff training and support, CYP's digital access, parental/carer and school support. However, there were also some challenges in securing referrals, and resources for staff and CYP, which sometimes affected Victim Support's ability to deliver the approach as intended.

- **Referrals:** Recruitment was initially challenging in some areas. Recruitment was widened nationally for the trial and facilitators explained that building local referral networks across England took time in those areas where they had no pre-existing relationships with local

stakeholders. There were also factors beyond facilitators' control that impeded recruitment – specifically, having to postpone recruitment due to the July 2024 general election and, therefore, starting recruitment during school holidays. Facilitators felt that these initial recruitment challenges were compounded by having to split recruited participants between treatment and control arms because twice as many participants would need to be recruited to fill the two cohorts with the optimum eight CYP.

The result of these recruitment difficulties was that some initial groups had lower participant numbers than planned.

> "It takes a lot of time for local authorities to build up that trust with us. We were a little bit naive in thinking that we could go to this new area and support there. If we had next year to do this all again it would look so different. We need to prove how good we are, but that takes time."
> – Facilitator, group 3

All facilitators, however, felt that following these initial challenges, they successfully built local referral networks and recruitment improved. In particular, some thought that establishing good relationships with local schools was very productive for securing referrals. These improvements in recruitment were largely due to the project leads having time to understand how best to promote the project and build trust within new localities. Over time, project leads found that making contact directly with agencies that might refer CYP to WeMatter – such as schools, healthcare professionals, and social workers – was more effective than going through LA networks.

- **WeMatter staff resources:** All facilitators felt adequately trained and supported to deliver the service. For example, one facilitator explained the training was very relevant and provided both the theoretical underpinning and practical guidance for delivering the service. Other facilitators also appreciated support they received from the WeMatter team, such as, signposting to further training, pastoral and practical support with more difficult cases.

> "I've worked with children and young people for about 12 years now in education and healthcare, and I have never had training that has been so relevant, both in the theoretical understanding and underpinnings of why we're doing it, but practically how to deliver it. For me personally, it was a real eye-opener and I've realised what I've missed out on previously. I felt very supported."
> – Facilitator, group 2

However, facilitators reported a more mixed picture in terms of their capacity to deliver the service over the duration of the trial (see the 'Lessons learned' section for further discussion). Some described being less familiar and confident with the administrative tasks of the trial and found these an additional burden.

They explained that the service recruited sufficient facilitators initially, but that some facilitators left during the trial period and had to be replaced. Facilitators felt that job insecurity and uncertainty over future funding of WeMatter were some of the reasons for

facilitator turnover, as well as having to do additional, trial-related administrative tasks they were not familiar with. Facilitator changes resulted in a departure from the intended approach in some treatment groups, because facilitators were not always consistent.

- **CYP resources:** CYP resources – digital access, support from parents/carers and schools, availability of time – were mostly available as intended. All CYP and parents/carers reported that CYP had access to digital resources in school and/or at home to be able to take part in WeMatter sessions. However, this access was disrupted during school holidays for some CYP attending the service at school. Those CYP and some parents/carers explained they were unable to access the service in alternative locations at those times. This may particularly have affected CYP with special educational needs and disabilities (SEND), who sometimes needed to access the service in school to get the appropriate support to attend sessions; and CYP living in temporary houses, such as safe houses, who also depended on being able to access WeMatter in school.

  In terms of parental/carer and school support, triage staff and facilitators reported that most parents/carers and schools they dealt with supported CYP to attend the service. However, some also pointed out there were a few parents/carers who were uncontactable at triage stage and therefore their CYP could not take part in the service. In addition, facilitators reported that a few secondary schools were less supportive of CYP in exam years attending the service, because those schools had concerns over CYP missing out on education.

  > "I think most of my families have been quite positive and they can be really quite open in that first call."
  > – Facilitator, group 2

  > "I've had a mixture of some parents who answer the call straight away and are so pleased … and others who are very rushed on the phone, they won't answer me no matter how many calls, texts I send."
  > – Facilitator, group 2

  > "Two of the schools are being stubborn and giving it's their GCSE year, why would you want them to miss eight hours of lessons … "
  > – Facilitator, group 1

Pre-engagement activities

All pre-intervention engagement activities were perceived to be delivered with fidelity by interviewees, including triage calls and facilitators' initial calls to parents/carers. Staff and parents' accounts of pre-engagement activities suggested these followed the intervention protocol in terms of the number of calls, their order, content discussed with parents, and length of time between the calls.

WeMatter triage staff reported they were able to process referrals within 48 hours as planned and had no challenges in terms of managing the referral volume, suggesting the triage team had

adequate capacity. Triage staff also thought the referral process was simple and clear, although some thought it could be improved by allowing for online referrals.

> "It's simple, it's made easy, it's not complex. […] It just feels like it runs really nicely."
> – Triage group 2

Parents/carers were all very positive about pre-engagement activities. They felt impressed by the speed with which the triage team contacted them, facilitator contact was initiated, and access to the service. In addition, all parents/carers shared positive feedback on the supportive and flexible approach of the triage team and facilitators.

> "[What stands out is] just how friendly [Facilitator] was when we spoke on the phone. I was quite nervous to explain something to someone I haven't met and still haven't met, but she made me feel really comfortable and made it as comfortable as possible which I really appreciated."
> – Treatment arm parent/carer of female, 8–12

Intervention (10-week intervention, including 2x one-to-one sessions and 8x 1-hour online group sessions based on Rock Pool's CYP Domestic Abuse Recovery Toolkit)

All the main elements of the intervention were delivered with fidelity, including the introductory and concluding one-to-one sessions and the eight-week block of group sessions.

CYP were broadly positive about the introductory calls with facilitators and reported that the calls reassured them about the service. However, a few CYP said they were not aware they would be receiving this call or what it would be about, prior to being asked to join the call at their school. To help ensure CYP are aware of the service prior to initial facilitator calls, some CYP and parents/carers suggested developing materials to explain the service to CYP.

Most CYP, parents/carers, and facilitators reported that the concluding one-to-one sessions between CYP and the facilitator were delivered closely after the last group session, as intended in the intervention protocol. In a couple of cases, interviews with CYP suggested these concluding sessions were delivered at a later date due to facilitator turnover and school holidays.

CYP, parents/carers, and facilitators indicated that group sessions were delivered as intended in terms of the number and frequency of sessions, as well as the content covered in those sessions and a tailored approach.

However, the IPE found some variations with regard to other aspects of how the intervention was delivered:

- **Group vs one-to-one sessions:** Most CYP participated in group sessions as intended. However, a small number of participants attended one-to-one sessions rather than groups (n = 12). Facilitators explained that this deviation from the intervention protocol occurred due to participant recruitment challenges combined with trial requirements. Facilitators observed that due to randomisation, there was no flexibility in participant allocation to groups, and group start and end dates. Therefore, where only one participant was recruited

on time for their group start date, WeMatter was delivered to those CYP as one-to-one sessions. We cannot be certain from the data, but it does not seem that any of these single-person 'groups' completed the intervention (possibly because the CYP were added to other groups), so preventing this seems to be crucial for intervention delivery.

> "The randomisation has been quite frustrating … just the way that it's worked out, some of mine will be one-to-one. […] It definitely limits the level of discussion. Some of the content would need adapting to make it suitable to one-to-ones, whereas it would have been less confrontational to open things up to the group."
> – Facilitator, group 1

- **Facilitator changes:** A few CYP and facilitators explained that in some WeMatter groups facilitators changed over the duration of the intervention, rather than remaining consistent as intended. (According to Victim Support, 14 groups had a change of facilitator.) This was due to facilitator turnover. Interviewed facilitators felt that job insecurity and uncertainty over future funding of WeMatter were some of the reasons for staff turnover, as well as having to do additional, trial-related administrative tasks they were not familiar with.

> "The nature of working in a charity is the cycle of funding. You've got to have nerves of steel to be able to just risk it and wait and wait and hope you get more funding."
> – Facilitator, group 3

- **Home tasks:** CYP did not recall being given non-mandatory home tasks and this was not observed by parents/carers, either. However, facilitators explained this lack of awareness may have been because home tasks involved suggestions to try using or doing some of the things CYP learned in the sessions, rather than actual tasks. Facilitators also highlighted that all participants received an end-of-programme pack outlining everything they covered in the sessions. A couple of parents/carers suggested such packs would be very useful to help CYP remember what they learned, but were not aware of their children receiving one. Future updates to the ToC and intervention protocol should consider what mechanisms of action the home tasks are supposed to trigger and whether they are necessary to intervention delivery.
- **One-to-one support between sessions:** Most CYP and parents/carers reported that facilitators did not engage with CYP between sessions to provide additional support. The service normally offered 'catch-up sessions' to CYP who missed a session, to cover the content they missed and help them stay on the course. However, these were not in the ToC or the intervention protocol, and were not commonly used during the trial. The consequences of this are discussed below, under 'Dosage'.

Key enablers to implementation were stakeholder relationships and facilitators' approach, and challenges were experienced around timescales and timings of recruitment and staff resourcing

The following key enablers helped the intervention be implemented as intended:

- **Stakeholder relationships:** Established local referral networks were crucial for recruitment, especially with schools and social workers.
- **Facilitators' skills and approach:** WeMatter facilitators felt that training and support worked well to help them deliver the service. CYP and parents/carers also shared very positive feedback on facilitators' supportive, friendly, and flexible approach, suggesting this was critical in building rapport with CYP and parents/carers and engaging them with the service.

The following barriers would be important to consider to support implementation of the service in the future:

- **Participant recruitment timescale:** Initial recruitment challenges revealed the importance of allowing sufficient time to build local referral networks and relationships, where these were missing prior to the trial. The CYP national lead and the operations manager explained it typically takes three months to (re-)build referral pathways, but this can sometimes stretch to six months to fully establish the service and build reputation in a local area. This contributed to insufficient number of referrals to run groups at the start of the trial.
- **Timing of the recruitment:** Challenges due to starting participant recruitment over the summer holidays highlighted the importance of timing and ensuring the recruitment starts when CYP, parents/carers, and schools are most available. This contributed to insufficient number of referrals to run groups over that period.
- **Timing of the intervention:** The majority of CYP participated at school, but that setting was not available during the school holidays; access via schools may be particularly important for CYP with SEND and for CYP living in temporary houses.
- **WeMatter staff resource challenges:** Facilitators highlighted broader factors which they felt created challenges in terms of WeMatter facilitator resource, specifically: job insecurity, uncertainty over future funding, and administrative burdens due to trial requirements. To support future delivery, it would be important to consider how the impact of these factors could be minimised or mitigated.

Reach

The proportion of parents/carers consenting to their children taking part in the intervention was similar to what Victim Support expected given engagement rates before the trial. There was significant representation of CYP with FSM status and disabilities/additional needs; however, older CYP and those from minoritised ethnic backgrounds were less well represented

Of parents/carers whose children were referred to WeMatter, 69% consented to CYP taking part in the service, which is in line with the previous take-up rate of 67% for the service (see Table 2). The make-up of CYP whose parents/carers consented was balanced in terms of gender, and a quarter of participants were from minoritised ethnic backgrounds groups (see Table 10). However, the CYP profile was not as balanced in terms of age, because there was a skew towards the younger, 8–12-year-old age group, which was consistent with the age profile in the previous internal evaluation of

WeMatter conducted by Victim Support.[13] There was also a significant representation of CYP with FSM status and disabilities/additional needs, with around two-thirds of CYP receiving FSM and around one-third having disabilities/additional needs.

Table 10. Profile of CYP whose parents/carers consented to taking part in WeMatter

Demographic category	Randomised CYP (n = 312)
Gender	
Woman	156 (50.0%)
Man	155 (49.7%)
Trans-man	1 (0.3%)
Year of birth	
2007–2008	25 (8.0%)
2009–2011	94 (30.1%)
2012–2016	193 (61.9%)
Ethnicity	
Asian	33 (10.6%)
Black	8 (2.6%)

[13] WeMatter was previously evaluated internally by the Victim Support research team between November 2022 and July 2023 and participant data collected for that evaluation showed a similar spread in terms of age: out of 82 CYP, there were 53 aged 7–11 and 29 aged 12–17. See: WeMatter Intervention Protocol, https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-intervention-protocol.pdf, p.21.

Demographic category	Randomised CYP (n = 312)
Mixed	34 (10.9%)
White	233 (74.7%)
Other ethnic group	3 (1.0%)
Prefer not to say	1 (0.3%)
Disability	
Has one or more disabilities[a]	112 (35.9%)
FSM status	
Has FSM status	210 (67.3%)
Does not have FSM status	95 (30.4%)
Prefer not to say	1 (0.3%)
Missing	6 (1.9%)

[a] A CYP would be marked as having a disability if they fell into one of the following categories: blind or partially sighted, deaf (Sign Language user), disclosed mental health problem, hearing impaired, ill health, physical frailty, learning difficulty, neurodiverse condition (e.g. autism, dyslexia), other long-term health condition, physical disability, other vulnerability.

WeMatter triage staff and facilitators thought the level of take-up of the intervention was at expected levels; however, this was only after initial participant recruitment challenges were overcome and staff had sufficient time to build local referral networks.

Staff also thought that older CYP were more difficult to recruit for the service and they suggested some potential reasons for this. One facilitator thought that older CYP had more barriers to taking part due to having more school and sometimes also work commitments. Another facilitator felt that older CYP may feel that they have already developed coping strategies and be perceived to need less support with this.

> "I don't know whether they just a get a little bit older and off the radar from the parents, maybe they've already developed those coping skills so parents are not seeing that they've got work to do based on what's happened to them … The 16/17-year-olds have quite a lot going on, they might have jobs, college can be quite intense."
> – Facilitator, group 1

Facilitators also highlighted challenges in recruiting some other groups into the service, notably CYP from ethnic minorities and those with SEND. Facilitators felt that CYP from minoritised ethnic backgrounds were sometimes more difficult to recruit and suggested that the stigma around seeking support with recovery from domestic abuse may be a significant barrier with those groups. A facilitator also thought that some referral organisations may view the digital nature of the service as a barrier for CYP with SEND to participate in the service, which may act as a barrier to referrals of CYP with SEND.

> "With us being digital, we have to get them [people referring CYP] to see past the digital aspect because they see it as a barrier."
> – Facilitator, group 3

The intervention reached the intended target population, with most CYP being eligible for the service

Service data showed that 429 out of 453 referred CYP met eligibility criteria with reference to age, experience of domestic abuse, and not currently experiencing abuse or living with the alleged perpetrator (94.7%). Based on this data, the service reached the intended target population, which was also the view expressed by facilitators and triage staff. They further explained that where CYP were ineligible, this was either due to not meeting the age criteria or because they still lived with a perpetrator.

Parents/carers acknowledged that their children needed support and cited emotional wellbeing and fast access among the reasons for taking part; some CYP welcomed the idea of talking to other CYP with similar experiences

All parents/carers we interviewed were eager for their children to access WeMatter. In some cases, parents/carers felt a sense of urgency for their child to receive support, because they reported delays in accessing support elsewhere, due to limited service availability in their area and/or long waiting times to get help.

Parents/carers pointed out several key reasons why they wanted their children to access WeMatter:

- **Emotional wellbeing:** Most talked about their children experiencing difficult emotions and struggling to manage their feelings and their mood. Parents/carers hoped that taking part in WeMatter would help improve the CYP's mood and emotional wellbeing through learning how to manage better and cope with challenging emotions.

  > "He is lashing out at me, in particular. I don't think he knows how to deal with things. […] He is angry, he is upset, so it is better for our relationship [if he

attends WeMatter] because he argues with me a lot at the moment."
– Treatment arm parent/carer of male, 8–12

- **Fast access:** Some parents/carers pointed out long waiting times to access similar types of support. The comparatively short waiting times to access WeMatter meant parents/carers felt very positive about their children attending the service.
- **Fun activities:** A few parents/carers also thought their children might find WeMatter activities interesting, based on the information provided by triage staff and facilitators.
- **Healthy future relationships:** A couple of parents/carers expressed worries that the experience of domestic abuse might affect CYP's future relationships. These parents/carers hoped that WeMatter would help empower CYP so they can protect themselves against abusive relationships in the future.

"My key motivation for wanting [CYP] to take part was for her to work on controlling her emotions and the healthy relationship side of things."
– Treatment arm parent/carer of female, 8–12

CYP were less able to explain why they wanted to take part than parents/carers. They varied in how much they knew about the service before they started attending and to what extent they felt that participation was their choice. Some CYP reported that their parents/carers explained about the service and that they agreed to take part. These CYP felt interested in talking to other CYP with similar experiences and discussing their feelings, which were the main reasons they cited for joining.

"[It would be good to join] because in the sessions we would talk about our feelings."
– Treatment arm CYP, female, 8–12

Other CYP, however, reported they first heard about the service when they were asked to join the initial call with the facilitator. For most participants in this category, this did not appear to affect their experience of the service, as they explained they enjoyed WeMatter. However, one child who felt their parent made a choice for them also displayed very low engagement with the service, raising questions around their informed consent to participate.

"I wasn't really sure what she was on about until I came to school and my teacher explained."
– Treatment arm CYP, male, 8–12

"I just had to do it, so I did it."
– Treatment arm CYP, female, 8–12

To ensure informed consent, some CYP, parents/carers, and stakeholders suggested there should be more public-facing marketing resources that could be used in recruitment and referrals – for example, a leaflet for parents/carers that could be distributed via schools, videos for younger and older CYP explaining what to expect if they took part in WeMatter.

"I'm all in favour of videos, sometimes the leaflet can be a bit dry."
– Family support worker

> "We need the literature first, as schools, because there are schools who still don't know about the service."
> – Local school stakeholder

12% of eligible parents/carers and CYP declined to take part in the intervention, often indicating practicalities around the timing of the allocated groups as a reason

Researchers were unable to interview eligible CYP (and their parents/carers) who declined to take part, due to safeguarding and logistical reasons. However, triage staff reported that where they were able to reach the parents/carers, very few parents/carers and CYP declined once their eligibility was confirmed. Staff explained that parents'/carers' reasons for declining mainly concerned the practicalities around the timing of WeMatter groups – for example, where times of WeMatter groups clashed with other commitments or they were unable to access sessions during school holidays. Another reason for declining was CYP's preference for one-to-one sessions.

Over half of participants completed WeMatter, attending at least five sessions required to complete the course; of those who did not, busy school periods and health issues were cited as reasons for dropping out

Facilitators explained that missing more than three out of eight sessions made it difficult for CYP to remain in the service, because they missed too much content. Therefore, participants who missed more than three sessions could not complete the course and left the service. If they were still interested in attending WeMatter, facilitators reached out to the triage team so that those CYP could be re-allocated to another group.

Younger CYP were more likely to be retained, with 67.7% (67 of 99) who were born between 2012 and 2016 completing five or more sessions, compared with 38.3% (18 of 47) born between 2009 and 2011, and 40.0% (4 of 10) born between 2007 and 2008 (see Table 11).

Table 11. Proportion of CYP in the treatment arm who completed five or more vs fewer than five sessions

Demographic category	Completed fewer than five sessions (n = 67, 42.9%)	Completed five or more sessions (n = 89, 57.0%)	Overall (n = 156)
Gender			
Woman	32 (45.1%)	39 (54.9%)	71 (100.0%)
Man	35 (41.2%)	50 (58.8%)	85 (100.0%)
Year of birth			

Demographic category	Completed fewer than five sessions (n = 67, 42.9%)	Completed five or more sessions (n = 89, 57.0%)	Overall (n = 156)
2007–2008	6 (60.0%)	4 (40.0%)	10 (100.0%)
2009–2011	29 (61.7%)	18 (38.3%)	47 (100.0%)
2012–2016	32 (32.3%)	67 (67.7%)	99 (100.0%)
Ethnicity			
Asian	9 (69.2%)	4 (30.8%)	13 (100.0%)
Black	0 (0.0%)	3 (100.0%)	3 (100.0%)
White	49 (40.5%)	72 (59.5%)	121 (100.0%)
Mixed	8 (47.1%)	9 (52.9%)	17 (100.0%)
Other ethnic group	0 (0.0%)	1 (100.0%)	1 (100.0%)
Prefer not to say	1 (100.0%)	0 (0.0%)	1 (100.0%)
Disability			
Has one or more disabilities[a]	25 (38.5%)	40 (61.5%)	65 (100.0%)
Does not have any disabilities	42 (46.2%)	49 (53.8%)	91 (100.0%)
FSM status			

Demographic category	Completed fewer than five sessions (n = 67, 42.9%)	Completed five or more sessions (n = 89, 57.0%)	Overall (n = 156)
Has FSM status	47 (42.7%)	63 (57.3%)	110 (100.0%)
Does not have FSM status	19 (44.2%)	24 (55.8%)	43 (100.0%)
Prefer not to say	1 (100.0%)	0 (0.0%)	1 (100.0%)
Missing	0 (0.0%)	2 (100.0%)	2 (100.0%)

[a] A CYP would be marked as having a disability if they fell into one of the following categories: blind or partially sighted, deaf (Sign Language user), disclosed mental health problem, hearing impaired, ill health, physical frailty, learning difficulty, neurodiverse condition (e.g. autism, dyslexia), other long-term health condition, physical disability, other vulnerability.

Facilitators highlighted some common factors leading to participants missing sessions and dropping out. One facilitator explained that the number of sessions missed can be higher at busy times at schools – for example, around Christmas when there are many activities or during SATS preparation and exams in primary schools. CYP's health and wellbeing issues were highlighted as another reason for missing some sessions – for example, CYP struggling with sleep. In addition, a facilitator explained that CYP who were on their own in their 'group' (due to insufficient participant numbers) appeared hesitant about remaining in the service, potentially because they felt more exposed in a one-to-one than in a group setting.

> "Where it would have been less confrontational to open things up to the group, you've got to ask them directly what do you think."
> – Facilitator, group 1

Despite these challenges resulting in some participants dropping out from the service, facilitators still felt that their WeMatter groups had high completion rates. They thought that the service successfully retained participants because it engaged parents/carers and schools, who then supported CYP to attend. In addition, one facilitator felt that CYP perceived the sessions as fun and interesting, which in their view also helped with retention.

> "By the time you've got the parents involved, then the school involved and met the young person, it's a high success rate. Drop-out rates are quite low once the child starts because we engage them and they know it's fun, it isn't like school work."
> – Facilitator, group 1

Investing time in building local relationships and reputation was critical to successful engagement with schools

Most thought that over the early trial period the service built good relationships with schools and that schools became the most productive referral sources, along with social workers. Within this, some variations were reported – for example, one facilitator observed that secondary schools were somewhat more likely to be challenging to engage, if they were concerned about CYP missing out on education due to attending WeMatter.

> "They [secondary schools] can be quite negative about it. It's trying to get them to understand eight weeks with us can make a huge difference to how they engage for the rest of the school year."
> Facilitator, group 1

In addition, one facilitator observed that schools were most engaged where they had a team approach to supporting CYP's wellbeing. In those instances, the facilitator felt that schools accepted external agencies as part of the team supporting CYP and were grateful for having access to specialist support.

> "I think the schools that [are most engaged] see us as part of the team around that child. So, the schools that are into multi-agency working already realise they can't do it all in-house and actually we're there to help."
> – Facilitator, group 3

Schools provided pastoral support to CYP attending the service during and after the WeMatter sessions

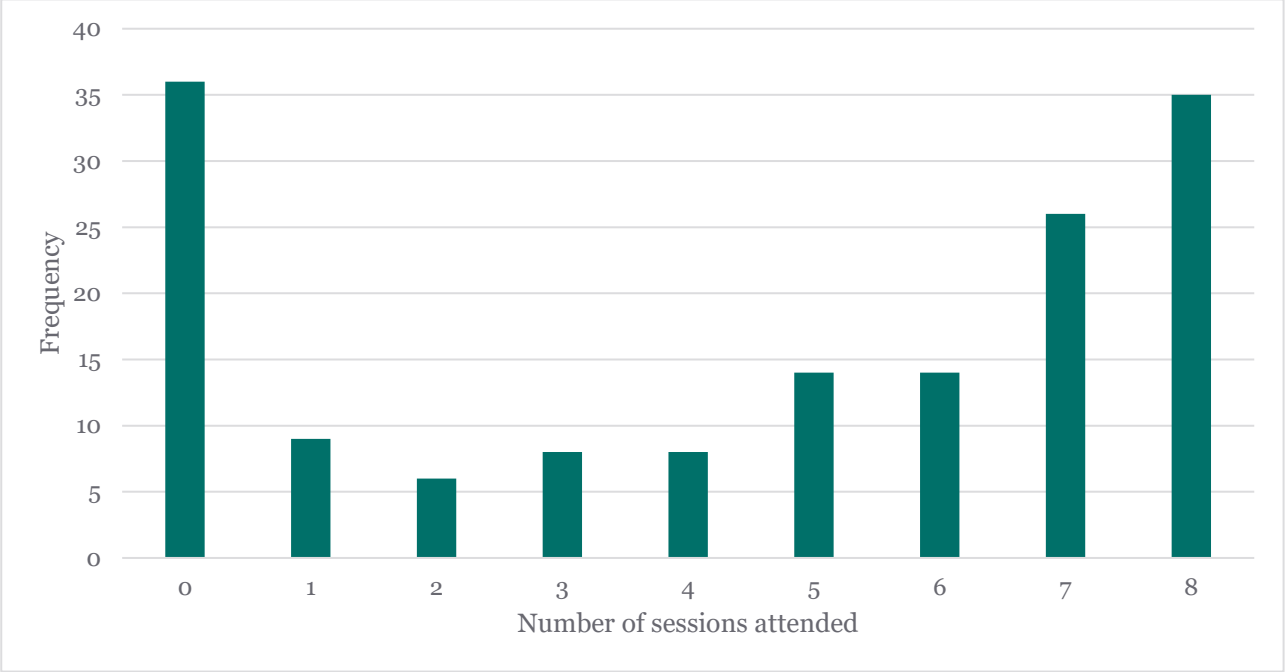
Schools had designated members of staff supporting CYP who attended the service. For example, designated staff took CYP to and from WeMatter sessions and were available, if needed, during the sessions. School staff also informally supported CYP after WeMatter sessions – for example, they checked if CYP felt fine after the sessions or, in one case, supported CYP with using the techniques they learned for managing difficult emotions.

Dosage

Over half of CYP randomised attended the minimum number of sessions Victim Support considers needed to complete the programme (five sessions). Lower dosage was primarily driven by attrition from the programme, with almost a quarter never attending a session

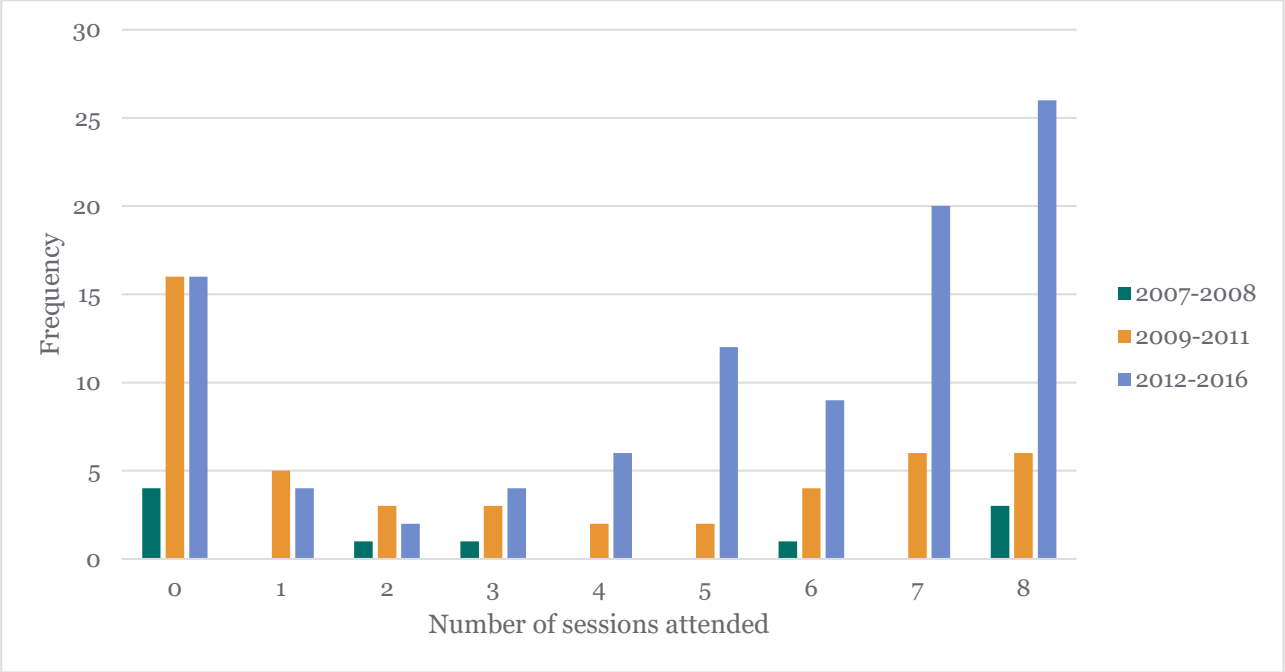
CYP randomised into the treatment arm attended an average of 4.44 sessions (n = 156). Most (n = 89; 57%) attended at least five WeMatter sessions – the minimum Victim Support considered enough to complete the course – with 35 (24.4%) attending all eight (Figure 8). Just under a quarter attended no sessions at all (n = 36; 23.1%).

Figure 8. Number of sessions attended by treatment arm CYP (n = 156)
(go to accessibility text)



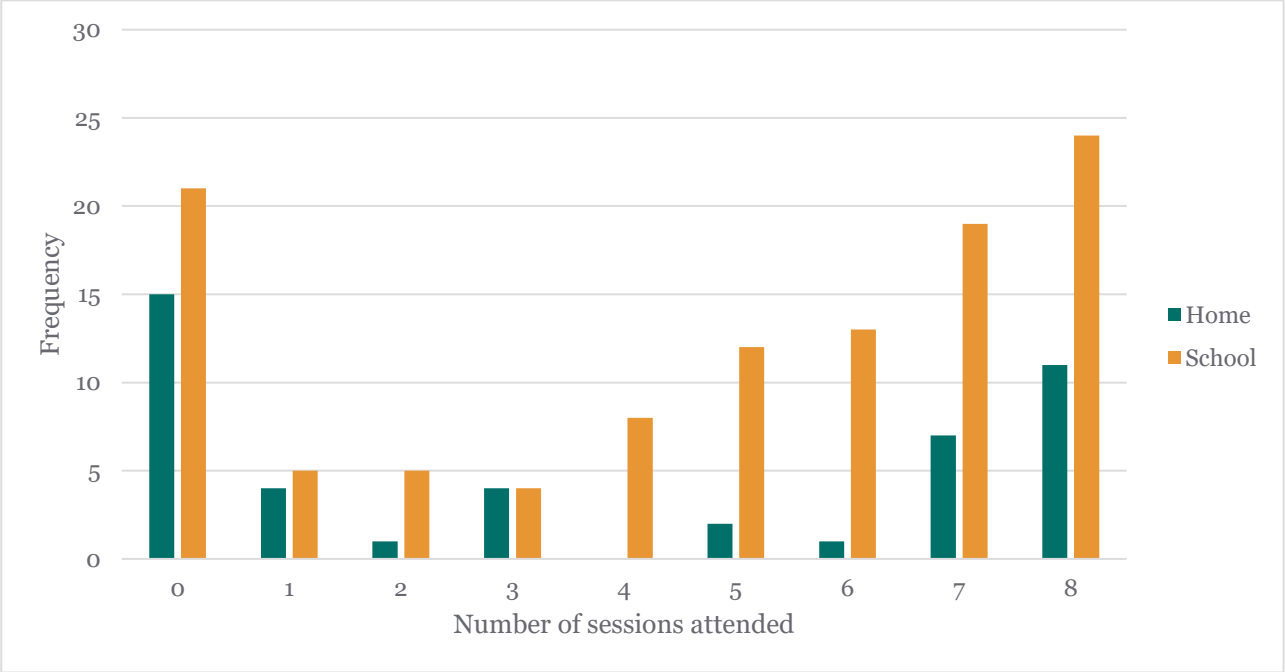
Treatment arm CYP born in 2012–2016 attended an average of 5.11 sessions – more than seen in older cohorts (2009–2011: 3.23 sessions; 2007–2008: 3.50 sessions; Figure 9). This pattern of completion exacerbated the skew in recruitment towards the youngest cohort, who made up 63.5% of all CYP randomised into the treatment arm.

Figure 9. Number of sessions attended by treatment arm CYP, by year of birth (n = 156) (go to accessibility text)



We observed a similar pattern when breaking down the treatment arm by delivery setting, with CYP taking part at home – already the minority at recruitment – having lower mean dosage (3.80 sessions) than CYP taking part at school (4.70 sessions; Figure 10).

Figure 10. Number of sessions attended by treatment arm CYP, by delivery setting (n = 156) (go to accessibility text)



We further explored dosage by the equality, diversity, inclusion, and equity (EDIE) characteristics available to us in the data and saw little variation between sub-groups. Where descriptive differences were apparent, the sample sizes involved were too low to allow for meaningful inference. Charts showing each of these breakdowns can be found, for reference, in 'Appendix F: Session attendance by CYP characteristics'.

CYP, parents/carers, and facilitators felt that CYP attended enough sessions for WeMatter to achieve a positive impact, but this finding may be subject to selection bias

Interviews with CYP, parents/carers, and facilitators suggested they thought that most CYP attended enough sessions for the intervention to have a desired effect. These CYP were interviewed as part of their final one-to-one session with their facilitator and were perceived to have completed a sufficient number of sessions to attend their final session.

For example, most CYP and parents/carers felt that CYP benefitted from attending WeMatter and highlighted specific things CYP felt they learned and applied in their lives, and the difference this made.

> "He remembers how to deal with his anger – counting, deep breaths."
> – Treatment arm parent/carer of male, 8–12

> "I've been feeling very calm. […] How they've helped me has got some stuff off my mind and made me realise that things are better if you're calm."
> – Treatment arm CYP, female, 8–12

> "Before I started We Matter, I was very angry, and I was taking my anger out on people that I loved. And I don't do that now."
> – Treatment arm CYP, female, 8–12

However, facilitators also suggested that CYP missing sessions potentially affected the peer support mechanism, which is important for achieving intended outcomes. They explained that where CYP missed sessions, their absence sometimes affected the group dynamic and rapport with other CYP, potentially reducing discussions and the extent to which CYP could benefit from peer support in those groups.

In addition, some facilitators stressed that the impact of missing sessions may depend on which sessions were missed and also whether catch-up sessions were held, which were not often offered during the trial. As one facilitator explained, missing the initial session can be challenging because it is important for building rapport, whereas missing the last session may have less impact because it involves going back over the content covered in previous sessions. Without catch-up sessions, CYP also lack the opportunity to make up for the content they missed. For this reason, catch-up sessions should be treated as an integral part of the intervention and added to the intervention protocol and the ToC.

Support to CYP and parents/carers was primarily provided during the scheduled sessions, and support by Victim Support outside these was limited during the trial

Facilitator support outside the group sessions was relatively rare: most CYP and parents/carers did not report receiving such support. Facilitators' understanding was that they should not offer CYP support outside the scheduled eight sessions during the trial, because this would lead to CYP receiving different levels of support. That included not offering individual catch-up sessions. However, there were a few cases where support was provided to help families deal with court hearings or other agencies.

Adaptation

WeMatter content was adapted as planned to suit different age groups and meet participants' individual needs; there were no variations in delivery settings

The form of certain WeMatter activities and elements was deliberately flexible so that they could be tailored to the needs of different participants. For example, facilitators explained – and this was also reflected in CYP interviews – that content and resources for younger WeMatter groups included more games, which younger CYP enjoyed, whereas older CYP preferred having more discussions. Facilitators noted they also adapted topics and resources based on age – for example, discussing future relationships and consent in relationships with older CYP, as well as signposting them to suitable apps.

> "I find that with the older children, the engagement looks different. Maybe they won't be too engaged with the games, but there will be that engagement that does grow over time. I feel that with younger people the engagement is there from the get-go."
> – Facilitator, group 2

Facilitators also noted that age differences in 8–12-year-old groups were occasionally too large – for example, older children were using more explicit language related to their experiences of domestic abuse, which could be confusing to younger children. For this reason, grouping based on age was adapted for two 12-year-old CYP because they were seen to fit better in a 13–15-year-old group than with 8–12-year-olds.

In addition, facilitators stressed their approach was flexible and tailored to individual needs in terms of participants' communication preferences. For example, some CYP with SEND preferred to text in the group chat rather than talk during sessions; one CYP was allowed to be partially visible, because they felt uncomfortable about being on camera. Also, where individual CYP needed materials to support them during WeMatter sessions – for instance, asking for paper copies of the materials used in sessions – facilitators liaised with schools to provide those materials.

> "Say it was a question I was uncomfortable with, and I didn't really want to answer it, then I would just put it in the chat that I didn't want to answer. And they were really calm and understanding about it."
> – Treatment arm CYP, male, 8–12

Some CYP, parents/carers, and facilitators also highlighted adjustments that were made to ensure the service was tailored to individual needs – for example, being flexible in terms of communication methods or adapting content and resources by age.

> "We had a member of staff who was neurodivergent and specialises in understanding children's needs, so he had a look over the materials and helped us to adapt them to make them more inclusive. So, we can make changes like that when it's necessary, and it still meets the criteria of what we're delivering."
> – Facilitator, group 1

Adaptations of this kind, therefore, did not undermine fidelity but rather supported fidelity of function in allowing the service to engage CYP with the content of the sessions in the most suitable terms.

There were no adaptations or variations in terms of planned settings: interviews suggested all WeMatter sessions were delivered at home or in schools. However, as mentioned, 12 CYP attended individual rather than group sessions (due to insufficient participants allocated to those groups), preventing any benefits from peer support.

Responsiveness

CYP engaged in, and enjoyed, activities and discussions in their WeMatter sessions. Most CYP and parents/carers reported that CYP looked forward to WeMatter sessions and some CYP also said they would miss them once they stopped

Interviews with younger CYP (age 8–12) suggested this age group particularly enjoyed games and interactive activities, which they described as fun and interesting.

> "WeMatter was all about having fun."
> – Treatment arm CYP, male, 8–12

> "It's fun to have more sessions, I could learn more stuff."
> – Treatment arm CYP, male, 8–12

Facilitators felt that levels of engagement increased over the duration of the course, as they built rapport with CYP and CYP got to know each other better. Within this, as one facilitator explained, there were some variations in engagement, depending on how extroverted or introverted, confident or not CYP were about talking in peer group settings. Variations in CYP's engagement were therefore perceived in relation to their character rather than demographic characteristics.

Most CYP and all parents/carers found the service acceptable and viewed particular aspects of the intervention in very positive terms. WeMatter, therefore, met a necessary condition of trial feasibility in terms of service acceptability to beneficiaries

Key reasons highlighted in interviews include:

- **Relevant focus/content:** All parents/carers perceived the focus of the service on recovery from domestic abuse experience as highly relevant and felt their CYP needed such support. Most CYP found the issues around healthy and unhealthy relationships and strategies to manage feelings relevant to their lives, so were open to engaging in activities and discussions around these topics.

  > "I liked the interactive activities. It helped to engage us as well, have us all chatting at the same time. […] They've all been quite helpful."
  > – Treatment arm CYP, male, 15–17

  > "I think they're really good about telling us what to do. Especially the ones where they tell us techniques about how to keep us calm. That was one of the most useful things I found. How to approach different situations, I found that really helpful."
  > – Treatment arm CYP, male, 15–17

  > "[I thought] yes, this is exactly what [my child] needs to help her look on the brighter side of things rather than the negative and how to cope with her anger."
  > – Treatment arm parent/carer of female, 8–12

- **Speed of access to support:** This was particularly appreciated by parents/carers, many of whom were impressed by fast access to WeMatter support compared with their broader experiences of limited service availability and long waiting lists.

  > "There are waiting lists for everything, so I think she was really lucky so got on. We expected to wait but we feel really lucky."
  > – Treatment arm parent/carer of female, 8–12

- **Ease of access:** Parents/carers also felt that WeMatter practical arrangements made access to support easier, specifically the digital nature of the service and a choice of setting.

- **Peer support:** Interviews with CYP suggested most enjoyed meeting other CYP with similar experiences and some also liked being able to make new friends in their WeMatter groups.

  "Being with other kids, it gives them the feeling that they're not going through it on their own. It's not just them."
  – Treatment arm parent/carer of male, 8–12

  "I made loads of friends, that was my favourite thing."
  – Treatment arm CYP, male, 8–12

- **Group setting:** Many CYP felt it was easier to participate in group support sessions rather than in individual support, which they thought could be too intense.

  "The fact that it was group sessions was good, it's not as awkward if it's group sessions. If it's a one-to-one, it's quite awkward, it's almost like an interview and it feels kind of strict."
  – Treatment arm CYP, male, 13–15

- **Privacy:** Parents/carers also appreciated that WeMatter allowed more privacy to CYP to discuss their feelings, away from their parents/carers and peers who may know them in their local area.

  "I think that is important to give the children the freedom to express the concerns without parents in the background."
  – Treatment arm parent/carer of male, 13–15

- **Flexibility:** CYP and parents/carers also appreciated how flexible facilitators were with adapting to their needs. CYP preferences were accommodated – for example, where a few asked to be in groups run by female facilitators or not to be fully visible on camera where they felt uncomfortable about this.

Quality

Most CYP and parents/carers shared very positive views of WeMatter facilitators and how they delivered the service. Both CYP and parents/carers approved of the WeMatter staff's approach, with parents/carers describing triage staff and facilitators as friendly, supportive and flexible, and CYP seeing their facilitators as funny, lively, and energetic

Interviews with CYP and parents/carers also suggested they found WeMatter staff had a clear understanding of the service and were willing and able to adapt the service to meet individual CYP and family needs.

"She seemed friendly, easy to talk to, so that was quite good."
– Treatment arm parent/carer of male, 8–12

Furthermore, most CYP were able to highlight aspects of the service they enjoyed and found useful – for example, specific activities, topics, and discussions with CYP with similar experience.

> "I'm just a very anxious person. I overthink a lot. And WeMatter made me realise that for one, it's okay to be in your head, but you can also talk about it."
> – Treatment arm CYP, female, 15–17

> "The sessions are fun, because we would be learning something. About how if you do something, how it could make someone else feel. We would be learning about how we have to care about ourselves."
> – Treatment arm CYP, female, 8–12

The intervention could be improved through providing marketing materials, feeding back to parents/carers, increasing facilitator retention and capacity (e.g. for catch-up sessions), and scheduling groups around school holidays where possible

Based on the discussion of the implementation of WeMatter in this section, the following areas for potential improvement in future delivery were identified:

- **Marketing materials:** Providing more marketing materials explaining the service to parents/carers and CYP was felt to be needed to support recruitment and ensure CYP better understand what participating in the service involves.
- **Feedback to parents/carers:** Some parents/carers wanted the service to provide occasional feedback on CYP's levels of engagement in sessions (but not the content of discussions, as they respected session confidentiality).
- **Facilitator retention:** Given the importance of facilitator consistency for the mechanisms of the service to achieve its outcomes, the service would benefit from wider consideration of how to support facilitator retention. Strategies for this may include obtaining long-term funding that could help to increase job security and boost morale, and the provision of external clinical supervision that may help facilitators to reflect on how their work affects them and supports their mental wellbeing. Team engagement and reflective practice events (where staff come together to think about their role, what is going well, what is challenging, and what can be improved) could also support this. Some facilitators suggested additional guidance and training on the randomisation process, and how to communicate this to parents/carers. Dedicated administrative staff could also reduce the burden and pressure on facilitators of trial-related tasks, including scheduling calls with parents, schools, and CYP and undertaking randomisation and data collection.
- **Timing of delivery of school sessions/managing disruption to digital access:** As issues with digital access during school holidays were reported, this barrier may need to be addressed through scheduling school sessions so that they run during termtime or assisting CYP to access the service in alternative ways, especially over the summer holidays when schools have a long break.
- **Managing CYP absences:** Barriers to the service being able to provide catch-up sessions would need to be considered to support participant retention – for example, ensuring sufficient facilitator capacity so they can support individual CYP through catch-up sessions.

Evaluation aims 2 and 3: Perceived impact and theory of change

What did we expect?

The WeMatter theory of change (ToC) identified the following priority outcomes for the service: improved CYP mental wellbeing; improved awareness and understanding of domestic abuse risks; improved ability to identify domestic abuse risks; improved understanding of healthy and unhealthy relationships; increased feelings of safety; and increased feelings of being supported. The IE took quantitative measures of mental wellbeing and feelings of being supported (as priority outcomes for which validated measures exist); the IPE investigated all priority outcomes. For the service to achieve these outcomes, the following mechanisms were identified as key: CYP can engage with support; CYP feel supported and validated by peers in WeMatter groups; CYP have trusting relationships with WeMatter facilitators.

Perceived impact

WeMatter was perceived to have a positive impact on CYP on many outcomes in the theory of change, including on all priority outcomes

There were reported improvements across all priority outcome areas in the interviews, as well as many other outcomes specified in the ToC. Key outcome areas where improvements were reported by CYP, parents/carers, and facilitators included:

- **Healthy relationships:** Many CYP and parents/carers reported examples where, as a result of WeMatter, CYP developed improved ability to identify signs of unhealthy relationships and feel more confident to assert their rights related to relationships.

  > "Before, one of my concerns was that he was constantly in and out of relationships and felt a need to be with someone, and now he seems more content in himself, like he doesn't need to fill the gap as such."
  > – Treatment arm parent/carer of male, 13–15

  > "It has made me know when to say something or go and tell someone."
  > – Treatment arm CYP, female, 13–15

  > "It's helped me a lot because now I feel like I can stand up for myself. Before I used to let people boss me around."
  > – Treatment arm CYP, female, 8–12

  Some facilitators and parents/carers noted the sessions led CYP to reflect back on parental abusive behaviours they had experienced or witnessed and helped them to understand that those behaviours were harmful. Some parents/carers and CYP also observed that CYP applied what they learned in the sessions to their friendships and other relationships and felt more confident in distinguishing supportive from abusive behaviours and standing up for themselves in friendships and relationships.

> "It has definitely helped improve [CYP's] understanding of healthy relationships. There's been a couple of things that happened between me and his mum, conversations that weren't right, and he's been able to call bad behaviour out and recognise that now. He said a few things to me that he wouldn't have said six months ago. So, I think it's definitely helped, and he's been able to stick up for himself more than he was in the past."
> – Treatment arm parent/carer of male, 13–15

- **Emotional self-regulation:** Most CYP and parents/carers greatly appreciated that WeMatter gave CYP skills to manage and cope with difficult emotions better and, as a result, feel calmer and more content. For example, some parents/carers reported CYP argued with them less frequently, their mood was less volatile and negative, and CYP used techniques they learned in the sessions for managing difficult feelings.

> "She used to be very volatile, we would be walking around on eggshells, but we haven't had that in a while. So, whether she is learning to control her emotions or is a little happier, I'm going to take that and run with it."
> – Treatment arm parent/carer of female, 8–12

Those CYP who recognised they were struggling with sadness or anger before starting the service echoed parents'/carers' comments. Some reported using the techniques they learned in WeMatter to manage their anger or sadness. Most CYP who used the techniques felt they helped them manage those feelings at least to some extent and some felt it helped them feel calmer. Some also thought that knowing how to manage their feelings better helped them argue less with their parents/carers or take out their anger on others.

> "Before I started We Matter, I was very angry, and I was taking my anger out on people that I loved. And I don't do that now."
> – Treatment CYP, female, 8–12

> "I used to be really, really shouty, I would scream my whole house down if I didn't like something. And now I don't do it."
> – Treatment arm CYP, female, 8–12

- **Feeling supported:** Most CYP appreciated being able to discuss their feelings and have their experiences validated in a safe space, which made CYP feel more supported and more open to discussing difficult feelings or situations with their parents/carers and other trusted adults and peers.

> "I don't know if it's because of WeMatter, but recently I've been talking to her [my mum] a lot more, being more social with her."
> – Treatment arm CYP, male, 13–15

> "I think I just talk more openly about things. I'm a very reserved person, and I struggle to open up. And We Matter has taught me that it's okay to open up".
> – Treatment arm CYP, female, 15–17

Some CYP commented how they enjoyed being able to discuss their feelings with CYP who had similar experiences and felt both the facilitators and other CYP listened to them and were respectful. Facilitators observed that connecting with other CYP with similar experiences made it easier for CYP to discuss their feelings by reducing the shame some may feel about their family's experience of domestic abuse. In doing so, facilitators felt CYP were empowered and given a voice about their experience.

> "I think there's a lot being said about those children feeling very alone and very much that no one understands the situation that they're experiencing and I think there might be an element of shame around those situations, especially for boys. So, being in a group with younger people who all have those similar interests and they might seem super cool, but actually they've also experienced the same things."
> – Facilitator, group 2

> "I had one little girl, she said she doesn't want her friends to know what she's been through. She doesn't talk to them about it because they don't understand, so she's looking forward to joining a group of other children who understand that."
> – Facilitator, group 1

Facilitators also felt that the positive experience of the service made some CYP more open to engaging with other support – for example, that it helped some CYP trust mental health services more. Some parents/carers also noted their CYP were talking to them more and were more open to discussing difficulties they may be having with them.

- **Mental wellbeing:** Most CYP and parents/carers felt that the improvements in the outcomes above helped CYP generally feel better, suggesting the intervention was perceived to have led to CYP's better mental wellbeing. CYP and parents/carers cited various improvements in different aspects of mental wellbeing, including in terms of CYP's mood, motivation, self-esteem, managing day-to-day tasks, and relationships.

  CYP mainly focused on improvements in terms of their mood and how they managed difficult feelings and situations. For example, they talked about feeling calmer and happier, less stressed and angry, and being better able to advocate for themselves. Parents/carers discussed such improvements, too, but also positive changes they observed in terms of wider behaviours and relationships.

  For example, one parent/carer noted that the child's improved mood meant they re-started seeing their friends after a period when they were isolated socially and were more motivated to deal with day-to-day tasks. Other parents/carers gave examples of improved relationships with their children – for example, a parent/carer reported their child became more protective of them, being more considerate about how tired the parent/carer felt or about her health condition.

There were also other priority outcomes where the findings on the perceived impact were more nuanced and could potentially be re-defined in the ToC:

- **Domestic abuse-related outcomes:** Reported improvements in CYP's understanding of healthy and unhealthy relationships suggested that this helped some CYP assess relationships in their lives for signs of abusive behaviours. However, CYP and parents/carers discussed these outcomes in wider terms of healthy and unhealthy relationships rather than specifically domestic abuse, which reflected the terminology and a trauma-informed approach used in WeMatter sessions.
- **Safety-related outcomes:** Interviews with CYP suggested that WeMatter contributed to their feelings of safety by providing a safe space and helping them open up to trusted adults and/or peers. Some CYP also felt the service helped them learn about safety planning and strategies. These findings suggest that WeMatter helped improve CYP's ability to keep themselves safe, which may be a more accurate way to define this outcome than the current wording, which may be too broad (i.e. 'increased feelings of safety').

Most priority outcomes are well defined in the ToC and adequately reflect the perceived impact of WeMatter. The findings indicate that some outcomes in the ToC could be adjusted to better reflect the service approach

Specifically, the following changes could be made to further refine the ToC:

- **Emotional regulation:** Outcomes related to emotional regulation may need to be highlighted as priority outcomes, given their perceived importance to CYP and parents/carers to improvements in CYP's mental wellbeing.
- **Domestic abuse-related outcomes:** Defining priority domestic abuse-related outcomes in terms of CYP's understanding of, and ability to identify and mitigate risks of, unhealthy (abusive) relationships may reflect the intervention better, because those are the terms and perspective used by the intervention and CYP and parents/carers.
- **Safety-related outcomes:** The safety-related outcome could be re-phrased to more specifically reflect the improvements in CYP's awareness and understanding of safety planning and strategies rather than overall feelings of safety, which may be too broad.

The IPE did not find that there were any outcomes of the intervention that were missing from the ToC.

Mechanisms

WeMatter was perceived to have achieved intended outcomes broadly through the mechanisms specified in the ToC: successfully engaging with the service, feeling validated and supported by their peers, and having trusted relationships with the facilitators. There are some additional considerations for these mechanisms to work as intended

The findings below outline to what extent the three key mechanisms worked as intended and whether any adjustments may be needed to how the service works or to the ToC.

Mechanism 1. Most CYP were able to successfully engage with the service: The ToC proposed that CYP would be able to successfully engage with the service because the service would be accessible, the WeMatter content and approach would be engaging, relevant, and tailored, and

CYP would be supported to attend WeMatter sessions by parents/carers and schools. All of these mechanisms were borne out, although certain barriers to access were also highlighted that may need to be addressed in future delivery.

Interviews with CYP, parents/carers, and facilitators suggested that the service was accessible due to key aspects including: the fast referral process and short waiting times, having a choice over the setting where the service is attended (i.e. home or school), and most parents/carers and schools supporting CYP to attend. In addition, some parents/carers and CYP also stressed that the digital nature of the service made it more accessible because they felt this provision addressed gaps in their local services, where these were absent, limited, or overstretched.

Interviews with CYP also suggested most CYP found the WeMatter content and approach engaging and relevant. Many CYP felt that topics such as healthy and unhealthy relationships or managing difficult emotions were of interest to them and that interactive activities and group discussions were interesting.

However, the service may need to consider some additional barriers to access when specifying mechanisms to ensure service accessibility:

- **Disruption to access during school holidays:** Some parents/carers, CYP, and facilitators reported this was the reason for some CYP absences.
- **Reassuring schools about missed education:** Some facilitators suggested that secondary schools were less likely than primary schools to support students to attend WeMatter, where they were concerned about students in exam years missing lessons. It may be helpful to consider how the benefits of WeMatter in terms of supporting students to be able to engage with education could be communicated to schools to address these concerns and bring them on board.

Mechanism 2. Most CYP felt validated and supported by their peers in WeMatter groups: Most CYP felt positive about WeMatter being delivered in groups rather than one-to-one sessions, for a number of reasons. CYP appreciated talking to peers with similar experience and having a safe space to share their feelings, which they sometimes could not do with their friends or parents/carers. CYP also felt that the group setting made conversations more relaxed than one-to-one sessions. Many CYP described others in their group as friendly and supportive and enjoyed talking to them. A few also felt they made friends and reported keeping in touch with people from their group outside the sessions.

> "I felt very comfortable, and I think it's a very open space. It's easy to talk, in a way that I normally wouldn't."
> – Treatment arm CYP, female, 15–17

Parents/carers liked the format of group sessions, too, because they thought that seeing other CYP with similar experiences may help their children feel they were not alone in their experience. Some also thought groups may be helpful because children could see how different people responded in similar situations and hear different views, which might help them understand what they were going through.

> "I thought it was good to help [CYP] and know they were not alone and that other people had experienced similar things, he would be able to bond or understand that he is not alone in feeling how he is feeling."
> – Treatment arm parent/carer of male, 8–12

Most parents/carers had little awareness of the interactions their children had with other CYP in their group, except in a few cases where CYP commented on this. A few parents/carers reported their children said others in the group were nice, friendly, and respectful and that they liked being able to hear about different people's experiences. Some also said that CYP wanted to keep in touch after the course but were unsure how to do that.

> "It can be beneficial to see different personalities and people in different situations for you to get different views. This helps children know that lots of different people go through this."
> – Treatment arm parent/carer of male, 13–15

> "They can understand each other and what they are going through, they can be more sympathetic."
> – Treatment arm parent/carer of male, 8–12

Facilitators thought that it was important to include diverse CYP within the groups and not separate some groups from others – e.g. CYP with SEND. They felt this was a strength of the service and one of the reasons the group dynamic worked well.

> "On the whole, diversity within group is more fruitful than grouping based on characteristics."
> – Facilitator, group 1

However, facilitators also highlighted certain factors that affected group dynamic negatively. Where groups were smaller due to participant recruitment challenges, absences, or attrition, facilitators felt this impacted the group dynamic negatively – for example, by limiting opportunities for discussions or reducing rapport. In these instances, this key mechanism for achieving service outcomes was weakened.

Mechanism 3. Most CYP reported trusted relationships with facilitators: CYP described facilitators in very positive terms, referring to them as 'cheerful, energetic, funny, kind, open-minded and non-judgemental'. Their feedback suggested that facilitators' approach and style to facilitating sessions worked well to engage CYP, by being lighthearted, flexible, and non-judgemental.

> "She's got really good energy. She's really understanding, and she took time to understand what me and the others were trying to say."
> – Treatment arm CYP, female, 8–12

Many parents/carers echoed CYP's comments as they found facilitators supportive, clear, and informative, whereas some also reported their children's comments on facilitators suggested they were fun and engaging.

> "They made it really fun and really engaging even though it was a serious topic."
> – Treatment arm parent/carer of female, 8–12

Where facilitators changed partway through the course, CYP varied in how they felt about this. Some enjoyed meeting different facilitators, but in other cases CYP rapport with facilitators may have been impacted by the change. For example, a couple of CYP in that situation did not know their facilitators' names.

Parents/carers (often the driving force behind CYP joining WeMatter) and schools were seen to be supportive and to facilitate CYP engagement with the programme

Many CYP reported their parents/carers wanted them to take part in WeMatter and this was the reason they initially joined the course. Those CYP attending at school also talked about school teachers taking them to the sessions and supporting their access in this way. One child also reported using the techniques they learned for managing difficult emotions with their teacher in day-to-day situations where they felt sad or angry.

> "We do this thing, it's like 10 levels. When I first get sad, we do the breath thing. If that doesn't work, we look for five things that are sparkly. If that doesn't work, we look for five things that are shiny. If that doesn't work, we think of things in our imagination."
> – Treatment arm CYP, female, 8–12

No CYP reported any issues or barriers in terms of parental/carer or school support for participating in the intervention, apart from lacking information about the service before their first meeting with the facilitator. CYP's initial understanding and experience of joining WeMatter could be improved by providing parents/carers and schools with tailored marketing materials – for example, videos – to explain the service to younger and older CYP.

The IPE did not identify any missing mechanisms for achieving desired outcomes

However, the IPE found that only a few CYP and parents/carers received support between WeMatter sessions – for example, through engagement with multi-agency meetings or referrals to specialist support. Therefore, in this sample of CYP and parents/carers, the service had limited ability to influence the extent to which CYP stay free of abuse (i.e. the mechanism 'CYP stay safe and free from ongoing abuse'). Based on this data, CYP staying free of abuse may be better treated as an assumption on the conditions needed for them to engage with the service, rather than a mechanism.

Moderators

We did not find evidence of significant differences in perceived outcomes or mechanisms between different demographic groups

Similar outcomes were reported in interviews with different groups of CYP and their parents/carers, when compared by age, gender, ethnicity, SEND, or FSM status. Facilitators did not report variations either in the level of engagement in WeMatter sessions or perceived outcomes across these different demographic groups.

However, it is worth noting that the IPE qualitative sample was skewed in terms of age and ethnicity towards the 8–12-year-old group and White British participants, with 21 and 19 out of 26 interviewed CYP being in the younger age group or White British, respectively. Although findings from these interviews did not suggest different outcomes based on age or ethnicity, further research with older CYP and those from minoritised ethnic backgrounds is needed to reach more conclusive findings. In particular, older CYP were less likely to be recruited and retained in the intervention.

Reported engagement and outcomes did not vary by delivery settings, although some interviewees indicated that access was easier at school and retention was higher in school-based delivery settings.

Participant outcomes were dependent on the fidelity with which the intervention was delivered. In some cases, key mechanisms – such as peer group dynamic and support, and relationships between CYP and facilitators – were weakened by challenges in service delivery, which led to smaller groups or facilitator change partway through the course.

Timing of sessions affected participant access for those attending WeMatter at school

Participants whose sessions were scheduled during school holidays experienced disruption if their access to the service depended on attending at their school, which in some cases led to leaving the course.

Unintended consequences

Some parents/carers and stakeholders expressed awareness of the risks involved in broaching difficult experiences and upsetting CYP, but felt this had not been a problem; however, an unintended consequence was missed lessons in some school groups

Parents were keen to stress that the sessions did not have any negative outcomes on how children felt, despite having dealt with broaching difficult experiences previously, and that their children never seemed worried or upset after the sessions.

> "He's never come home upset or come home more worried. That's one of the things that did play on my mind, because I thought other kids talking about certain things might trigger things in his mind. But I didn't get any vibes of that. I can't really say there were any negatives."
> – Treatment arm parent/carer of male, 8–12

Missing out on education, however, was highlighted as an unintended negative consequence for some CYP attending WeMatter in school, particularly for those behind with their work in key subjects or in exam years. In those instances, the timing of sessions can be important to avoid missing lessons.

> "It was not ideal because it is outside of the timetable, so she will miss parts of her first period."
> – Treatment arm parent/carer of female, 8–12

Differentiation

WeMatter sets itself apart by offering provision where no alternative services may exist, and by offering greater accessibility, anonymity, and peer support

The interviewed LA representative felt there was very limited support available for CYP who have experienced domestic abuse. For example, their local domestic abuse service offered support for people over 16 years old, and their local women's centre offered therapeutic services, including those for women affected by domestic abuse. In their LA, if a CYP is under a child protection plan, a social worker would try to identify a support programme and in severe situations the social worker would be involved personally in offering healthy relationship support; however, this would only apply in a few select cases where immediate support is needed.

The interviewed school Pastoral Care Lead described a local early intervention programme that offers one-to-one in-person sessions in school to support CYP aged 4–17 living with or affected by domestic abuse. Six sessions are offered and adults are not allowed (compared with WeMatter, where an adult is required in the vicinity). In their experience, the waiting time for this service could be up to two years.

Some parents/carers and CYP were not aware of any services in their area that they could compare to WeMatter. However, a few described one-to-one sessions with a family worker; measures put in place in school – for example, a school chaplain offering one-to-one sessions; and receiving support in primary school from their local Multi-Agency Support Team (MAST). Two interviewed parents/carers described being signposted to Child and Adolescent Mental Health Services (CAMHS). However, both reported that CAMHS were unable to support their CYP: one CYP had to receive therapy before being eligible to qualify for CAMHS support, but there was a seven-month waitlist for therapy, and the other CYP had to wait until their family court process had ended to receive the support.

Where parents/carers and CYP were aware of other services, key aspects in which WeMatter was different were highlighted:

- Shorter waiting times to access the service (sometimes seen to be significantly shorter).
- Group setting rather than one-on-one support, which some CYP and parents/carers felt made it easier for CYP to participate.
- Anonymity due to geographical mix of participants, which parents/carers recognised as a benefit because it reduced worries around privacy.
- Online delivery instead of in-person, which was felt to make the service more accessible and flexible, allowing it to provide support across different areas.
- Non-medical setting and context, which some parents/carers felt made WeMatter easier to use for CYP compared with health services, because they thought their children may feel something is wrong with them when accessing a health service.

Evaluation aims 4 and 5: Implementation of the evaluation

What did we expect?

We expected recruitment into the trial to come through WeMatter's usual referral sources, which include police, GPs, schools, and social services. The trial was to be introduced to the CYP's parent/carer during the initial conversation on the triage call and parents/carers provided with a letter giving more information to enable informed consent. Facilitators would then call parents/carers and, after consent was given, randomisation was done by the facilitators during this follow-up call. This assigned the CYP to either the treatment or control arm.

Outcome measures were collected by facilitators during one-to-one sessions with CYP. For those CYP in the treatment arm, these would have been the introduction and conclusion sessions for the intervention; for the control arm the baseline measure would have been taken soon after triage and the endline measure during their introduction call. All CYP were to complete the Stirling Scale at baseline and endline, including those who ceased participating in the intervention. Following the September 2024 review meeting, we introduced a secondary outcome measure, the Social Support Scale, which was to be administered to CYP aged from 13 to 17 years old from that point, alongside the Stirling Scale.

Fidelity to the evaluation protocol

Randomisation was followed in general, but Victim Support amended the allocation for some CYP

CYP were automatically allocated to specific groups when they were randomised, as planned. In some instances, group allocation was unsuitable for CYP – for example, because they were not available on those dates. Facilitators and project leads felt there was a lack of clarity on what they should do in those situations. They addressed this issue by randomising CYP who were in that situation again, hoping they would be allocated to a suitable group. However, facilitators quickly felt this approach became challenging due to an increasing number of CYP needing to change groups, so they instead moved CYP to other, more suitable WeMatter groups within the treatment arm, rather than randomising them again. On both of those accounts, this was a departure from the trial protocol.

> "We moved two 11/12-year-olds to another group. They were better suited to that secondary age group rather than that primary age group."
> – Facilitator, group 3

Facilitators found the randomisation process clear and felt that using the spreadsheet provided by the evaluator to assist them with the randomisation process was straightforward. However, CYP availability for the blocked groups posed a challenge

Facilitators explained that the spreadsheet made it easy for them to see on the call with the parent/carer which blocks and groups individual CYP would be in. In addition, facilitators felt that

having a script setting out how to explain randomisation to parents/carers was very helpful and made it easier to clarify the rationale and process to parents/carers.

The following barriers led to some CYP being randomised more than once or re-allocated across treatment groups:

- Parents/carers confirmed their children's availability for particular group dates and times when they gave consent; however, when facilitators discussed group dates and times with CYP and schools, it sometimes transpired that these clashed with lessons or other activities important to the CYP or from the school's perspective.
- Sometimes baseline data was not collected in the designated two-week period between the CYP's randomisation and group start.

Outcome measures were easy for CYP to complete and were seen to be appropriate

The outcome measures and questionnaires worked well in terms of CYP ability and willingness to answer those questions. Facilitators and CYP generally found the questionnaires used to collect outcome data easy to understand and appropriate in terms of their focus and presentation. For example, CYP thought that the language used was mostly easy to understand and felt comfortable answering those questions. Some CYP also commented they liked the visual presentation of questions (colours used, table format), that the forms were not too long, or that they enjoyed scoring statements about how they were feeling.

> *"I had fun answering them."*
> – Treatment arm CYP, male, 8–12

> "I love answering questions. I like them because it keeps me entertained."
> – Treatment arm CYP, female, 8–12

Facilitators did not report any major challenges in terms of using the questionnaires with CYP. Some even felt that collecting baseline outcome data from CYP provided additional nuance and richness to the information they collected about CYP during their introductory one-to-one session.

However, there were certain aspects of the questionnaires that some facilitators or CYP felt worked less well, without causing any major difficulties in answering those questions. For example, a facilitator felt that the way statements were worded in the primary outcome measure could sometimes feel patronising to older CYP (16–17-year-olds), and that the secondary outcome measure felt more appropriate for this group. A few CYP highlighted some aspects of the primary outcome measure they found less clear. For example, some felt that options such as 'quite a lot of the time' and 'some of the time' were too similar to be easy to choose from. Others felt that some statements were too similar – for example, 'feeling calm' and 'feeling relaxed'.

> "I worry sometimes that I'm patronising a 16- or 17-year-old with the first set [of questions]."
> – Facilitator, group 2

Facilitators did not report any challenges in terms of recording outcome data. There were no missing items in the endline Stirling Scale measure for any CYP who completed it. One participant

had several missing items at baseline and was subsequently excluded from the analysis (which would always have happened because they also did not provide an endline measure).

Data collection and consolidation provided significant challenges during the trial, and were linked to increased staff workloads. Given the fixed capacity during the trial, the data collection requirements caused significant pressure within and issues for Victim Support

WeMatter project leaders and the operations manager, who were responsible for collating, checking, and providing required data, highlighted the following enablers. They observed that it was clear which data was required, which tools they should use to collect that data, and the format and frequency in which the data should be provided to the evaluator. They also noted that the tools provided by the evaluator – the Excel data collection sheets – were clear in terms of how they were organised and how data fields were specified. To further improve data collection tools, facilitators suggested that Excel sheets are combined into a single sheet with different tabs, which they felt would make data recording, checking, and management easier.

> "I think we were clear on the process. […] We realised later on in the trial that instead of having separate sheets, it would be easier to collate them together and just have different tabs."
> – Project leader 1

However, they also highlighted multiple barriers that affected their ability to provide the required data:

- **Data management challenges:** Manual data management was a significant challenge. Staff explained the Victim Support case management system (CMS) is usually used to collect monitoring data. However, they were not able to use their CMS in this trial because the data required for the evaluation could not be readily exported to Excel. For this reason, any data updates, changes, or reports (for example, periodic consent and attrition reports for different groups of CYP) needed to be done manually. Staff were also unable to work in the same Excel sheet, due to difficulties around having different users working simultaneously on the same file. Consequently, all facilitators added data for their CYP groups into individual Excel files and this data was then collated in a master Excel sheet by the project leaders and the operations manager.

  Project leaders and the operations manager observed that both of these aspects of data management increased their workload, as well as making it more difficult to track data changes in an accurate and timely manner. Staff explained that because individual WeMatter group Excel sheets were live documents where attendance and attrition data was recorded weekly, they sometimes struggled to keep up with all the updates and transfer them into the master sheet.

- **Staff resources:** A lack of dedicated data specialist resource was highlighted as a major issue in the interview with Victim Support leadership. They thought this role was essential to allow the WeMatter team to provide the required data and felt that many of the challenges involved in data collection were due to the lack of this resource. Victim Support

leadership explained that this role was lacking in the team because the charity was unclear on what the evaluation would involve at the point when it applied for the funding and had put its typical delivery model into the submission.

> "If we were funded for a full-scale trial, I'd have members of the WeMatter team that were data analysts."
> – Victim Support leadership

The workload associated with data collection, management, and reporting was spread across team members involved in service delivery. Facilitators collected consent and randomisation data, as well as baseline and endline outcome measure data. Facilitators and project leaders felt that these data collection and management tasks led to high workload at times, as facilitators struggled to split their time between activities needed to set up new groups and run their groups, as well as collect and record data. Project leaders also felt unsure whether they always had the right skills to manage and provide the required data effectively.

> "I think that [data collection and recording] added a lot to the facilitators' workload and work capacity."
> – Triage staff 1

- **Challenges in collecting baseline data:** Some facilitators felt that the original two-week period between randomisation and the start of WeMatter groups was sometimes too short to allow them to set their groups up and collect CYP baseline data. Facilitators explained that sometimes CYP could not attend the group they were randomised into because their baseline data could not be collected on time. They thought that the extension to four weeks was adequate.
- **Challenges in collecting endline data:** Sometimes it was difficult to reach CYP after they completed their last group session, or there were issues with getting hold of school staff who needed to arrange for CYP to attend their final one-to-one session (where endline data was also collected). Victim Support staff felt some schools may not have engaged with the process of scheduling the final session because they assumed the support had ended. School staff had worked hard to facilitate their pupils to attend the sessions and the final session was an additional request. Their capacity to respond may have been limited when the final session fell in school holidays or at a busy end of term. Project leaders also explained that no endline data was collected from CYP who left the service, because they did not want to engage further with the service. Victim Support staff shortages also contributed to not collecting timely endline data.

> "Some schools will be a bit funny about letting us do that final appointment. So, in that situation, we would then take that to the parent and see if they can do it from home. We've even used a support worker or social worker to see if they can facilitate that final meeting. We do try and exhaust every option."
> – Project leader 1

Uptake

Triage staff and facilitators thought that the rate of consent to take part in the trial was high: they felt very few parents/carers whose children were eligible for the service declined to take part

Triage staff and facilitators emphasised that the main reasons for parents/carers to decline to participate in the trial concerned CYP's availability to start WeMatter sessions or their perceived emotional readiness to engage with a recovery service at that point in time. Triage staff further explained that they had no cases where parents/carers consented to CYP taking part in WeMatter but refused to take part in the trial. However, it is worth noting that participation in the trial was a condition of taking part in the service and therefore this may have been a factor in parents'/carers' consent for CYP to participate in the trial.

Although take-up of WeMatter varied, the trial was unable to confidently conclude to what extent alternative service availability, or the strength of the referral network, impacted this

The project leaders and the operations manager reported higher referrals in those local authorities that had no or very limited alternative services. Conversely, referrals were sometimes lower in those areas with more support provision, because this allowed CYP and their parents/carers more choice of services depending on whether they preferred one-to-one or group support, in-person or online. However, this was not always the case. As project leaders observed, there were local authorities that had some support provision, but existing services were unable to meet the demand and therefore there was still an expected volume of referrals to WeMatter.

Monitoring of the control arm

Despite their CYP being on the waitlist, parents/carers of CYP in the control arm expressed positive views of WeMatter

Some acknowledged they initially felt disappointed their children would need to wait and could not receive support sooner. However, this did not prompt negative feelings about the service or the trial for two reasons. First, control arm parents/carers recognised that support services were stretched and waiting lists were common. Commenting on this, triage staff and facilitators pointed out that parents/carers were sometimes aware that comparatively other support services' waiting times were much longer.

> "Mine have all been quite enthusiastic to be having the support. Even if they are allocated to a waiting list group, they are so relieved. It's a waiting list, but compared to the lengths of some other waitlists, eight weeks is not long."
> – Facilitator, group 1

> "I was a bit disappointed it takes so long but I understand there are lots of children out there going through this, so it takes time to get the slots."
> – Control arm parent/carer of male, 8–12

Second, control arm parents/carers felt that despite having to wait, they and their children felt supported by WeMatter during the waiting period. Parents/carers explained this was because facilitators checked in with them and their children during this period. For example, one control arm parent/carer felt their child already received some support while waiting because the facilitator listened to them and suggested some techniques for managing difficult emotions.

> "They've been available for me since day 1, so you don't really feel like you're waiting."
> – Treatment arm parent/carer of female, 8–12

This was echoed by CYP in the control arm, who also felt positive about their initial contact with facilitators while on the waitlist, which was during the calls to collect baseline data. CYP in the control arm talked about feeling they were listened to after their calls with facilitators and one child also reported learning techniques to manage difficult emotions. This was after taking the baseline measures and therefore suggests that there was a small amount of contamination, as some CYP in the control group received some (minimal) support from facilitators during their waiting period. They did not express any negative feelings about waiting to start their WeMatter groups and felt excited about the prospect of upcoming sessions.

The couple of cases mentioned above where CYP in the control arm reported that facilitators supported them and suggested coping techniques indicate that some CYP may have received a certain level of support during the waitlist period.

Control arm parents/carers did not seek additional support while their CYP was on the waitlist

Reasons for not seeking additional support varied. For example, one parent/carer explained their child did not appear to be struggling emotionally and was happy to wait for WeMatter to start rather than look for other support sooner. Another parent/carer reported their relationship with social services had broken down, making it more challenging to seek other support. Control arm parents'/carers' comments were echoed by some stakeholders. For example, a stakeholder from a school whose students participated in the trial thought their control arm CYP did not access any other support.

However, parents/carers sometimes reported that their children's schools were providing some level of informal support already, helping bridge the waitlist period. For example, a parent/carer felt their child was supported by the teachers and safeguarding lead at their school in a proactive and empathetic way. The school responded to the parent/carer's concerns about their child following a visit stipulated by social services to their father. The school monitored the child and contacted the social worker to describe the impact of the visit on the CYP.

Acceptability

Interviews with facilitators, triage staff, and project leaders suggested they had mixed feelings about the acceptability of the randomisation

On the one hand, WeMatter staff understood and accepted the need for randomisation to help the service determine its outcomes and establish how best to support CYP. On the other hand, some

triage staff and facilitators also felt frustrated about having to randomise CYP into treatment and control arms. Allocating CYP to the waitlist sometimes made them feel they were letting them down, when they thought CYP needed prompt support.

> "It's been really frustrating, particularly when there's many that are on the waiting list groups and none on the immediate start, but I can't bring that support earlier when I know they would benefit from it. I think that's something I've found quite difficult."
> – Facilitator, group 2

> "When you read that risk assessment and that young person is in desperate need of support, and you know that you then have to tell that person that they are on the waiting list; morally, I do find that a little bit difficult to deal with."
> – Facilitator, group 3

Facilitators and triage staff also felt that the specific randomisation process used sometimes made the service less able to meet individual CYP needs. For example, staff reported challenges with CYP being randomised into groups that then turned out to be unsuitable for them, mainly when CYP were unable to attend groups at specific dates or times. Facilitators and project leaders explained they would normally re-allocate CYP to a more suitable group in those situations; however, randomisation made this more difficult. As a result, they felt that randomisation made WeMatter less flexible than its usual approach.

Parents/carers also had mixed feelings about randomisation, although they broadly found it acceptable. Parents/carers felt satisfied that they were informed about the rationale for allocating CYP into treatment and control arms. They understood that random allocation was part of the evaluation, which needed to help the service find out how best to support CYP. However, a few parents/carers thought that CYP were starting at different times to establish if it was more beneficial to receive support earlier or later, suggesting there may also have been some confusion over the rationale for randomisation.

Interviews with parents/carers further suggested that randomisation and the possibility of CYP having to wait to access support also prompted some mixed feelings. Some treatment arm parents/carers discussed feeling relieved once they heard their child was allocated to immediate start, because they felt the child needed support at that time and were concerned about the prospect of having to wait. At the same time, parents/carers also felt tolerant of randomisation and the waitlist because they were relieved to be offered any support at all or knew that waiting times for other services were longer. For these reasons, parents/carers generally found randomisation acceptable.

> "I have been asking for [CYP] to speak to someone from last September so getting the phone call saying they can speak to someone and they can open up is a brilliant thing."
> – Control arm parent/carer of male, 8–12

Parents'/carers' views on randomisation of siblings varied and they sometimes felt conflicted over whether they thought it was better for siblings to be in the same group or different groups. A few

parents/carers noted that having siblings in different groups can be logistically difficult, because it could make it more challenging to support one child to attend WeMatter if the other child/children also needed their support at that time with something else. A couple of treatment arm parents/carers also commented they felt it was unfair for one of their children to access support sooner than the other, when both needed it.

However, some parents/carers also felt there were potential benefits of having siblings in different WeMatter groups. For example, a few noted their children may be more open to share and discuss their feelings without their siblings in their group. Another parent/carer whose older child was in a treatment group and younger child in a control group felt this was beneficial, because the younger child felt more relaxed about starting their group since they heard more about what to expect from their sibling. (We do not have the number of sibling combinations because the information on groupings was unreliable, but an IE sensitivity analysis that dropped all siblings gave results that were nearly identical to the main analysis.)

> "I think it will benefit them more doing it separately, rather than being on the same call."
> – Treatment arm parent/carer of male, 8–12

Parents/carers and CYP did not raise objections to participating in the evaluation and providing their data through completing questionnaires or taking part in interviews

The only concerns raised were related to the prospect of waiting to access support due to the evaluation design. However, parents/carers were very much aware that waiting times for other services were even longer, which made the WeMatter shorter waitlist period feel more acceptable.

The IPE highlighted two major issues to address to make participation in the evaluation more acceptable to Victim Support: allowing the service to retain its usual flexibility within the evaluation design, and improving WeMatter team capacity and skills for data collection and management

Triage staff, facilitators, and project leaders felt the evaluation made them less able to meet the needs of individual CYP. This partly concerned group allocation and the need for the service to be flexible around matching groups to CYP's availability. In addition, facilitators and project leaders felt that the evaluation affected their ability to provide catch-up sessions to CYP who missed some sessions, which was the usual approach for the service and which they felt was important for participant retention.

The evaluation would furthermore be more acceptable to delivery partner staff if issues with data collection and management processes were addressed, including evaluation-related administrative burden placed on staff. Specifically, WeMatter project leaders and the operations manager, as well as Victim Support leadership, strongly believed the team required dedicated data specialist resource to both provide quality assurance and reduce the burden on staff involved in service delivery. Staff also suggested that data collection tasks should be allocated differently, so that evaluation-related work was reduced for facilitators – for example, by not tasking them with randomisation. Project leaders and the operations manager also felt their data management work

would be more acceptable if they were able to rely more on the organisation's CMS and reduce the amount of manual data handling.

Improvements to the evaluation

Victim Support staff made several suggestions for optimising evaluation procedures and timings relating to randomisation and data management

The recommendations from Victim Support to improve the evaluation for a full-scale trial are:

- **Longer time between randomisation and the start of WeMatter group sessions:** Project leaders suggested the period between randomisation and WeMatter group start needed to be longer than the original two weeks to allow for all set-up and data collection activities to complete before the first group session. They were satisfied with the increase to four weeks that was implemented in September 2024.
- **Randomising into lists rather than blocks:** To allow the service to meet individual CYP needs in terms of group allocation, Victim Support leadership and WeMatter project leaders and the operations manager were interested in exploring the possibility of switching from blocked randomisation to two-group randomisation. They felt that abandoning blocks and instead having lists of treatment and control arm CYP – split by age groups and school vs home location – would allow them more flexibility in allocating individual CYP to groups that worked in terms of CYP availability or support needs.
- **Improvements in terms of data management:** Victim Support leadership and WeMatter project leaders and the operations manager thought data management procedures could be improved if they were able to utilise the charity's CMS to automate some data management tasks. Having a dedicated data specialist on the WeMatter team was another suggested improvement, seen as important for streamlining data management processes and reducing manual work. In addition, an option for facilitators to input baseline and endline outcome data into an online survey rather than Excel sheet was raised. WeMatter project leaders and the operations manager felt this change would be likely to reduce their data-related workload, because it would remove the need for them to collate CYP data from individual Excel sheets completed by facilitators for their WeMatter groups.

A range of improvements are needed to help reduce CYP dropping out of the service and attrition from the trial. To reduce drop-out from the service, project leaders and Victim Support leadership were keen to:

- **Reintroduce catch-up sessions for those CYP who missed some of their WeMatter sessions:** Staff stressed the importance of catch-up sessions for CYP retention, because some CYP left the service due to missing too many sessions.
- **Reduce attrition due to the randomisation process:** Some CYP left the intervention (and the trial) because they were not available to attend WeMatter groups they were randomised into.
- **Address disruption to access to WeMatter sessions due to school holidays:** Support CYP with accessing WeMatter in alternative locations, or greater flexibility around

scheduling and allocation to avoid allocating CYP to the school-based groups that are affected by school holidays if CYP are unable to attend at alternative venues.

> "I think we've learned that summer holidays wasn't a great one to start with. So maybe the beginning of the academic year is quite a good time."
> – Project leader 1

Three main suggestions were made to reduce attrition from the trial and address missingness of outcome data:

- **Offer incentives to CYP to provide outcome data:** CYP did not always respond to facilitator contact to organise their final one-to-one sessions, and schools were sometimes unresponsive at this stage or found it difficult to organise the one-to-one session. Financial incentives to CYP for providing outcome data – for example, shopping vouchers – may reduce attrition from the trial by providing an additional motivation for CYP to complete their outcome surveys.
- **Collect endline data from CYP who left the service:** Facilitators and project leaders explained that endline outcome data was not collected for those CYP who left the service because those CYP did not want to engage with the service anymore and staff also felt they needed their consent to continue contacting them. Greater clarity over the distinction between consent to take part in the service and consent to take part in the trial would help address this issue to some extent. This would need to be clearly set out to parents/carers and CYP at the outset of the project, so they understand that consenting to trial participation means they will still be contacted for their endline data even if they have left the service.
- **Use dedicated staff to collect outcome data:** Facilitators and project leaders also explained that tasking facilitators with outcome data collection on top of service delivery sometimes led to high workload. This meant that facilitators sometimes did not have the capacity to re-contact CYP who did not respond to initial attempts to organise final one-to-one sessions and collect endline data. To address this challenge, Victim Support allocated additional staff resource for collecting endline data where CYP were unresponsive. A member of the triage team was able to take over the task of re-contacting CYP and collecting their endline data. Project leaders noted that having this additional resource was helpful to lessen the burden on facilitators and collect more endline data. Their experience suggested that using dedicated staff for collecting outcome data from all CYP – rather than only those who are difficult to reach after their groups ended – would both help reduce attrition and reduce the burden on facilitators.

No difficulties with obtaining parental/carer consent for CYP to be part of the trial were reported

This was not seen as an area requiring improvement by triage staff, facilitators, and project leaders.

Recruitment for qualitative research could be improved by introducing more flexibility for when CYP interviews are conducted, better communicating the research to CYP earlier on, and considering approaches that make recruitment more inclusive and accessible

The following could improve recruitment for qualitative research:

- **Timing of interviews:** Facilitators and project leaders noted logistical challenges arising from the approach where interviews were planned to follow CYP's final WeMatter group session or their final one-to-one session. They explained it was sometimes difficult to match CYP's final session times with researcher availability, impacting which CYP could be recruited. Potential improvements to address this challenge may include devising alternatives to this approach, which would make interview scheduling more flexible, while not compromising on safeguarding requirements. Alternatively, increasing the interviewer team may also help address this challenge by providing more flexibility in terms of availability to conduct interviews.
- **Explaining about qualitative research to CYP at the start:** Project leaders also suggested that the prospect of taking part in qualitative interviews should be explained to CYP early in the process. They felt this would help CYP feel more relaxed and open about taking part in qualitative interviews.

  > "I think it's also key that we give them as much information as possible within that first contact with them. So, they fully know the commitment, they know that it's not just the one initial assessment we're asking them to do."
  > – Triage staff 1

- **Diversity of qualitative CYP sample:** The qualitative recruitment approach in the trial required facilitators to identify and recruit CYP, aiming for a mix of participants based on the sample criteria provided by the evaluator. Although a diverse sample was achieved, there were some groups that were less well represented, particularly the older WeMatter participants (only 5 out of 26 CYP in the IPE sample were aged 13–17). To achieve a more diverse sample in a full-scale trial, it may help for researchers to have greater control over the recruitment process. For example, researchers could pre-select a wider pool of potential participants based on their anonymised data, including a mix in terms of sample criteria. This approach could also mitigate against potential bias in participant selection.

  Project leaders also felt that it was important for facilitators to judge the extent to which CYP would feel comfortable talking to interviewers. They felt this consideration was sometimes at odds with trying to ensure diverse participants were recruited – for example, if some groups felt less comfortable to take part. This is another area that would benefit from greater attention to identify any barriers to taking part in interviews and solutions to overcome them. Exploring alternative interview approaches may also help widen the range of CYP who feel open to taking part in interviews – for example, offering CYP an option to text their answers rather than talk.

Discussion

The IPE found that the core elements of the intervention were mostly delivered with fidelity. This included pre- and post-engagement activities, as well as the main eight-session block, which was delivered as planned in terms of the number and frequency of sessions, the content covered in those sessions, and the approach used. The main deviations from the planned approach occurred where challenges in service delivery affected key service mechanisms. For example, CYP's access to the service in the school setting was sometimes disrupted due to school holidays, facilitators were not always consistent due to staff turnover, and peer interaction and support were limited in some groups with low participant numbers due to challenges in participant recruitment. In addition, post-engagement activities were also sometimes delayed due to challenges in scheduling the final sessions.

Key enablers for successful service delivery were identified as follows: access to digital technology at home or school; trained and skilled facilitators; and parental/carer and school support for CYP to attend WeMatter sessions. However, service delivery was sometimes affected by the following challenges: disruption linked to school holidays; participant recruitment timescale not allowing enough time for referral network building in new areas; and staff turnover.

All parents/carers and most CYP shared positive views on the service, which was acceptable to them due to: the perceived relevance of its focus and content; fast and easy access compared with other services; facilitators' approach described as fun, supportive, and flexible; the group setting and peer interaction element where delivered; and privacy due to group participants being from different areas.

To improve service delivery further, a varied range of improvements was suggested. Some improvements concerned participant recruitment – for example, highlighting the need for tailored marketing materials for CYP and parents/carers, a longer recruitment timescale, or finding ways to increase participant diversity. Other improvements focused on overcoming challenges to service delivery – for example, ensuring digital access during school holidays, improving facilitator retention, offering catch-up sessions to CYP who missed some sessions. In addition, some parents/carers expressed interest in having more feedback on CYP engagement in sessions, as well as handouts and similar materials to help CYP remember what they learned.

The IPE suggested that WeMatter was perceived to be effective in achieving its intended outcomes. Key outcome areas where improvements were reported by CYP, parents/carers, and facilitators concerned CYP's understanding of healthy relationships, their ability to manage their emotions, and feeling supported, as well as an overall improved mental wellbeing. These findings suggest that most priority outcomes are well defined in the ToC and adequately reflect the perceived impact of WeMatter. In addition, where the service was delivered with fidelity, the IPE found that these outcomes were achieved through the mechanisms specified in the ToC.

However, the IPE also highlighted certain areas of the ToC that could be refined, notably in how outcomes related to domestic abuse and safety are defined. Although some CYP and parents/carers thought the service helped CYP recognise signs of abusive behaviours, CYP and parents/carers did not discuss this with explicit reference to domestic abuse, reflecting the trauma-informed approach

of the service, which did not use those concepts. CYP also discussed improvements in terms of their awareness of safety planning, rather than generally improved feelings of safety as defined in the ToC. The ToC could, therefore, be further refined to reflect the concepts and content covered in WeMatter sessions more closely, specifically the focus on healthy and unhealthy relationships, and safety planning and strategies. In addition, the ability to manage difficult emotions could be highlighted as a priority outcome, given its importance to CYP and parents/carers.

The ToC could further be improved to show more clearly which WeMatter activities were flexible, non-mandatory, and less critical for achieving intervention outcomes, as opposed to standardised activities such as the 10-session-block with CYP. This would include clarifying the role and importance of home tasks. We also include catch-up sessions for those CYP who missed WeMatter sessions in the ToC. The IPE suggested that these were important for CYP retention within the service and therefore should be shown in the ToC as an integral element of the intervention.

With respect to the evaluation of implementation, the IPE suggested that the trial was conducted as planned in terms of when randomisation was carried out and the outcome data being collected in the final one-to-one session. However, the IPE also found certain deviations in how these activities were conducted. First, where CYP were randomised into groups that did not suit them, staff randomised them again or re-allocated them to another group. Second, no endline data was collected from CYP who withdrew from the service, partly because of challenges with reaching those CYP and partly because CYP's consent for the service and the trial were not clearly distinguished in the consent process. Third, school holidays sometimes delayed final one-to-one sessions and therefore also the endline data collection.

Certain aspects of the evaluation design were perceived to work well and others seen to pose challenges for service delivery. Staff appreciated a clear randomisation process, helpful script to explain the trial to parents/carers, outcome measures and questionnaires that CYP found easy to complete, and clear data collection requirements and tools. In addition, the waitlist design was mostly acceptable to parents/carers and CYP because the waitlist period was still seen as shorter than the waiting times for other services. However, the evaluation design and processes were also perceived to involve significant challenges in three main areas. Staff felt that randomisation made the service less flexible, because they were unable to meet individual CYP needs in terms of group allocation and start dates. In addition, various data management challenges led to high workload for staff – specifically, the manual nature of data handling and a lack of data specialist resource. The third challenge concerned difficulties in collecting endline data – for example, struggling to reach CYP and schools to organise final one-to-ones and endline data collection sessions.

To improve the evaluation design and processes, the trial would need to allow the service to retain its usual flexibility, as well as be planned to ensure adequate WeMatter staff capacity and skills to support data collection and management. The following changes were suggested by Victim Support to achieve those improvements: randomising CYP into age group- and setting-based lists rather than blocks of 20, to allow for more flexibility in group allocation; and a range of improvements in terms of data collection and management, including having a data specialist resource and using Victim Support's CMS to automate some aspects of data management.

The IPE also indicated improvements were needed to reduce attrition during the trial. Suggested improvements from Victim Support broadly fell into two categories: those addressing challenges

leading to drop-out from the service and those addressing difficulties in collecting endline data. Allowing more flexibility in group allocation (via suggested changes to randomisation), offering catch-up sessions, and addressing disruption due to school holidays were identified as important for reducing attrition from the service. In addition, to overcome challenges in endline data collection, Victim Support suggested improvement including the use of incentives for CYP, and using dedicated staff (rather than WeMatter facilitators) to collect endline data.

The findings above were drawn from a broad range of interviews with different groups involved in WeMatter, whose accounts of the service and the evaluation methods broadly reinforced each other. Having this wide range of interviews, and comparing and synthesising data across different groups and perspectives, is a strength of the IPE design, increasing confidence in the findings. This mix of perspectives and experiences also allowed the IPE to ensure a detailed and comprehensive coverage of all key aspects of the service set-up and delivery, as well as the evaluation implementation methods. In addition, staging interviews across the trial period ensured good recall of experiences across different stages of the trial but also helped capture more informed reflections from staff later on in the process.

Another strength of the WeMatter IPE is its formative aspect, because the findings identify both key areas for improvement to optimise the service delivery, and measures that are needed to improve the evaluation design and data collection processes for a full-scale trial. In doing so, the evaluation offers broader insights on considerations and requirements in terms of evaluation design, data collection and management processes, and resources needed for conducting RCTs in the charity sector and for evaluating interventions supporting vulnerable groups. It highlights the importance of ensuring adequate data specialist resource and capacity for data collection and management, as well as dedicated staff for evaluation-related tasks. It also brings into focus the importance of ensuring that the evaluation design balances methodological rigour with the need to allow the service to operate in its normal ways, including having flexibility if that is a usual aspect of the service.

The main limitation of the IPE design was the lack of data from CYP and parents/carers who withdrew from the service and the trial. This gap was due to challenges in organising interviews with CYP who withdrew because of logistical and safeguarding difficulties. In addition, certain groups of CYP were less well represented in the IPE sample – most notably, those from older age groups (13–15 and 16–17-year-olds) and CYP from minoritised ethnic backgrounds. Further research with both CYP who withdrew and their parents/carers and CYP from less well represented groups is needed to understand their experiences of, and views on, WeMatter.

Another limitation is that fidelity could not be explored through observation of WeMatter sessions, due to the sensitive topics being discussed and risk that having observers might inhibit group dynamic and discussion. The findings around the fidelity of WeMatter sessions are therefore based only on reports from staff and CYP, and could not be corroborated or challenged through researcher observations.

COST EVALUATION

Evaluation questions

The cost evaluation aimed to answer the following research questions:

1. What was the total cost of running the WeMatter service for a year?
3. What was the average cost per CYP accepted to receive WeMatter during the trial?
4. What is the cost of introducing WeMatter to a new local authority (start-up costs)?
5. What are the estimated values of the prerequisites for running WeMatter?

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

Evaluation design overview

We broke cost items down between recurring costs, prerequisites, and start-up costs. New cost items that were identified during the delivery period and the process and implementation evaluation were categorised and added. We collected costs data for delivering the service from 3 June 2024 until 3 June 2025 from Victim Support. Items categorised as 'costs to other public services' and 'costs to wider society' were estimated using information gathered during the interviews with the relevant stakeholders.

A detailed overview of the cost evaluation design is available in the published evaluation protocol.[14]

Deviations from the protocol

There were no deviations from the cost evaluation as set out in the evaluation protocol.

Findings

The total cost for Victim Support to deliver a national WeMatter service for a year is estimated to be £329,075, based on the delivery model employed in this trial (but excluding costs incurred for evaluation activities). Table 12 breaks down the total costs into seven line items, for different types of costs.

[14] See: https://foundations.org.uk/wp-content/uploads/2024/08/WeMatter-evaluation-protocol.pdf

Table 12. Recurring costs to deliver a national WeMatter service all over England

Item	Type of cost	Total costs over a year (£)	Total costs over a year incurred (excluding evaluation-specific costs) (£)	Details
Salary of WeMatter core team	Recurring staff costs	337,492	236,244	An Operations Manager, CYP Project Leaders, (Senior) Triage & Early Interventions Officers, and CYP Programme Facilitators – a total of 10.2 FTE
Non-salary costs for WeMatter core team	Recurring staff costs	12,622	12,622	Disclosure and Barring Service (DBS) checks, work mobile phones, travel expenses, and training
Central support	Recurring staff costs	48,107	48,107	Costs for HR, finance, and payroll services for the WeMatter core team
IT equipment	Recurring equipment costs	12,468	12,468	Costs for access to software (e.g. Zoom licences, access fee for Compass – Victim Support's case management system), access to IT tech support, and new IT equipment when needed (e.g. laptops, display screen equipment (DSE) setups including laptop raisers, mice, keyboards, headphones, etc.), for the WeMatter core team
Other office expenses	Recurring equipment and materials costs	8,427	8,427	Postage, stationery, telephone costs, line maintenance, and any small office equipment
Other costs	Recurring other intervention costs	11,207	11,207	Translator services and Rock Pool support
Total		430,323	329,075	

Note. Cost data was provided by Victim Support. Data on costs associated with the evaluation represents an estimate.

The key assumptions underpinning these estimates are:

- The team structure with nine full-time staff and two part-time staff as specified in Table 12, including four full-time programme facilitators and two facilitators with 0.6 FTEs.
- Similar costs for buying new IT equipment for the WeMatter core team going forward as during the trial period.
- Victim Support was able to inherit a lot of its existing IT equipment and spent around £4,000 (out of the £12,468 for IT equipment) buying new IT equipment during the trial period. We assume that it will spend a comparable amount buying new IT equipment for the same team structure going forward to replace depreciated items, in which case £12,468 would be a good estimate for the total annual costs on IT equipment.
- No expenses were spent on providing IT access for CYP in the trial, because schools and parents/carers were able to provide this.
- Victim Support identified that the only cost explicitly related to the evaluation (i.e. which would not have been incurred outside the context of the evaluation) was a proportion of salary costs. It estimated that about 30% of staff time was devoted to evaluation activities across the year. In our reporting above, we assume that this means costs without an evaluation would be 30% lower, although this may be an under-estimate because some salary costs may be fixed costs.

What was the total cost of running the WeMatter service for a year?

The total estimated cost of running the WeMatter service for a year during the pilot trial was £329,075, and the overall cost including activities needed for the evaluation was £430,323. The estimated delivery costs are not expected to change after the trial, apart from increases in staff costs due to increases in National Insurance. Victim Support has indicated that it plans to keep a similar overall team structure going forward to meet the demand for WeMatter, but to expand the size of the team to support any evaluation activities and to be able to deliver WeMatter at greater scale. It also expects to have similar non-staff costs outside the trial.

What was the average cost per CYP accepted to receive WeMatter during the trial?

We estimate the average cost per CYP randomised during the trial period, if we exclude the costs of the evaluation, to be £329,075 / 312 = £1,054.73. The complexity of the trial, staff turnover (possibly linked to trial requirements), and the lower number of referrals especially in the first months of the trial meant that the cost per CYP randomised into the trial was higher than Victim Support's original estimate of £500 per CYP. That estimate was based on Victim Support's planned capacity to serve 752 CYP during the trial period.

When comparing the costs of WeMatter with those of delivering the in-person one-to-one business-as-usual service (BAU), Victim Support indicated that the main differences in

expenditure would be the office and travelling costs for the staff, because other costs are standard. It estimated on average that it might cost £1,200 more per staff member for BAU compared with WeMatter. Assuming a similar core-team structure as specified in Table 12 for delivering BAU, the total costs of delivering BAU for a year will be around £341,075 (total delivery cost of £329,075 + travel at £1,200 x 10). Victim Support has estimated that non-office-based staff incur extra costs like a home working allowance, and staff travelling to the office incur travel expenses and office costs. It expects the overall staff costs of BAU to be higher than the costs of WeMatter because of its higher direct costs. Further, WeMatter facilitators can take on much larger caseloads than BAU caseworkers, meaning that there would probably be a major difference in terms of cost per CYP.

What is the cost of introducing WeMatter to a new local authority (start-up costs)?

It is difficult to provide a single estimate for the start-up costs of introducing WeMatter to a new area, because that depends heavily on how intensively Victim Support conducts outreach, and its approach can vary a lot between areas. Victim Support has shared an indicative estimate of approximately £22,000, which consists of £8,000 of the operations manager's time and £14,000 of the full core team's time during the start-up period.

What are the estimated values of the prerequisites for running WeMatter?

There are no major prerequisites for Victim Support to deliver WeMatter, other than the referral pathways Victim Support has established already for other services it provides, which could also be used for WeMatter. However, there are prerequisites from other public services and the wider society, mainly in terms of the existing IT equipment CYP can use to access WeMatter services in schools or community centres, or at home.

Cost implications for other public services

The main costs to other public services of delivering WeMatter involve the staff time handling WeMatter referrals at the referral agencies, and any time school staff spend helping CYP access and complete WeMatter sessions. The main costs to wider society involve any time CYP and their parents/carers spend on WeMatter-related activities.

Useful learnings for full-scale RCT

We have the following recommendations for conducting the cost evaluation in the full-scale RCT, based on learnings from this trial:

- To conduct a more extensive and robust cost evaluation, we would need to start working with Victim Support on setting up the systems for recording time and direct costs as early as possible. Victim Support does not normally keep timesheets to record the time its staff spend on different tasks. Therefore, the evaluation team will need to work with Victim Support to set up a recording system in order to evaluate time costs more precisely. This

might require investment in recording systems, and collecting this data would require additional recording/reporting by all Victim Support staff. It is crucial to start this process as early as possible, because recording retrospectively would be challenging. To allow for more granular analysis such a new reporting system could split time recorded by activity (e.g. running sessions vs individual CYP communications) to better understand time spent.

- The recruitment pipeline into the WeMatter service should ideally be established prior to the commencement of a full-scale RCT, so a limited amount of Victim Support staff time would need to be spent soliciting referrals (also see 'Recommendations and next steps'). This would allow for more accurate capture of costs in a scenario where WeMatter is widely used and referred to.

INTERPRETATION

This project was a pilot focused on assessing the feasibility of a full-scale RCT, but also included an IE and the IPE. Although we cannot conclude that WeMatter has an effect, it does have evidence of promise, which suggests that it would be worthwhile to run a large-scale study.

The evidence from the IE and IPE suggests that WeMatter achieved its aim of improving mental wellbeing. The IE found that it led to an increase of 4.62 on endline Stirling scores, when accounting for baseline, which is a 'moderate' effect (fixed-effect coefficient: 4.62; SE: 1.07; 95% CI: 2.49 to 6.76; $p < .001$; Glass's Delta = 0.74). This was consistent with the views of parents/carers in IPE, who perceived the intervention to have improved CYP mental wellbeing. It is also supported by the results of Victim Support's previous internal pilot, which found a 'large' effect, as measured by the Short Warwick–Edinburgh Mental Wellbeing Scale. This was also despite a small amount of contamination between trial arms, with some control CYP reporting receiving support from facilitators during their time on the waitlist.

However, although triangulating these data sources shows that they reinforce each other, all three sources are biased towards those who stayed engaged with the WeMatter programme and completed the intervention (including providing endline data). Our evaluation had biased attrition, because CYP in the treatment arm who did not complete the intervention were less likely to have outcome data; the interviewed CYP in the IPE (and their parents/carers) were only drawn from those who had completed the intervention; and the Victim Support pilot was a pre-post comparison, which collected endline data in the concluding session from CYP who completed the service. Further, although our evaluation had a large sample for a pilot (n = 312), it may not be a sufficient sample for a well-powered trial (depending on what the true, unbiased effect size of treatment is).

There was no quantitative testing of the ToC, but the outcomes and mechanisms were supported by IPE data. We demonstrated that it would be possible to take a secondary measure of social support for older CYP, but we did not have enough data to analyse the measure. The IPE suggested that all parts of the ToC were supported, but that it could be refined. 'Increased ability to manage and cope with difficult emotions' should become a priority outcome in the ToC, since the CYP's need to learn how to do this was one of the motivations parents/carers gave for accessing the service, and improvements in this ability were perceived as important by both parents/carers and CYP. The ToC could be refined to be more consistent with the terminology and content of the programme – for instance, so it references 'awareness of safety planning' rather than 'increased feelings of safety' and reframes the two priority domestic abuse-related outcomes in terms of CYP's understanding of – and ability to identify and mitigate – risks of unhealthy (abusive) relationships. The role of different parts of the programme and their mechanisms of action could be clarified – for instance, the take-home tasks and the action plans, which did not appear to be much used during the trial. In contrast, catch-up sessions appear to be important for retention and therefore should be added to the intervention protocol and the ToC.

The most crucial thing for the success of the intervention will be to make sure that the inputs are all available: sufficient recruitment to support the formation of age-banded groups, availability of settings (especially during the school holidays), and continuity of facilitators.

The intervention showed evidence of promise despite the group size often being smaller than the target of eight CYP. The modal group size in the intervention arm was 7 (5 out of 28 groups); but the range was 2 to 14, with 7 also being the median. We do not know what the optimal group size is, but it was clear that groups of one and two were too small; while we cannot be certain, it seems likely that groups of one or two are more likely to lead to attrition because they are too small to provide group-based support. There were five groups of one CYP at randomisation, but no groups of one in the final sample. This is because those CYP all dropped out, with four attending no sessions at all and the final one attending just two sessions.

The service recruited most participants in the youngest age band (8–12) and few CYP in the older age band (16–17), and the older CYP were also less likely to be retained. However, it is hard to draw conclusions about causality because age and group size were correlated: the older CYP were in smaller groups, which were more likely to break up. Again, it will be important in a full-scale trial to assess the effectiveness of WeMatter for different age groups. There was also a high proportion of participating CYP with a disability, which suggests it should be possible to explore differential effects in a full-scale trial. We did not see any differences by gender. The sample was majority White and if that reflects the broader usage and likely sample for a full-scale trial, then we do not see any prospect of meaningful subsample analysis by ethnicity.

The school setting was more popular than home, which may reflect more referrals from schools. (This was the perception of Victim Support staff. The CYP datasheets did not have the source of referral to Victim Support for about one-third of CYP, but the data we have suggests that local authorities and schools were the most productive source of referrals.) This suggests that it is particularly important to design delivery around the school holidays, because CYP accessing WeMatter from school were generally not able to access the intervention outside termtime, which may have led to them dropping out – though we also note that CYP receiving WeMatter at school were also more likely to be retained at endline than those participating from home. In a scaled-up trial, it will be important to investigate whether there is a differential impact in school and home settings, as well as any differential attrition.

The intervention was not delivered as intended because high turnover of facilitators meant there was not continuity for the CYP. The IPE found mixed feeling about whether this affected the experience for CYP. It probably exacerbated the problems with data collection, because much of the data was collected by facilitators. Vice versa, having to collect data probably contributed to the high turnover of staff.

There was evidence of feasibility of a full-scale trial, albeit with some modifications of the trial design. Recruitment needs to begin in advance of the trial and we now have an idea of the likely pace of recruitment, which can inform the length of a full trial. Outcome data should not be collected by facilitators and more generally there should be a specific data manager, whose job is to ensure quality of the evaluation data. Data needs to be collected from all CYP, not only those who complete the intervention. There may need to be processes to ensure that schools facilitate endline data collection for groups that are run in a school setting. Randomisation should be into lists rather

than blocks, in order to retain maximum flexibility for delivery. Detailed recommendations are given in 'Recommendations and next steps', below.

The strengths of the findings are that multiple sources of data support each other, all indicating that WeMatter has evidence of promise. Limitations include that all these data sources are biased towards those who completed the evaluation. Further, although the sample size was large for a pilot it may not have been large enough for well-powered statistical analysis (meaning that statistical inference would have been more likely to result in false positives). There was also some contamination between treatment and control arms, with some CYP receiving support from the facilitators during the waitlist period. However, if anything, that is conservative (biased against the intervention) because it might have increased the wellbeing of CYP in the control arm. Finally, the waitlist design can only measure improvement at the end of the intervention – i.e. short-term outcomes. This is the point where the intervention is most likely to be effective at improving wellbeing; evidence from the IPE is that CYP felt supported by their facilitators and the peers within their groups. Ideally we would measure whether this improvement compared with the control translates into continued wellbeing in the long term. However, a waitlist design cannot address this (because the control group receives the intervention in the short to medium term).

RECOMMENDATIONS AND NEXT STEPS

Lessons learned

Evaluation

We learned that a funded recruitment period is needed prior to the start of the trial. Referrals throughout the trial were lower than anticipated. This led to a lower than anticipated sample size and the blocks for the randomisation filled slower than expected, leading most WeMatter groups to be smaller than the target size and some were too small to be viable. This problem was particularly acute in the first three months of the trial, which was due to a combination of contextual factors that are particular to this trial and the lack of a funded set-up period in which Victim Support could (re-)build referral networks. Further, the projected recruitment from Victim Support (on which the power calculations were based) did not take into account the need to deliver control groups or that recruitment would not occur throughout the entire trial period because of the need to deliver the final waitlist groups. Sample size projections should be made in discussion with an evaluator, who can inform the deliver partner about the requirements of potential trial designs.

Randomisation into the trial proved to be acceptable to Victim Support staff and parents, but we learned that the randomisation process needs to be simple and flexible to meet the delivery partner's needs. It should also include sufficient guidance and training on how to implement the randomisation. We anticipated that there might be objections to randomisation; and Victim Support noted a potential risk to recruitment because we introduced an extra stage into their triage process, to allow parents/carers to receive and study written recruitment materials in order to give informed consent. Victim Support also required a randomisation process that could be implemented on the call when consent was given. Reassuringly, the conversion rate of referrals was no different from the WeMatter team's business as usual and Victim Support did not report complaints or hesitancy from parents/carers or CYP. Parents/carers in the IPE reported that, even if their CYP was allocated to the waitlist control, they still received WeMatter faster than they could access other services. However, some delivery staff members were not entirely comfortable with allocating CYP to the control group and there was some contamination, where control CYP received check-ins and support during their time on the waitlist. Victim Support staff operated the randomisation process, which they said was clear, but they had difficulty in maintaining the WeMatter groups allocated from the randomisation blocks and in several cases changed the group that a CYP was assigned to. A major cause of this was the connection of the blocks to the delivery time and setting, so that if a CYP's availability changed then they could not attend their allocated group.

Taking the outcome measure from CYP was easier than anticipated, but scheduling data collection was difficult and there may have been biased attrition. It was feasible to collect the Stirling Scale and, partway through the trial, we introduced a second Social Support Scale for older CYP. However, it was difficult to schedule endline data collection for CYP who received the intervention at school, because teachers did not view the concluding session as a part of the programme.

Particularly worryingly, data was not collected from CYP who dropped out of the intervention, resulting in biased attrition. The expectation that outcome data would be collected from all CYP was written into the evaluation protocol, but in practice there was a lack of separation between the intervention and the evaluation.

We learned that data collection should be completely separate from intervention delivery, with independent assessors collecting the data. CYP had to consent to the evaluation in order to receive the intervention, so when they withdrew from the intervention Victim Support staff were unsure whether they should also consider that they had withdrawn from the evaluation. This was compounded by the fact that the outcome measure was taken during the concluding session, which is one of the intervention activities. The evaluation protocol anticipated that facilitators would collect all outcome data, because Victim Support felt that to safeguard vulnerable CYP the data collection should be done by trained facilitators in a therapeutic context. This proved burdensome for the facilitators, who had to schedule calls, run extra sessions for data collection with control CYP, and enter outcome data. Therefore, later in the trial, another member of Victim Support's staff took on responsibility for data collection from some CYP. This worked well, suggesting that the facilitators do not need to be involved in data collection. That could lead to a more robust trial design and reduce the risk of bias, because facilitators will inevitably be more familiar with CYP in the treatment arm (with whom they have been conducting WeMatter sessions) than those in the control. It could also help reduce facilitator turnover, by reducing the burden of evaluation activities.

The evaluation underlined the need for a dedicated resource for data management and to reduce manual data management, as far as possible. We needed to collect complex and sensitive personal data, which is not all collected as a matter of course. Because of the personal nature of some of the data and the lack of a suitable central system, facilitators had to fill in separate Excel sheets, which then needed to be combined. The trial data we received required extensive review and cleaning. It was difficult to track attrition or the timing of data collection during the trial (i.e. the difference in time between baseline and endline data collection in the treatment and control groups), or in the datasets we received. Ultimately many CYP were removed from the main analysis as a result. Foundations should expect to ringfence resource for data collection and data management in trials.

Many of these issues might have been mitigated by a trial design that imposed fewer restrictions on intervention delivery, with the evaluator assuming more responsibility for processes that are specifically the domain of the evaluation, rather than embedding them within the flow of intervention delivery. Such a separation would also help to draw a clearer distinction between intervention and evaluation delivery.

Intervention

The intervention had universally positive feedback from our interviews with parents/carers and their CYP who had completed it. It delivered prompt care compared with other services, even when CYP were on the waitlist. CYP enjoyed participating, including in the group-based activities; and they found the facilitators approachable, engaging, and flexible to their needs.

The majority of groups in the evaluation were school-based. Going forwards, it will be important to facilitate access to the intervention during school holidays or ensure that school-based groups only

run during termtime (while managing any additional wait times this might introduce). Victim Support may also want to consider scheduling of groups in relation to busy periods for schools, such as exam times.

We do not know what group size is optimal. We did find evidence of promise the intervention was effective, despite most groups being the smaller than the target of eight CYP. However, the initial group size needs to be large enough to sustain a group dynamic and peer support, even if there are some CYP absences or drop-outs. Some of the groups in the evaluation failed to meet this criterion, due to a combination of the recruitment pipeline and the need for randomisation. It did prove to be possible for Victim Support to increase group size by combining the home and school settings, and being flexible about the age groups (though 8–12, which was an initial age range, was sometimes felt to be too wide).

In Victim Support's view, the facilitators need to be able to provide catch-up sessions in order to support retention, which would be enabled by reducing facilitator workload. This is related to another factor that could improve the intervention: designing strategies to retain facilitators, which includes addressing factors like job security, which are inherent to the sector; but also factors that are related to the evaluation, such as decreasing the burden of data collection. Decreasing the amount of data collection and data management that facilitators do would increase the amount of time they can spend delivering to CYP, which feeds back into job satisfaction and retention.

Parents/carers and CYP suggested that more marketing materials explaining the service would be useful. Some parents/carers would have liked more feedback on their CYP's engagement with the service.

Research recommendations

To test the intervention in a full trial, we recommend the following changes:

Recruitment

Implement a funded period of at least three months before the trial starts, to allow Victim Support time to set up referral pipelines. Recruitment patterns from the present trial indicate that after this point, we might expect between 40 and 60 CYP to be referred each month.

Sample size/power

We carried out updated power calculations with key results replacing assumptions made in the evaluation protocol. These calculations suggested a full-scale trial should seek to recruit n = 992 CYP if aiming for a standardised effect size of 0.2 (conventionally considered 'small') or n = 208 if aiming for a standardised effect size of 0.5 (conventionally considered 'medium'). We did not use the effect size of 0.74 observed in this evaluation because of the high risk of bias associated with it and so used two common thresholds instead. For a more detailed breakdown of the power calculations, their results, and assumptions made, see 'Appendix I: Note on WeMatter power calculations for a full trial'.

Timing and settings

School-based groups are only able to operate during termtime, so that needs to be taken into account when triaging and allocating CYP. Other safe settings could be explored so that CYP who cannot join from home can still get support during school holidays. We observed a strong preference for participation in a school setting over home in this trial (preferred for 138 of the 165 CYP included in our main analysis), which may be related to referral pathways from schools being particularly fruitful, so school availability is likely to be a key constraint on future research.

Randomisation

Simplify the randomisation by removing the blocking. The loss of stratification may reduce power but should also result in fewer participants being assigned to WeMatter groups that are too small or being moved between groups. A consequence of this change would be that there is no natural point at which to collect baseline and endline measures from the control arm. We would therefore advise setting baseline and endline collection to occur a fixed number of days after consent or randomisation.

Data management and monitoring

Establish a 'data manager' role dedicated to managing the trial's processes, including a responsibility for all data management. This could be a member of the evaluation team, or a member of research staff embedded at Victim Support, but they should have some knowledge and experience of trials and be answerable to the evaluation team. This individual would monitor records of randomisation to ensure it is carried out with fidelity, manage collection of outcome data in a timely fashion, and maintain a clean central record of the trial's progress. They – along with anyone in the delivery team responsible for managing data – should have a direct line of communication to the evaluation team to ensure prompt discussion of any data collection issues and the input of the evaluation team into solving them.

Wherever possible, data management should be automated and centralised, to minimise the risk of manual errors being introduced when combining multiple datasets that different individuals are working with.

Collection of outcome measures

It is critical that the party responsible for data collection makes every effort to obtain endline data from CYP in the treatment arm who have stopped attending their WeMatter sessions. The evaluation protocol set out this expectation, but the evidence from this trial suggests that there should be an explicit process for that, which is closely monitored. We recommend developing a formal contact strategy describing how to seek responses, including the numbers of contacts that should be attempted, instructions to vary the time of day calls are made and the mode of contact used (if other modes are available), and processes for logging all contact attempts for monitoring purposes. Flagging the need for endline data collection with schools at the outset might help with data collection from those in school-based groups.

To help with the processes described above, future evaluations should explore the possibility of offering a cash or voucher incentive for completing the baseline and endline measures. All trial materials will need to make clear that these incentives are strictly for completing the data collection exercise and are in no way associated with attendance or non-attendance of their WeMatter sessions or the one-to-one sessions.

Taken together, these changes should help to reduce attrition, but will also reinforce that giving data for the evaluation is separate from participating in the intervention.

Outcome measures should be taken by independent outcome assessors from the evaluation team, who are not involved in delivery of the intervention. This model, which Victim Support operated successfully in the last six months of the trial, would mitigate the risk of bias caused by differential familiarity with facilitators at the time of endline data collection. These assessors would maintain direct contact with the trial manager (see above) to ensure that outcome data is collected at the right points in time, solving one of the major shortcomings of this study.

Cost evaluation

We recommend the use of timesheets to enable accurate reporting of Victim Support staff time on various activities. However, this would need to be balanced with the (additional) administrative requirement that poses for Victim Support staff.

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APPENDICES

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

Item	Statements	Never	Not much of the time	Some of the time	Quite a lot of the time	All of the time
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

Wellbeing sub-component	Item	Related item on the Stirling Scale
	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 has not been used in the current study.

Appendix B: Social Support Scale

"The next few questions are about people you feel close to, including relatives and friends."

		None	One	Two or more
1	How many relatives who live with you do you feel close to?	0	1	2
2	How many relatives who do not live with you do you feel close to?	0	1	2

		None	One	Two or more
3	How many friends would you describe as close, or good, friends?	0	1	2

"I would now like you to think about your family and friends (by family I mean those who live elsewhere as well as those who live with you). Here are some comments that people have made about their family and friends. Please say how true you think they are for you."

		Not true	Partly true	Certainly true
4	There are people I know who do things to make me happy	0	1	2
5	There are people I know who make me feel loved	0	1	2
6	There are people I know who can be relied on no matter what happens	0	1	2
7	There are people I know who would see that I am taken care of if I need to be	0	1	2
8	There are people I know who accept me just as I am	0	1	2
9	There are people I know who make me feel an important part of their lives	0	1	2
10	There are people I know who give me support and encouragement	0	1	2

Appendix C: Sensitivity analysis models

Table 13. Mixed-effects linear regression model for the primary ITT analysis – excluding outliers

	Coefficient	Standard error	*p*-value	95% confidence intervals
Treatment	4.67	1.01	< .001	[2.65–6.70]
Baseline Stirling score	0.65	0.06	< .001	[0.52–0.78]

Note. The dependent variable is the endline Stirling score (ranging from 12 to 60). The treatment effect estimates the effect of being randomised into the treatment arm. Baseline Stirling score was included as a control variable for any baseline differences.

Table 14. Mixed-effects linear regression model for the primary ITT analysis – excluding CYP with siblings in the intervention

	Coefficient	Standard error	*p*-value	95% confidence intervals
Treatment	4.45	1.28	.001	[1.89–7.01]
Baseline Stirling score	0.70	0.08	< .001	[0.53–0.86]

Note. The dependent variable is the endline Stirling score (ranging from 12 to 60). The treatment effect estimates the effect of being randomised into the treatment arm. Baseline Stirling score was included as a control variable for any baseline differences.

Table 15. Mixed-effects linear regression model for the primary ITT analysis – including CYP with uncertain WeMatter group allocation

	Coefficient	Standard error	*p*-value	95% confidence intervals
Treatment	4.65	0.97	< .001	[2.70–6.61]
Baseline Stirling score	0.56	0.06	< .001	[0.44–0.68]

Note. The dependent variable is the endline Stirling score (ranging from 12 to 60). The treatment effect estimates the effect of being randomised into the treatment arm. Baseline Stirling score was included as a control variable for any baseline differences.

Appendix D: IPE sample

Table 16. CYP qualitative research sample: detail

	Wave 1	Wave 2
Total number of participants	9	17
Type of participant		
CYP focus group	5	5
CYP one-to-one in control arm	2	2
CYP one-to-one in treatment arm	2	10

	Wave 1	Wave 2
Age		
8–12 yrs	7	14
13–17 yrs	2	3
Gender		
Man	7	9
Woman	2	8
Other	-	-
Ethnicity		
White	9	11
Black	-	3
Asian	-	1
Mixed	-	1
Other	-	1
Main language		
English	9	17
SEND status		

	Wave 1	Wave 2
Neurodiverse (autism)	1	10
Delivery setting		
Home	4	5
School	5	12

Interviews included CYP from the following local authorities: Stoke-on-Trent City Council, Torbay Council, Redditch Borough Council, East Staffordshire Borough Council, Wychavon District Council, Plymouth City Council, Westmorland and Furness Council, Forest of Dean District Council, Lichfield City Council, Newcastle-Under-Lyme Borough, Wolverhampton City Council, Kirklees Borough Council, Brent, West Yorkshire, Barnet, Lincoln City Council, Gateshead County Council, Birmingham County Council.

Table 17. Parent/carer qualitative research sample: detail

	Wave 1	Wave 2
Total number of participants	5	2
Type of participant		
Parent/carer treatment arm	3	1
Parent/carer control arm	2	1
Age		
8–12 yrs	4[a]	1
13–17 yrs	1	-

	Wave 1	Wave 2
Gender		
Man	3	1
Woman	2	-
Other	-	-
Ethnicity		
White	5	1
Main language		
English	5	1
SEND status		
Neurodiverse (autism)	1	1
Delivery setting		
Home	3	1
School	2	-

[a] Demographic data missing for one treatment arm parent/carer participant.

Appendix E: Stirling scores by CYP characteristics

Table 18. Summary of endline Stirling scores and the change from baseline Stirling scores broken down by CYP characteristics

	Control arm mean endline (change from baseline)	Treatment arm mean endline (change from baseline)	Total mean endline (change from baseline)
Total	42.07 (−0.99)	45.93 (+3.94)	43.99 (+1.46)
Gender			
Woman	40.52 (−1.82)	43.69 (+3.38)	42.01 (+0.63)
Man	43.71 (0.00)	47.95 (+4.44)	45.96 (+2.36)
Trans-man	**48.00 (−2.00)**		**48.00 (−2.00)**
Year of birth			
2007–2008	**42.40 (+4.00)**	**47.25 (+3.50)**	**44.56 (+3.78)**
2009–2011	**39.33 (−0.20)**	**43.71 (+5.29)**	**41.66 (+2.72)**
2012–2016	**42.70 (−1.57)**	**46.46 (+3.59)**	**44.55 (+0.97)**
Ethnicity			
White	42.27 (−1.30)	45.91 (+3.76)	44.13 (+1.29)
Other ethnic group	41.45 (0.00)	46.00 (+4.69)	43.47 (+2.08)

	Control arm mean endline (change from baseline)	Treatment arm mean endline (change from baseline)	Total mean endline (change from baseline)
Disability			
Has one or more disabilities[a]	41.32 (−0.95)	44.78 (+4.35)	43.49 (+2.37)
Does not have any disabilities	42.34 (−1.00)	46.87 (+3.60)	44.26 (+0.95)
FSM status			
Has FSM status	42.60 (−0.11)	46.38 (+4.62)	44.54 (+2.32)
Does not have FSM status	41.11 (−2.36)	44.04 (+2.38)	42.46 (−0.17)
Missing	41.50 (−5.00)	56.00 (+3.50)	48.75 (−0.75)
Public care status			
Looked-after child	45.50 (+8.50)	-	45.50 (+8.50)
No	41.99 (−1.22)	45.93 (+3.94)	43.97 (+1.37)
Main language			
English	42.07 (−0.99)	45.95 (+4.05)	43.99 (+1.50)
Other	-	44.00 (−5.00)	44.00 (−5.00)

	Control arm mean endline (change from baseline)	Treatment arm mean endline (change from baseline)	Total mean endline (change from baseline)
Referral source			
School	44.23 (+0.31)	45.58 (+5.79)	45.03 (+3.56)
GP/health	38.83 (−1.33)	46.00 (−3.00)	40.62 (−1.75)
Internal Victim Support	41.04 (−0.88)	46.96 (+2.96)	44.23 (+1.19)
Local authority	43.70 (−0.48)	46.17 (+2.61)	44.78 (+0.88)
Other agency	38.00 (−4.43)	43.44 (+5.22)	41.06 (+1.00)
Police	29.00 (−11.00)	-	29.00 (−11.00)
Referral by parent/guardian	44.33 (−0.44)	45.17 (+7.00)	44.67 (+2.53)
Delivery setting			
Home	41.67 (+0.25)	44.53 (+2.93)	43.26 (+1.74)
School	42.14 (−1.20)	46.24 (+4.16)	44.13 (+1.41)

Appendix F: Session attendance by CYP characteristics

Figure 11. Number of sessions attended by treatment arm CYP, by gender (n = 156) (go to accessibility text)

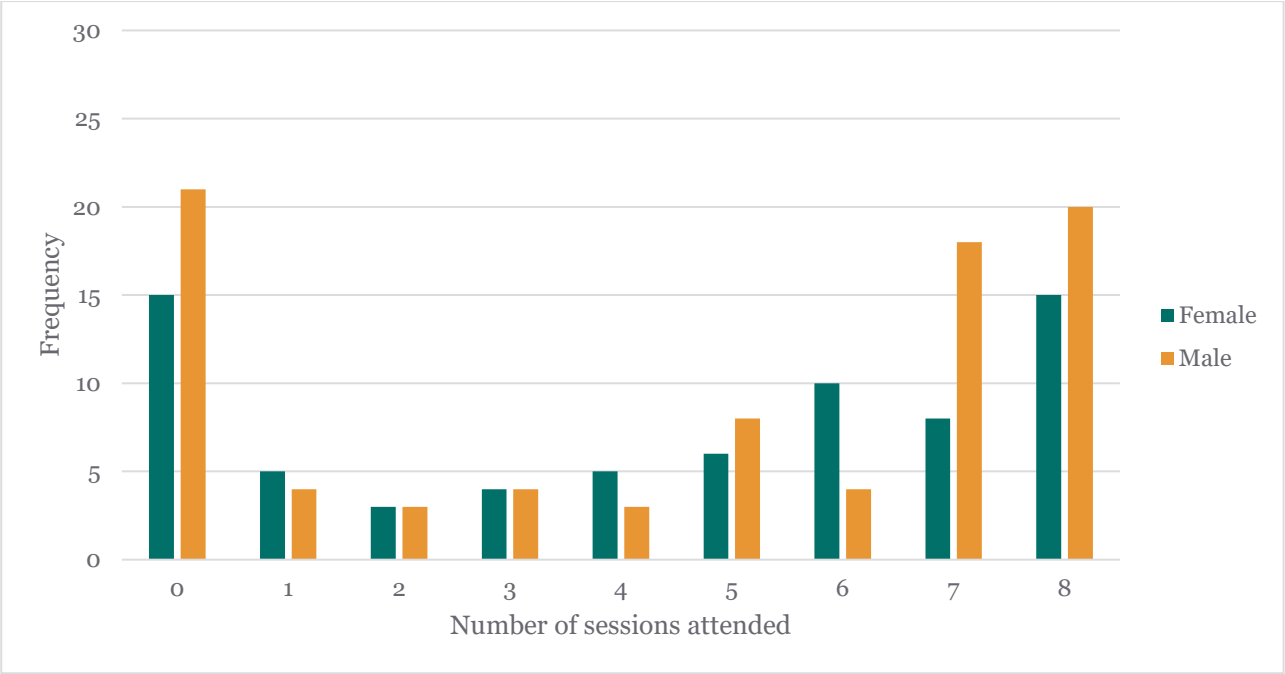


Figure 12. Number of sessions attended by treatment arm CYP, by ethnicity (n = 156) (go to accessibility text)

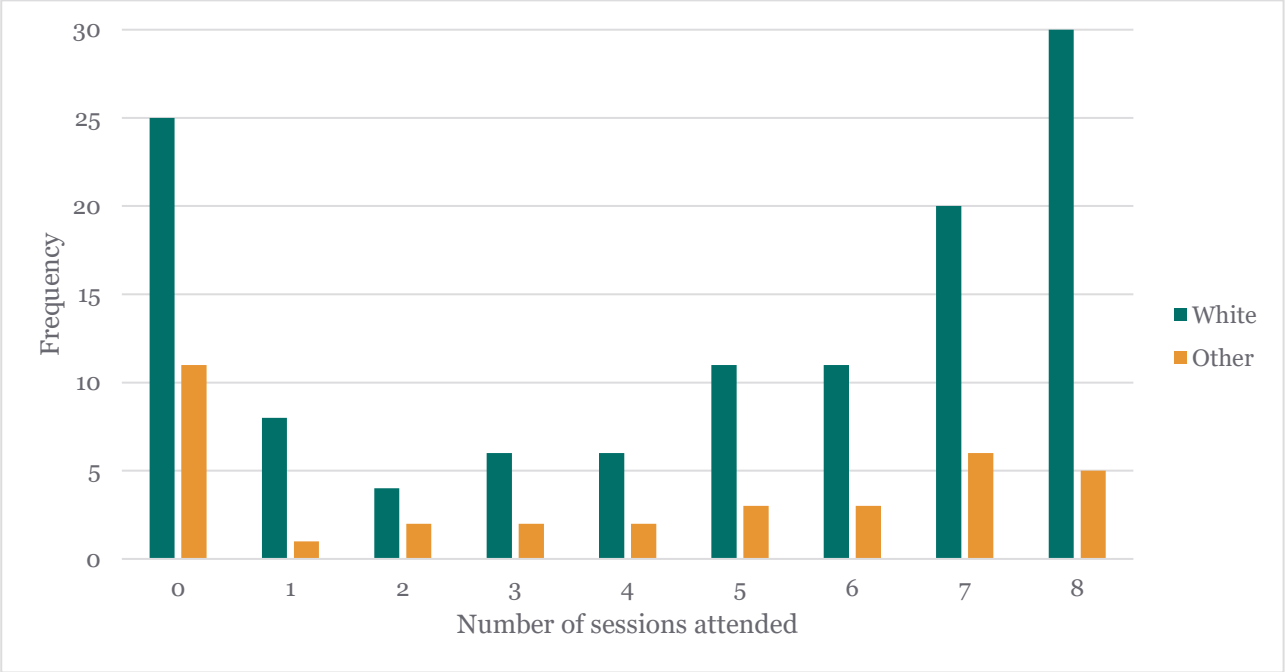
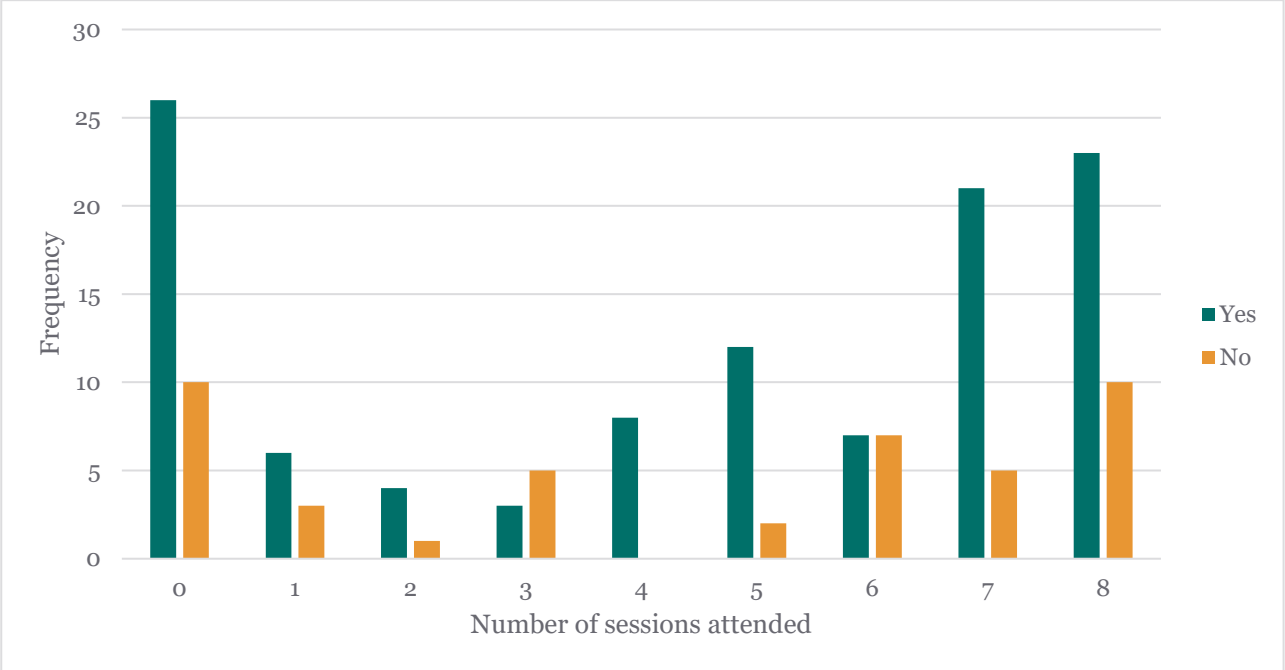
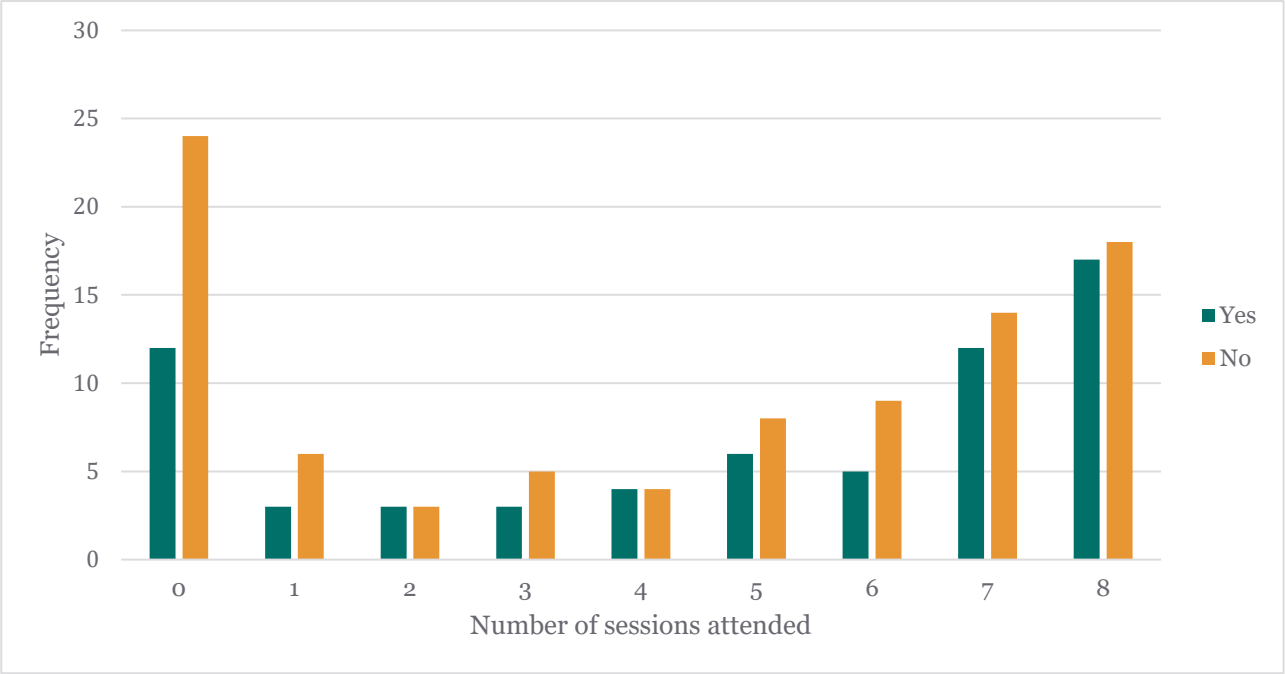


Figure 13. Number of sessions attended by treatment arm CYP, by FSM status (n = 153) (go to accessibility text)



Note. Number of sessions for those who preferred not to say (n = 1) or were not asked (n = 2) are not included.

Figure 14. Number of sessions attended by treatment arm CYP, by disability (n = 156) (go to accessibility text)



Appendix G: 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. 8x 1-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 for digital devices, facilitator access to training and support)?	Service data Interviews with triage team and facilitators Feedback from Victim Support managers
Reach	What was the level of take-up of the intervention? How did it vary by key EDIE characteristics?	Service data on participation and opt-out reasons

Aspects of IPE	IPE research questions	Method(s) for collection
	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/drop-out 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?	Interviews with facilitators and triage team Interviews 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 Interviews 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? 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 and 3 – Perceived impact and theory of change		

Aspects of IPE	IPE research questions	Method(s) for collection
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 parents/carers and/or schools for participating in the intervention? Were there missing and/or mis-specified mechanisms in the ToC?	Interviews with facilitators, beneficiaries, and parents and carers Interview with Rock Pool representative
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

Aspects of IPE	IPE research questions	Method(s) for collection
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 Interviews with beneficiaries and parents and carers Interview with Rock Pool representative
Aims 4 and 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

Aspects of IPE	IPE research questions	Method(s) for collection
		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, referers, 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

Appendix H: Learnings from the bridge funding period

Foundations and the Evaluation Task Force provided bridge funding to design and pilot improvements to data collection and the evaluation design, including to overcome challenges identified during the trial. This required collection of data from CYP who were receiving the intervention, but it did not require a control (waitlist) group, so CYP were randomised into two groups, both of which received the intervention immediately.

Verian, Victim Support, and Foundations held a workshop on 8 May 2025 to decide what changes to implement. Verian then developed new data collection materials. Victim Support recruited CYP and then conducted randomisation calls for the bridge funding cohort from 20 June to 18 July 2025. The bridge funding period for the evaluator ended on 12 September 2025. The first draft of the bridge funding report was delivered on 22 August 2025, in order to inform decision making about progressing to a full trial. The delivery of WeMatter groups continued after this date, but the reporting occurred before the course was completed, so endline data was not in scope for the report.

During the bridge funding period Victim Support continued to collect quantitative data (baseline data and administrative data), which it supplied to Verian. Verian also conducted an interview with staff at Victim Support on 7 August 2025, to assess the success of the changes.

Verian, Victim Support, and Foundations agreed to make and evaluate the following changes.

Simplify randomisation

What we did

We simplified the randomisation process so that CYP in the treatment arm were no longer assigned to a WeMatter group during their triage call. This involved moving from 'block' to 'list' randomisation – i.e. instead of the randomisation sheet having CYP IDs grouped into blocks, it contained a single list of pre-generated pre-randomised CYP IDs. During the call, if a parent gave consent, then their CYP would be entered into the next open space on the list, with the associated CYP ID and an assigned trial arm.

What did we expect?

This change aimed to give Victim Support more flexibility to schedule WeMatter groups, meaning that CYP would not need to be re-allocated between groups after randomisation and that group sizes would increase, approaching the intended eight CYP and avoiding 'groups' of one or two CYP.

What did we find?

The CYP randomised in the bridge funding period were allocated to 15 separate WeMatter groups, of which 2 (13%) contained either 1 or 2 CYP. This is an improvement over the main trial, which saw 11 of 32 groups (34%) beneath this threshold. However, this was in part achieved because Victim Support combined participants from the two randomised arms into the same WeMatter groups, which in a real trial would only be possible at points when treatment arm CYP are receiving the intervention at the same time as control arm CYP whose participation in the trial (on the waitlist) has already finished.

Victim Support reported that the new randomisation process provided more flexibility in allocating CYP to WeMatter groups based on their availability and individual needs. Staff explained that, as a result, participant retention in the service improved because fewer CYP needed to move between groups. Staff found the new approach also gave them more control over group size, which helped avoid undersized groups.

Specify outcome data collection dates

What we did

We set dates for baseline and endline collection from each CYP at 14 and 112 days after their randomisation, respectively. The simplified randomisation described above necessitated this change.

What did we expect?

The baseline data for CYP in the bridge funding period was scheduled to be collected between 4 July and 1 August 2025. We expected most data to be collected on or close to the specified dates.

What did we find?

Of the 87 CYP who provided valid baseline data, 25 (29%) completed it on the specified day (14 days after randomisation). However, most (n = 57, 66%) completed baseline within 3 days of their assigned date. A further 22 completed baseline more than 3 days ahead of their assigned date, and 8 did so more than 3 days after it. Victim Support explained that difficulty collecting the data on the pre-specified dates was due to external constraints rather than internal capacity. It was reliant on parents or schools, who were not always available on the specified dates.

Develop a contact strategy and call log

What we did

Verian developed a contact strategy describing in broad terms how Victim Support should attempt to reach CYP enrolled in the trial to collect their outcomes. We also supplied a call log for them to record all contact attempts.

What did we expect?

Lower levels of attrition than observed in the trial. Only baseline data was available at the time of analysis.

What did we find?

Attrition between baseline and randomisation was higher in the bridge funding period (40/127, 31%) than in the main trial (56/313, 18%). Victim Support did not complete the call log, so we cannot judge the effectiveness of the contact strategy or whether it was followed.

Victim Support staff felt that the contact strategy and call log duplicated their existing processes and were therefore an additional burden. Staff explained that Victim Support have their own contact strategy already and record contacts on their customer relationship management system. In their view, the introduction of a separate call log caused duplication and increased the overall data entry burden for staff. Staff felt this was a challenge, especially given the other capacity pressures on the staff engaging with parents/carers, schools, and CYP as part of outcome data collection. Victim Support therefore felt they needed to prioritise calls to schedule outcome data collection over completing the call log Verian provided.

Collect outcomes through an online form

What we did

Verian developed an online form for Victim Support to use to collect outcomes. The person collecting the data entered the scores directly into the online form, replacing the previous Excel spreadsheet.

What did we expect?

Reduced data missingness and inconsistencies in the data, and reduced burden on Victim Support staff.

What did we find?

There were no errors in the baseline data collected using the online form.

Victim Support reported that the online form was very easy to use and required significantly less time and work from staff collecting the outcome data. Staff also thought the form helped improve data accuracy compared with the approach used in the trial, because data was automatically shared with Verian rather than combined and updated from multiple data sheets.

Use independent data collectors

What we did

We asked Victim Support to assign a dedicated member(s) of staff to handle all data collection. These staff members would not be facilitators and therefore would not be familiar to the CYP.

What did we expect?

This data collection method is preferable to the one we designed for the pilot, where facilitators collected the data, because it is less likely to lead to bias. In the pilot, there was a deviation from protocol, when Victim Support started to use other staff to collect data because of the burden of data collection on facilitators. This deviation established that it was feasible for an independent data collector to create a safe environment for CYP during data collection. During the bridge funding period, we tested the feasibility of a model where Victim Support staff who were not involved in delivering the intervention would conduct the data collection. We also aimed to reduce the burden on facilitators and therefore to increase the amount and quality of data collected.

What did we find?

Victim Support assigned two members of staff as independent assessors, and these staff members carried out 65 of the 87 baseline interviews (75%). Partway through the bridge funding period, Victim Support ceased the use of independent data collectors and reverted to using facilitators to collect baseline measures, citing excessive burden on the assessors and concerns about effects on intervention delivery. This may in part be due to how the change was implemented: assessors took on the entire pre-intervention one-to-one session along with baseline data collection. Victim Support explained that doing this left facilitators unable to build rapport before starting the group

sessions, and that some felt they were going into group sessions without vital information about the CYP attending.

We did not find evidence of an improvement in the quality of data submitted by Victim Support. Inconsistencies led to five exclusions: two CYP with the same unique identifier so they could not be linked back to the randomisation sheet, and a further three with a date for baseline collection that was earlier than their date of randomisation. The proportion of randomised CYP lost to exclusions at this stage was similar to that observed in the main trial, at around 4% for both.

Reintroduce catch-up sessions

What we did

Victim Support re-introduced catch-up sessions for CYP who had missed WeMatter sessions. It ordinarily offers these catch-up sessions as a routine part of delivery but had stopped doing so for CYP enrolled in the evaluation.

What did we expect?

Fewer CYP withdrawing from the intervention and an increased number of sessions attended.

What did we find?

Victim Support confirmed it re-introduced catch-up sessions and found these helped improve participant retention and CYP engagement with the service. It reported that group sizes and dynamics were more stable, thus helping maintain peer interaction and support as an important aspect of the service.

Staff highlighted that delivering the catch-up sessions can be taxing on resources and that the number may need to be capped to prevent the intervention becoming one-to-one support. Any future trial should seek to refine the definition of the intervention to specify the number of one-to-one sessions that are permissible, and consider whether and how those sessions contribute to dosage.

Conclusion

We piloted improvements to data collection and the evaluation design. The simpler randomisation appeared successful at reducing the number of undersized WeMatter groups, and Victim Support found the improved flexibility in intervention delivery helpful. Changing the randomisation approach meant we also needed to change when outcomes were collected, and Victim Support was able to collect most baseline data on or close to the specified date. However, attrition between randomisation and baseline was high and some baseline measures were taken more than three days early or late. Without data from the call log – which Victim Support did not complete – it is difficult to judge exactly why this was the case and what changes might be made to address it.

We found further evidence that using independent assessors to collect baseline/endline data is in principle feasible, given adequate resources. However, there is a clear risk that combining outcome collection with the one-to-one sessions run at the start and end of the trial will undermine

intervention delivery. We therefore advise splitting the two, with independent assessors conducting dedicated data collection calls and facilitators separately leading the one-to-one sessions. This would mean a stricter demarcation between intervention delivery and evaluation activities – the norm for many trials – reducing the risk of bias arising from familiarity with the data collector. Additionally, since the data collection itself is much shorter than the one-to-one sessions, it may be easier to schedule an appointment on or close to the specified date. Were the evaluator to take on all data collection, they would also be able to directly handle most of the data management, considerably reducing the burden on Victim Support and minimising the loss of CYP from the trial due to data issues.

Appendix I: Note on WeMatter power calculations for a full trial

The pilot trial aimed to update key assumptions made in the evaluation protocol's power analyses to better inform sample size planning for a full-scale efficacy trial. Below, we set out what we have learned on each assumption in turn, before presenting updated power calculations.

Impact of the intervention (MDES)

The pilot estimated a standardised effect size of 0.74 (Glass's Delta). However, high levels of attrition mean there is a serious risk that this effect size overstates the true impact of the intervention. We have therefore used more conservative target MDES in our updated power calculations.

Treatment effect heterogeneity (variability in standardised treatment effects across blocks)

For the same reason, we consider observed heterogeneity in treatment effects between blocks to be unsafe for use in power calculations. We therefore retained the two assumed levels used in the evaluation protocol.

Intracluster correlation coefficient (ICC)

We estimated an ICC of 0.19 in the pilot findings, which is very slightly higher than the upper value considered in the evaluation protocol. We have used this estimate in our updated power calculations.

Variance explained by baseline measures

We observed a 53% correlation between baseline and endline Stirling scores in the control arm, which was very close to the lower of the two values considered in the evaluation protocol (55%). We have used the observed correlation in our updated power calculations.

Cluster size

In the pilot, block sizes were smaller than anticipated due to slower than planned recruitment. However, the target block size (n = 16) was based on the number of CYP ideally needed for WeMatter support groups. We therefore advise retaining that target and following the recommendations in the report on recruitment to allow a full-scale trial to meet it.

Attrition

We observed a 47% attrition rate in the pilot. If we consider only CYP dropping out – rather than exclusions due to errors in randomisation or data collection – then the attrition rate in the control arm was 37%. Such high levels of attrition in a full-scale trial would mean that any impact estimates would be subject to a serious risk of bias and could not be considered robust. We have therefore planned our power calculations around lower levels of attrition than observed in this pilot, under the assumption that actions the report advises to mitigate attrition have been taken. For the lower value, we used 5% attrition, which is a commonly used threshold in trials for considering the impact of missingness. For the upper value, we used 20%, which was the largest attrition level considered by the evaluation protocol. We also present attrition of 37% as a point of comparison, but do not think it prudent to plan for.

Power calculations

Table 19 shows that the number of CYP the trial should aim to recruit depends chiefly on the size of the intervention's effect and the levels of attrition expected. If we assume a small effect size with high treatment effect heterogeneity and 20% attrition, we suggest a target sample size of n = 992 CYP (pre-attrition). For a moderate effect size, the target sample size shrinks to n = 208 CYP (again, pre-attrition), even if attrition remains at 20%. These two estimates are highlighted in Table 19. Lower levels of attrition and less heterogeneity in treatment effect both reduce the sample size needed to achieve any target MDES.

We ran the power calculations using the *PowerUp!* package in R statistical software. All calculations assumed an average block size of 16 CYP, alpha = 0.05, two-tailed testing, and the conventional threshold for power of 80%.

Table 19. Power calculations for a future trial

Scenario	1	2	3	4
Target MDES	0.2	0.2	0.5	0.5
Variability in standardised treatment effects across blocks	0.5	0.0	0.5	0.0
ICC	0.19	0.19	0.19	0.19
Proportion of variance explained by baseline	0.28	0.28	0.28	0.28

Required sample size (CYP)	**5% attrition**	832	528	176	112
	20% attrition	**992**	624	**208**	144
	37% attrition	1,248	784	256	176

Our results convey a broad range of suggested target sample sizes, which can make planning difficult. One option is to favour one of the more conservative estimates to avoid commissioning an underpowered trial. Taking that approach, we advise a target sample size of n = 992 CYP, which is still not hugely greater than the sample size of n = 752 CYP planned for this pilot. There are good reasons to think this may be a conservative target:

- The observed estimates of impact from the pilot trial – even potentially subject to a great deal of bias – were considerably higher than 0.2.
- The observed ICC might have been inflated by smaller than expected group sizes, in which case the study is more highly powered than these numbers suggest.

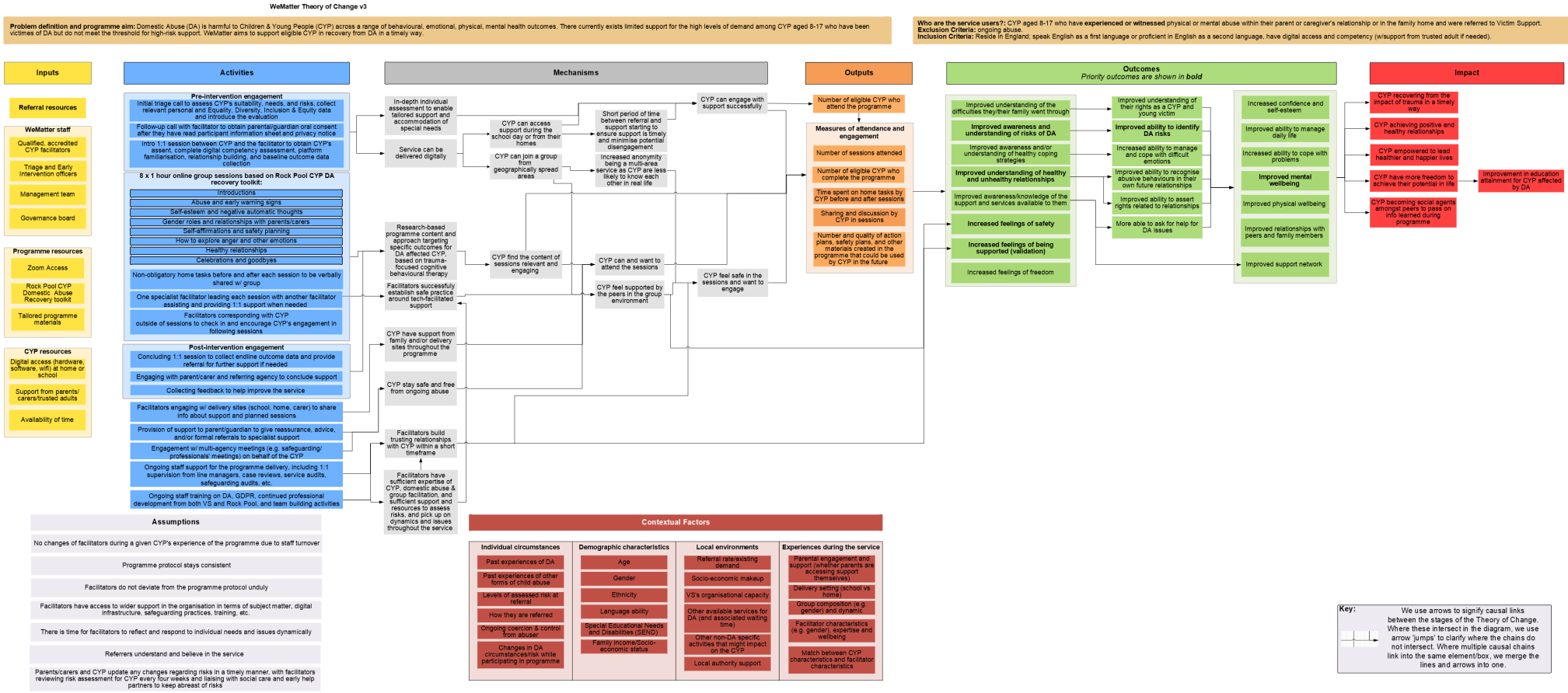
We do not advise planning on the basis of 37% attrition, because levels of attrition that high risk undermining the trial for reasons other than power.

Fieldwork duration

In the middle months of the pilot, Victim Support was able to recruit between 45 and 59 CYP each month. We can use this range to estimate how long Victim Support would need to recruit for a full-scale trial given the target sample size. If we assume 48 CYP are recruited each month (i.e. 3 blocks of 16 CYP), then it would take 21 months to recruit a sample of n = 992 CYP compared with 5 for a sample of n = 208. (Note that this does not include the time needed for intervention delivery and data collection after recruitment.)

The suggested sample sizes and fieldwork durations depend on a continual pipeline of referrals to Victim Support. Should the target sample size approach the total size of the target population for the intervention in the trial areas, then we should expect recruitment to slow and eventually stop.

Appendix J: Theory of change



Appendix K: Accessibility text

Figure 1. Participant journey for consented CYP in treatment and control arms

Figure 1 is a flowchart that shows the process for CYP who consented to take part in the trial, including the sequence and timings of trial stages. Each stage is shown within a box, going from top to bottom, connected by arrows.

All CYP followed the first three stages, which took place over two to four weeks:

- Stage 1: Referral
- Stage 2: Consent
- Stage 3: Randomisation into either the treatment or control arm (occurring between 5th June 2024 and 17th January 2025).

Next, the diagram splits into two parallel streams for treatment and control arms.

- Stage 4: Facilitators collected a baseline measure of wellbeing from all CYP. For the treatment arm, this took place during an introductory one-to-one call ahead of intervention delivery. For the control arm, facilitators arranged a separate one-to-one call in the same week.
- Stage 5: Treatment CYP attended the 8 weekly WeMatter support group sessions (occurring between 17th June 2024 and 9th May 2025). Control CYP received no intervention while on the waitlist.
- Stage 6: Facilitators collected the endline measure of wellbeing from all CYP. For the treatment arm, this took place during a concluding one-to-one call. For the control arm, it took place during an introductory one-to-one call ahead of intervention delivery now that their period on the waitlist had ended.
- Stage 7 and 8: Control CYP attended the 8 weekly WeMatter support group sessions (occurring between 16th August 2024 and 18th June 2025) followed by the concluding one-to-one session. These two stages took place over approximately 10 weeks

Click to return to main text.

Figure 2. Process from referral to randomisation

Figure 2 presents a linear flowchart consisting of five sequential steps, each represented by a rectangular box connected by arrows going from left to right, indicating the progression of the process. The steps are, from beginning to end:

1. Referral received
2. Triage call (needs & eligibility assessment)
3. Consent materials shared by email
4. Case allocated to a lead facilitator

5. Facilitator contacts safe parent/carer (consent & randomisation)

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Figure 3. Example of an unfilled block from our randomisation sheet. Number, CYP ID, and Group assigned were pre-generated by Verian. The Group ID was the block number plus a letter indicating allocation to trial arm.

Figure 3 shows an example of an unfilled randomisation block in the Excel sheet Victim Support used to carry out the randomisation during a call with the CYP and their parent or carer.

The top section provides empty spaces to fill out the following information:

- Names of Facilitator 1 and 2 leading the groups.
- Delivery setting for the group sessions – either home or school.
- Age group of the CYP in this block.
- Start dates for treatment group sessions and control group sessions.
- The date when Victim Support close the block to new bookings.

The bottom section consists of 6 columns and 20 rows. Each row corresponds to a spot for one CYP within the block.

Three columns are pre-filled by Verian:

- Number: a variable counting from 1 at the top of the block to 20 at the bottom, indicating the order in which facilitators booked CYP into the block.
- CYP ID: an arbitrary unique identifier.
- Group assigned: a pre-randomised variable set to either “immediate start” or “waitlist”.

A further three columns are left blank for the facilitator taking the call:

- Group ID
- Time of call
- Date of call

Click to return to main text.

Figure 4. Cumulative count of CYP randomised by month

Figure 4 is a line graph that shows how the number of CYP recruited and randomised increased cumulatively over the trial’s duration.

The horizontal axis represents months over which the trial recruited, starting from June 2024 and ending in January 2025. The vertical axis shows the cumulative number of randomised CYP, starting at 0.

The graph gives the following cumulative totals for each month:

- June 2024: 24 CYP randomised
- July 2024: 44 CYP randomised
- August 2024: 82 CYP randomised
- September 2024: 141 CYP randomised
- October 2024: 194 CYP randomised
- November 2024: 245 CYP randomised
- December 2024: 290 CYP randomised
- January 2025: 312 CYP randomised

Each of these values is marked on the graph, and a line connects them to show how the total number increased over time.

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Figure 5. Intervention group sizes at randomisation (n of groups = 32)

Figure 5 is a bar graph showing the distribution of treatment arm group sizes at randomisation into the WeMatter trial. The horizontal axis represents group size (number of CYP), ranging from 1 to 10. The vertical axis shows the frequency of each group size, starting at 0.

The graph shows the following frequencies for each group size:

- 1 CYP: 5 groups
- 2 CYP: 6 groups
- 3 CYP: 4 groups
- 4 CYP: 1 group
- 5 CYP: 3 groups
- 6 CYP: 2 groups
- 7 CYP: 2 groups
- 8 CYP: 3 groups
- 9 CYP: 2 groups
- 10 CYP: 4 groups

Click to return to main text.

Figure 6. Participant flow diagram for treatment and control arms

Figure 6 is a flow diagram showing the progression of participants through the trial, including the numbers excluded at each stage. It is divided into three main stages: referrals, randomisation and baseline, and analysis.

Stage 1: Referrals

A total of 453 CYP were referred to Victim Support. Of those, the following were excluded:

- 17 who attended programme outside the trial.
- 24 who did not meet eligibility criteria.
- 49 who could not be contacted.
- 51 who did not consent to the trial.

Stage 2: Randomisation and baseline

312 CYP were randomised: 156 to the treatment arm 156 to the control. CYP were excluded from each arm sequentially.

The treatment arm exclusions were as follows:

- 9 for whom randomisation was applied incorrectly.
- 22 who had no or incomplete baseline measure.
- 2 who provided baseline measure after attending first group session.

The control arm exclusions were as follows:

- 2 for whom randomisation was applied incorrectly.
- 21 who had no or incomplete baseline measure.

That left 123 treatment CYP and 133 control CYP with valid baseline measures.

Stage 3: Analysis

CYP were excluded from each arm sequentially to reach the final analysed sample.

The treatment arm exclusions were as follows:

- 34 who had no or incomplete endline measure.
- 7 who had uncertain WeMatter group allocation.

The control arm exclusions were as follows:

- 8 who had endline collected after first session.
- 16 who had no or incomplete endline measure.
- 26 who had uncertain WeMatter group allocation.

That left 82 treatment CYP and 83 control CYP to be included in the analysis.

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Figure 7. Intervention group sizes at analysis (n of groups = 28)

Figure 7 is a bar graph showing the distribution of group sizes for groups containing at least one treatment arm CYP at analysis. The horizontal axis represents group size (number of CYP), ranging from 2 to 12. The vertical axis shows the frequency of each group size, starting at 0.

The graph shows the following frequencies for each group size:

- 2 CYP: 3 groups
- 3 CYP: 1 group
- 4 CYP: 2 groups
- 5 CYP: 4 groups
- 6 CYP: 3 groups
- 7 CYP: 5 groups
- 8 CYP: 1 group
- 9 CYP: 1 group
- 10 CYP: 2 groups
- 11 CYP: 3 groups
- 12 CYP: 1 group
- 14 CYP: 1 group

Click to return to main text.

Figure 8. Number of sessions attended by treatment arm CYP (n=156)

Figure 8 is a bar graph showing the distribution of the number of sessions attended by treatment arm CYP. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The graph shows the following frequencies for each number of sessions attended:

- 0 sessions: 36 CYP
- 1 session: 9 CYP
- 2 sessions: 6 CYP
- 3 sessions: 8 CYP
- 4 sessions: 8 CYP
- 5 sessions: 14 CYP
- 6 sessions: 14 CYP
- 7 sessions: 26 CYP
- 8 sessions: 35 CYP

Click to return to main text.

Figure 9. Number of sessions attended by treatment arm CYP, by year of birth (n=156)

Figure 9 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by year of birth band. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The frequencies for each year of birth band are:

2007–2008 (n = 10):

- 0 sessions: 4 CYP
- 1 session: 0 CYP
- 2 sessions: 1 CYP
- 3 sessions: 1 CYP
- 4 sessions: 0 CYP
- 5 sessions: 0 CYP
- 6 sessions: 1 CYP
- 7 sessions: 0 CYP
- 8 sessions: 3 CYP

2009–2011 (n = 47):

- 0 sessions: 16 CYP
- 1 session: 5 CYP
- 2 sessions: 3 CYP
- 3 sessions: 3 CYP
- 4 sessions: 2 CYP
- 5 sessions: 2 CYP
- 6 sessions: 4 CYP
- 7 sessions: 6 CYP
- 8 sessions: 6 CYP

2012–2016 (n = 99):

- 0 sessions: 16 CYP
- 1 session: 4 CYP
- 2 sessions: 2 CYP
- 3 sessions: 4 CYP
- 4 sessions: 6 CYP
- 5 sessions: 12 CYP
- 6 sessions: 9 CYP
- 7 sessions: 20 CYP
- 8 sessions: 26 CYP

Click to return to main text.

Figure 10. Number of sessions attended by treatment arm CYP, by delivery setting (n=156)

Figure 10 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by delivery setting. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The frequencies for each delivery setting are:

Home (n = 45):

- 0 sessions: 15 CYP
- 1 session: 4 CYP
- 2 sessions: 1 CYP
- 3 sessions: 4 CYP
- 4 sessions: 0 CYP
- 5 sessions: 2 CYP
- 6 sessions: 1 CYP
- 7 sessions: 7 CYP
- 8 sessions: 11 CYP

School (n = 111):

- 0 sessions: 21 CYP
- 1 session: 5 CYP
- 2 sessions: 5 CYP
- 3 sessions: 4 CYP
- 4 sessions: 8 CYP
- 5 sessions: 12 CYP
- 6 sessions: 13 CYP
- 7 sessions: 19 CYP
- 8 sessions: 24 CYP

Click to return to main text.

Figure 11. Number of sessions attended by treatment arm CYP, by gender (n=156)

Figure 11 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by gender. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The frequencies for each gender are:

Female (n = 71):

- 0 sessions: 15 CYP
- 1 session: 5 CYP
- 2 sessions: 3 CYP
- 3 sessions: 4 CYP
- 4 sessions: 5 CYP
- 5 sessions: 6 CYP

- 6 sessions: 10 CYP
- 7 sessions: 8 CYP
- 8 sessions: 15 CYP

Male (n = 85):

- 0 sessions: 21 CYP
- 1 session: 4 CYP
- 2 sessions: 3 CYP
- 3 sessions: 4 CYP
- 4 sessions: 3 CYP
- 5 sessions: 8 CYP
- 6 sessions: 4 CYP
- 7 sessions: 18 CYP
- 8 sessions: 20 CYP

Click to return to main text.

Figure 12. Number of sessions attended by treatment arm CYP, by ethnicity (n=156)

Figure 12 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by ethnicity. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The frequencies for each ethnicity group are:

White (n = 121):

- 0 sessions: 25 CYP
- 1 session: 8 CYP
- 2 sessions: 4 CYP
- 3 sessions: 6 CYP
- 4 sessions: 6 CYP
- 5 sessions: 11 CYP
- 6 sessions: 11 CYP
- 7 sessions: 20 CYP
- 8 sessions: 30 CYP

Other (n = 35):

- 0 sessions: 11 CYP
- 1 session: 1 CYP
- 2 sessions: 2 CYP
- 3 sessions: 2 CYP

- 4 sessions: 2 CYP
- 5 sessions: 3 CYP
- 6 sessions: 3 CYP
- 7 sessions: 6 CYP
- 8 sessions: 5 CYP

Click to return to main text.

Figure 13. Number of sessions attended by treatment arm CYP, by FSM status (n=153)

Figure 13 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by Free School Meals status. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The frequencies for each FSM status are:

FSM status: Yes (n = 110):

- 0 sessions: 26 CYP
- 1 session: 6 CYP
- 2 sessions: 4 CYP
- 3 sessions: 3 CYP
- 4 sessions: 8 CYP
- 5 sessions: 12 CYP
- 6 sessions: 7 CYP
- 7 sessions: 21 CYP
- 8 sessions: 23 CYP

FSM status: No (n = 43):

- 0 sessions: 10 CYP
- 1 session: 3 CYP
- 2 sessions: 1 CYP
- 3 sessions: 5 CYP
- 4 sessions: 0 CYP
- 5 sessions: 2 CYP
- 6 sessions: 7 CYP
- 7 sessions: 5 CYP
- 8 sessions: 10 CYP

Click to return to main text.

Figure 14. Number of sessions attended bytreatment arm CYP, by disability (n=156)

Figure 14 is a grouped bar graph showing the distribution of the number of sessions attended by treatment arm CYP, broken down by disability status. The horizontal axis represents the number of sessions attended, ranging from 0 to 8. The vertical axis shows the frequency for each number of sessions, starting from 0.

The graph displays two sets of bars for each session count, corresponding to two disability statuses. The frequencies for each disability status are:

Disability: Yes (n = 65):

- 0 sessions: 12 CYP
- 1 session: 3 CYP
- 2 sessions: 3 CYP
- 3 sessions: 3 CYP
- 4 sessions: 4 CYP
- 5 sessions: 6 CYP
- 6 sessions: 5 CYP
- 7 sessions: 12 CYP
- 8 sessions: 17 CYP

Disability: No (n = 91):

- 0 sessions: 24 CYP
- 1 session: 6 CYP
- 2 sessions: 3 CYP
- 3 sessions: 5 CYP
- 4 sessions: 4 CYP
- 5 sessions: 8 CYP
- 6 sessions: 9 CYP
- 7 sessions: 14 CYP
- 8 sessions: 18 CYP

Click to return to main text.