Foundations
What Works Centre for Children & Families

WEMATTER: A RANDOMISED CONTROLLED TRIAL

Evaluation protocol

Intervention developer	Victim Support
Delivery organisation	Victim Support
Evaluator	Verian (Verian Group UK Ltd)
Principal investigator	Prof Natalie Gold
Protocol author(s)	Prof Natalie Gold, Dr James Thom, Priya Menon, Dr Sarah Bowen, Penny Stothard, and Pieter Cornel
Type of trial	Two-arm partially nested randomised controlled trial
Age or status of participants	8–17 years old
Number of participating local authorities	All areas in England
Number of children and families	992
Primary outcome(s)	Mental wellbeing
Secondary outcome(s)	Feelings of being supported

Contextual factors	Individual circumstances, demographic characteristics, local environmental factors, experiences during the service, facilitator factors

Summary

Background

Domestic abuse is estimated to affect one in five children and has been shown to negatively impact children's emotions (Calder & Regan, 2008), behaviours, and social and physical health outcomes (Children's Commissioner, 2018; Hughes et al., 2017; Kitzmann et al., 2003). However, research has shown that timely support for children and young people (CYP) who are victim-survivors of domestic abuse can mitigate or avert these negative outcomes (Mullender et al., 2002). Despite this, a recent report found that only 29% of parent victim-survivors in England and Wales who wanted support for their children were able to access it (Domestic Abuse Commissioner, 2022). Therefore, there is a need to improve the provision and access to support for CYP victims. To do this, we must first address a major barrier to improving services: that we have very little evidence about which services improve outcomes for children who have experienced domestic abuse.

Intervention

WeMatter is a digital, group-based support service for CYP between the ages of 8 and 17 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, which designed the service based on the Rock Pool CYP Domestic Abuse Recovery Toolkit.

The service lasts 12 weeks in total and includes an introductory 1:1 session, 10 weekly online group sessions, and a final 1:1 session. The group sessions incorporate activities, games, and discussions that use simple cognitive behavioural therapy (CBT) and allow CYP to support each other. CYP can join from school or home, whichever is their preferred setting. Digital delivery means CYP can engage with peers who have been through similar experiences, but who they are unlikely to know in real life. It also means that the service can easily be offered nationally, because Facilitators can deliver the sessions remotely to CYP from different areas in the same sessions.

Aims

The evaluation will consist of an impact evaluation (IE) of the effects of WeMatter on CYP's mental wellbeing and feelings of being supported, an implementation and process evaluation (IPE) to assess how and whether WeMatter works as intended, and a cost evaluation.

The IE will address the following research questions:

- **Primary research question:** What is the short-term impact of WeMatter on the mental wellbeing of participating CYP, compared to a no-intervention (waitlist) control?

- **Secondary research question:** What is the short-term impact of WeMatter on participating CYP's feelings of being supported, compared to a no-intervention (waitlist) control?

The overarching aims of the IPE for this project are:

- To assess the extent to which WeMatter is implemented as planned, and identify any variations, including when and why they take place.
- To explore the experience of WeMatter from the perspective of those receiving the intervention (CYP and their parents/carers) and of those involved in delivering it in schools (this will vary across schools but will probably be pastoral care or safeguarding leads) and referring CYP to WeMatter, such as local authority stakeholders, with a view to identifying the facilitators and barriers to effective delivery.
- Where possible, to also explore whether equality, diversity, inclusion, and equity (EDIE) characteristics (age, gender, ethnicity, disability, and diagnosed/undiagnosed extra needs) of CYP shape their perceptions and experience of the intervention.
- To qualitatively assess the mechanisms of change as captured in the theory of change (ToC).
- To qualitatively assess the extent to which WeMatter is perceived to achieve the targeted outcomes, both in the short term and the longer term.

The aim of the cost evaluation will be to provide an analysis of:

- The total cost of running WeMatter for a year.
- The average cost per CYP accepted to receive WeMatter – i.e. CYP who are referred to WeMatter, who are deemed eligible to receive the service, and whose needs assessment suggests WeMatter is an appropriate intervention for them.
- Costs of introducing WeMatter to a new local authority (start-up costs).
- Estimated values of the prerequisites for running WeMatter.

Methods

The IE will be a two-armed, partially nested randomised controlled trial (RCT). We will randomise participating CYP one by one on entry into the trial, by assigning them to an ordered list of pre-randomised participant IDs. Those in the treatment arm will start WeMatter as soon as possible (within 2–5 weeks of initial referral). CYP randomised to the waitlist control arm will not start WeMatter until after they have finished taking part in the trial. The primary outcome will be CYP mental wellbeing, measured using the Stirling Children's Wellbeing Scale (Stirling Scale). The secondary outcome will be feelings of being supported, measured by the Multidimensional Scale of Perceived Social Support (MSPSS). We will collect the primary and secondary outcome measures from all CYP at two time points: a baseline data collection call planned as soon as possible after parents/carers give consent to participate in the evaluation, and an endline data collection call planned to take place 14 weeks after randomisation. We will randomise CYP once we have collected their baseline data.

For the IPE, we will use a combination of administrative data supplied by Victim Support, qualitative interviews, and observations of WeMatter group sessions. We will carry out fieldwork with a sample of service recipient CYP and parents/carers, the Victim Support delivery team, participating schools, and local authorities/referral organisations.

To assess the costs of delivering WeMatter, we will collect data from Victim Support on the prerequisites and start-up costs, as well as the recurring costs for running the service. We will also conduct interviews with Victim Support staff to supplement the cost data.

Ethical approval was obtained from Verian's Research Ethics Committee on 30 January 2026. The ethics reference is 26/B001/01.

Timeline

Recruitment will begin in February 2026. Victim Support will deliver WeMatter for the evaluation between February 2026 and June 2027. Victim Support may continue to deliver WeMatter past June 2027 for CYP in the waitlist control arm. Between February 2026 and June 2027, Victim Support will recruit CYP to the trial, collect consent from a safe parent/carer, and collect participant information (e.g. CYP characteristics, parent/carer contact information, CYP attendance at WeMatter sessions). During this period, Verian will collect evaluation data. This will include collecting baseline and endline outcome measures from CYP, conducting interviews with CYP, parents/carers, Victim Support staff, and referral agencies, and collecting cost data from Victim Support.

During the fieldwork period, the evaluation team will meet with Foundations – What Works Centre for Children & Families and Victim Support monthly to review the evaluation approach. The evaluation team will deliver the interim evaluation report in December 2026 and the final evaluation report in October 2027. The evaluation team will upload the analysis code and pseudonymised data on GitHub and Foundations' data archive from October 2027.

Contents

Background and problem statement

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 recognises CYP who witness, experience, or are exposed to the effects of domestic abuse as victim-survivors in their own right. This recognition means that local authorities have a statutory duty to provide CYP victim-survivors support within safe accommodation when they need it.

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). It described 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 in 2021/22 for the report, 26% had waiting lists exceeding one month, and 4% had waiting times in excess of six months.

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 had been evaluated, so we do not know whether 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 arm, or uses inconsistent and non-validated outcome measures (Foundations, 2023a). This means that there is limited scope to make generalisable causal inferences about which interventions improve outcomes.

WeMatter (WM) 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 uses 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 (including peer support) – 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 who have been exposed to domestic abuse, 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 – based on six studies found in a rapid review of the evidence (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 of the six studies using CBT found in Spencer et al.'s (2023) rapid review investigated group therapy for children and adolescents (McWhirter, 2011). It found that group therapy had a positive effect. However, the study had a small sample size and short follow-up period. There is some evidence for the effectiveness of 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 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 in 2024/25.[3] The pilot evaluation consisted of a pilot randomised controlled

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[1] Further details on the pilot of WeMatter are 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 WeMatter.

[3] See: https://foundations.org.uk/wp-content/uploads/2025/11/we-matter-pilot-randomised-controlled-trial.pdf.

trial (RCT) and an implementation and process evaluation (IPE). The focus of the pilot was not on providing robust estimates of impact but rather on trialling methods that would help inform the design of a full-scale RCT, while providing some indicative evidence about the impact of the intervention. The pilot evaluation found that among CYP eligible for analysis, mental wellbeing at endline, as measured by the Stirling Scale (which provides scores from 12 to 60) was 45.93 (SD: 7.30) in the treatment arm, compared with 42.07 (SD: 7.35) in the control arm. There is more detail about the Stirling Scale in 'Appendix A: The Stirling Children's Wellbeing Scale'. The primary intention to treat 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 was 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 cause for caution about the robustness of these estimates, which are likely to be positively biased (i.e. to overestimate the effect). There were high levels of attrition overall, with more attrition in the intervention arm than in the control arm, and with those in the intervention arm who did not complete the service being less likely to supply endline data. A significant contributing factor was that Victim Support did not collect endline data for CYP who ceased to engage, in part due to their limited staff capacity during the pilot. In the full-scale trial, Verian will conduct the data collection, with the aim of increasing endline data availability across the board (and especially in the intervention arm).

Based on the findings from the pilot evaluation, Foundations commissioned Verian in November 2025 to conduct a full-scale RCT evaluation of the WeMatter. This protocol sets out plans for the full scale RCT.

Intervention and theory of change

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. Further detail on WeMatter can be found in the Intervention Protocol.[4]

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 help them recover from the impact of trauma, achieve positive relationships, and lead healthy and happy lives (Mullender et al., 2002), and that cognitive behavioural therapy (CBT) may be effective for both adults and children who have been exposed to domestic abuse (Guillermo-Anasicha et al., 2022; Spencer et al., 2023; Tirado-Muñoz et al., 2014; Trabold et al., 2020; Warshaw et al., 2013). WeMatter differs from other common provision 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 of effectiveness specifically for these features, especially for CYP.

The WeMatter pilot evaluation, conducted by Verian, demonstrated how the effectiveness of the WeMatter service can be robustly evaluated (see 'Background and problem statement'). The next step is to run a full-scale RCT to robustly evaluate the impact of WeMatter on CYP's mental wellbeing and feelings of being supported.

What? (Materials and procedures)

The 12-week intervention was developed based on Rock Pool's CYP Domestic Abuse Recovery Toolkit.[5] It makes use of trauma-informed CBT techniques, incorporating specific targeted activities, games, and discussions.

The intervention consists of 10 weekly 1-hour group sessions, delivered by 2 specialist Facilitators, with introductory and concluding 1:1 sessions for each CYP and their Facilitator. CYP are triaged within 48 hours of referral and then begin the 12-week service (ideally within the next 2 weeks). If a

[4] See: https://foundations.org.uk/wp-content/uploads/2026/05/we-matter-randomised-controlled-trial-intervention-protocol.pdf

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

CYP misses a session, the Facilitator will contact them to schedule a catch-up session to enable the CYP to keep up with the service and rejoin their group for subsequent sessions.[6] CYP who engage with at least six sessions (excluding the introductory and concluding sessions) are considered to have completed the service. Rock Pool recognises this level of participation as enough for meaningful engagement because from a programme integrity perspective, CYP will have attended more sessions than they missed.

The minimum group size for the session to be considered group work is 4 CYP, and the maximum is 12. This is based on Victim Support's extensive experience of delivering sessions across a wide range of age groups, as well as feedback from CYP and Facilitators. Groups of fewer than four can often feel intense for individuals, whereas groups of four or more tend to encourage healthier interaction and engagement. Groups larger than 12 have been tried and tested, but they can become chaotic and difficult to manage.

The CYP toolkit sessions follow a pre-determined order and modular structure:

1. Introductions
2. Safety and relationships with parents and carers
3. Self-esteem and negative automatic thoughts
4. Abuse and early warning signs
5. Self-affirmations and positive self-talk
6. How to explore anger and other emotions
7. Healthy relationships and consent
8. Staying safe in relationships and online
9. Ending and future planning
10. Celebrations and goodbyes.

Facilitators check in with CYP outside group sessions to encourage engagement and provide opportunities for reflection. Between sessions, CYP are given non-mandatory tasks, called 'try it yourself at home' tasks, designed to help them practise the skills and strategies introduced during the group. This allows them to reflect on what the techniques are like for them, identify what worked well, and seek additional advice or support if needed. This approach ensures that new strategies are not simply introduced and left for CYP to implement on their own, but that CYP are instead supported through guided practice and ongoing engagement.

To qualify for the intervention CYP need to have digital access and competency (with support from a trusted adult if needed). As the intervention is delivered in English, the CYP also have to be proficient in English (which is assessed with the safe parent/carer in the triage call).

Who provides?

The intervention is delivered by Victim Support, an independent charity in England and Wales that provides specialist support to victim-survivors and witnesses of crime. The WeMatter team consists

[6] In cases where the CYP does not want a catch-up session, or the parent/carer or school are unable to facilitate the extra session, Facilitators aim to cover missed content within an extended concluding 1:1 session. In addition, all CYP receive an end of programme pack, which includes all the information covered throughout the sessions, meaning they will have access to any content they may have missed.

of managers, triage officers, administrators, and a group of WeMatter Facilitators who engage with CYP and parents/carers, and who deliver the sessions:

- **Area Manager:** Provides strategic leadership and oversight for service delivery, maintaining strong relationships with funders and evaluators to support operational excellence, compliance, and contract management.
- **Senior Operations Manager:** Leads the operational delivery of the WeMatter service, ensuring high-quality standards across all functions.
- **Project Leader:** Ensures effective programme delivery and is accountable for increasing the number of referrals into the service and strengthening stakeholder relationships across England.
- **Triage and Early Intervention Officers:** Initial point of contact for CYP accessing support, assessing support needs, initiating engagement, and ensuring informed consent for participation in the evaluation and intervention.
- **Service Delivery Assistants:** Support communication between all key stakeholders, and ensure smooth coordination of pre- and post-course activities.
- **CYP Programme Facilitators:** Responsible for delivering the CYP Recovery Toolkit to CYP, ensuring a trauma-informed and empowering experience throughout the programme. Victim Support has four full-time and two term-time CYP Programme Facilitators.

All CYP Programme Facilitators are accredited by Rock Pool in the delivery of the trauma-informed psycho-educational CYP Domestic Abuse Toolkit. Also, every member of the service team (e.g. triage officers, administrators, project leaders, etc.) is trained in the toolkit. All Victim Support staff complete mandatory safeguarding training, and the WeMatter team also receive internal CYP training which highlights the risk of engaging in digital support and potential online harms. The Victim Support team also receives additional rigorous training on neurodivergence, domestic abuse, and gathering insights from CYP focus groups. Victim Support also offers continuing professional development (CPD) opportunities throughout the year for all staff, including CPD from Rock Pool.

How?

Facilitators lead a 1:1 introduction session, 10 group sessions, and a 1:1 conclusion session. The intervention is delivered digitally through Zoom. The target group size is 8 CYP, but there could be groups of up to 12 or down to 4. Group members generally remain the same throughout the whole service.

Where?

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

Where? (Local areas)

Digital sessions are delivered in a school or home setting. All local authorities across England can refer CYP to WeMatter by emailing or calling Victim Support. Key local authority and associated professionals who can refer CYP to WeMatter include social workers, teachers, youth workers, family support workers, health professionals, and the police. Referrals can also come from charities,

internal Victim Support services, and parents/carers. Victim Support does normally also accept direct referrals from CYP aged 13 or and above. However, for the purposes of the evaluation CYP must be referred by an adult, because parental consent is required for the CYP to participate in the research.

When?

The intervention consists of 10 weekly 1-hour group sessions, delivered by 2 specialist Facilitators trained to deliver the Rock Pool Toolkit. All CYP will complete an introductory 1:1 session with their Facilitator in the week or 2 before the first group session. CYP will also have a concluding 1:1 session with their Facilitator in the week or 2 after the 10th group session.

Tailoring?

Groups are formed based on CYP's preferred delivery setting (school or home) as well as their age, 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 default age group cohorts are 8–12, 13–15, and 16–17, although Victim Support may make slight alterations if specific groups are slow to fill.[7]

Facilitators adapt session materials based on the results of the 'all about me' assessment in the introductory 1:1 session to accommodate CYP's support needs (e.g. reading difficulty, autism). Group dynamics are taken into consideration from the initial point of risk assessment during the triage call and are also considered following the 'all about me' assessment. For example, if a CYP has triggers related to loud noises, Victim Support would avoid placing them in a group with another CYP who has additional needs that may cause them to shout unpredictably. Facilitators manage group dynamics initially by establishing a group contract, which sets out expectations throughout the sessions. During the delivery of the service, break-out rooms can be offered to CYP who may need additional support, such as taking a short pause from the session or having a brief conversation with a Facilitator. Facilitators remain mindful of group dynamics and adapt activities to ensure a safe and supportive environment for all participants.

Theory of change

The theory of change (ToC) was developed during the pilot evaluation and was updated to reflect its findings. The ToC seeks to establish the mechanisms, the outputs of these mechanisms and the related outcomes, and the eventual long-term impacts of the intervention. Based on input from Victim Support, the ToC also establishes the contextual factors that may impact the outcomes of the intervention alongside the intended mechanisms as well as the assumptions necessary for the intended outputs. This ToC informs the design of the evaluation, specifically in terms of the outputs, mechanisms, and outcomes that need to be evaluated (see Figure 1).

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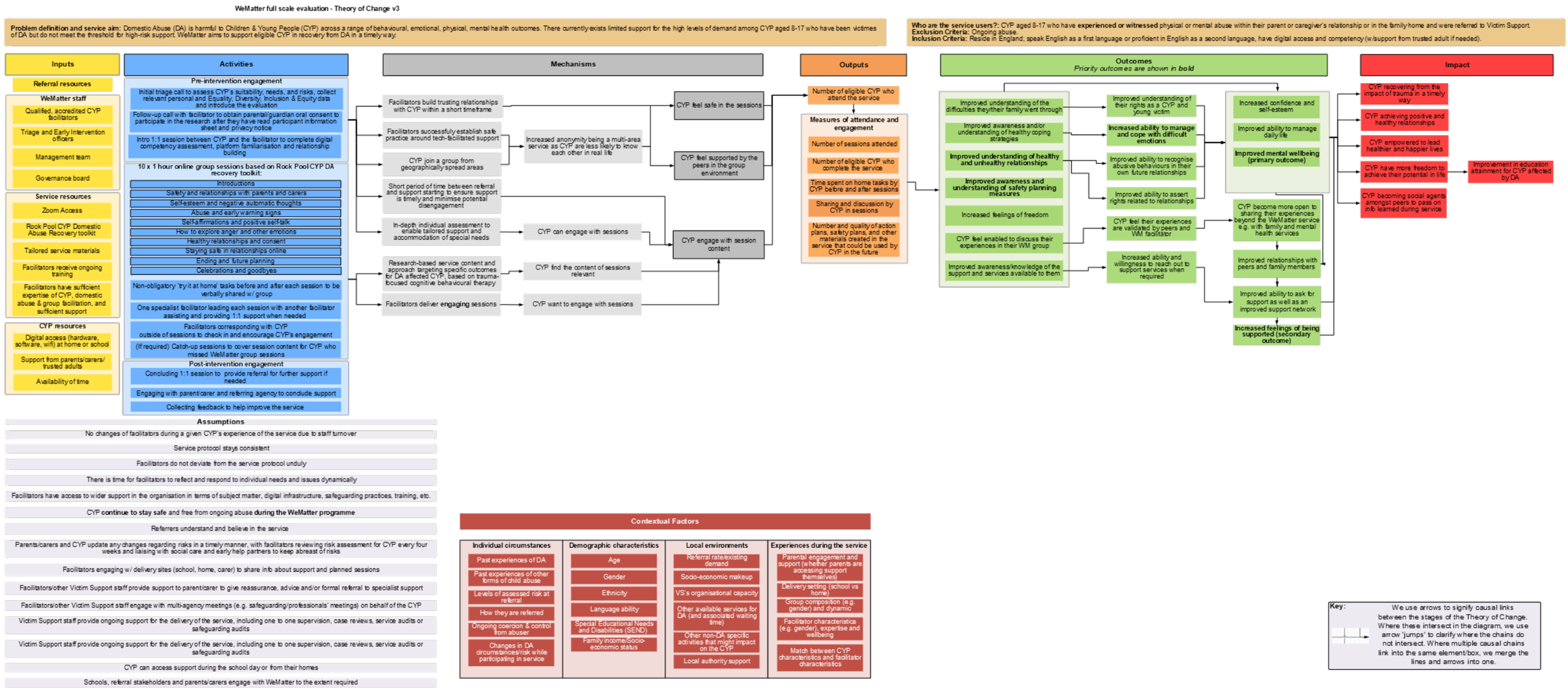
[7] Victim Support bases group allocations on stage of development rather than biological age. This means considering a young person's overall abilities, including academic level, understanding, maturity, neurodiversity, and any SEND needs, and placing them in the most appropriate group. These decisions are informed by input from the parent/carer, professionals working with the CYP, and information gathered during the initial 1:1 introduction session. For example, 11- and 12-year-olds who attend secondary school are typically placed in a 13–15 age group cohort. This approach is based on consistent feedback from both parents/carers and CYP.

Figure 1. Theory of change (ToC)



Inputs

To deliver the intervention Victim Support needs the following inputs:

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

Activities

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

- Pre-intervention engagement includes the initial triage call to assess CYP's suitability, needs, and risks, to collect relevant personal and equality, diversity, inclusion, and equity (EDIE) data, and a follow-up call by the WeMatter Facilitator to obtain parental/guardian consent for their CYP to take part in the service and evaluation.
- The introductory 1:1 session between the CYP and the Facilitator to complete a digital competency assessment, familiarise the CYP with the platform, and build the CYP–Facilitator relationship.
- Ten one-hour group sessions based on the Rock Pool CYP Domestic Abuse Recovery Toolkit, each session covering a domestic abuse-related topic – e.g. abuse and early warning signs, safety planning, and exploring anger. If CYP miss a session, Victim Support will aim to schedule a catch-up session to allow them to continue with the subsequent sessions of the service.
- During the intervention CYP can also complete non-mandatory home tasks (called 'try it yourself at home' tasks) before and after each session. For example, do something you enjoy, try to identify a negative thought, or practise saying positive things about yourself. Facilitators also provide 1:1 support when needed during the group sessions and correspond with CYP outside sessions to check in and encourage CYP's engagement in the following sessions.
- After the intervention Facilitators have a concluding 1:1 session with each CYP to provide referral for further support if needed.

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

- Facilitators engage with delivery sites (school, carer) to share information about support and planned sessions.
- Facilitators/other Victim Support staff provide support to parents/carers to give reassurance, advice, and/or formal referral to specialist support.
- Facilitators/other Victim Support staff engage with multi-agency meetings (e.g. safeguarding/professionals' meetings) on behalf of the CYP.

- Victim Support staff provide ongoing support for the delivery of the service, including one-to-one supervision, case reviews, service audits, or safeguarding audits.
- WeMatter Facilitators receive ongoing training on domestic abuse, the General Data Protection Regulation (GDPR), and CPD from both Victim Support and Rock Pool. They also engage in team-building activities.

Mechanisms, outputs, and outcomes

During the pilot, we sought to answer the following questions regarding the mechanisms and outcomes of WeMatter:

- What are the mechanisms that lead to identified outcomes?
- What are the inputs that the mechanisms operate on to produce change?
- What are the outcomes produced by these mechanisms?
- What outcomes were considered a priority and why?
- What are the contextual factors that may have a moderating and/or direct effect on the outcomes?

There are three key mechanisms for the service to successfully achieve the desired outputs and outcomes:

- **CYP can successfully engage with session content and support:** Based on the Rock Pool Domestic Abuse Recovery Toolkit, WeMatter is tailored for CYP: content is age-appropriate (tailored for younger and older cohorts) and delivery style is designed to be interesting and fun. This means CYP engage positively with sessions, finding them relevant and enjoyable. CYP acquire new knowledge, understanding, skills, and tools. The service also ensures CYP with special needs can engage successfully by tailoring the support based on the results of the initial assessment of individual needs. Furthermore, Facilitators engage with safe parents/carers/schools outside the sessions, run catch-up sessions with CYP who miss group sessions, and support CYP outside sessions to avoid CYP dropping out of the service.
- **CYP feel supported by peers in their WeMatter groups:** The digital delivery mode allows CYP to join a group from different geographic areas, reducing the likelihood that CYP in a group know each other offline. This increased anonymity makes it easier for CYP to share and explore their trauma experiences in a group setting. In addition, the Facilitators are trained to be able to establish safe practices around tech-facilitated support in the groups, and pick up on dynamics and issues in a timely manner, so CYP can feel safe in the group environment and feel supported and validated by their peers.
- **CYP feel safe in the session and have trusting relationships with the Facilitators:** The accredited Facilitators have sufficient expertise, along with ongoing training and support from the wider team, to establish safe practice around tech-facilitated support and to build trusting relationships with the CYP in a short timeframe. The Facilitators assess risks, and individual needs and issues, in a timely way to make sure CYP feel safe and supported throughout the service.

All three mechanisms contribute to a series of outputs relating to the attendance and engagement in the service, including: number of eligible CYP who attend the service, number of sessions attended, number of eligible CYP who complete the service, time spent on home tasks by CYP

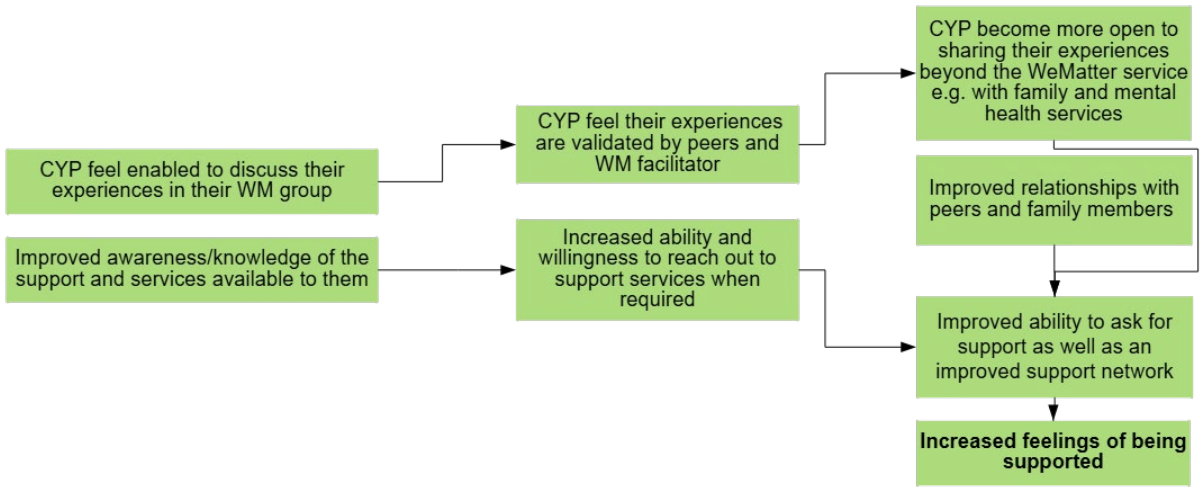
before and after sessions, sharing and discussion by CYP in sessions, number and quality of action plans, safety plans, and other materials created as part of the service that could be used by CYP in the future. Attendance and engagement with the service then result in a set of outcomes and impacts. Together with Victim Support we identified priority outcomes that were the focus of the pilot evaluation (outcomes identified as priority outcomes are in **bold**):

- **'Improved mental wellbeing'** was identified as a key aim of the service by Victim Support, following from outcomes that are a direct result of increased awareness and knowledge of session content and the skills and tools covered. This is the primary outcome of the RCT and will be measured using the Stirling Children's Wellbeing Scale.
- **'Improved understanding of healthy and unhealthy relationships'** was another key outcome because it led to the other relevant (non-priority) outcomes: 'improved ability to recognise abusive behaviours in their own future relationships' and 'improved ability to assert rights related to relationships'. Improved understanding of healthy and unhealthy relationships will be explored qualitatively through the IPE.

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

- **'Increased ability to manage and cope with difficult emotions'**, resulting from 'improved awareness and/or understanding of healthy coping strategies'.
- **'Improved awareness and understanding of safety planning measures.'**
- **'Increased feelings of being supported'**, resulting from 'improved ability to ask for support as well as an improved support network'. There are two outcome pathways, as shown in Figure 2, that lead to 'improved ability to ask for support as well as an improved support network':
    - As a result of CYP feeling supported by peers in group sessions and Facilitators building trusting relationships with CYP, 'CYP feel enabled to discuss their experiences in their WeMatter group'. This leads to 'CYP feeling their experiences are validated by peers and WeMatter Facilitator', resulting in 'CYP becoming more open to sharing their experiences beyond the WeMatter service – e.g. with family and mental health services', which in turn leads to 'improved relationships with peers and family members' and then an 'improved ability to ask for support as well as an improved support network'. However, we also recognise that sharing experiences may not always have positive consequences and may deteriorate relationships. The IPE will explore any unintended consequences of WeMatter on CYP and/or their parents/carers.
    - As a result of attending and engaging with WeMatter, CYP have an 'improved awareness/knowledge of the support and services available to CYP', which leads to an 'increased ability and willingness to reach out to support services when required', and so an 'improved ability to ask for support as well as an improved support network'.

Figure 2. ToC outcomes related to 'increased feelings of being supported'



There were also other outcomes intended to be improved through WeMatter participation: 'improved understanding of the difficulties they/their family went through' leads to an 'improved understanding of their rights as a CYP and young victim-survivor'; and 'increased feelings of freedom'.

Collectively, all of the aforementioned outcomes lead to the following outcomes: 'increased confidence and self-esteem', 'improved ability to manage daily life', 'improved mental wellbeing', and 'improved relationships with peers and family members'. The IPE will explore these outcomes and also seek to understand the mechanisms of change, and whether and how the outcomes are inter-related.

Contextual factors

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

- **Individual circumstances** such as past experiences of domestic abuse, past experiences of other forms of child abuse, levels of assessed risk at referral, how CYP are referred to Victim Support, ongoing coercion and control from abuser, and changes in domestic abuse circumstances during the service.
- **Demographic characteristics** such as age, gender, ethnicity, language ability, special educational needs and disabilities (SEND), and family income/socio-economic status.
- **Local environmental factors** such as referral rate/existing demand for domestic abuse intervention services, socio-economic makeup, Victim Support's organisational capacity, other non-domestic abuse-specific influences such as availability of appropriate local housing that might produce an impact on CYP, and local authority support. One important factor is availability of alternative domestic abuse intervention services in the area and the waiting time to access the service. The WeMatter Intervention Protocol will include more

details about alternative services that exist, including the 1:1 support offered by Victim Support in some areas.
- **Experiences during the service** such as parental engagement and support, delivery setting (school vs home), group composition and dynamic, Facilitator characteristics, expertise and wellbeing, and whether there is a match between CYP and Facilitator characteristics (e.g. gender).

Assumptions

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

Impact evaluation

Research questions

The impact evaluation (IE) will seek to answer the following **primary research question:**

What is the short-term impact of WeMatter on the mental wellbeing of participating CYP, compared with a no-intervention (waitlist) control?

It will also seek to answer the following **secondary research question:**

What is the short-term impact of WeMatter on participating CYP's feelings of being supported, compared with a no-intervention (waitlist) control?

Design

Our aim is to run a high-quality trial designed to, where possible, minimise bias according to the RoB-2 tool (Higgins et al., 2011). The RoB-2 covers six domains of bias: selection bias, performance bias, detection bias, attrition bias, reporting bias, and other bias. Running a trial with low risk of bias will enhance the credibility of our findings and enable comparison with other experimental evaluations in children's social care and related policy domains.

We will carry out a two-armed, partially nested randomised controlled trial (RCT). The design is 'partially nested' because participants in the treatment arm will receive WeMatter in groups, causing clustering of outcomes that will not apply to the waitlist control arm (Lohr et al., 2014).

Verian will randomise participating CYP one by one on entry into the trial by assigning them to an ordered list of pre-randomised participant IDs. Those in the treatment arm will start WeMatter as soon as possible (within 2-5 weeks). In most cases, this should be two to five weeks after their initial referral, depending on availability of enough other CYP to run the WeMatter group sessions. CYP randomised to the waitlist control arm will start WeMatter after they have finished taking part in the trial, no sooner than 16 weeks after randomisation.

The IE's outcomes are derived from the intervention's theory of change. The primary outcome will be CYP mental wellbeing, measured using the Stirling Children's Wellbeing Scale (Stirling Scale) (Liddle & Carter, 2010). The secondary outcome will be feelings of being supported, measured by the Multidimensional Scale of Perceived Social Support (MSPSS). We restricted the IE to these two outcomes to avoid overburdening participating CYP with lengthy data collection sessions.

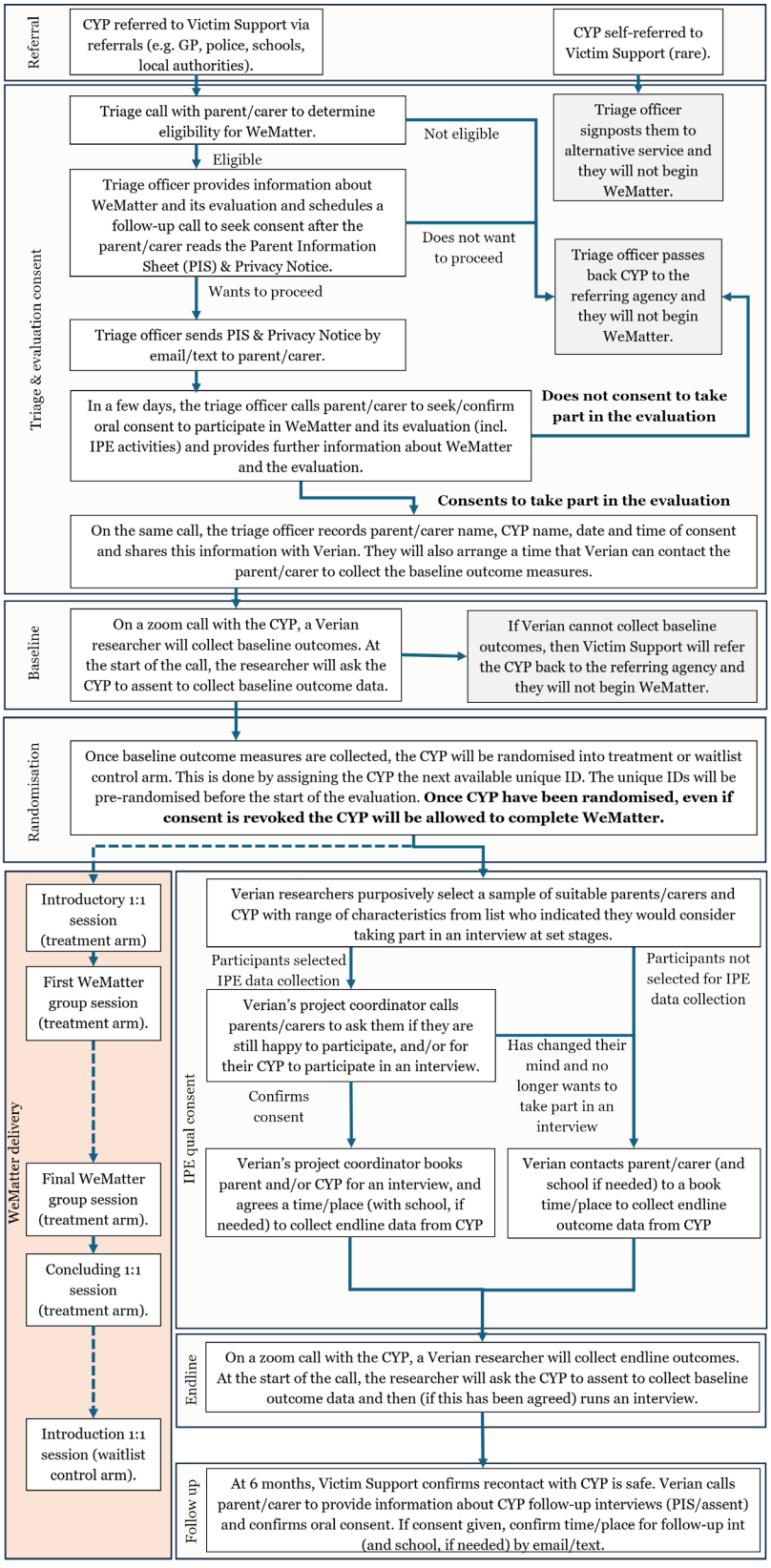
We will collect the primary and secondary outcome measures at two time points: a baseline data collection call planned to take place as soon as possible after parents/carers give consent to participate in the evaluation, and an endline data collection call planned to take place 14 weeks after randomisation. We will randomise CYP once we have collected their baseline data. Because participants will have the option to enter the trial as they are referred to Victim Support, every participant will have their own endline data collection call date, set with reference to their own randomisation date.

Table 1 summarises the trial design and Figure 3 illustrates the evaluation process, including the consent process and data collection points.

Table 1. Summary of impact evaluation trial design

Trial type and number of arms		Two-arm partially nested randomised controlled trial, with individuals randomised to a treatment or waitlist control arm using a pre-generated list of pre-randomised CYP IDs
Unit of randomisation		Individual
Stratification variables (if applicable)		Not applicable
Primary outcome	**Variable**	Mental wellbeing
	Measure (instrument, scale)	Stirling Children's Wellbeing Scale (12-item questionnaire, each item a Likert scale from 1 to 5, resulting in aggregated scores between 12 and 60)
Secondary outcome(s)	**Variable(s)**	Feelings of being supported
	Measure(s) (instrument, scale)	Multidimensional Scale of Perceived Social Support (MSPSS), a 12-item questionnaire, with response options ranging from 'very strongly disagree' (1) to 'very strongly agree' (7)

Figure 3. Trial process



Referral, eligibility and consent

Victim Support will recruit CYP to the evaluation through existing WeMatter referral pathways, including schools, GPs, social services, the police, or charities. This is the standard process for referring CYP into WeMatter. Referrals will happen continuously, so participants will enter the trial and complete it on an ongoing basis, rather than all being recruited before the trial's start.

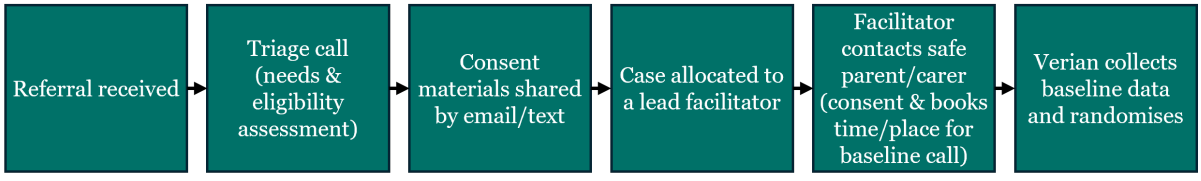
Within 48 hours of referral, a Victim Support triage officer will conduct an initial triage call with the CYP's safe parent/carer. The triage officer will offer the parent/carer the opportunity for their child to participate in the service and its evaluation. At this point, the triage officer will complete the critical discussions risk assessment. This tool considers factors such as exposure to domestic abuse, suicidal thoughts, environment and impacts. The triage officer will inform the parent/carer that, due to funding conditions, participating in the service is conditional on participating in the evaluation (see 'Ethics and participation' for more detail).

After the initial triage call, the triage officer will send the parent/carer written materials about the intervention and trial, including the associated data collection and processing required. Approximately three days later, a Victim Support Facilitator will recontact the parent/carer by phone to confirm that they have read and understood the written materials, and to collect consent. Victim Support will then arrange a baseline data collection call between the participant and Verian to collect baseline data and carry out the randomisation.

If participants are not eligible for WeMatter or do not consent to participate in the evaluation, the triage officer will pass them back to the referrer or will signpost/refer them to alternative support, following Victim Support's standard processes. Parents/carers of CYP participating in the evaluation may also withdraw their consent to be part of the evaluation at any time by informing Victim Support and/or Verian. If this happens after randomisation, the CYP will continue to receive WeMatter as planned but any data collected by Victim Support about the participant will not be shared with Verian.

The process from initial referral to randomisation is shown in Figure 4.

Figure 4. Process from referral to randomisation



Randomisation

Verian will randomise participating CYP one by one on entry into the trial. Randomisation will take place at the end of the baseline data collection call, after taking the baseline measure(s). We will create an ordered list of pre-randomised participant IDs and will enter the participant into the next open space on the list, with the associated CYP ID and assigned trial arm. We will use the randomizr package in R statistical software to generate the randomised list of allocations using

simple random assignment (Coppock, 2025). Because participants will always be assigned the next available ID in the list, this approach will achieve random allocation to trial arms with respect to point of entry into the trial. We will communicate the outcome of the randomisation to Victim Support so they can notify the participant's safe parent/carer. At the end of the baseline data collection call, the CYP will be considered to be fully enrolled in the trial.

Participants

The trial's participants will be those CYP who are referred to Victim Support while the trial is recruiting, meet the trial's eligibility criteria, and consent to take part. An individual is eligible if they meet each of the following criteria:

- Have been referred to Victim Support and have witnessed or directly experienced domestic abuse, but no longer experience it and no longer live with the alleged perpetrator of the abuse
- Are between the ages of 8 and 17 years old at the time of referral
- Reside in participating local authorities – i.e. all areas in England
- Speak English as a first language or are proficient in English as a second language
- Are eligible to participate in WeMatter based on a risk assessment conducted during the triage call; this will exclude individuals whose risk is considered too high to participate in WeMatter sessions – i.e. CYP witnessing ongoing domestic abuse and/or with the alleged perpetrator living in the family home who has not given consent for support[8]
- Have digital access and competency to be able to join the online group sessions (with support from a trusted adult if needed, and/or with support from the pot of funding available from Victim Support to purchase IT equipment)
- Are not engaging in any other support in relation to their experience of domestic abuse.

Sample size/minimum detectable effect size calculations

We ran power calculations that suggest an expected minimum detectable effect size (MDES) of between 0.14 and 0.23, depending on levels of attrition and the degree of heterogeneity in treatment effects between different WeMatter groups (Table 2). This range compares favourably with the estimated effect of 0.74 reported in the pilot, but the pilot report cited several reasons to think that estimate might be positively biased. We considered two scenarios (Scenario 1 = no variability in treatment effects across groups; Scenario 2 = high variability in treatment effects across groups), each at three levels of attrition (5%, 20%, and 37%).

[8] Risks will be assessed in the triage call using Victim Support's CYP Critical Discussion Tool to determine whether the risk is standard or high for a CYP. This tool considers factors such as exposure to domestic abuse, suicidal thoughts, environment, and impacts. Parents/carers and CYP will be asked at the start of the service to update any changes in risks and the risk assessment will be reviewed every four weeks by the facilitators for all CYP in the service. Victim Support also links with social care and early help partners to keep abreast of risk.

Table 2. Minimum detectable effect size (MDES) calculations

		Scenario 1	Scenario 2
MDES (5% attrition)		0.14	0.18
MDES (20% attrition)		0.16	0.20
MDES (37% attrition)		0.18	0.23
Proportion of variance in outcome explained by Level 1 covariates		0.28	0.28
Intracluster correlation coefficient (ICC)		0.19	0.19
Variability in standardised treatment effects across blocks		0.0	0.5
Alpha		0.05	0.05
Power		0.8	0.8
One-sided or two-sided?		Two-sided	Two-sided
Average block size (average number of CYP per group)		16	16
Number of blocks		62	62
Pre-attrition sample size	**Intervention**	496	496
	Control	496	496
	Total	992	992

MDES calculation methods and assumptions

We ran the power calculations using the PowerUp! package in R statistical software (Bulus et al., 2021). PowerUp! does not include a function for estimating power on partially nested trials, so we instead assumed nesting/blocking in both arms. This reduces power and so is likely to generate conservative estimates for MDES.

All calculations assumed an average block size of 16 CYP, alpha = 0.05, two-tailed testing, and the conventional threshold for power of 80%. We used the ICC and the proportion of variance in outcome explained by Level 1 covariates observed in the pilot. We were unable to reliably estimate heterogeneity in treatment effects between blocks from the pilot data and so instead used the same values that were assumed in the pilot trial's power calculations. We set the highest attrition level at 37% to match the pilot trial's control arm attrition rate.[9] The lower values reflect our expectation

[9] The pilot trial encountered some issues with attrition that were specific to the treatment arm, and which we expect to have been resolved by scheduling endline interviews independently of intervention delivery. We therefore judged the control arm to be a more useful guide to levels of attrition in the present trial.

that attrition in this trial will be lower than in the pilot, due to design decisions that aim to reduce attrition.

Outcome measures

Primary outcome

The primary outcome measure will be CYP mental wellbeing, which is one of the priority target outcomes of WeMatter. We will measure mental wellbeing using the Stirling Children's Wellbeing Scale (Stirling Scale), which is validated for use with children aged 8–15 years old and has shown strong internal reliability (Cronbach's alpha: 0.82–0.85) (Liddle & Carter, 2015). We expected this age range to cover most participants in the trial, because approximately 92% of pilot participants were in this age range when they took part.[10]

The Stirling Scale consists of 12 items, each with 5-point Likert response scales, with response options that range between 'never' (1) and '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).

Secondary outcome

One of the immediate outcomes the ToC sets out for WeMatter is that CYP feel supported and validated by peers in groups and have trusting relationships with Facilitators. Therefore, the IE's secondary outcome measure will be 'feelings of being supported' measured using the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988).

The MSPSS scale consists of 12 items measuring the extent of a child's social networks (with response options ranging from 'very strongly disagree' (1) to 'very strongly agree' (7)). The items are divided into three factor groups, relating to source of social support: family, friends, or significant other. (See 'Appendix B: Multidimensional Scale of Perceived Social Support' for the full list of items.) Social support is assessed using the mean score (summing the scores for each item and dividing by 12), with a minimum possible score of 1 and a maximum score of 7, which we will refer to as the 'Social Support score'. The MSPSS has been shown to be psychometrically robust with strong internal validity, and has been used successfully in young people aged between 8 and 24 in Germany, South Africa, and China (Bruwer et al., 2008; Hitchcock et al., 2015; Koğar & Koğar, 2024; Sun & Guo, 2024).

Data collection methodology

Baseline

Victim Support will aim to schedule the baseline data collection call as soon as consent is given, if possible. Verian will carry out the baseline data collection call.

[10] This figure is approximate because we were only able to collect year of birth, not full date of birth.

Endline

Verian will schedule and carry out the endline data collection calls with every trial participant, using contact details passed on by Victim Support. A Verian staff member will first contact the participant, via their parent/carer and/or school, at least one week before their allotted endline data collection date to arrange a call as close to that date as possible.

The pilot encountered high levels of attrition, especially among CYP in the treatment arm who stopped attending WeMatter group sessions. We will therefore undertake the following to reduce attrition and mitigate the concomitant risk of bias:

- Offer a £20 voucher incentive for completing the endline data collection session, even if they do not complete WeMatter
- Follow a contact strategy with 2–5 call or text message attempts to arrange endline interviews, varying time of day and mode of contact where possible
- Follow up by phone with participants who fail to attend their endline data collection session.

Victim Support will also routinely check in with all CYP monthly, as part of their risk assessment. We will monitor attrition levels throughout the trial and, if necessary, make changes to our planned fieldwork approach.

There is no longer-term follow-up for the IE because the waitlist design means that both arms would have received the intervention by that point.

Blinding

We will not allocate CYP to their pre-randomised ID until after completing baseline data collection, so the interviewer should always be blind to arm allocation when collecting the baseline. We will also not inform the Verian staff member carrying out each endline interview which arm the participant was allocated to. The endline interviewers should therefore also be blind to arm allocation, although there is always a chance that the parent or child may reveal which arm they were in during the call. To account for this, endline interviewers will record whether the child revealed which arm they were in during endline data collection.

Analysis plan

The Statistical Analysis Guidance produced by What Works for Children's Social Care is still applicable for the work of Foundations: https://foundations.org.uk/wp-content/uploads/2026/05/foundations-statistical-analysis-plan-guidance.pdf

Primary analysis

The primary analysis will be an intention to treat (ITT) analysis examining the effects of WeMatter on mental wellbeing, as measured by aggregate scores on the Stirling Scale. The main predictor variables will be a dummy variable representing allocation to treatment and an indicator for baseline Stirling scores to account for variation between CYP in mental wellbeing at the start of the trial.

Our planned analysis is a partially nested heteroscedastic mixed-effects linear regression model, which was recommended as the best-performing model for RCTs with clustering in the treatment arm but not in the control by a simulation study (Candlish et al., 2018). We describe this structure analytically as individual CYP i nested within cluster j, where clustering represents assignment to WeMatter groups in the treatment arm. CYP in the control arm will be treated as a single pseudocluster.

The primary analysis model specification is as follows:

$$y_{ij} = \beta_0 + \beta_1 T_{ij} + \beta_2 X_{ij} + \theta_j T_{ij} + \gamma_{ij}(1 - T_{ij}) + \varepsilon_{ij} T_{ij}$$

Where:

- y_{ij} is the endline Stirling score for the i_{th} individual in cluster j
- T represents allocation to treatment (0 = control arm, 1 = treatment arm) with coefficient β_1 representing the average ITT impact of treatment on endline Stirling scores
- X is a vector of control variables (including only the baseline Stirling score) and β_2 its coefficient
- The error terms $\theta_j \sim N(0,\ \sigma_\theta^2)$, $\gamma_{ij} \sim N(0,\ \sigma_\gamma^2)$, and $\varepsilon_{ij} \sim N(0,\ \sigma_\varepsilon^2)$ are respectively the random effects representing between-cluster variation in the treatment arm, individual variation in the control arm, and individual variation in the treatment arm.

We will report the estimated coefficients, standard errors, 95% confidence intervals, and effect size of the intervention both in absolute terms and as a proportion of the standard deviation in the control arm (Glass's Delta). We will use the standard threshold of 0.05 to determine statistical significance.

Secondary analysis

Secondary outcome: We will carry out an ITT analysis to determine the effects of WeMatter on perceptions of social support, as measured by the MSPSS scale. This secondary model will use the same model specification as our primary analysis, but where y is the aggregate score of the MSPSS scale collected at endline and X is a vector of control variables including only baseline Social Support scores.

Subgroup effects: We will conduct descriptive analysis on subgroup differences with respect to the following characteristics: age group, preferred setting, gender, ethnicity, and local authority. In each case, we will report mean aggregate Stirling scores and Social Support scores at endline, and change from baseline, broken down by trial arm. Evidence from the pilot suggests that the sample is likely to be unevenly distributed such that sample sizes in many sub-groups will be too small to support meaningful inferential analyses. We therefore do not plan to carry out any subgroup interaction models.

Exploratory analysis

Additional specifications: We will run a series of exploratory analyses with varying specifications of the primary analysis model to determine whether its findings are robust to choices of statistical methodology. These will include using demographic covariates to account for imbalance at baseline (if observed), an unclustered model that does not account for clustering in

the treatment arm, and a more conservative estimator with a fixed effect representing the WeMatter group CYP in the treatment arm were assigned to.

Varying cases included: We will carry out sensitivity analyses varying the cases that are included in the main analysis if there is uncertainty around which WeMatter groups some CYP attended (e.g. if they attended sessions from multiple groups). The purpose of these analyses is to determine whether the findings of the main analysis are distorted by inclusion of small numbers of CYP with an atypical experience of the intervention.

Timeliness of data collection: It will not always be possible to collect endline data on the planned date. We will therefore compare the mean interval (in days) between randomisation and actual endline data collection, across trial arms. Our planned data collection methodology is intended to prevent any systematic difference in fieldwork between treatment and waitlist control arm so we expect to see similar intervals in both arms. If this is not the case, then we will explore the use of weighting or matching to construct a comparable sample in each arm to re-run the main analysis model on.

Missing data: If there is missing data, we will need to consider why. In line with the statistical guidance from Foundations, we will report the full sample baseline characteristics and the baseline characteristics of those lost to follow-up, in a table side by side.

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

However, a key threat to the validity of a randomised trial is attrition and missing participant outcome data. These issues can severely impact the reported estimates' risk of bias. This risk was readily apparent in the pilot for this study, as a result of which we made several changes to the fieldwork methodology for the present trial. We will therefore monitor attrition rates throughout the trial and, if necessary, make changes to improve response to the endline data collection survey.

If missingness in outcome data turns out to be severe, we will follow best practice to try to address these issues, depending on the type of or reason for missing outcome data. For example, if there are missing item responses, we will explore using multiple imputation models to impute the missing outcome responses. Otherwise, if there is evidence of differential attrition between the treatment and control arms, we will construct weights that balance these arms according to individuals' characteristics (e.g. age, gender, special education needs status, ethnicity, English as alternative language status, free school meal status). Although these practices can provide reasonable adjustments to address issues related to missing data, their use is controversial and is also associated with an increased risk of bias of trial estimates (e.g. see Higgins et al., 2019).

Compliance: The ITT analyses described above will estimate the impact of *offering* CYP WeMatter, rather than the impact of actually receiving it. This is because it is possible that some CYP who are offered access to WeMatter decide not to participate in the sessions (i.e. there may be non-compliers). Non-compliance would dilute the estimated effects of actually participating in WeMatter. If this happens, we will initially assess the prevalence of participant non-compliance by

examining descriptively attendance at the sessions. We will then also consider conducting two types of analyses to estimate the effects of the intervention on compliers:

1. Estimation of treatment on the treated (TOT) effects, estimated by scaling ITT estimates and standard errors according to the prevalence of non-compliance in the treatment arm, as shown in Bloom (2008). We will use the same definition of compliance as in the pilot: CYP who attended at least 6 of the 10 WeMatter group sessions.
2. Descriptive analysis of endline outcomes by dose in the treatment arm (number of WeMatter sessions attended).

Contextual factors analysis

Other contextual factors in this trial – beyond the characteristics of the CYP, their circumstances, and their local area – may affect delivery of WeMatter. For example: the level of experience of the Facilitator, how the activities are planned and organised, whether there are commonalities between child and Facilitator (e.g. same sex), etc. However, we do not expect this trial to have sufficient statistical power to examine that variation inferentially. Where possible, we will explore the impact of contextual factors through the qualitative elements of the IPE.

Implementation and process evaluation

Aims

The implementation and process evaluation (IPE) will add context and detail to the results of the IE by providing evidence about how the intervention is delivered, broader contextual factors that shaped delivery and its perceived impact on participating CYP and the WeMatter delivery team.

The overarching aims of the IPE for this project are:

- To assess the extent to which WeMatter is implemented as planned, and identify any variations, including when and why they take place.
- To explore the experience of WeMatter from the perspective of those receiving the intervention (CYP and their parents/carers) and of those involved in delivering it (staff and Facilitators, local authority stakeholders, schools), with a view to identifying the Facilitators and barriers to effective delivery.
- Where possible, to also explore whether EDIE characteristics (age, gender, ethnicity, disability, and diagnosed/undiagnosed extra needs) of CYP shape their perceptions and experience of the intervention.
- To qualitatively assess the mechanisms of change as captured in the ToC.
- To qualitatively assess the extent to which WeMatter is perceived to achieve the targeted outcomes, both in the short term and the longer term.

Research questions

The research questions for our IPE are outlined in Table 3, based on the aims set out above.

Table 3. Implementation and process research questions

Aspects of IPE	IPE research questions	Method(s) for data collection
IPERQ 1. To what extent was the intervention implemented as intended?		
1.1 **Fidelity to the Intervention Protocol**	To what extent was the intervention delivered as intended? *(10 x 1-hour weekly group digital sessions, with a pre- and post-group 1:1 session delivered by 2 specialist Facilitators, ideally within two weeks of referral)* How did Victim Support work with schools and parents to ensure they were on board and were able to provide safe space for CYP to access the service?	Groups with Victim Support triage team and Facilitators Administrative data Paired interviews with Victim Support Managers Interviews with schools and parents/carers Observations of 8 WeMatter sessions

Aspects of IPE	IPE research questions	Method(s) for data collection
1.2 **Reach**	What was the level of take-up of the intervention (geographically across England and based on the number of referrals)? How did it vary by key EDIE characteristics (age, gender, ethnicity, disability, and diagnosed/undiagnosed extra needs)? What factors drove the decision to participate/not participate in the intervention? What initiatives, if any, were taken to retain CYP in the service? Was there any variation across areas? To what extent were CYP retained in the intervention? Was there any variation across areas/demographic or EDIE characteristics?	Monitoring data on participation and opt-out reasons Groups with Victim Support Facilitators, triage team, and Managers Interviews with CYP and parents/carers (treatment arm) Interviews with schools and local authorities
1.3 **Dosage**	To what extent did beneficiaries engage with WeMatter (including individual and group activities, 'try it yourself at home' activities, catch-up sessions, or other additional support from Facilitators)? How did this vary, if at all, by key demographic and EDIE characteristics? What level of support did Facilitators provide to CYP, parents, or carers outside the WeMatter sessions?	Administrative data Paired interviews with Victim Support Facilitators Interviews with CYP and parents/carers (treatment arm)
1.4 **Adaptation**	Was intervention delivery adapted in any way? What were the drivers? Did a change in Facilitators occur in the intervention period?	Interviews with schools Administrative data Observations of 8 WeMatter sessions
IPERQ2. What were beneficiaries' and delivery teams' experience of set-up and delivery of the intervention? What were future beneficiaries' experience of the waiting list?		
2.1 **Responsiveness (delivery staff)**	What was the Victim Support delivery team's experience of training and materials received for delivery of the sessions?	Groups with Victim Support Facilitators, Project Leads and Managers, triage staff

Aspects of IPE	IPE research questions	Method(s) for data collection
2.2 **Acceptability (delivery staff/referral organisations)**	What worked well and what were the areas for improvement in the delivery of the intervention, from the perspective of Victim Support delivery staff (Facilitators, Project Leads, and Managers)? What were the barriers and facilitators to delivery of the intervention? How acceptable was the service to school staff and local authorities? To what extent did the experience vary across schools and local authorities/referral organisations?	Groups with Victim Support Facilitators, Project Leads and Managers, triage staff Interviews with local authorities/referral organisations, schools
2.3 **Responsiveness (CYP and parents/carers)**	What were CYP's and parents' initial expectations of the service on referral? How did this align with service experience? Were CYP able to establish safe and trusted relationships with Facilitators? How did this affect their experience of the service, if at all? What worked well and what are the areas for improvement? (Settings, content, delivery) What were the drivers for CYP to drop out of the intervention? (Those who completed less than 6 sessions)	Interviews with CYP and parents/carers (treatment arm) of CYP Observations of 8 WeMatter sessions Interviews with CYP who dropped out of the intervention Administrative data (collected from CYP who dropped out of the intervention)
2.4 **Acceptability (CYP and parents/carers)**	How acceptable was the service to beneficiaries? To what extent did CYP engage with support received (delivery format and content of intervention?) Did this vary by EDIE and/or demographic characteristics?	Interviews with CYP and parents/carers (treatment arm) of CYP Interviews with CYP who dropped out of the intervention Administrative data (collected from CYP who dropped out of the intervention)
2.5 **Differentiation**	How does this intervention compare with other services/support for similar profiles of victim-survivors of domestic abuse?	Interviews with CYP and parents/carers (treatment arm) Interviews with local authorities/referral organisations, schools
2.6 **Mechanisms**	Were there any facilitators and barriers for CYP and parents to attending and completing the intervention?	Interviews with CYP and parents/carers (treatment arm)

Aspects of IPE	IPE research questions	Method(s) for data collection
		Interviews with CYP who dropped out of the intervention
IPERQ3. To what extent was the intervention perceived to achieve expected outcomes?		
3.1 **Perceived impact (delivery staff/referral organisations)** **Unintended consequences**	What did Victim Support Facilitators and local authorities/referral organisations and schools perceive as the outcomes of the intervention? Were they aligned with intended outcomes? How does WeMatter fit with existing service provision? Were there any positive or negative unintended outcomes – from the perspective of local authorities/referral organisations, schools, andVictim Support Facilitators	Paired interviews with Victim Support Facilitators Interviews with schools, local authorities/referral organisations Interviews with CYP and parents/carers (treatment arm)
3.2 **Perceived impact (CYP and parents/carers)** **Unintended consequences**	What were CYP's and parents' perceptions of outcomes in the short term (on completion of the intervention) and in the longer term (6 months after completion of the intervention)? Did this align with the intended outcomes? Were there any unintended consequences for CYP and/or their parents/carers as a result of CYP attending WeMatter?	Interviews with CYP and parents/carers (treatment arm) Follow-up interviews with CYP and parents/carers (treatment arm)
IPERQ4. How were outcomes moderated by contextual factors?		
4.1 **Moderators**	What influenced whether the service was perceived to have worked, and for whom? E.g. how did perceived outcomes vary by delivery setting (home vs school), participant demographics, EDIE characteristics?	Groups with Victim Support Facilitators, project leads, and Managers Interviews with local authorities/referral organisations, schools Interviews with CYP and parents/carers (treatment arm)
4.2 **Adaptation**	Were any adaptations made? Did adaptations in delivery have any implications on perceived outcomes?	Groups with Victim Support Facilitators, Project Leads, and Managers Interviews with CYP and parents/carers (treatment arm) Administrative data

Aspects of IPE	IPE research questions	Method(s) for data collection
IPERQ5. How could the intervention be improved?		
5.1 **Quality**	What improvements, if any, can be made to the set-up, management, and delivery of the intervention – e.g. staff training; engagement with schools, CYP, and parents/carers; contact with local authorities/referral agencies; content and materials, data collection, Facilitator support?	Administrative data on participation and opt-out reasons Interviews with Victim Support Facilitators, triage team, Project Leads, and Managers Interviews with CYP and parents/carers (treatment arm) Interviews with schools and local authorities/ referral organisations
5.2 **Quality**	What are the other opportunities for improvement? What are the considerations for scale-up/further roll-out of the intervention?	Administrative data on participation and opt-out reasons Interviews with Victim Support Facilitators, triage team, Project Leads, and Managers Interviews with CYP and parents/carers (treatment arm) Interviews with CYP who dropped out of the intervention and parents/carers Interviews with schools and local authorities/ referral organisations

Design and methods

The IPE will use a mix of qualitative interviews, observations, and administrative data supplied by Victim Support. We will triangulate data across the different workstreams to answer each of the IPE research questions set out in Table 3.

This section captures our approach to sampling and recruitment of participants, fieldwork, and analysis of insights.

We will carry out fieldwork with a sample of service recipient CYP and parents/carers, Victim Support delivery team, participating schools and local authorities/referral organisations. Table 4 shows the number of interviews we will carry out across participant categories. Below is a summary of the qualitative research methods for each group.

Methods

In-depth interviews and small-group discussions with the Victim Support triage team, WeMatter Facilitators, and WeMatter beneficiaries and their families will provide much of the IPE data, alongside administrative data provided by Victim Support – e.g. attendance data. We will also have interviews with representatives from schools, local authorities, and referral organisations. In addition, we will interview the WeMatter Project Leads and Managers (who manage the Facilitator team and are part of the project delivery team).

Through interviews we will assess the hypothesis set out in the theory of change and perceived impacts of the intervention, and explore the expectations and experiences of the following beneficiaries:

- **18 CYP who participated in the intervention** (treatment arm)
  On completion of the 10 group sessions ('endline') and 1:1 post-delivery session, we will conduct 1:1 interviews with CYP to understand their circumstances and characteristics in detail, and how the intervention affected them individually.
- **12 parents/carers of CYP who participated in the intervention** (treatment arm)
  Interviews with parents/carers will focus on their expectations of the intervention, perceptions of outcomes achieved and any expectations about longer-term outcomes.
- **6 CYP and 4 parents/carers of CYP who dropped out** of the intervention – i.e. CYP in the treatment arm who attended less than 6 sessions
  We will conduct 1:1 interviews with 6 CYP who did not complete the intervention – i.e. attended less than 6 WeMatter sessions. Understanding the experience of CYP who did not complete WeMatter was identified as a key gap in the pilot trial. The aim of these interviews will be to explore CYP's and parents'/carers' experiences of WeMatter and understand the reasons for CYP disengaging from WeMatter. These interviews will supplement any administrative data that Victim Support collects from those who disengaged from the intervention.
- **CYP and parent/carer follow-up interviews**
  We will also conduct follow-up interviews with eight CYP and four parents/carers six months after completion of the intervention, to qualitatively assess any longer-term impacts of WeMatter. We will aim to speak to a sample of the same families who were included in the endline interviews. Victim Support will conduct brief monthly check-in calls with

families to understand whether family circumstances have changed and to confirm the perpetrator is still not living in the family home. These calls will not seek to provide additional support or advice and will be with the parent/carer (not the CYP), and will provide reassurance that families are suitable to be invited to a follow-up interview.

Interviews will be carried out by a Verian interviewer trained in a trauma-informed approach to qualitative research and with experience of working with CYP. The interview process will be adapted for the younger group (aged 8–12 years old) to better suit their needs. For instance, the interviewer will make sure to use age-appropriate language and speak at a slower rate with a more emphasised intonation with younger CYP. We will request that a safe parent/carer/adult is in close proximity as per Victim Support's safeguarding policy.

Sampling approach overview: To investigate the influence of various demographic characteristics on how CYP experience the intervention and perceive its outcomes, we will adopt a purposive sampling strategy, ensuring representation across diverse CYP age groups, genders, intervention delivery settings (home or school), local authorities or regions, free school meal status, and English as a second language status.

We will aim to include CYP belonging to minoritised ethnic communities and with disability or diagnosed/undiagnosed extra needs in the IPE sample, to examine their experience of the intervention and perceptions of outcomes. As far as possible, we will include at least two to three CYP with EDIE characteristics in each round of fieldwork (subject to availability of this data from Victim Support collected during the triage call and variation in the trial sample).

Retention of Facilitators was identified as a challenge in the pilot. If this happens again as part of delivery of the service, we will aim to include a mix of CYP who experienced a change in Facilitators during the intervention and those who did not, so that the IPE can understand whether this has any implications for CYP's experience and perceptions of outcomes.

Recruitment approach: Verian will lead on recruiting CYP and their parent/carer for the IPE research activities, integrating this into the data collection process for the IE to minimise the burden on CYP and parents/carers. (See Figure 3 for the complete process.) On completion of the call with CYP to collect baseline outcome data for the IE, Verian will select a sample of suitable CYP and parents/carers with a range of characteristics (as captured in the section on sampling approach) from the list of treatment CYP whose parent/carer had indicated to the triage officer their consent to participating in the evaluation, and being contacted about the qualitative interviews, as captured in Figure 3. After half the WeMatter sessions have been completed, Verian will call the parent/carer to provide information about the qualitative interviews and send this to parents/carers via a text link or email. Verian will then obtain oral consent from the parent/carer for their CYP to take part in an interview. On gaining consent, the Verian researcher will confirm the time/place that they had agreed (on the baseline call) for the endline IE call, and confirm that the parent/carer and CYP are able to extend the endline call for the IPE interview. If not, an alternative date and time will be agreed. In advance of the interview, Verian will share details of the research, including a profile photo and some interesting facts about the researcher with the CYP (via parent email/text or to the school) to help to reduce any potential anxiety around the interview. At approximately Week 12 (after completing the 10 group sessions and final 1:1 session), Verian will conduct the IPE interview on the same call as taking the endline data.

To support CYP and parent/carer recruitment to follow-up interviews six months after completing WeMatter, Victim Support will conduct brief monthly check-in calls with a small sample of treatment families from Week 12. On receipt of confirmation that it is a safe contact, Verian will call the parent/carer to provide information about the follow-up interviews and confirm oral consent. If consent is received, Verian will schedule a date/time for the follow-up interview with the CYP, parent/carer, and/or school and will confirm interview details (date/time/place) via email/text to the parent/carer or school (most likely to be the safeguarding lead or pastoral lead).

We will ensure all participants have all the information they need to provide informed consent (or assent in the case of CYP). We will provide all of the participants (and their parents/carers) with a participant information sheet (parent/carer-facing and CYP-facing versions) and a privacy notice that explains the personal data we will be collecting, how it will be processed, and their right to withdraw consent to collecting and processing this data. This will be shared (via a link in a text/email) after Verian makes contact with the selected parents/carers to tell them about the research, meaning that parents/carers can make an informed decision about taking part. These materials will be based on those developed with input from the Lived Experience Experts, Victim Support, and Foundations during the pilot trial to ensure they use language that participants and their parents can understand. Although children cannot provide informed consent, they will also be asked to provide their assent during the first point of contact with the interviewer, thus involving them in the decision-making process. We will follow the Market Research Society (MRS) guidelines on gaining consent from and interviewing minors.

Interviews with CYP are anticipated to last 30 minutes and interviews with parents/carers will last 45 minutes. Interviews will be conducted online (via Zoom). An incentive of £30 will be paid to all CYP and parents/carers who participate in the qualitative interviews. Incentives for CYP will be paid to the parents/carers and will follow MRS guidelines for incentives paid to children.

Service delivery team – Victim Support

Verian will conduct qualitative interviews online to explore in detail the experience of intervention set-up and delivery, and to understand the expected outcomes. The target audience will include:

- Up to six service Facilitators
- Two triage staff
- Up to four Project Leads and Managers.

We will carry out one paired interview lasting approximately an hour with two triage team members to deliver an in-depth understanding of their experience of the referral and recruitment process.

We will also conduct separate paired or triad interviews lasting approximately an hour with service Facilitators (there are four full-time and two term-time Facilitators), Service Leads, and Managers. In these interviews, we will examine the approach to delivery to determine fidelity to the intended design and explore their experience of service set-up (training and support received, materials provided, and engagement with schools, local authorities, CYP, and parents/carers) and barriers and facilitators to delivery. We also aim to cover the delivery team's perspective on the expected outcomes.

Sampling approach overview: As far as possible, we will aim for a mix of genders, ethnic communities, and experience of WeMatter across the Facilitator interviews to enable us to draw out any variation in experience.

Recruitment approach: All Victim Support Service Facilitators, triage staff and Service Leads/Managers will be invited to participate and interviews/groups carried out with those who volunteer to participate. The invitation will be accompanied by a participant information sheet about the trial, what the research entails, and how any information they share will be used. For those who consent to participate, online interviews will be scheduled. Should the number of delivery team staff volunteering to participate exceed the number of interviews required, we will adopt a first-come-first-served approach, ensuring a mix of Facilitators across the different characteristics mentioned in the sampling approach section.

Local authorities/referral organisations and schools

We will carry out individual or paired interviews with stakeholders from local authorities/referral organisations and schools. We will explore their awareness of the intervention and experience of engagement with Victim Support staff and the referral process, if relevant. We will interview:

- Local authority/referral organisation staff responsible for referring CYP into the WeMatter service – likely to be social workers or staff within Children's Services (three to six members of staff)
- Staff in schools who are responsible for liaising with Victim Support and facilitating delivery of the intervention at the school (three to six members of staff). This will vary across schools and typically tends to be representatives from the pastoral or safeguarding team. In some cases, it may be a Headteacher, Teaching Assistant, or Class Teacher. Where it is not, we will invite the Class or Form Teacher to part of the interview to explore the perceived impact of WeMatter on their pupils.

These interviews will last approximately one hour and will explore the local authority/referral organisation and school staff experience of engagement with Victim Support in the referral, set-up, and delivery of the intervention, and any barriers and facilitators. In these interviews, we will also cover their expectations of outcomes and any early outcomes observed during and/or directly after the service period, if relevant.

Sampling approach overview: We will aim to include a geographical mix of local authorities and schools. All stakeholders will need to be aware of WeMatter and have engaged with it, either through referrals or by supporting CYP participating in it.

Recruitment approach: Victim Support will assist Verian on recruitment of local authority and school stakeholders. As a first step, Victim Support will provide the names of all local authorities and schools who have referred into WeMatter or where a CYP known to them has engaged in WeMatter. Verian will purposively select local authorities and schools from this list. Victim Support will then contact the selected local authorities and schools and ask permission for Victim Support to share their contact details with Verian so that Verian can share information about participating in the research. Where permission is given, Victim Support will share details of a key contact within the relevant local authorities and schools with Verian. Verian will then share

information and a privacy policy with these key contacts. There will be no payment of incentives to local authority or school stakeholders.

Table 4. Qualitative data collection audiences and methods

Target audience	Project stage	Quantity	Method
Round 1: May–June 2026			
Facilitators and CYP in WeMatter sessions	Service delivery phase	4	1-hour observations
CYP	Endline	9	30-minute interview
CYP who have dropped out	Endline	3	30-minute interview
Parents/carers	Endline	6	45-minute interview
Parents/carers of CYP who have dropped out	Endline	2	40-minute interview
Victim Support triage staff (2 participants)	Service delivery phase	1	1-hour paired interview
Victim Support Facilitators (2–3 participants)	Service delivery phase	1	1-hour paired/triad interview
Victim Support Project Leads and Managers (1–2 participants)	Service delivery phase	1	1-hour paired interview
Local authority/referral organisation staff (1–2 participants)	Service delivery phase	1	1-hour interview
School staff (1–2 participants)	Service delivery phase	1	1-hour interview
Round 1 follow-up: October–November 2026			
CYP	Follow-up	4	30-minute interview
Parents/carers	Follow-up	2	30-minute interview
Round 2: November–January 2027			

Target audience	Project stage	Quantity	Method
Facilitators and CYP in WeMatter sessions	Service delivery phase	4	1-hour observations
CYP	Endline	9	30-minute interview
CYP who have dropped out	Endline	3	30-minute interview
Parents/carers	Endline	6	45-minute interview
Parents/carers of CYP who have dropped out	Endline	2	45-minute interview
Victim Support Facilitators (2–3 participants)	Service delivery phase	2	1-hour paired/ triad interview
Victim Support Project Leads and Managers (1–2 participants)	Service delivery phase	2	1-hour paired interview
Local authority/referral organisation staff (1–2 participants)	Service delivery phase	2	1-hour interview
School staff (1–2 participants)	Service delivery phase	2	1-hour interview
Round 2 follow-up: May–June 2027			
CYP	Follow-up	4	30-minute interview
Parents/carers	Follow-up	2	30-minute interview

Cost evaluation

The cost evaluation will provide an analysis of:

- The total cost of running WeMatter for a year
- The average cost per CYP accepted to receive WeMatter – i.e. CYP who are referred to WeMatter, who are deemed eligible to receive the service, and whose needs assessment suggests WeMatter is an appropriate intervention for them
- Costs of introducing WeMatter to a new local authority (start-up costs)
- Estimated values of the prerequisites for running WeMatter.

The pilot RCT conducted an indicative cost evaluation, including identifying useful learnings for the cost evaluation for this full trial. We made two recommendations:

1. Establish a more detailed time and cost reporting system for Victim Support staff involved in the delivery of WeMatter from the start of the trial. In particular, because Victim Support staff do not usually keep timesheets we need to establish a process for capturing time spent (ideally broken down by types of activities).
2. Ensure there is an established referral pipeline, so a limited amount of Victim Support staff time would need to be spent soliciting referrals. This would also allow for more accurate capture of costs if WeMatter is widely used and referred to. This recommendation was taken forward by Foundations, who provided funding for Victim Support to maintain its referral pipeline before the full trial fieldwork.

The cost evaluation below is designed based on our learnings from the pilot RCT.

Table 5 provides an overview of cost items broken down between recurring costs, prerequisites, and start-up costs. New cost items might be identified during the delivery period and the process and implementation evaluation, and we will update the list accordingly. We will collect cost data for delivering the service from February 2026 until July 2027 from Victim Support, as well as any available data/estimates on the start-up costs and valuation of the prerequisites. This data will be collected by Victim Support on an ongoing basis, and shared monthly. Items under 'costs to other public services' and 'costs to wider society' will be estimated using information gathered during the interviews with relevant stakeholders. All costs will be projected to August 2027.

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

Table 5. Overview of cost analysis items

Type	Item	Data source(s)
Recurring costs		
Staff costs to Victim Support	Salary of WeMatter Facilitators	Victim Support
Staff costs to Victim Support	Time costs of other Victim Support staff (e.g. triage officers, management team, governance board) on activities related to WeMatter (e.g. undertaking community engagement and promotion activities, handling referrals, arranging and completing triage calls, completing admin tasks, data monitoring and reporting, providing staff support and training, completing case reviews and service audits, conducting victim and stakeholder involvement activities, managing the WeMatter Youth Advisory Board, etc.)	Victim Support
Facilities, equipment, and materials costs to Victim Support	Expenses incurred by Victim Support on WeMatter-related activities	Victim Support
Facilities, equipment, and materials costs to Victim Support	Funds from Victim Support to help CYP get digital access to WeMatter	Victim Support
Costs to wider society (quantifiable but unmonetisable)	Time of CYP on WeMatter-related activities	Interviews with CYP Interviews with parents/carers Interviews with Facilitators
Costs to wider society (presented separately as units of time)	Time costs of parents/carers on WeMatter-related activities	Interviews with CYP Interviews with parents/carers
Costs to wider society	Expenses incurred by CYP and their families on WeMatter-related activities	Interviews with CYP Interviews with parents/carers
Costs to other public services	Time costs of staff at schools, community centres, and referrers on WeMatter-related activities	Interviews with parents/carers Interviews with Facilitators Interviews with representatives from local authority and referral agency

Type	Item	Data source(s)
Costs to other public services	Expenses incurred by schools, community centres, and referrers on WeMatter-related activities	Interviews with Facilitators Interviews with representatives from local authority and referral agency
Prerequisites (listed and valued but not included in the cost estimates)		
Other intervention costs to Victim Support	Licence to use the Rock Pool CYP Domestic Abuse Recovery Toolkit	N/A
Staff costs to Victim Support **Costs to other public services**	Existing referral pathways	N/A
Costs to other public services **Costs to wider society**	Existing access to IT equipment and Zoom	N/A
Start-up costs		
Staff costs to Victim Support	Assessing demand and other preparation work before introducing WeMatter to a new LA	Victim Support
Staff costs to Victim Support **Costs to other public services**	Introducing WeMatter to the established referral pathways and setting up new referral pathways where required	Victim Support
Staff costs to Victim Support	Administrative costs associated with hiring and training new staff	Victim Support
Staff costs to Victim Support **Facilities, equipment, and materials costs to Victim Support**	Setting up the required operational infrastructure and procedures	Victim Support

Ethics and participation

Verian is the independent evaluator for this research, and as such is responsible for securing ethical approval. During the project planning and design phases, and following our approach in the pilot RCT, we are following Verian's research ethics review process to ensure the proposed project approach meets ethical standards and represents a balanced and responsible approach to achieve the aims of this evaluation. The ethics panel selected for this project consists of three Directors, all external to the project team. Their entire role on this project is to ensure it meets the organisation's high ethical standards.

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

Participants' parents will be provided information in writing via text message and/or email on their right to withdraw from the trial, in the form of a parent information sheet and a project privacy notice. The privacy notice will detail what data Verian will process, how Verian will do so, the legal basis and purpose(s) for processing data, and participants' rights. The document will also provide contact information to raise concerns, exercise rights, or escalate issues if needed. It will also inform participants that we will disclose to authorities if they say anything that raises concern about their safety or wellbeing. See Figure 3 for the detailed flow of the consent process.

The recruitment materials the ethics panel will review and sign off are:

- The Evaluation Protocol
- The triage call and follow-up consent call scripts
- The participant information sheet
- Interview topic guides (as indicated by the ethics panel).

Ethics clearance and input regarding these materials and the overall trial was granted by Verian's Research Ethics Committee on 30 January 2026. The ethics reference is 26/B001/01.

Participant consent

As described in the section on 'Referral, eligibility, and consent', this project relies on the parent/carer of a CYP referred for WeMatter to actively consent and opt into participating in the evaluation of WeMatter. The parent/carer of the CYP will be given the opportunity for their child to participate in the service and its evaluation during the initial triage call with Victim Support and will be informed that participating in the service is conditional on enrolling in the evaluation. This poses the risk of parents feeling a sense of pressure or coercion, if there is no easily accessible alternative provision for their child.

Following the initial triage call, eligible parents/carers will receive a participant information sheet and privacy notice by text message and/or email that provides further detail about the evaluation and how their and their child's data will be handled. The participant information sheet will make it clear that parents can withdraw their child(ren) from the evaluation at any point following the randomisation, if they have opted in, and that their child(ren) could continue receiving WeMatter

even if they opt out of the evaluation. The parents/carers will then have a follow-up call with the triage officer to seek their informed oral consent.

Participants who are not eligible for WeMatter or whose parents/carers do not consent to participate in the evaluation will be passed back to the referrer or will be signposted/referred to/advised on alternative provision following Victim Support's standard processes. Parents/carers of CYP participating in the evaluation may also withdraw their consent to be part of the evaluation at any time by informing Victim Support and/or Verian. See Figure 3 for the visualisation of the consent process.

Safeguarding approach

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

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

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

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

- If the concern is a threat to life or significant threat to the participant's immediate health or wellbeing, call the relevant emergency services (police, ambulance, fire).
- Ask the participant if they are okay.
- Ascertain whether the Field Researcher knows how to help the participant directly themselves (where possible and appropriate).
- Inform the participant (or the parent, if the participant is a CYP and the concern does not seem caused or exacerbated by the parent) that they have become concerned about their safety or wellbeing, and immediately end the interview (and recording) and consider the participant fully withdrawn from the research process.

- Provide information relating to help that may be available to the participant (e.g. support organisations) or their parent.
- Ensure as far as is possible that the participant receives any promised incentive before they leave.
- As soon as possible (within 24 hours), inform the Project Safeguarding Lead (Pieter Cornel) responsible for providing support to the end user about the expressed concern. Researchers are not to reveal any unnecessary details about the content of the interview.
- If they have cause for concern that the participant is at risk of harm, complete the safeguarding escalation template (within 24 hours). Share the completed template with the Project Safeguarding Lead (Pieter Cornel) and the Verian Chief Safeguarding Officer (CSO).
- The CSO will assess the case (including information provided to help ascertain whether the participant can help themselves). The CSO will contact Victim Support and Foundations to let them know there has been a safeguarding event and that Verian has taken appropriate action.
- Record the incident in the project incident log and review, with Pieter Cornel, whether any research materials or processes need to be amended to prevent further incidents.

Registration

The trial was preregistered with the Open Science Framework (OSF) on 9 February 2026. The OSF registration of the project, and the Evaluation Protocol as uploaded, can be found here: https://osf.io/a65cb/overview.

Data protection

Verian (trading as Verian Group UK Ltd) will serve as data processor for the data used for the project evaluation, with Foundations as data controller for this data (jointly with Victim Support). Victim Support will share personal data for CYP and parents with Verian, to allow Verian to conduct the baseline and endline data collection and to recruit participants for interviews.

Verian is registered with the Information Commissioner's Office for all our research and other activities, holding ISO27001 accreditation which certifies the legal, physical, and technical controls involved in our information risk management process. We also hold the Cyber Essentials Plus Certificate, and abide by the UK GDPR, the Data Protection Act 2018, and the Data (Use and Access) Act 2025. We embed data protection by design in all our work, and our project team includes a GDPR Champion. We can also draw on Verian's Compliance team, who consult on all data privacy issues.

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

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

Verian's lawful basis for processing CYP's and WeMatter Facilitators' personal data is legitimate interests (as per article 6(1)(f) of the UK GDPR) and we have considered that your interests and fundamental rights do not override those legitimate interests). It is necessary in Verian's

'legitimate interests' to process the personal data identified above in order to deliver a meaningful randomised controlled trial (RCT) that has been commissioned by Foundations.

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

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

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

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

Finally, following completion of the project, the data shared with us as part of this project (excluding any qualitative research data or contact information) will be provided to Foundations to be stored in their data archive in an anonymised form. Data collected and held by Foundations is kept for 1 year after delivery of the final report, which means the information is expected to be deleted in October 2028.

Personnel

Delivery team

- Ben Donagh: Area Manager for West Midlands, West Mercia, Greater Manchester (Rochdale) and WeMatter
- Emma Jordan: Senior Operations Manager
- Vanessa Rowland: Senior Operations Manager (Project Lead, North)
- Vacancy: Project Lead, North
- Elijah Giraudel: Project Lead, Midlands
- Jessica Cressey: Project Lead, South

- Sarah Hurst: CYP Programme Facilitator
- Demi Holland: CYP Programme Facilitator
- Fern Goodwin: CYP Programme Facilitator
- Onyi Nnoruka: CYP Programme Facilitator
- Nicky Barrowcliffe: CYP Programme Facilitator
- Andy Caress: CYP Programme Facilitator
- Amy Stephenson: Triage & Early Intervention Officer
- Rebecca Bradley: Triage & Early Intervention Officer
- Marie Cockett: Service Delivery Assistant
- Veronica Wheeler: Service Delivery Assistant.

Evaluation team

- Prof Natalie Gold: Principal Investigator/Project Director
- Dr James Thom: Impact Evaluation Lead
- Priya Menon: IPE Lead
- Pieter Cornel: Trial Delivery Lead
- Penny Stothard: IPE Manager
- Dr Sarah Bowen: Impact Evaluation Manager
- Marios Zampetis: Senior Project Coordinator (qualitative recruitment)
- Maine Charlton: Project Coordinator (data collection).

Timeline

Dates	Activity	Staff responsible/ leading
January 2026	Foundations sign off the Evaluation Protocol with ethics approval obtained from Verian's Research Ethics Committee	Arnaud Vaganay (Foundations)
February 2026	Victim Support start processing referrals for the trial – i.e. recruitment for the trial starts	Ben Donagh; Vanessa Rowland
February 2026	Evaluation Protocol registered onthe Open Science Framework (OSF)	Pieter Cornel
February 2026	First cohort of WeMatter groups in the trial start	Ben Donagh; Vanessa Rowland
February 2026 –ongoing	Data collection (baseline and endline) and randomisation	Pieter Cornel; Maine Charlton
March 2027	Recruitment into the trial stops. The last scheduled paired treatment/control arm starts early October, to allow recruited participants in the control arm to complete a 10–12 week waiting period and then a 10-week WeMatter service, with data collection at the end of the service completed July 2027	Ben Donagh; Vanessa Rowland
July 2027	Final data collection for impact evaluation	Pieter Cornel; Maine Charlton
October 2027	WeMatter delivery completes (final xControl arms have received WeMatter)	Ben Donagh; Vanessa Rowland
October 2027	Final evaluation report completed	Prof Natalie Gold
October 2027	Analysis code and pseudonymised data published on GitHub and Foundations' data archive	Dr James Thom

Appendix A. The Stirling Children's Wellbeing Scale

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

Item	Statements	Never	Not much of the time	Some of the time	Quite a lot of the time	All of the time
1	I think good things will happen in my life	1	2	3	4	5
2	I have always told the truth	1	2	3	4	5
3	I've been able to make choices easily	1	2	3	4	5
4	I can find lots of fun things to do	1	2	3	4	5
5	I feel that I am good at some things	1	2	3	4	5
6	I think lots of people care about me	1	2	3	4	5
7	I like everyone I have met	1	2	3	4	5
8	I think there are many things I can be proud of	1	2	3	4	5
9	I've been feeling calm	1	2	3	4	5
10	I've been in a good mood	1	2	3	4	5
11	I enjoy what each new day brings	1	2	3	4	5
12	I've been getting on well with people	1	2	3	4	5
13	I always share my sweets	1	2	3	4	5
14	I've been cheerful about things	1	2	3	4	5
15	I've been feeling relaxed	1	2	3	4	5

The Stirling Scale key

Wellbeing sub-components and related items

Wellbeing sub-component	Item	Related item on the Stirling Scale
Positive emotional state	9	I've been feeling calm
	14	I've been feeling cheerful about things
	15	I've been feeling relaxed
	10	I've been in a good mood
	12	I've been getting on well with people
	11	I enjoy what each new day brings
Positive outlook	8	I think there are many things I can be proud of
	5	I feel that I am good at some things
	1	I think good things will happen in my life
	4	I can find lots of fun things to do
	6	I think lots of people care about me
	3	I've been able to make choices easily
Social desirability	2	I have always told the truth
	7	I like everyone I have met
	13	I always share my sweets

Each item is scored 1 to 5.

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

Appendix B. Multidimensional Scale of Perceived Social Support

Item	Statements	Very strongly disagree	Strongly disagree	Mildly disagree	Neutral	Mildly agree	Strongly agree	Very strongly agree
1	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3	My family really tries to help me.	1	2	3	4	5	6	7
4	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6	My friends really try to help me.	1	2	3	4	5	6	7
7	I can count on my friends when things go wrong	1	2	3	4	5	6	7
8	I can talk about my problems with my family	1	2	3	4	5	6	7

9	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12	I can talk about my problems with my friends.	1	2	3	4	5	6	7

References

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

Bruwer, B., Emsley, R., Kidd, M., Lochner, C., & Seedat, S. (2008). Psychometric properties of the Multidimensional Scale of Perceived Social Support in youth. *Comprehensive Psychiatry*, *49*(2), 195–201. https://doi.org/10.1016/j.comppsych.2007.09.002.

Bulus, M., Dong, N., Kelcey, B., & Spybrook, J. (2021). PowerUpR: Power Analysis Tools for Multilevel Randomized Experiments. *R Package Version 1.1.0*. https://CRAN.R-project.org/package=PowerUpR.

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

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

Children's Commissioner. (2018). *'Are They Shouting Because of Me?' Voices of Children Living in Households with Domestic Abuse, Parental Substance Misuse and Mental Health Issues*. Children's Commissioner for England London.

Commissioner, D. A. (2022). *A Patchwork of Provision: How to Meet the Needs of Victims and Survivors across England and Wales*. The Domestic Abuse Commissioner for England and Wales, London.

Coppock, A. (2025). *randomizr: Easy-to-Use Tools for Common Forms of Random Assignment and Sampling* (Version 1.0.0) [R package]. https://declaredesign.org/r/randomizr.

Foundations. (2023a). *Improving Outcomes for Children with Child Protection Concerns who have been Exposed to Domestic Abuse*. Foundations. https://foundations.org.uk/wp-content/uploads/2024/02/improving-outcomes-for-children-with-child.pdf

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

Foundations. (2025). WeMatter: A pilot randomised controlled trial. Foundations. https://foundations.org.uk/wp-content/uploads/2025/11/we-matter-pilot-randomised-controlled-trial.pdf

Guillermo-Anasicha, J. A., Ramírez-Coronel, A. A., & Martínez-Suárez, P. C. (2022). Cognitive-behavioral therapy for psychological harm in domestically abused women: Systematic review and meta-analysis. *Ciencia Digital*, *6*(3), 61–83. https://doi.org/10.33262/cienciadigital.v6i3.2167.

Higgins, J. P. T., Altman, D. G., Gøtzsche, P. C., Jüni, P., Moher, D., Oxman, A. D., Savović, J., Schulz, K. F., Weeks, L., & Sterne, J. A. C. (2011). The Cochrane Collaboration's tool for assessing risk of bias in randomised trials. *BMJ*, *343*, d5928. https://doi.org/10.1136/bmj.d5928.

Hitchcock, C., Ellis, A. A., Williamson, P., & Nixon, R. D. V. (2015). The prospective role of cognitive appraisals and social support in predicting children's posttraumatic stress. *Journal of Abnormal Child Psychology*, *43*(8), 1485–1492. https://doi.org/10.1007/s10802-015-0034-7.

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

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. *The Lancet Public Health*, *2*(8), e356–e366. https://doi.org/10.1016/S2468-2667(17)30118-4.

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

Kitzmann, K., Gaylord-Harden, N., Holt, A., & Kenny, E. (2003). Child witnesses to domestic violence: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *71*, 339–352. https://doi.org/10.1037/0022-006X.71.2.339.

Koğar, H., & Koğar, E. Y. (2024). The structure of the multidimensional scale of perceived social support: A meta-analytic confirmatory factor analysis. *Cambridge Prisms: Global Mental Health*, *11*, e126. https://doi.org/10.1017/gmh.2024.118.

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

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

Linde, D. S., Bakiewicz, A., Normann, A. K., Hansen, N. B., Lundh, A., & Rasch, V. (2020). Intimate partner violence and electronic health interventions: Systematic review and meta-analysis of randomized trials. *Journal of Medical Internet Research*, *22*(12), e22361. https://doi.org/10.2196/22361.

Lohr, S., Schochet, P. Z., & Sanders, E. (2014). *Partially Nested Randomized Controlled Trials in Education Research: A Guide to Design and Analysis*. National Center for Education Research.

McWhirter, P. T. (2011). Differential therapeutic outcomes of community-based group interventions for women and children exposed to intimate partner violence. *Journal of Interpersonal Violence*, *26*(12), 2457–2482. https://doi.org/10.1177/0886260510383026.

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

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

Spencer, L. H., Hendry, A., Makanjuola, A., Pisavadia, K., Davies, J., Albustami, M., Anthony, B. F., Wilkinson, C., Fitzsimmons, D., Hughes, D., Edwards, R. T., Lewis, R., Cooper, A., & Edwards, A. (2023). *What is the effectiveness and cost-effectiveness of interventions in reducing the harms for children and young people who have been exposed to domestic violence or abuse: A rapid review*. https://doi.org/10.1101/2023.05.10.23289781.

Sun, X., & Guo, C. (2024). Evaluating the Multidimensional Scale of Perceived Social Support (MSPSS) in children aged between 8–14 years. *Journal of Child and Family Studies*, *33*(4), 1297–1308. https://doi.org/10.1007/s10826-024-02794-2.

Tirado-Muñoz, J., Gilchrist, G., Farré, M., Hegarty, K., & Torrens, M. (2014). The efficacy of cognitive behavioural therapy and advocacy interventions for women who have experienced intimate partner violence: A systematic review and meta-analysis. *Annals of Medicine*, *46*(8), 567–586. https://doi.org/10.3109/07853890.2014.941918.

Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2020). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. *Trauma, Violence, & Abuse*, *21*(2), 311–325. https://doi.org/10.1177/1524838018767934.

Warshaw, C., Sullivan, C. M., & Rivera, E. A. (2013). *A Systematic Review of Trauma-Focused Interventions for Domestic Violence Survivors: (566602013-001)* [Data set]. https://doi.org/10.1037/e566602013-001.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, *52*(1), 30–41. https://doi.org/10.1207/s15327752jpa5201_2.