



EVALUATION PROTOCOL

A cluster randomised controlled trial of a whole school trauma-informed practice programme in secondary schools

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Principal investigator: Julian Edbrooke-Childs

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Evaluating institution: Anna Freud

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Project title¹	A cluster randomised controlled trial of a whole school trauma-informed practice programme in secondary schools
Developer (Institution)	Knowledge Change Action and Warren Larkin Associations Ltd
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Trial design	Two-arm cluster randomized controlled trial, with a nested mixed methods convergence design qualitative-driven implementation and process evaluation
Trial type	Efficacy
Evaluation setting	Mainstream secondary schools

¹ Please make sure the title matches that in the header and that it is identified as a randomised trial as per the CONSORT requirements (CONSORT 1a).

<p>Target group</p>	<p>The programme is a whole school approach but the target group for the evaluation is Year 8 and Year 9 pupils (aged 12-14 years) and school staff</p>
<p>Number of participants</p>	<p>Numbers of pupils reached by the programme = 35,000-47,818 pupils across year groups in 50 schools</p> <p>Optimal sample size for the evaluation = 18,649 Year 8 and 9 pupils in 100 schools</p> <p>Optimal sample size for the evaluation (school staff) = 15,867</p>
<p>Primary outcome and data source</p>	<p>Externalising difficulties measured with the conduct problems and hyperactivity subscales of the Strengths and Difficulties Questionnaire (Goodman, Meltzer, & Bailey, 1998)</p>
<p>Secondary outcome and data source</p>	<p>Pupil-reported surveys</p> <p>Measure A: Strengths and Difficulties Questionnaire (Goodman et al., 1998)</p> <p>Outcomes: mental health difficulties, prosocial behaviour</p> <p>Variables: 1) internalising difficulties, 2) impact score, 3) prosocial behaviour</p> <p>Measure B: Student Engagement Instrument (Appleton et al., 2006)</p> <p>Outcomes: safe social connection(s) with teachers, safe social connection(s) with peers, school inclusion</p> <p>Variables: 4) teacher-student relationships, 5) peer support for learning, 6) control and relevance of school work, 7) future aspirations and goals</p> <p>Measure C: Illinois Bully Scale (Espelage & Holt, 2001)</p> <p>Outcome: bullying</p> <p>Variable: 8) bullying perpetration, 9) bullying victimisation</p> <p>Staff-reported surveys</p>

	<p>Measure A: Attitudes Related to Trauma-Informed Care (ARTIC 35) (Baker et al., 2021)</p> <p>Outcomes: knowledge and awareness, confidence, emotionally safe environment, vicarious trauma, empathy-focussed behaviours</p> <p>Variables: 1) underlying causes of problem behaviour and symptoms, 2) self-efficacy at work, 3) response to problem behaviour, 4) reactions to work, 5) empathy and control</p> <p>Measure B: Professional Quality of Life Scale (ProQOL) (Stamm, 2010)</p> <p>Outcomes: wellbeing, burnout</p> <p>Variables: 6) compassion satisfaction, 7) compassion fatigue, 8) burnout</p> <p>Local school data (and National Pupil Database for longer-term outcomes)</p> <p>Outcome: school attendance and exclusions</p> <p>Variables: 1) attendance, 2) exclusions, 3) permanent exclusions</p>
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Protocol version history

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1.2 [latest]		
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Study rationale and background

More than one in three young people are exposed to potentially traumatic events by the age of 18 years (Lewis et al., 2019). Experiencing or witnessing traumatic events can, for some, result in enduring distress and difficulties and changes in brain structure and function, which may impact cognitive, social, and emotional development (e.g., McCrory, Gerin, & Viding, 2017).

It is also recognised that young people from marginalised groups may be more likely to experience potentially traumatic events based on their identity, and responses by the support system may be more likely to be re-traumatising. For example, Hispanic and Black young people have been shown to be more likely to experience potentially traumatic events and higher levels of trauma-related mental health difficulties (Andrews et al., 2015). In a study examining young people who had been involved in crime, higher levels of race-based trauma were associated with higher levels of criminal behaviour (Kang & Bruton, 2018).

Although definitions and models of trauma-informed practice vary in the literature, they can be understood as a multi-component framework that incorporates the principles of trauma into the culture and practices of an organisation (Lang, Campbell, & Vanderploeg, 2015). For example, one model includes six principles of trauma-informed practice: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, choice, and voice; and equity, diversity, and inclusion (SAMHSA, 2014). Trauma-informed practices aim to increase understanding of the impact of trauma and how to recognise it, avoiding replicating patterns that result in re-traumatisation, and embedding policies and practices, for example, that are underpinned by interpreting behaviour in the context of trauma and patterns that may have been advantageous during or after the event.

The variety of conceptualisations and approaches, coupled with the inherently broad nature of interventions targeting culture, are likely to have contributed to the lack of evidence on the effectiveness of trauma-informed practices (Gaffney, Jolliffe, & White, 2021). Still, evidence indicates that many whole-school interventions include staff training, organization-level changes and practice changes, and student trauma-screening (Avery et al., 2020). The implementation of whole-school trauma-informed practice delivers on policy to implement whole-school social, emotional, and mental wellbeing approaches in schools (e.g., Social, emotional and mental wellbeing in primary and secondary schools (2022), National Institute of Care and Health Excellence Guideline).

More Good Days At School (MGDAS) is a whole-school trauma-informed practice programme. It focusses on building capacity for school staff in understanding the impact of trauma and the importance of staff-pupil relationships and enabling staff to have access to relational approaches for addressing challenging behaviour and boost self-resilience for staff. There are three overarching stages to the programme: collaborative enquiry to understand the needs

of the school, delivery of training (for staff, senior leadership teams, and pastoral/inclusion leads), and reflective practice. A pilot evaluation found evidence of promise that school staff, over the course of MGDAS, felt better able to talk to pupils about their emotions, to manage their own emotions, and to manage challenging behaviours (Rose, McGuire-Snieckus, & Wood, 2016). There were also indicators of improvements in pupils' mental health, behaviour, and academic attainment, and reductions in sanctions and exclusions, over the course of MGDAS.

The aim of the present evaluation is to address the gap in evidence on the effectiveness of whole-school trauma-informed practice programmes. This evaluation offers an opportunity to explore the effect of MGDAS on pupil and staff outcomes and explore some of the drivers that prevent young people from becoming involved in violence and crime.

The overall design of the study is a cluster (school) randomised controlled efficacy trial, with a nested mixed methods convergence design qualitative-driven implementation process evaluation.

Intervention

MGDAS defines trauma-informed practice in accordance with best practice definitions: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (SAMHSA, 2014, p.9).

We co-produced two logic models with the MGDAS programme team, informed by their theory of change. The first logic model pertains to pupils (figure 1) and the second to school staff (figure 2).

An intervention description (Hoffmann et al., 2014) is presented in Table 1, below.

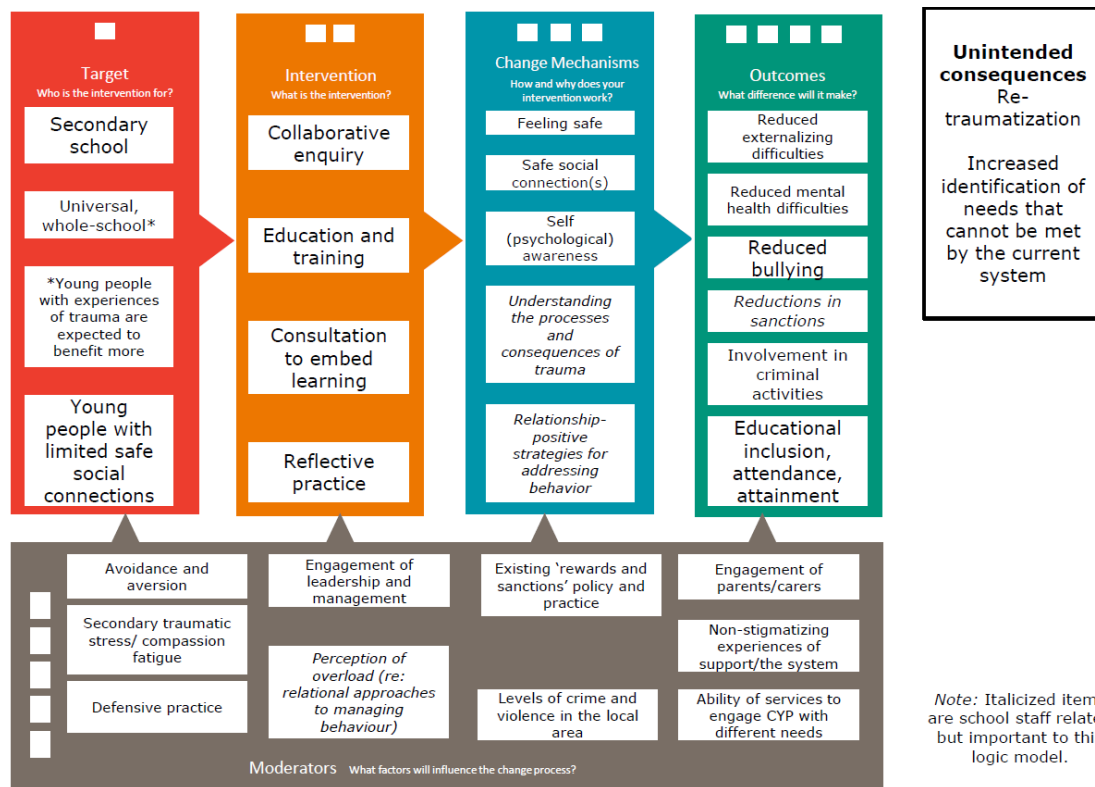


Figure 1: Evaluation logic model for pupils.

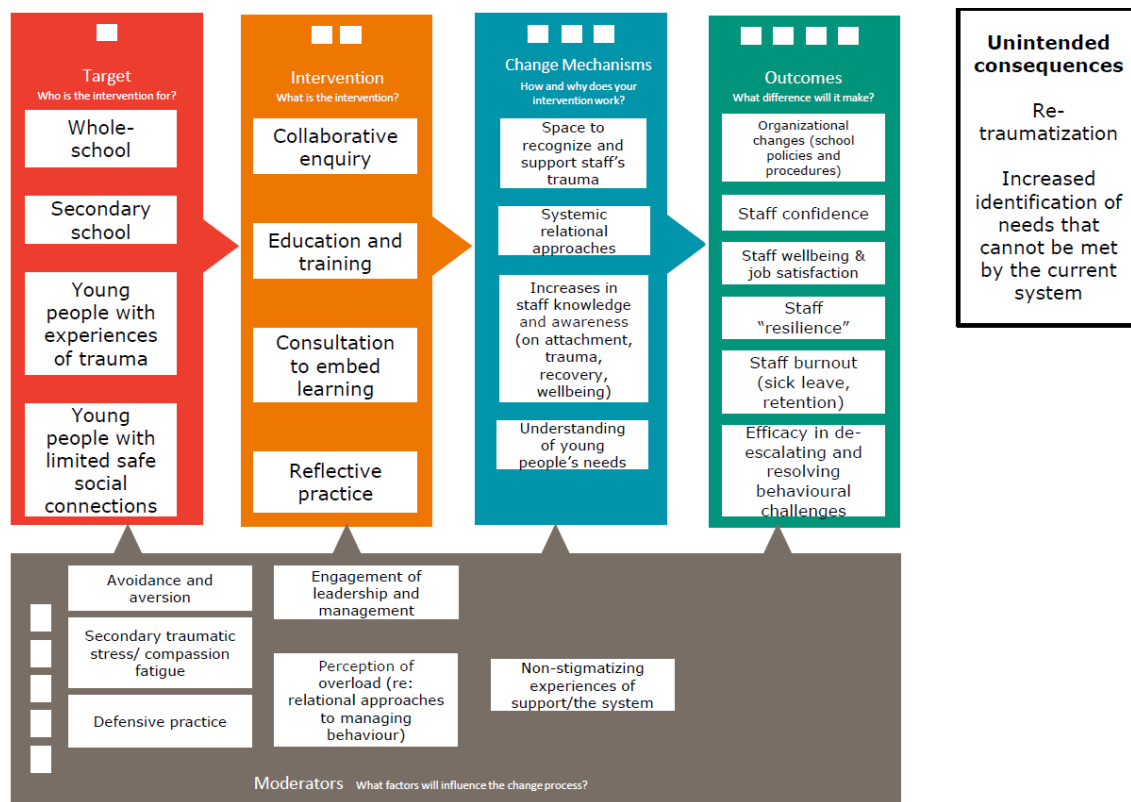


Figure 2: Evaluation logic model for school staff.

Table 1: Intervention description.

Item	Description
Brief name	More Good Days At School (MGDAS): Building relationships to promote health, happiness, and learning.
Aims	<p>The aim of MGDAS is to interrupt the school to offending/prison pipeline and reduce the impact of adverse experiences, and associated reduced social relationships and support, through increasing protective factors and school engagement. To do so, an environment of emotional and relational safety is promoted, reducing pupils' stress response, and ensuing avoidance or externalising behaviours, and increasing their capacity to learn and develop a pro-social identity. Developing at least one good relationship with a safe, reliable adult in the school setting is key to building an environment of emotional and relational safety.</p> <p>For school staff to be enabled to create an environment of emotional and relational safety, they also need to experience such an environment. MGDAS aims to support the wellbeing of school staff through learning and development on the impact of collective trauma and building the capacity of the school to be reflective and supportive of staff, in turn increasing the capacity of adults in the network to support the wellbeing of pupils.</p>
Content	<p>The intervention is a universal whole-school approach. The content focusses on training and capacity building for all school staff in four areas:</p> <ol style="list-style-type: none"> 1. Understanding the impact of individual and collective adverse experiences and trauma; 2. Understanding the importance of the staff-pupil relationship as being foundational to helping pupils to address barriers to learning and increase engagement;

3. Using relational rather than punitive approaches for addressing challenging or dysregulated behaviour;
4. Using tools, techniques, and strategies to look after one's own mental health and that of others (e.g., pupils, colleagues).

The programme is delivered during school time. There are three main stages of the programme.

Stage one is collaborative enquiry. It involves focus groups with staff and surveys with pupil to identify existing knowledge and practice, and strengths and challenges, to inform and co-design priorities for enabling the school to become trauma-informed. This stage is also an opportunity for the delivery team to form relationships and model the trauma-informed approach with school staff by using for example, collaborative, empowering, and asset-based approaches.

Stage two is training and stage three reflective practice, delivered in person and online. Training is tailored to different audiences, and it is supported by a learning platform with resources (e.g., further e-learning courses, journals, workbooks).

School staff participate in three taught modules:

1. Brain science, trauma, and resilience (part 1): two-hour training on the brain, attachment, and child development.
2. Brain science, trauma, and resilience (part 2): two-hour training on behavioural manifestations of trauma and stress and ways of responding to these manifestations to promote emotional and relational safety.
3. Relationships, trauma, and the brain: three-hour emotion coaching training for responding to dysregulated behaviour (e.g., recognising, validating, and labelling feelings; setting limits on behaviour; problem solving to support emotional regulation skills).

Senior, pastoral, and inclusions leads participate in three taught modules:

1. Therapeutic ideas for non-therapists: three-hour training on fundamental knowledge and skills in therapeutic processes, using appropriate therapeutic techniques, and limitations of therapeutic practices for school staff.

	<p>2. Reflective practice: two-hour training on reflective practice techniques.</p> <p>3. Building and maintaining individual and community resilience: three-hour training on resilience, supporting one's own mental health, and supporting the mental health of staff in their school.</p> <p>Senior leads participate in two additional workshops:</p> <ol style="list-style-type: none"> 1. Reflective practice: 4.5 hours over three sessions to increase confidence and competence in reflective practice and to build an action plan on becoming trauma-informed. 2. Review of policies, processes, and procedures: three hours over two sessions to first review, update, and possibly re-write behaviour and attendance management policies; consider reward structures; and discuss emotional and mental wellbeing support processes. Then in the follow-up session, senior leads review progress in implementing changes to policies, processes, and procedures. <p>Pastoral and inclusion leads participate in an additional workshop: Reflective practice: 4.5 hours over three sessions to explore the impact of working with vulnerable pupils and families and how (if at all) this has changed over the course of the programme.</p> <p>Senior, pastoral, and inclusion leads can use the online learning platform to curate their own directory of locally relevant information, resources, and support. In particular, the directory aims to provide information and signposting for wraparound support for vulnerable pupils and their families. This dynamic directory can then be accessed by all school staff.</p>
Providers	<p>The delivery team is comprised of staff from two organisations (Knowledge, Change, Action and Warren Larkin Associated Ltd.) from practitioner and research backgrounds including: clinical psychology, criminal justice, education, homelessness, nursing, and social work.</p>

Impact evaluation

Research questions or study objectives

The overarching research question is: How effective is the implementation of a whole-school approach to trauma-informed practice, including senior leadership support, frontline practitioner training, and ongoing reflective practice (context), in improving safe social connections (mechanism) and reducing externalising difficulties (primary outcome), thereby reducing the likelihood of young people becoming involved in crime and violence in the future (long-term outcome)?

The primary research question is: Is there a difference in mean externalising difficulties at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?

The secondary research questions for pupils are:

1. Is there a difference in mean mental health difficulties at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
2. Is there a difference in mean prosocial behaviours at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
3. Is there a difference in mean safe social connections with teachers at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
4. Is there a difference in mean safe social connections with peers at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
5. Is there a difference in mean school inclusion at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
6. Is there a difference in mean bullying (perpetration and victimisation) at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?
7. Is there a difference in educational attendance at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?

8. Is there a difference in exclusions (fixed-term and permanent) at the end of programme follow up between pupils in secondary schools receiving MGDAS and business as usual compared to pupils in secondary schools receiving business as usual only?

The secondary research questions for school staff are:

1. Is there a difference in mean knowledge and awareness of trauma at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
2. Is there a difference in mean confidence in working with young people who have experienced trauma at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
3. Is there a difference in mean wellbeing at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
4. Is there a difference in mean burnout at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
5. Is there a difference in mean ability to create an emotionally safe environment at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
6. Is there a difference in mean understanding of vicarious trauma and the need for staff support at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?
7. Is there a difference in mean empathy-focussed behaviours for behaviour management at the end of programme follow up between staff in secondary schools receiving MGDAS and business as usual compared to staff in secondary schools receiving business as usual only?

Design

The overall design of the study is a cluster (school) randomized controlled efficacy trial, with a nested mixed methods convergence design qualitative-driven implementation process evaluation. A cluster trial is proposed as the intervention is implemented at a cluster-level (whole-school). A two-arm design will be used: MGDAS and business as usual (treatment arm) and business as usual only (control arm). We propose business as usual as the control condition, as there are a range of mental health and wellbeing initiatives being implemented in schools. Although MGDAS is expected to change the mental health and wellbeing initiatives

being implemented in schools, we have included MGDAS and business as usual as the direct intervention is delivered to staff. The trial design is summarised in Table 2, below.

The primary outcome is pupils’ externalising difficulties. The secondary outcomes for pupils are: mental health difficulties, prosocial behaviours, safe social connection(s) with teachers, safe social connection(s) with peers, school inclusion, bullying, academic attendance, exclusions, and academic attainment (long-term). The secondary outcomes for school staff are: knowledge and awareness of trauma, confidence, wellbeing, burnout, emotionally safe environment, vicarious trauma, and empathy-focussed behaviour.

The primary and secondary outcomes have primarily been identified using the theory of change for MGDAS and the evaluation logic models. As there is a lack of previous trials of whole-school trauma-informed practice approaches, there is a lack of evidence on which to base the selection and prioritisation of outcomes. Indeed, this gap in evidence is precisely what the present evaluation aims to address. Nonetheless, it does result in challenges to empirically verifying the amount of expected change in the prioritised outcomes, as they are measured using the selected standardised measures (identified from the YEF measures database) within the timeframes of the study.

Table 2: Trial design.

Trial design, including number of arms		Two-arm cluster randomized controlled trial
Unit of randomisation		Cluster (school)
Stratification variables (if applicable)		Local Authority or Combined Authority
Primary outcome	variable	Externalising difficulties
	measure (instrument, scale, source)	Conduct problems and hyperactivity subscales of the Strengths and Difficulties Questionnaire (Goodman et al., 1998)
	Variable	Pupil-reported surveys Variables: 1) internalising difficulties, 2) impact score, 3) prosocial behaviour

		<p>Variables: 4) teacher-student relationships, 5) peer support for learning, 6) control and relevance of school work, 7) future aspirations and goals</p> <p>Variable: 8) bullying perpetration, 9) bullying victimisation</p> <p>Staff-reported surveys</p> <p>Variables: 1) underlying causes of problem behaviour and symptoms, 2) self-efficacy at work, 3) response to problem behaviour, 4) reactions to work, 5) empathy and control</p> <p>Variables: 6) compassion satisfaction, 7) compassion fatigue, 8) burnout</p> <p>Local school data</p> <p>Variables: 1) attendance, 2) fixed-term exclusions, 3) permanent exclusions</p>
<p>Secondary outcome(s)</p>	<p>measure (instrument, scale, source)</p>	<p>Pupil-reported surveys</p> <p>Measure A: Strengths and Difficulties Questionnaire (Goodman et al., 1998)</p> <p>Outcomes: mental health difficulties, prosocial behaviour</p> <p>Variables: 1) internalising difficulties, 2) impact score, 3) prosocial behaviour</p> <p>Measure B: Student Engagement Instrument (Appleton et al., 2006)</p> <p>Outcomes: safe social connection(s) with teachers, safe social connection(s) with peers, school inclusion</p> <p>Variables: 4) teacher-student relationships, 5) peer support for learning, 6) control and relevance of school work, 7) future aspirations and goals</p> <p>Measure C: Illinois Bully Scale (Espelage & Holt, 2001)</p> <p>Outcome: bullying</p> <p>Variable: 8) bullying perpetration, 9) bullying victimisation</p> <p>Staff-reported surveys</p>

		<p>Measure A: Attitudes Related to Trauma-Informed Care (ARTIC 35) (Baker et al., 2021)</p> <p>Outcomes: knowledge and awareness, confidence, emotionally safe environment, vicarious trauma, empathy-focussed behaviours</p> <p>Variables: 1) underlying causes of problem behaviour and symptoms, 2) self-efficacy at work, 3) response to problem behaviour, 4) reactions to work, 5) empathy and control</p> <p>Measure B: Professional Quality of Life Scale (ProQOL) (Stamm, 2010)</p> <p>Outcomes: wellbeing, burnout</p> <p>Variables: 6) compassion satisfaction, 7) compassion fatigue, 8) burnout</p> <p>Local school data</p> <p>Outcome: academic attendance and exclusions</p> <p>Variables: 1) attendance, 2) fixed-term exclusions, 3) permanent exclusions</p>
<p>Baseline for primary outcome</p>	<p>Variable</p>	<p>Externalising difficulties</p>
	<p>measure (instrument, scale, source)</p>	<p>Conduct problems and hyperactivity subscales of the Strengths and Difficulties Questionnaire (Goodman et al., 1998)</p>
	<p>Variable</p>	<p>Pupil-reported surveys</p> <p>Variables: 1) internalising difficulties, 2) no baseline for impact score, 3) prosocial behaviour</p> <p>Variables: 4) teacher-student relationships, 5) peer support for learning, 6) control and relevance of school work, 7) future aspirations and goals</p> <p>Variable: 8) bullying perpetration, 9) bullying victimisation</p> <p>Staff-reported surveys</p> <p>Variables: 1) underlying causes of problem behaviour and symptoms, 2) self-efficacy at work, 3) response to</p>

		<p>problem behaviour, 4) reactions to work, 5) empathy and control</p> <p>Variables: 6) compassion satisfaction, 7) compassion fatigue, 8) burnout</p> <p>Local school data</p> <p>Variables: 1) attendance, 2) fixed-term exclusions, 3) no baseline for permanent exclusions (given their relatively low frequency)</p>
<p>Baseline for secondary outcome</p>	<p>measure (instrument, scale, source)</p>	<p>Pupil-reported surveys</p> <p>Measure A: Strengths and Difficulties Questionnaire (Goodman et al., 1998)</p> <p>Outcomes: mental health difficulties, prosocial behaviour</p> <p>Variables: 1) internalising difficulties, 2) no baseline for impact score, 3) prosocial behaviour</p> <p>Measure B: Student Engagement Instrument (Appleton et al., 2006)</p> <p>Outcomes: safe social connection(s) with teachers, safe social connection(s) with peers, school inclusion</p> <p>Variables: 4) teacher-student relationships, 5) peer support for learning, 6) control and relevance of school work, 7) future aspirations and goals</p> <p>Measure C: Illinois Bully Scale (Espelage & Holt, 2001)</p> <p>Outcome: bullying</p> <p>Variable: 8) bullying perpetration, 9) bullying victimisation</p> <p>Staff-reported surveys</p> <p>Measure A: Attitudes Related to Trauma-Informed Care (ARTIC 35) (Baker et al., 2021)</p> <p>Outcomes: knowledge and awareness, confidence, emotionally safe environment, vicarious trauma, empathy-focussed behaviours</p> <p>Variables: 1) underlying causes of problem behaviour and symptoms, 2) self-efficacy at work, 3) response to</p>

		<p>problem behaviour, 4) reactions to work, 5) empathy and control</p> <p>Measure B: Professional Quality of Life Scale (ProQOL) (Stamm, 2010)</p> <p>Outcomes: wellbeing, burnout</p> <p>Variables: 6) compassion satisfaction, 7) compassion fatigue, 8) burnout</p> <p>Local school data</p> <p>Outcome: academic attendance and exclusions</p> <p>Variables: 1) attendance, 2) fixed-term exclusions, 3) no baseline for permanent exclusions (given their relatively low frequency)</p>
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Randomisation

Randomisation will be performed by a Clinical Trials Unit not otherwise involved in the research, stratified by Local Authority (LA) or Combined Authority (CA). Randomisation will happen at two time points: one in November 2023 (cohort 1) and one in February 2024 (cohort 2). This is to maximise the recruitment of schools. Randomisation will be 1:1 conducted in Stata 17 (or R) and the evaluators and delivery team will not be involved in the randomisation process. Kent is a much larger and geographically diverse region than the other participating regions, and for Kent stratification by urban/rural may also be conducted. Once randomisation has been performed and the identities of schools revealed to an evaluation coordinator in the team not otherwise involved in the trial (for the practicability of the research), details of those schools assigned to the intervention will be passed to the delivery team such that intervention delivery can commence.

Participants

In total, up to 100 mainstream secondary schools will be included in the study and randomised. The study will be conducted in at least three LAs out of the following who have agreed to participate at the time of writing: Kent, Slough, Wiltshire, Lancashire, Nottinghamshire. Following this, other local authorities and combined authorities will be approached to maximise school recruitment, provided that a minimum of two schools can be recruited for randomisation. A proportionate number of schools in each area will be recruited. We will initially approach all 144 schools to account for schools who do not wish to be involved (101 from Kent, 14 from Slough, and 29 from Wiltshire). All Academy, Private, and State schools in each area will be eligible unless there are indicators that mean involvement may be high risk (e.g., serious incidents in the last 12 months). Based on the programme

team's experience and feedback from LA partners, we understand that there has been an increase in families turning to Private schools as mainstream schools have been unable to meet the needs of the child. We will cap the number of Private schools included to 6.4% in each area in line with the national average of young people privately educated (Private Education Policy Forum, 2022). Schools will be excluded if more than 10% of school staff have received two days or more of trauma-informed practice training through other providers, if there are any planned strategic or operational changes, or if there are ongoing risks that could potentially undermine staff engagement with the programme.

Schools will be selected to achieve a mix in rural/city schools. In the event we are required to prioritise the schools to be involved, we will select schools in the second and third quartiles for that region for:

- Ethnic diversity. This will be measured using proportion of pupils not from White British backgrounds, as granularity of ethnic data varies between the LAs.
- Proportion of pupils eligible for free school meals (FSM).
- Proportion of pupils with a statement of special educational needs or disabilities (SEND) and/or emotional health care plans (EHCPs). As data varies between LAs, it may be SEND and EHCP combined, one or the other, or both.

These characteristics were chosen as indicators of levels of need for trauma-informed practice, from a social determinants perspective. We would choose to prioritise schools in the second and third quartiles for that region as MGDAS is anticipated to be most suitable for these schools; schools with lower levels of need may be less likely to benefit from the programme, whereas schools with higher levels of need may require more targeted support.

All pupils in Years 8 and 9 (aged 12 to 14, Key Stage 3) in participating schools will be eligible to take part. These year groups were selected as they will not have major school transition points during the duration of the study, avoiding the confounding effect and disruptions to data collection of transitions. Although the programme is a whole-school intervention, two year groups were selected to avoid over-burdening schools with data collection, which may result in lower levels of data quality.

Parents/carers of pupils in Years 8 and 9 in participating schools will receive information about the study and opt-out consent details. Over the following 2-3 weeks, they will be able to complete an opt-out form. Over this time, the study will be introduced to pupils by school staff (e.g., in assemblies). The evaluators will provide materials including a video that schools can use for this introduction. We will also provide online Question & Answer (Q&A) sessions for pupils and Q&A materials for schools to use. For schools requiring additional support, the evaluators will attend in-person for introductory and/or Q&A sessions.

During lesson/tutor time, school staff will provide the information sheet to pupils and those who provide assent will complete an online questionnaire (which will be repeated for the mid-programme and end of programme follow ups) (see outcomes measures). The survey is estimated to take no longer than 20 minutes to complete.

All school staff (irrespective of role, as it is whole-school approach) in participating schools will be eligible to take part, and school staff who provide informed consent will complete an online survey (at baseline, mid-programme and end of programme follow up) on understanding and practice of trauma-informed care and other areas (see outcome measures). The survey is estimated to take 17 minutes to complete.

Once all baseline data has been collected schools will be randomised to a) business-as-usual and MGDAS or b) business-as-usual only.

The single point of contact at each school will complete a support description survey, covering business as usual support and new support implemented during the course of the trial. These surveys will be completed twice, at the early and late stages of the trial. The single point of contact will also complete a brief cost survey for cohorts 1/2 respectively in June/July 2024 and April/July 2025 (see cost data reporting and collecting).

Participating schools will collect administrative data on study participants and, after the end of the study, data from the trial will be linked with national data (see outcome measures).

Sample size calculations

Table 3 below shows the number of Year 8 and 9 pupils, staff, and schools in the initial three LAs participating at the time of writing. Figures from the initial three LAs were used as the basis for pupil numbers, but have been retained now that recruitment has expanded, as they remain broadly representative of national figures. Based on there being 55,086 Year 8 and 9 pupils in 144 schools in these LAs, there would be 383 eligible pupils per school, deflating to 249 pupils per school assuming 35% study refusal and then deflating to 186 per school assuming 25% attrition. This results in a maximum sample size of 18,649 pupils assuming 100 schools are recruited (see below).

Based on there being 40,619 full time equivalent school staff in these LAs, there would be 282 eligible staff per school, deflating to 212 staff per school assuming 25% study refusal and then deflating to 159 staff per school assuming 25% attrition. This results in a maximum sample size of 15,867 school staff across 100 schools. It should be noted this is likely to be an overestimate. The full time equivalent of all school staff estimates were taken from national data. Those data included a much larger number of schools in the three LAs than in the data received from LAs. However, the estimates of numbers of schools are based on the data received from LAs. Therefore, the numbers of staff in the calculations are likely to be higher than in reality within schools in the trial.

Table 3: Numbers of pupils, staff, and schools.

	Kent	Slough	Wiltshire	Overall
Number of pupils on roll ^a	92039	14322	31354	137715
Number of Year 8 and 9 pupils ^b	36815.6	5728.8	12541.6	55086
Full time equivalent of all school staff ^c	29374	3783	7462	40619
Number of secondary schools ^a	101	14	29	144
No. of Year 8 and 9 pupils per school				383
No. of Year 8 and 9 pupils per school with 35% study refusal				249
No. of Year 8 and 9 pupils per school with 25% attrition				186
No. of year 8 and 9 pupils in 100 schools assuming 25% pupil attrition (optimal sample size)				18649
No. of staff per school				282
No. of staff per school with 25% study refusal				212
No. of staff per school with 25% attrition				159
No. of staff in 100 schools assuming 25% attrition (optimal sample size)				15867

Note. ^a = Data provided by Local Authorities. ^b = Number on roll divided by five year groups multiplied by two. ^c = Data from GOV.UK (2023). Higher rates of attrition have been used than the 10% recommended in Youth Endowment Fund guidance given feedback from LA partners about the level of pressure schools are currently under.

There is a lack of evidence on which to estimate the anticipated effect size, despite a number of systematic reviews on whole school trauma-informed practice interventions (Avery et al., 2021; Berger, 2019; Bunting et al., 2019; Cohen & Barron, 2021; Gherardi, Garcia, & Stoner, 2021; Han et al., 2021; Maynard, Farina, Dell, & Kelly, 2019; Roseby & Gascoigne, 2021; Thomas, Crosby, & Vanderhaar, 2019).

Table 4 shows the acceptable numbers of pupils and schools based on different assumptions underpinning the sample size calculations. The primary outcome is externalizing difficulties, measured by the conduct problems and hyperactivity subscales of the Strengths and Difficulties Questionnaire (Goodman et al., 1998). The sample size calculation is based on a cluster randomised controlled trial (CRCT) design.

A sample size of 36 schools and 5,580 pupils would enable us to detect a minimum detectable effect size (MDES) of 0.2 (YEF's required maximum MDES), including adjustments for attrition of schools and pupils. However, given the lack of existing evidence on which to estimate the effect size; the potential for smaller effects with a whole school approach; and the additional value that sub-group, mediation, and moderation analyses would provide in this area where existing evidence is very limited, we will aim for an optimum target of 100 schools and 18,649 pupils, which would provide us with an MDES of 0.12. However, given the timescales and resources for the project, if this is not achievable, a secondary target of 70 schools and 11,160 pupils would still allow an MDES of 0.14 whilst maximising power for the additional analyses

and longer term analyses examining educational and criminal outcomes. The lower limit of schools is 55-60: 55 schools would allow an MDES of 0.15 accommodating attrition of up to five schools, and 60 schools would allow an MDES of 0.15 accommodating attrition of up to 10 schools and an MDES of 0.14 assuming attrition of no schools.

Table 4. Sample size calculations for different minimum detectable effect sizes.

Mean externalising difficulties control arm	5.21	5.21	5.21	5.21	5.21	5.21	5.21	5.21	5.21
SD externalising difficulties control arm	2.96	2.96	2.96	2.96	2.96	2.96	2.96	2.96	2.96
Mean externalising difficulties intervention arm	4.63	4.66	4.7	4.73	4.76	4.8	4.83	4.86	4.9
SD externalising difficulties intervention arm	2.96	2.96	2.96	2.96	2.96	2.96	2.96	2.96	2.96
Minimum detectable effect size	0.20	0.19	0.17	0.16	0.15	0.14	0.13	0.12	0.10
Number of schools needed per arm	15	17	20	22	25	30	35	41	53
Number of schools needed per arm assuming 15% attrition	18	20	24	26	29	35	41	48	62
Number of pupils needed per arm	2790	3162	3720	4092	4650	5580	6510	7626	9858

Note. The mean externalising difficulties control arm estimate, and the SD estimates, are based on the combined female and males scores from Elia et al. (2020). The intraclass correlation coefficient has been assumed as 0.03. There is a lack of evidence on which to base assumptions for the pre-post correlation of externalising difficulties, so the sample size calculations have not been adjusted to account for this. Correspondingly, the sample size calculations are conservative. The average cluster size was assumed to be 186, based on Table 3, which accounts for 25% pupil attrition, meaning the number of pupils needed per arm does already incorporate attrition. The coefficient of variation in cluster size has been assumed as 0.5, alpha as 0.05, and power as 0.8.

Table 4: Final sample size calculation.

	PARAMETER	PARAMETER	PARAMETER	PARAMETER	PARAMETER	PARAMETER	PARAMETER	PARAMETER	PARAMETER	
Minimum Detectable Effect Size (MDES)	0.20	0.19	0.17	0.16	0.15	0.14	0.13	0.12	0.10	
Pre-test/ post-test correlations	level 1 (participant)	-	-	-	-	-	-	-	-	
	level 2 (cluster)	-	-	-	-	-	-	-	-	
Intracluster correlations (ICCs)	level 1 (participant)	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	
	level 2 (cluster)	-	-	-	-	-	-	-	-	
Alpha	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	
Power	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	
One-sided or two-sided?	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	Two-sided	
Average cluster size (if clustered)	186	186	186	186	186	186	186	186	186	
Number of clusters	Intervention	18	20	24	26	29	35	41	48	62
	Control	18	20	24	26	29	35	41	48	62
	Total	36	40	48	52	58	70	82	96	124
Number of participants	Intervention	2790	3162	3720	4092	4650	5580	6510	7626	9858
	Control	2790	3162	3720	4092	4650	5580	6510	7626	9858
	Total	5580	6324	7440	8184	9300	11160	13020	15252	19716

Note. Number of clusters has been inflated to account for 15% school attrition.

Outcome measures

Pupil self-reported surveys will be collected at baseline, mid-programme and end of programme follow up, with the end of programme follow up being the primary endpoint. The baseline survey will include demographic questions: date of birth, gender, and ethnicity (GOV.UK, n.d.).

Three standardised measures from the YEF measures database will be used:

1. The 25-item Strengths and Difficulties Questionnaire (Goodman et al., 1998) with the eight-item impact supplement used at mid-programme and end of programme follow up. It is a widely used measure with evidence of reliability and validity (Goodman, Lamping, & Ploubidis, 2010). The primary outcome will be assessed using the externalising difficulties score, which is the sum of the conduct problems and hyperactivity subscales. Two secondary outcome will be assessed:
 - a) Mental health difficulties. Two variables will be used: i) the internalising difficulties score, which is the sum of the emotional symptoms and peer relationship problems subscales, and ii) the impact score (at mid-programme and end of programme follow ups), which is the sum of five scores on distress caused by difficulties and the impact of difficulties interfering with home life, friendships, classroom learning, and leisure activities.
 - b) The prosocial behaviour subscale score will be used as a secondary outcome.
2. Twenty-nine items of the School Engagement Instrument, measuring five subscales (Appleton et al., 2006). It has been used in previous studies with evidence of reliability and validity (e.g., internal consistency of the subscales = 0.72-0.88) (Appleton et al., 2006). Three secondary outcomes will be assessed:
 - a) Safe social connection(s) with teachers. One variable will be used: the teacher-student relationships subscale score.
 - b) Safe social connection(s) with peers. One variable will be used: the peer support for learning subscale score.
 - c) School inclusion. Two variables will be used: the control and relevance of school work subscale score to measure engagement with school work, and the future aspirations and goals subscale score to measure engagement in school work in term of its relevance for the future.
3. Thirteen items of the Illinois Bully Scale, measuring two subscales (Espelage & Holt, 2001). It has been used in previous studies with evidence of reliability and validity (e.g., internal consistency of subscales = 0.87-0.88) (Espelage & Holt, 2001). One secondary outcome will be assessed:
 - a) Bullying. Two variables will be used: i) the bullying (perpetration) subscale score and ii) the victimisation subscale score.

There is a maximum of 78 items in total and, based on an average of four items being completed in one minute, will take approximately 19.5 minutes to complete.

Staff self-reported survey responses will be collected at baseline, mid-programme and end of programme follow up, with the end of programme follow up being the primary endpoint. The baseline survey will include demographic questions: gender and ethnicity (GOV.UK, n.d.).

Two standardised measures will be used:

1. The 35-item Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker et al., 2021). It is not a measure in the YEF measures database, as the database does not contain staff-reported measures. It has been used in previous studies with evidence of reliability and validity (e.g., internal consistency of 0.90 for the total score) (Baker et al., 2021). Five secondary outcomes will be assessed:
 - a. Knowledge and awareness. One variable will be used: the underlying causes of problem behaviour subscale score.
 - b. Confidence. One variable will be used: the self-efficacy at work subscale score.
 - c. Emotionally safe environment. One variable will be used: the response to problem behaviour and symptoms subscale score.
 - d. Vicarious trauma. One variable will be used: the reactions to work subscale score.
 - e. Empathy-focussed behaviours. One variable will be used: the empathy and control subscale score.
2. The 30-item Professional Quality of Life Scale (ProQOL) (Stamm, 2010). It measures quality of life in terms of compassion satisfaction, compassion fatigue, and burnout. It is a widely used measure with evidence of reliability and validity (e.g., internal consistency = 0.75-0.88) (Stamm, 2010). Two secondary outcomes will be assessed:
 - a. Wellbeing. One variable will be used: the compassion satisfaction subscale score.
 - b. Burnout. Two variables will be used: i) the compassion fatigue subscale score, and ii) the burnout subscale score.

There is a maximum of 67 items, which will take approximately 17 minutes to complete.

Participating schools will collect administrative data on study participants: pupil demographic characteristics (date of birth, sex, ethnicity, social care status), educational attendance and exclusions, FSM eligibility, and SEND and/or EHCP. The administrative data will also include the pupils' Unique Pupil Number. These data are based on standard school data collection for national reporting purposes, meaning schools will already be collecting this information. These data will be shared with us through a secure file transfer portal following signature of a Memorandum of Understanding. The data will be submitted twice (summer 2024 and summer 2025) and will cover the entirety of the pupils' records at the school.

Given the year groups and timeframes of the evaluation, there will not be local attainment data from schools, and therefore we will examine this as part of the longer-term follow up using the National Pupil Database (NPD) (see below). This will be done independently by the Anna Freud beyond this YEF-funded evaluation. We considered alternatives, such as a teacher-completed rating of performance for each pupil, but we have not chosen this to avoid school staff burden and the corresponding likelihood of inconsistent data quality.

Table 6 shows how the above outcome measures and their subscales map onto the mechanisms and outcomes from the logic models for pupils and staff.

Table 5: Mapping of logic models onto measures.

Outcome	Variable	Measure	Research question	Aligned logic model component
Pupils				
Externalising difficulties	Externalising difficulties	Strengths and Difficulties Questionnaire	Primary	Reduced externalizing difficulties
Mental health difficulties	Internalising difficulties	Strengths and Difficulties Questionnaire	2.1	Reduced mental health difficulties
	Impact score			
Prosocial behaviour	Prosocial behaviour	Strengths and Difficulties Questionnaire	2.2	N/A
Safe social connection(s) with teachers	Teacher-student relationships	School Engagement Instrument	2.3	Safe social connection(s)
Safe social connection(s) with peers	Peer support for learning	School Engagement Instrument	2.4	Safe social connection(s)
School inclusion	Control and relevance of school work	School Engagement Instrument	2.5	Educational inclusion, attendance, attainment
	Future aspirations and goals			
Bullying	Bullying perpetration	Illinois Bully Scale	2.6	Reduced bullying
	Bullying victimisation			
Academic attendance	Number of authorised absences	Local school data and National Pupil Database for long-term follow up	2.7	Educational inclusion, attendance, attainment
	Number of unauthorised absences			

Exclusions	Number of fixed term exclusions	Local school data and National Pupil Database for long-term follow up	2.8	Educational inclusion, attendance, attainment
	Permanent exclusions			
Staff				
Knowledge and awareness	Underlying causes of problem behaviour and symptoms	Attitudes Related to Trauma-Informed Care	3.1	Understanding the processes and consequences of trauma
				Increases in staff knowledge and awareness (on attachment, trauma, recovery, wellbeing)
Confidence	Self-efficacy at work	Attitudes Related to Trauma-Informed Care	3.2	Staff confidence Staff "resilience"
Wellbeing	Compassion satisfaction	Professional quality of life	3.3	Staff wellbeing and job satisfaction
Burnout	Compassion fatigue	Professional quality of life	3.4	Staff burnout (sick leave, retention)
	Burnout			
Emotionally safe environment	Responses to problem behaviour and symptoms	Attitudes Related to Trauma-Informed Care	3.5	Feeling safe*
				Reductions in sanctions
Vicarious trauma	Reactions to work	Attitudes Related to Trauma-Informed Care	3.6	Space to recognise and support staff's trauma
Empathy-focussed behaviours	Empathy and control	Attitudes Related to Trauma-Informed Care	3.7	Relationship-positive strategies for addressing behaviour
				Understanding of young people's needs
				Systemic relational approaches

Note. Mechanisms and outcome of the logic model not included in the above are: self (psychological) awareness for pupils, which will be assessed using qualitative data; involvement in criminal activities for pupils, which is beyond the timeframe of this evaluation; organizational change, which will be assessed through the support description survey; and efficacy in de-escalating and resolving behavioural challenges, which will be assessed using qualitative data. * = Although feeling safe is included in the table above, it is a pupil mechanism in the logic model and being assessed through staff survey data. Therefore, it will also be assessed using pupil qualitative data.

It is acknowledged that the number of secondary outcomes could be perceived as large. We feel this is commensurate with the scope of the programme, the focus on pupil and school staff outcomes, and the range of mechanisms and outcomes in the logic models. Three pupil questionnaires and two staff questionnaires will be used.

Compliance

Compliance with MGDAS will be assessed with three methods. Information gathered from these methods will be compared against intended delivery using the MGDAS intervention description.

1. Activity data will be collected by the MGDAS programme team to examine, for example, number and types of sessions delivered and number and types of school staff attending each session (see cost data reporting and collecting). A composite score of school-level compliance with MGDAS will be created based on the number of staff and the number of sessions attended.
2. The support description survey completed by the single point of contact at each school, to examine changes to policies and practices implemented by schools after the MGDAS programme. This will also be used to examine whether there are differences in the levels of changes to policies and practices according to assigned condition (i.e., MGDAS and business as usual, business as usual only). We will create a composite score of school-level compliance with assigned condition based on the number and type of changes implemented and the stage of implementation. It should be noted that we are not attempting to restrict implementation of changes to policy and practice for schools allocated to business as usual only.
3. School staff descriptions of the MGDAS programme and trauma-informed policies and practices implemented following the programme, and MGDAS programme implementers' descriptions of delivery (see implementation and process evaluation).

Analysis

Analyses will be conducted masked to group assignment following the intention-to-treat principle. The analyses will use maximum likelihood estimation meaning all participants will be included, even those with missing follow up data points, in line with the intention-to-treat principle. The treatment effect on the primary outcome (externalising difficulties) will be estimated using four-level (time, pupil, school, LA) mixed effects models with the outcome at 1st and 2nd follow up and random-effects accounting for clustering of repeated observations within pupils within schools within LAs. Covariates will include dummy coded indicators for group, time, and group*time interaction terms plus the baseline level of the outcome. Schools will be randomised at one of two time points and therefore the training inputs will take place

at different points in the year. To account for this, temporal effects will also be controlled for in the model. A similar approach will be used for secondary pupil and staff outcomes and for the per protocol and complete case analyses.

We will add further covariates to examine whether ethnicity, FSM eligibility, SEND/EHCP, and fidelity (using compliance with MGDAS and compliance with assigned condition, described above) are associated with differential levels of effectiveness. Moderation and mediation analyses will be conducted using appropriate techniques. For example, within level interaction terms will be included in mixed effects models to examine whether allocation to treatment vs. control groups predicts different levels of externalising difficulties for pupils from different ethnic, FSM eligibility, and SEND/ECHP groups, or analyses will be conducted stratifying groups. Cross-level interaction terms will be included in mixed effects models to examine whether allocation to treatment vs. control groups predicts different levels of externalising difficulties for pupils in schools where staff report higher levels of empathy-focused behaviours. Multilevel structural equation modelling may be used to examine mediation effects, for example whether increases in safe social connection(s) with staff mediates the relationship between allocation to treatment vs. control group and decreased externalising difficulties. Standard data quality checks will be performed in the data preparation stage before analysis, including: impossible values, distribution of scores and residuals, outliers, low frequency categorical variables, linearity, and homogeneity of variance. Violations will be managed with appropriate techniques. Descriptive statistics of the implementation data will be used to identify levels of implementation and engagement.

Longitudinal follow-ups

After the end of the YEF-funded study, Anna Freud will link the quantitative data on pupils to national data from the National Pupil Database through the Office for National Statistics Secure Research Service. This will enable us to examine longer-term impacts on school exclusions and academic attainment. As this is beyond the timeframes of the present study, it will be conducted as non-costed work by Anna Freud, with the intention of submitting a peer-review journal article. Longer-term analyses will also be conducted by YEF as part of the YEF Data Archive.

Implementation and process evaluation

The overarching approach is a realist process evaluation (Pawson & Tilley, 1997). It is a theory-based approach that involves using different methods to collect data that are analysed individually and interpreted together to assess our pre-specified hypothesis about why, how,

and for whom the programme is effective, as articulated in the logic model. A realist process evaluation was chosen because a single method would not enable us to answer the nuanced question of interest of what works for whom and why (CECAN, 2020) nor to answer all of the questions on efficacy, implementation and process, and contextual factors.

Research questions

Implementation and process evaluation (IPE) research questions are:

1. To what extent is the MGDAS programme implemented as intended?
2. Are some elements of the MGDAS programme implemented more successfully than other elements?
3. What are the facilitators and barriers to implementation of the MGDAS programme?
4. What changes to policy and practice do school staff implement following the MGDAS programme?
5. What are the facilitators and barriers to changing policy and practice for school staff following the MGDAS programme?
6. What is the perceived need for the intervention amongst MGDAS implementers and school staff?
7. What is the experience of the MGDAS programme for implementers and school staff?
8. What is the experience of pupils of support from schools following the MGDAS programme and do different groups of pupils (i.e., ethnic groups, eligibility for FSM, SEND/EHCP) have different experiences of support?
9. To what extent, and how, does the MGDAS programme impact school culture?

An objective of the IPE is to examine unintended consequences through monitoring of adverse events described below.

Research methods

To address the IPE research questions, two types of information will be collected: from all schools and from case study schools.

All schools

One staff member (e.g., the single point of contact for MGDAS) will be asked to complete a support description survey twice (Autumn 2023 and Spring/Summer 2025). It will comprise closed- and opened-end questions on the policies, practices, and provisions for mental health and wellbeing support at the school. The information from these surveys will be used to examine business as usual support and any changes to support over the course of the study.

Our adverse events monitoring procedure will require the single point of contact for MGDAS at each school in both the treatment and control arms to notify the evaluators (through

completion of a secure online form) of any safeguarding issues that arise during the course of the study. This brief form will capture the category of the event (e.g., suicide attempt, self-harm, risk to others) and whether they think the event was related to involvement in the study, with a brief description of why. We will also ask school staff in interviews/focus groups (see case study schools) about their perception of whether the type and nature of safeguarding issues has changed over the course of the study and, if so, why they think that. This information will enable us to examine unintended consequences of MGDAS, for example if there is a greater number of events in schools in the intervention than control arm.

Case study schools

Four schools across at least three LAs will be selected as qualitative school-level case studies. Schools will be selected based on their ability to engage in the evaluation and diversity of socio-demographic characteristics. To ensure case studies represent diverse groups of pupils and schools, we will sample schools according to pupil-reported ethnic diversity, FSM eligibility/Index of Multiple Deprivation (IMD)/Income Deprivation Affecting Children Index (IDACI), and SEND and/or ECHP. Although schools may represent multiple groups, at this stage we have two criteria: a) at least two schools with high levels of ethnic diversity (33%+ from minoritized ethnic groups reported by the pupil survey), at least one school with high levels of FSM eligibility (33%+ for their LA from public information) or schools within the 30% most deprived areas according to the 2019 IMD/IDACI (to align with how IMD/IDACI are reported), and at least one school with high levels of SEND and/or EHCP (33%+ for their LA from public information); and b) two schools from urban and two schools from rural areas. We propose focusing on intervention arm schools, based on the research questions. We will also purposely recruit schools at earlier and later stages of the training programme across the two cohorts randomised in November 2023 (cohort 1) and February 2024 (cohort 2). This will be to get a range of views of pupils' and staff members' experiences of the programme.

A small number of school-level case studies was selected to enable rich data from each school to be collected. Given the complexity of understanding changes to school practice and culture, a multi-informant approach will be needed in case studies. In addition, qualitative research is never intended to produce generalisable knowledge, but to provide in-depth understanding of the views and experiences of participants.

Interviews will be conducted with 5-7 pupils per case study during site visits (i.e., up to 28 in total) in Jan-Feb 24 for both cohorts 1 and 2. Interviews/focus groups will be conducted with 5-7 school staff members per case study, in person during site visits or online/telephone to accommodate staff schedules (i.e., up to 28 in total); we will also interview 5-7 MGDAS implementers in May-July 2024 for both cohorts 1 and 2.

Analysis

Data analysis will follow the stages of thematic analysis (Braun & Clarke, 2006). Possible contextual differences in themes/subthemes will then be analysed using the framework approach (Ritchie & Spencer, 1994) which is a way of organising the dataset for analysis according to particular characteristics (e.g., ethnicity, FSM eligibility, and SEND/EHCP). This approach will enable the research team to examine whether the themes and subthemes identified during the previous step vary by pupil, school, or intervention characteristics, including triangulating information from different qualitative data sources. Analyses will be conducted by respondent (pupil, school staff, MGDAS implementer) by case study.

A triangulation design convergence model will be conducted to answer the ultimate research question (Cresswell & Clark, 2018): How effective is the implementation of a whole-school approach to trauma-informed practice, including senior leadership support, frontline practitioner training and ongoing reflective practice (context), in improving safe social connections (mechanism) and reducing externalising difficulties (outcome), thereby reducing the likelihood of young people becoming involved in crime violence in the future (long-term outcome)? In the final report, the separate analyses of the CRCT and IPE data will be interpreted together, for which we will meet with the steering group including MGDAS programme team members.

Implementation and monitoring data collected by the MGDAS programme team will be used to examine the number of sessions provided to schools, the types of sessions, and the levels of engagement of school staff in these sessions. Data will be analysed using descriptive statistics.

The support description survey completed by the single point of contact at each school will be used to examine what business as usual support comprises, what trauma-informed practice following the MGDAS programme comprises, and the similarities and differences between the two. Both quantitative and qualitative analyses will involve descriptively summarising the data.

Table 6: Implementation and process evaluation summary.

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed	Implementation/ logic model relevance
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Qualitative	Interviews	Up to 28 pupils	Thematic and framework analyses	IPE 1, IPE8, IPE 9	Examine implementation; assess contexts, mechanisms, and outcomes
Qualitative	Interviews/focus groups	Up to 28 school staff	Thematic and framework analysis	IPE 1, IPE 4, IPE 5, IPE 6, IPE 7, IPE 9	Examine implementation; assess contexts, mechanisms, and outcomes
Qualitative	Interviews/focus groups	5-7 implementers	Thematic analysis	IPE 1, IPE 2, IPE 3, IPE 6, IPE 7, IPE 9	Examine implementation; assess contexts, mechanisms, and outcomes
Quantitative	Implementation monitoring data	50 schools in the intervention arm	Descriptive statistics on numbers and types of sessions delivered and numbers of school staff engaged	IPE 1	Examine implementation
Mixed methods	School support description survey	100 schools	Descriptive statistics and descriptive summaries of free text responses	IPE 1, IPE 4, IPE 5	Examine implementation

Cost data reporting and collecting

We will follow YEF guidance for the costs analysis. We will use a bottom-up approach to calculate costs of delivery from different perspectives. Two perspectives will be considered.

We will work with the programme team to determine their costs for delivering the whole-school trauma-informed practice programme (i.e., staff and labour, programme procurement, buildings and facilities, material and equipment, incentives for taking part if any, and other inputs). These costs will be presented for the whole programme and an average cost per school.

We will use the activity data collected by the programme (also see compliance) to examine the school staff roles and time required to take part in the programme. The programme team will also estimate the amount of out-of-session time required for school staff taking part in the programme (by role). We will use public data to calculate the wage costs of staff time (Department for Education, 2013). We will work with LA partners to estimate non-wage costs of staff time for each of the three LAs. We will review these costs with the LA partners to ensure they align with each of the different regions.

The single point of contact in each school will complete a brief survey at the end of the first year (cohort 1 – June 2024, cohort 2 – July 2024) and at the end of the data collection period (cohort 1 – April 2025, cohort 2 – July 2025). This will ask about any other costs incurred as a result of taking part in the programme activities (excluding the evaluation). In particular, it will ask about amount of staff time (by role) for coordinating involvement in the programme and freeing up staff time to attend the programme; it will also ask about any additional building and facilities, material and equipment, and other inputs.

Costs from the school perspective will also be presented for the whole programme and an average cost per school (and also possibly per LA).

The above costs reflect the costs of schools taking part in the MGDAS programme. In discussion with the programme team, it was decided that costs arising from changes to policy or practice that schools in the intervention arm chose to take up following MGDAS are out-of-scope as: a) they are not a required part of the programme, b) they are likely to be highly varied (e.g., due to school needs), and c) they would not form an expected cost of delivering the programme when rolling it out to future schools.

Diversity, equity and inclusion

The target proportion of the evaluation sample by different ethnic groups is shown in Table 8, below. It is based on the weighted average of the proportions from the three participating LAs.

Table 7: Ethnic breakdown.

	Kent	Slough	Wiltshire	National	Target
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Asian or Asian British	5.66%	53.17%	2.81%	12.78%	12.99%
Black, Black British, Caribbean or African	4.28%	7.00%	1.88%	5.99%	4.54%
Mixed or multiple ethnic groups	6.45%	11.72%	3.88%	6.82%	7.10%
White	80.91%	22.21%	88.06%	70.44%	72.11%
Any other	1.26%	4.08%	0.85%	2.31%	1.68%
Missing data	1.43%	1.82%	2.50%	1.66%	1.57%

Note. The target is based on the weighted average across the initial three LAs (Kent, Slough, and Wiltshire). LA and national figures represent pupils in state-funded nursery, primary, secondary, special schools, non-maintained special schools, and pupil referral units (further breakdown by school type was not available) in England for the 2022/23 academic year. Data were taken from: <https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics/2022-23>.

Diversity, equity, and inclusion (DEI) is incredibly important in the present evaluation as individuals from marginalised groups are disproportionately more likely to experience trauma, to experience trauma in relation to their marginalised identity(ies), and to experience re-traumatisation in relation to how their experiences of trauma are heard (or not heard) and supported (or not supported) (e.g., Andrews et al., 2015; Kang & Bruton, 2018).

Anna Freud is committed to DEI in all its work. We have a top-down and bottom-up approach to DEI, comprising of an organisation-wide strategy and department-specific initiatives. We have six diversity networks which enable staff from all areas of the organisation to raise concerns and suggestions (anti-racism, LGBTQIA+, neurodiversity and mental health, accessibility, anti-classism, and faith and spirituality).

We have and will continue to explicitly consider DEI in the co-design and delivery of this study. We will work with our diversity networks to step back and critically appraise our approach to ensure we are not replicating patterns of systemic discrimination in our approach. The project

team will be supported throughout by Anna Freud's DEI Lead, who will ensure that DEI is considered at every milestone and who will sit within the steering group. All staff receive DEI training.

We will ensure that our recruitment materials and data collection instruments are inclusive in terms of both what we ask for and how we ask for it; e.g., gender will be collected in self-reported data for this reason, with sex collected in local school data and the NPD. We will ensure materials are inclusive of young people with SEND as this group is over-represented in those with experience of trauma. We have developed guidance as an organisation around appropriate language and terminology to use in relation to DEI. We also regularly develop different versions of information sheets and consent forms to suit different reading ages; e.g., using pictorial representation where possible, which can be preferable to younger children.

During recruitment, we will review the characteristics of children and young people taking part and if any groups, based on the LA's demographic information, appear to be under-represented, we will work with our DEI Lead and LA partners to identify how we could change our approaches to be more inclusive. In our guidance to schools in delivering the study, we will explicitly ask them to use their existing strategies and approaches, to supporting children and young people from marginalised groups, to help make the evaluation more inclusive; e.g., ensuring there is a support worker (and a private space) to help children and young complete the study materials.

We have a long track record of working with marginalised communities, including those relevant to the present study (minoritized ethnic groups, eligible for FSM, SEND/EHCP). In co-design, we have worked with the programme team to include DEI in our approach to identify schools for the overall trial and for the case studies. We will draw on our own research about making mental health research more inclusive to young people from minoritized ethnic groups (e.g., explaining why we are collecting data on ethnicity in this study). Feedback has been that transparency in information sheets about who is conducting the evaluation, and what our motivations are for the study, helps to build trust between prospective participants. Highlighting the independent role of the evaluation may help in building trusting relationships between the evaluators and individuals with higher levels of distrust in schools or other statutory organisations.

An important part of our approach to addressing DEI is through hearing the voice of children and young people at all stages of the design and delivery of the evaluation. We will recruit a young person paid peer researcher and a young person's advisory group of 6-8 members, approaches we successfully use in many previous and ongoing projects. We use the Lundy Model of Participation (Lundy, 2007).

The peer researcher will be involved in all stages of the project and will work as part of the research team. This means they will be involved in making strategic decisions about the study

and in the operational delivery of the study. Similarly, the advisory group will meet quarterly and/or around key milestones for the project. They will be involved in informing strategic decisions (e.g., areas to further explore in interviews/focus groups) and in helping us to interpret findings in relation to the lived experiences of children and young people. Crucially, they will be involved in the development of research materials to help ensure they are accessible, inclusive, and sensitive to different marginalised groups. We will train and support the peer research and advisory group, and at the outset identify their goals for being involved, what they would like to gain from the experience, and how we can best support them during their involvement.

Ethics and registration

Ethics approval has been received from University College London (UCL) Research Ethics Committee (REC) (ID: 14037/012).

To protect both researchers and participants, the safeguarding procedures of UCL and/or Anna Freud will be adhered to at all times. The evaluation team is supported by the Safeguarding Lead for the project (Talbot) who trains and supports staff, oversees the safeguarding procedure, and reviews safeguarding issues that arise. The PI (Edbrooke-Childs) is a member of Anna Freud's Safeguarding Oversight Group. This group comprises senior staff at Anna Freud and is chaired by Dr Dickon Bevington (Medical Director at Anna Freud and Child and Adolescent Psychiatrist). All researchers will have received safeguarding training at Anna Freud. There is a possibility that safeguarding concerns may arise from answers given in surveys, interviews, or focus groups. If any safeguarding issues are identified, UCL and/or Anna Freud safeguarding policies will be adhered to. This involves the PI being immediately informed. Before data collection, schools will give us the contact for their safeguarding lead, who will also be notified of safeguarding issues and will then take action as necessary. Should further input be required, the PI will work with the Anna Freud Safeguarding Oversight Group to identify next steps. Participants will be informed of the limits to confidentiality in information sheets; i.e., that the only time in which confidentiality may be breached would be when harm to self or others is raised.

Researchers conducting interviews/focus groups with pupils and school staff will debrief with one of the senior members of the team after each interview/focus groups.

We recognize the potential of re-traumatization when conducting research on trauma and trauma-informed practice. We will not ask people about direct or indirect experiences of trauma. We will ensure participants understand what will happen and that they have time to consider if now is the right time for them to take part. All participants are informed in the information sheets that participation in the evaluation is voluntary and they are free to withdraw their personal data from being processed. Our team is experienced in conducting

research with vulnerable groups, and we will work with schools to ensure there are clear processes for supporting pupils and staff if they become distressed.

We also recognize that schools themselves are potentially traumatized systems (Esaki et al., 2013). We understand the strain schools are currently under. Transparency in expectations again will be important and we will work collaboratively with schools to address any barriers to involvement. We will use a mentalization approach throughout our interactions with schools.

Pupils are signposted to sources of support in the information sheet:

“If you feel upset by any of the questions we ask you, you should tell your parent or guardian, staff you trust at your school, or the researchers. You can find the researchers’ contact details in the box on the first page. You can also use the following free sources of support:

- Anna Freud Centre Crisis Messenger: Text AFC to 85258. It is a free 24/7 text service for anyone in crisis anytime, anywhere.
- The Mix: Call 0808 808 4994. The Mix are there to help you take on any challenge that you’re facing.
- Samaritans: Free to call service 24 hours a day, call them on 116 123
- Childline: Free to call service 24 hours a day, call them on 0800 1111”

School staff are signposted to sources of support in the information sheet:

“If you feel upset by any of the questions you are asked as part of this study, you should tell a researcher or your school’s safeguarding or pastoral lead. If you do not feel able to ask us for help, we encourage you to make contact with an external support service such as The Samaritans (Tel. 116 123, www.samaritans.org) or Education Support (Tel. 08000 562561, <https://www.educationsupport.org.uk/get-help/help-for-you/helpline/>).”

If participants become upset during the interviews, this will be managed by the researcher emphasising that participants are not expected to talk about anything that they are not comfortable discussing and that they can stop taking part at any time. The researchers are experienced in interviewing children, young people, and vulnerable groups and will also receive interview training from senior team members prior to data collection, including an overview of semi-structured interviewing techniques, practice conducting semi-structured interviews, managing participant distress, and managing safeguarding issues.

When interviews are conducted with pupils in person, we will ensure a member of school staff is in the vicinity. In person interviews will be conducted in rooms that enable the discussions to be private but can be overlooked by school staff.

Data protection

Anna Freud and UCL are joint controllers of the data for this project. YEF will become an additional data controller at the end of the project when the data are transferred to the YEF archive.

The UK GDPR basis for processing these data is legitimate interest (Article 6(1)(f)) and research purposes (Article 9(2)(j)) and DPA (2018) Schedule 1 part 1 paragraph 4. The processing of special category personal data within this trial is justified under the UK GDPR, specifically Article 9(2)(j). Article 9(2)(j) permits processing for archiving purposes in the public interest, scientific or historical research or statistical purposes. After the project has ended (winter 2025), we will share the information we have gathered about pupils who have taken part with the Department for Education (DfE). This is so we can look at longer-term impacts on educational records. The DfE will replace all identifying information about the young people who have taken part in the study (their name, gender, date of birth, home address) with the young person's unique Pupil Matching Reference number in the DfE's National Pupil Database. Once this has been done, it is no longer possible to identify any individual young person from the study data. This process is called pseudonymisation. Once this has been done, we (Anna Freud and UCL) will delete identifying information, except for consent forms. Consent forms (with names on them) will be held as long as the data are held, so for at least 10 years (April 2035). For pupils, parent/carer opt out consent and young person assent will be collected, both of which refer to the YEF Data Archive. For school staff, consent will be collected.

The information from audio recordings will be kept for no longer than 9 months. As soon as the audio recordings have been written up in text, the audio recording will be deleted and it will not be possible to identify an individual from the write up.

Anna Freud and UCL operate with strict Information Governance (IG) policies in place, complying with relevant legislation (e.g., GDPR, Data Protection Act 2018). IG Leads keep us up to date with security protocols and standards. All staff receive annual data protection training, and researchers receive additional research IG training.

The Data Protection Impact Assessment (DPIA) and associated documentation has already been developed and signed off by UCL and Anna Freud. This process ensures we are complying with data protecting regulations and protecting individual data subjects' rights.

Data sharing agreements will be signed between Anna Freud and UCL; data sharing agreements will also be signed with schools before the submission of local school data. Quantitative/survey data will be collected, stored, and managed on secure UCL systems, and qualitative interview/focus group data will be collected, stored, and managed on secure Anna Freud systems (so there will be little/no data sharing between the organisations). If another organisation is used to transcribe audio files from interviews/focus groups, only one with a data sharing agreement already in place will be used. Established processes for the secure

transfer of data to and from the transcription service will be followed. Data sharing agreements, privacy notices, and participant information sheets/consent forms will include information about the YEF Data Archive. Data collection and transfer across all strands of the evaluation will only take place via approved secure mechanisms; e.g., use of encrypted Dictaphones for qualitative data. All evaluation data will be stored securely on our organisations’ servers, kept strictly confidential, and only accessed by the project team.

Stakeholders and interests

Delivery Team

Table 8: Delivery team roles and responsibilities.

Name and affiliation(s)	Role and responsibilities
Catherine Gordon – Director of Learning, KCA	Quality Assurance lead; Trainer and Associate Supervision; Trainer-Consultant; Content lead
Kate Cairns - Social worker, KCA	Trainer-Consultant and content lead
Barry Golten - Homelessness expert, KCA	Trainer - Consultant
Anisha Gadhia - Legal and criminal justice senior leader and practitioner, KCA	Programme oversight; Trainer-Consultant
Ann Berry - Registered General Nurse and Public Health Commissioner, KCA	Trainer-Consultant
Richard Holds - KCA Managing Director	Strategic oversight and Collaborative Enquiry contingency resource
Diane Blandford – Associate, KCA	Associate Trainer
Polly Wright – Associate, KCA	Associate Trainer
Dean Reilly-Sharp – Associate, KCA	Associate Trainer
Rachael Pryor – Associate, KCA	Associate Trainer
Brian Roberts – Associate, KCA	Associate Trainer
Julie Revels – Associate, KCA	Associate Trainer
Nicky Spencer-Hutchings – Associate, KCA	Associate Trainer
Sally Poskett – Associate, KCA	Associate Trainer
Sheila Mulvenny – Associate, KCA	Associate Trainer
Tom Pyne – Associate, KCA	Associate Trainer

Warren Larkin - Consultant clinical psychologist, WLA Ltd.	Associate Trainer, Collaborative Enquiry lead and Programme Oversight
Colin Baker, PhD - Research expert, WLA Ltd.	Collaborative Enquiry survey lead
Andrew Parker - Research consultant, WLA Ltd.	Collaborative Enquiry Focus Group lead
Rob Dickinson - Experienced service manager, WLA Ltd.	Associate Trainer and Focus Group lead

Evaluation Team

Table 9: Evaluation team roles and responsibilities.

Name and affiliation(s)	Role	Responsibilities
Prof. Julian Edbrooke-Childs; Head of Evaluation at Anna Freud, Professor of Evidence Based Child and Adolescent Mental Health at UCL, Co-Director of the Evidence Based Practice Unit.	Principal Investigator	Overall leadership and management of budget and risks/issues; responsibility for delivery project to time and target; strategic point of contact for YEF and KCA/WLA.
Prof. Jessica Deighton; Director of Applied Research and Evaluation at Anna Freud, Professor in Child Mental Health and Wellbeing at UCL, Co-Director of the Evidence Based Practice Unit.	Methods Specialist	Oversight and scrutiny of the methodological conduct of the research as a critical friend to the project and PI.
Nick Tait; Programme Manager for the Child Outcomes Research Consortium (CORC) at Anna Freud.	Engagement Lead	Oversee the engagement strategy, ensuring bidirectional communication between schools and the evaluation team
Georgina Mutton; Membership and Development Officer for CORC at Anna Freud.	Communications Support	Operational conduct and support for communications primarily with schools.
Dr Emily Stapley; Senior Research Fellow at Anna Freud and the Evidence Based Practice Unit. Dr Emily McDougal to provide cover during maternity leave.	Implementation and Process Evaluation Lead	Leadership and management of the design and delivery of the IPE with a specialism on qualitative research.
Angelika Labno and Navya Malik; Researcher Officer at Anna Freud and the Evidence Based Practice Unit.	Research Officer	Operational conduct and delivery of the research.

Dr Suzet Tanya Lereya; Senior Research Fellow at Anna Freud and the Evidence Based Practice Unit.	Quantitative Lead	Leadership and management of the design and delivery of the quantitative research.
Ben Ritchie; Informatics Lead at Anna Freud and the Evidence Based Practice Unit.	Informatics Lead	Leadership and management of the local school data, including information governance.
Holly Rowland; Research Officer - Data at Anna Freud and the Evidence Based Practice Unit.	Research Officer - Data	Operational conduct and delivery of the research with a focus on the local school data.
To be appointed from our pool of paid young people experts by experience at Anna Freud.	Peer Researcher	Working on all aspects of the project to ensure expertise by experience is integrated throughout.
Rachel Hart; Information Governance Lead at Anna Freud.	Information Governance Manager	To oversee and support the project in the adherence to best practice in relation to information governance.
Bernadette Martin; Head of Participation at Anna Freud.	Head of Participation	To oversee and support the Peer Research and ensure principles of co-production are considered and addressed throughout the project.
Charli Atkinson-Ryan; Head of Equity, Diversity, and Inclusion at Anna Freud.	EDI Manager	To support the project to ensure equity, diversity, and inclusion is considered and addressed throughout.
Dr Laura Talbot; Joint AMBIT Lead at Anna Freud.	Safeguarding Lead	Oversee the project's safeguarding policy. Working with researchers to prepare for and respond to safeguarding issues.
Prof. Peter Fonagy; Chief Executive of Anna Freud and Head of the Division of Psychology and the Language Sciences at UCL.	Senior Advisor (not costed)	Senior scrutiny of the methodological and intellectual conduct of the research.

Risks

1. School buy-in (medium).

1a. Low pupil survey response rate (particularly in control schools).

1b. Low staff survey response rate, including consent to take part in the evaluation (due to capacity).

Given the pressures on schools, ensuring there is strategic and operational buy-in will be crucial, both for implementation and sustainability of the evaluation. Clear communications

and expectations (including timelines) from the outset will be important so schools are clear about the requirements of being involved. We are working with the programme team to ensure we have clear, joined-up communications and to ensure we have buy-in from LA partners to help communicate the importance of the project to senior leads. Establishing a single point of contact for each school (and a deputy contact should the primary be unavailable or away) has proven successful in previous projects. We have published research on the implementation and sustainability of school-based mental health interventions, which we will draw on for this project, in addition to our extensive experience of conducting research in these settings. The proposal is based on established processes successfully used in previous and ongoing projects to collect data from schools.

Incentives for both intervention and control schools have been included in the budget (£1000 per school) to reimburse for time in supporting the evaluation and collecting data; this is an approach we have adopted in other projects to ensure all schools receive something from their involvement. A smaller number of school years have been targeted for primary data collection, as we find it better to target a smaller number of years and focus on high quality data whereas targeting all years can be overwhelming for schools. We have also reviewed and reduced our data collection requirements to minimize burden. We have selected school years and scheduled evaluation activities to avoid peak exam periods. Higher levels of attrition (20% for schools and 25% for pupils) have been taken into account in the sample size calculations.

Ensuring taking part is as easy as possible will be important to make the evaluation feasible for busy school staff. Clear guidance and supporting documentation provided by the evaluators will help to ensure staff can just pick up the information and go (e.g., talking points when describing the evaluation, assembly plans, videos, and power point slides).

2. Timelines (medium).

As known from the outset, the timelines for the project are tight, and this has been taken into account in the planning and set up of the research. The programme and evaluation teams are mitigating this by setting up as much as possible early on (e.g., we have already received the ethics approval). We are planning to approach more schools than required to avoid delays due to school sign up. The programme team have kindly adjusted their delivery times to accommodate baseline pupil data collection ahead of randomisation. Whilst we are planning the programme and evaluation delivery rigorously to be completed within the available timeframe, an outstanding risk is the impact of external delays (e.g., industrial action, restrictions to movement due to COVID-19, changes to school priorities) as there is little possible contingency time.

3. Confidentiality and information governance (low).

Risks to data safety and security during collection, storage, and access are mitigated through only using approved tools and processes for data collection. Quantitative data will be collected using UCL RedCap in the UCL Data Safe Haven, where it will be stored and accessed. Qualitative data will be collected either a) in person using an encrypted Dictaphone and stored and accessed on Anna Freud secure servers or b) online using Anna Freud approved MS Teams and stored and accessed on Anna Freud secure servers. Only approved members of the research team will have access to the data, through UCL/Anna Freud/Office for National Statistics platforms.

4. Data security during file transfer (low).

Risks to data safety and security during transfer are mitigated in the following ways:

- Qualitative data will be transferred in terms of sending audio files to a transcription service and through receiving transcripts from the service. This risk is mitigated through only using an approved transcription service, already with a data sharing agreement with Anna Freud and using established secure transfer mechanisms (Transcription Centre: <https://www.transcriptioncentre.co.uk/>). Interviews/focus groups conducted on Anna Freud approved MS Teams may be transcribed on MS Teams.
- Data will be received from schools using the UCL Data Safe Haven secure file transfer portal.
- Data will be shared for a) linking to the National Pupil Database and b) transfer to the funder, using the Office for National Statistics Secure Research Service, an established and highly protected system for data sharing, storage, and linkage.

5. Participant reidentification (low).

Risks to re-identification of participants are mitigated in the following ways:

- Identifiable data held by UCL and Anna Freud will be deleted after data linkage, except for the consent forms which, along with the anonymised research data, will be retained for 10 years.
- Audio files will be deleted on verification of the transcripts; during verification the transcripts will be anonymised.
- Findings of the research will be shared (e.g., publications) but they will not identify any participant and illustrative quotes will be reviewed before publication to ensure they would not enable others to identify a given participant.
- The Office for National Statistics Secure Research Service is highly protected and widely used system, and only approved and authorised researchers are able to access it. The data linkage process means that, once the data have been linked and are being analysed, it is extremely unlikely that an individual could be re-identified. Moreover, there are strict rules and safeguards in place to ensure that the data are only used to examine the impact of interventions under study, rather than for other purposes.

6. Programme and evaluation team cross-working (low).

Effective working relationships have already been established between the programme and evaluation teams. Regular ongoing communication will be important, especially to continue to ensure clarity over roles in the implementation of the research.

7. Safeguarding (medium).

As described in the section on ethics, we have robust safeguarding infrastructure in place. This risk is rated as medium as there is potential for sensitive information to be disclosed during qualitative data collection in particular, which has again been accounted for in planning. Similarly, risks to re-traumatisation have also been taken into consideration.

Timeline

Cohort 1 Dates	Cohort 2 Dates	Activity	Staff responsible/ leading	Number of Anna Freud days
01.05.23-28.07.23		Ethics approvals	Anna Freud	23
01.06.23-31.08.23		Operational set up	Anna Freud	43
01.08.23-18.07.25		Ongoing operational support and liaison with schools	Anna Freud	50.5
01.05.23-30.09.25		Project meetings	Anna Freud	85
01.05.23-30.09.25		Budget, timelines, risk, and issues reviewing	Anna Freud	48
11.09.23-no later than 15.12.23 (although will be sought as soon as possible)		Schools sign Memorandum of Understanding (required for sharing of school local data)	Anna Freud/Schools	34
11.09.23-13.10.23	11.09.23-21.12.23	Parents/carers of Year 8 and 9 pupils in participating schools sent study information	Anna Freud/Schools	15
27.10.23	08.01.24	Parent/carer opt-out deadline	Anna Freud	-
25.09.23-17.11.23	15.01.24-02.02.24	Baseline data collected (pupil survey, school staff survey, support description survey)	Anna Freud	28.5
13.11.23-17.11.23	29.01.24-02.02.24	Data review and chasing	Anna Freud	11
20.11.23-24.11.23	05.02.24-09.02.24	Randomization	Anna Freud	-
27.11.23-31.03.25	19.02.24-20.06.25	More Good Days At School (MGDAS) programme delivery beings	KCA/WLA	-
29.01.24-16.02.24		Statistical analysis plan drafting (cohorts 1 and 2)	Anna Freud	5

22.04.2024-10.05.2024	24.06.24-12.07.24	Mid-programme follow-up data collected (pupil survey, staff survey)	Anna Freud	22.5
06.05.2024-10.05.2024	08.07.24-12.07.24	Data review and chasing	Anna Freud	11
13.05.2025-24.05.2024	24.06.24-19.07.24	Implementer qualitative data collected	Anna Freud	20
20.05.2024-31.05.2024	08.07.24-19.07.24	MGDAS costs data from intervention schools collected	Anna Freud	17
20.05.2024-31.05.2024	08.07.24-19.07.24	Monitoring and implementation data collected and collated	Anna Freud	10
20.05.2024-31.05.2024	08.07.24-19.07.24	Local school data received	Anna Freud	42
13.01.25-14.02.25		School staff and pupil qualitative data collected (cohort 1 and 2)	Anna Freud	38
10.03.25-28.03.25	23.06.25-18.07.25	1End of programme follow up data collected (pupil survey, staff survey, support description survey)	Anna Freud	15
24.03.25-28.03.25	14.07.25-18.07.25	Data review and chasing	Anna Freud	11
21.04.25-02.05.25	01.07.25-18.07.25	MGDAS costs data from intervention schools collected	Anna Freud	17
21.04.25-02.05.25	01.07.25-18.07.25	Monitoring and implementation data collected and collated	Anna Freud	16.5
21.04.25-02.05.25	01.07.25-18.07.25	Local school data received	Anna Freud	42
01.05.25-21.11.25		Data analysis and report write-up	Anna Freud	210
21.11.25		Evaluation report submitted	Anna Freud	-
24.11.25-28.11.25		Data submitted to YEF Archive	Anna Freud	3

References

- Andrews, A. R., Jobe-Shields, L., López, C. M., Metzger, I. W., De Arellano, M. A., Saunders, B., & Kilpatrick, D. G. (2015). Polyvictimization, income, and ethnic differences in trauma-related mental health during adolescence. *Social Psychiatry and Psychiatric Epidemiology*, 50(8), 1223-1234. <https://doi.org/10.1007/s00127-015-1077-3>
- Appleton, J. J., Christenson, S. L., Kim, D., & Reschly, A. L. (2006). Measuring cognitive and psychological engagement: Validation of the Student Engagement Instrument, *Journal of School Psychology*, 44(5), p.427-445.
- Avery, J. C., Morris, H., Galvin, E., Misso, M., Savaglio, M., & Skouteris, H. (2021) Systematic Review of School-Wide Trauma-Informed Approaches. *Journal of Child Adolescent Trauma*, 14(3), p.381-397.
- Baker, C. N., Brown, S. M., Overstreet, S., Wilcox, P. D., & New Orleans Trauma Informed Schools Learning Collaborative, Validation of the Attitudes Related to Trauma-Informed Care Scale (ARCTIC). (2021). *Psychological Trauma: Theory, Research, Practice, and Policy*, 13(5), p.505-513.
- Berger, E. (2019). Multi-tiered Approaches to Trauma-Informed Care in Schools: A Systematic Review. *School Mental Health*, 11(4), p.650-664.
- Braun, V., & V. Clarke. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), p.77-101.
- Bunting, L., Montgomery, L., Mooney, S., MacDonald, M., Coulter, S., Hayes, D., & Davidson, G. (2019). Trauma informed child welfare systems – A rapid evidence review, 16, 2365. <https://doi.org/10.3390/ijerph16132365>
- CECAN. (2020). Complexity Evaluation Framework. <http://randd.defra.gov.uk/Default.aspx?Menu=Menu&Module=More&Location=None&ProjectID=20401>.
- Elia, C., Karamanos, A., Silva, M. J., O'Connor, M., Lu, Y., Dregan, A., et al., Harding, S. (2020). Weight misperception and psychological symptoms from adolescence to young adulthood: longitudinal study of an ethnically diverse UK cohort. *BMC Public Health*, 20, p.712. <https://doi.org/10.1186/s12889-020-08823-1>
- Cohen, C. E., & I. G. Barron. (2021). Trauma-Informed High Schools: A Systematic Narrative Review of the Literature. *School Mental Health*, 13(2), p.225-234.
- Cresswell, C. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research*. 3rd ed. London: Sage.
- Department for Education (2013). *Statistics: school workforce*. <https://www.gov.uk/government/collections/statistics-school-workforce>

Esaki, N., et al. (2013). The Sanctuary Model: Theoretical framework. *Families in Society*, 94(2), p.87-95.

Espelage, D. L., & Holt, M. K. (2001). Bullying and victimization during early adolescence: Peer influences and psychosocial correlates *Journal of Emotional Abuse*, 2:2-3, p.123-142.

Gaffney, H., Jolliffe, D., & White, H. (2021). *Trauma Informed Care: Toolkit technical report*. London: Youth Endowment Fund

Gherardi, S. A., Garcia, M., & Stoner, A. (2021). Trauma-Informed Schools: Theoretical Gaps, Practice Considerations and New Directions. *International Journal of School Social Work*, 6(1). <https://doi.org/10.4148/2161-4148.1070>

Goodman, A., Lamping, D. L. & Ploubidis, G. B. (2010). When to Use Broader Internalising and Externalising Subscales Instead of the Hypothesised Five Subscales on the Strengths and Difficulties Questionnaire (SDQ): Data from British Parents, Teachers and Children. *Journal of Abnormal Child Psychology*, 38, p.1179–1191 .

Goodman, R., Meltzer, H., & Bailey, V. (1998) The Strengths and Difficulties Questionnaire: a pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, 7(3), p.125-30.

GOV. (2023). UK School workforce in England: reporting year 2022. <https://explore-education-statistics.service.gov.uk/find-statistics/school-workforce-in-england>

GOV.UK. (n.d.). List of ethnic groups. <https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups>

Han, H. R., et al. (2021). Trauma informed interventions: A systematic review. *PLoS One*, 16(6), p.e0252747.

Hoffmann, T. C., et al. (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. *BMJ: British Medical Journal*, 348, p.g1687.

Kang, H. K., & Burton, D. L. (2014). Effects of racial discrimination, childhood trauma, and trauma symptoms on juvenile delinquency in African American incarcerated youth. *Journal of Aggression, Maltreatment & Trauma*, 23(10), p.1109-1125. doi:10.1080/10926771.2014.968272

Lang, J. M., Campbell, K., & Vanderploeg, J. J. (2015). *Advancing trauma-informed systems for children*. Farmington, CT: Child Health and Development Institute.

Lewis, S. J., Arseneault, L., Caspi, A., Fisher, H. L., Matthews, T., Moffitt, T. E., Odgers, C. L., Stahl, D., Teng, J. Y., & Danese, A. (2019). The epidemiology of trauma and post-traumatic stress disorder in a representative cohort of young people in England and Wales. *The Lancet Psychiatry*, 6(3), p.247-256. [https://doi.org/10.1016/S2215-0366\(19\)30031-8](https://doi.org/10.1016/S2215-0366(19)30031-8)

Lundy, L. (2007). 'Voice' is not enough: conceptualising Article 12 of the United Nations Convention on the Rights of the Child. *British Educational Research Journal*, 33(6) p.927-942.

Maynard, B. R., Farina, A., Dell, N. A., & Kelly, M. S. (2019). Effects of trauma-informed approaches in schools: A systematic review. *Campbell Systematic Reviews*, 15(1-2), 10.1002/cl2.1018

McCrory, E. J., Gerin, M. I., & Viding, E. (2017). Annual research review: childhood maltreatment, latent vulnerability and the shift to preventative psychiatry—the contribution of functional brain imaging. *Journal of child psychology and psychiatry*, 58(4), p.338-357.

Pawson, R., & Tilley, N. (1997). *Realistic Evaluation*. London: Sage.

Private Education Policy Forum. (2022). Fact Finder tool on private education. <https://www.pepf.co.uk/fact-finder/facts-and-figures/#:~:text=In%20England%2C%20the%20proportion%20of,This%20amounted%20to%20569%2C000%20pupils>.

Rose, J., McGuire-Snieckus, R., & Wood, F. (2016) *Impact Evaluation of the Attachment Aware Schools Project for Stoke and B&NES Virtual Schools: A Pilot Study*, Bath: IfE, Bath Spa University

Roseby, S., & Gascoigne, M. (2021). A systematic review on the impact of trauma-informed education programs on academic and academic-related functioning for students who have experienced childhood adversity. *Traumatology*, 27(2), p. 149-167.

Stamm, B. H. (2010). *The Concise ProQOL Manual*, 2nd Ed. Pocatello, ID: ProQOL.org

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-Informed Practices in Schools Across Two Decades: An Interdisciplinary Review of Research. *Review of Research in Education*, 43(1), p.422-452.



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