EVALUATION PROTOCOL

MindWorks

Ending Youth Violence Lab

Principal investigator: Tom McBride

YOUTH ENDOWMENT FUND

MindWorks

Evaluation protocol

Evaluating institution: Ending Youth Violence Lab

Principal investigator(s): Tom McBride

Project title[1]	MindWorks: A two-arm cluster randomised controlled trial (cRCT), with schools as the unit of randomisation, evaluating a systemic CBT-based intervention for young people aged 11-16 who struggle with emotional regulation and are showing disruptive and aggressive behaviours.
Developer (Institution)	Anna Freud
Evaluator (Institution)	Ending Youth Violence Lab (EVYL; part of Behavioural Insights Team; BIT)
Principal investigator(s)	Tom McBride
Protocol author(s)	Tom McBride, Dr Clare Tanton, Dr Emily Gray, Dr Akanksha Vardani
Trial design	Two-arm cluster randomised controlled trial, with schools as the unit of randomisation
Trial type	Internal pilot and efficacy trial, with embedded implementation and process evaluation

[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).

Evaluation setting	Schools (mainstream and Alternative Provision)
Target group	Young people aged 11-16 with difficulties with emotional regulation showing disruptive and aggressive behaviours, at risk of, or with a history of, exclusion.
Number of participants	30 schools, with an anticipated sample of 22 pupils per school (660 total participants) across pilot and efficacy
Primary outcome and data source	• Conduct behaviours (as reported by school staff - TRF: externalising scale)
Secondary outcomes and data source	• Emotional and behavioural difficulties (self-report young person, SDQ) • Emotional regulation skills (self-report young person, SECQ: self-management subscale) • Aggression (self-report young person, RPAQ) • Relationship quality between young person and school staff (self-report school staff, STRS) • School attendance (school administrative data). • School suspensions/exclusions/transfers (school administrative data).
Exploratory outcomes and data source	• Prosocial behaviour (self-report young person, SDQ: prosocial subscale) • Relationships with peers (self-report young person, SDQ: peer problems subscale) • Emotional difficulties (self-report young person, SDQ: emotional problems subscale)

Protocol version history

Version	Date	Reason for revision
1.1	19.06.26	Integrating feedback from GECo panel, YEF and AI review and updating primary outcome
1.0	19.01.26	

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

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Study rationale and background

Emotional regulation difficulties expressed as aggressive and disruptive behaviours by young people present a significant societal challenge, often leading to school exclusion, limited opportunities, and long-term involvement in the criminal justice system. These behaviours are frequently rooted in complex systemic issues, including developmental adversity, poverty, discrimination, and trauma.

Conduct problems involve a persistent pattern of aggressive, violent, deceitful, or rule-breaking behaviours. There is good evidence that cognitive behavioural therapy (CBT) interventions can support young people with conduct problems[2]. Traditionally, interventions have focused on single–component skills: problem-solving skills, training, and anger management skills training have been found to be effective in reducing aggressive behaviours,[3] [4] with evidence suggesting that these skills work in different ways to reduce aggression and should therefore be combined for maximum benefit[5]. Solution-focused strategies and social skills training have also been found to support young people with conduct problems, and are often included in CBT interventions.

There is a growing evidence base for delivering CBT interventions for conduct problems in school settings. A meta-analysis of 249 school-based studies targeting aggressive behaviours found an overall mean effect size of ~0.28 for interventions for children with identified behavioural problems [6]. Delivering CBT interventions within schools allows the intervention to be embedded in the young person's daily life, and school-based programmes can coordinate with educational goals supporting both personal and educational development, enabling the two to support one another. However, challenges include variable implementation quality, competing academic demands and ensuring confidentiality within the school environment.

Evidence also shows that interventions engaging a young person's system (e.g. family, school, peers) are more impactful for conduct problems by ensuring consistency across the young

[2] Gaffney, H., Farrington, D. P., & White, H. (2021, June). Cognitive behavioural therapy: Toolkit technical report. Youth Endowment Fund.

[3] Kazdin, A. E., Siegel, T. C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. Journal of Consulting and Clinical Psychology, 60(5), 733–747.

[4] Lochman, J. E. (1981). Effects of a cognitive-behavioral program on self-reported aggression in delinquent and nondelinquent boys. Journal of Consulting and Clinical Psychology, 49(5), 668–672.

[5] Sukhodolsky, D. G., Golub, A., & Cromwell, E. N. (2005). Dismantling anger control training for children: A randomized trial. Behaviour Therapy, 36(1), 15–23.

[6] Wilson, S. J., & Lipsey, M. W. (2007). School-based interventions for aggressive and disruptive behavior: Update of a meta-analysis. American Journal of Preventive Medicine, 33, S130–S143.

person's environment[7.] Complex systemically-focused models such as Functional Family Therapy and Multisystemic Therapy have shown promise in improving conduct behaviours amongst young people[8]. It is therefore important to develop and rigorously evaluate interventions that engage not only the young person but also the environment around them, including their family, school, and community.

Further to this, CBT is rooted in Western cultural values, emphasising individualism, personal responsibility, and verbal expression, which can conflict with collectivist or non-Western cultural beliefs[9]. Additionally, ethnic minority participation in standard randomised controlled trials for CBT is low, meaning there is limited high-quality evidence for its effectiveness in these communities.[10]

CBT's success for racially minoritised groups can be limited by a lack of cultural and systemic integration.[11] For example, racism acts as a cumulative risk factor for poor mental health, and standard disorder-specific CBT models often fail to reference the social context of racism and discrimination, meaning these factors are rarely included within case formulations.[12] Further compounding the risk of harm, many therapists report they lack the confidence or training to discuss racism and ethnicity, leading to avoidance or neutrality.[13]. This can lead to racially minoritised clients experiencing retraumatisation within therapy when their disclosures of racial trauma are met with invalidation, dismissal, or erasure by the therapist.[14]

This is a particularly important consideration as conduct problems and subsequent disciplinary action is frequently rooted in complex systemic issues, including developmental

[7] Henggeler, S. W., Sheidow, A. J., & Lee, T. (2009). Multisystemic therapy (MST). In J. H. Bray & M. Stanton (Eds.), The Wiley-Blackwell handbook of family psychology (pp. 370–387). Wiley Blackwell.

[8] Hartnett, D., Carr, A., Hamilton, E., & O'Reilly, G. (2017). The effectiveness of functional family therapy for adolescent behavioral and substance misuse problems: A meta-analysis. Family process, 56(3), 607-619; Van der Stouwe, T., Asscher, J. J., Stams, G. J. J., Deković, M., & van der Laan, P. H. (2014). The effectiveness of multisystemic therapy (MST): A meta-analysis. Clinical psychology review, 34(6), 468-481.

[9] Huey Jr, S. J., Park, A. L., Galán, C. A., & Wang, C. X. (2023). Culturally responsive cognitive behavioral therapy for ethnically diverse populations. Annual Review of Clinical Psychology, 19, 51-78.

[10] Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. The Cognitive Behaviour Therapist, 12, e10.

[11] Huey Jr, S. J., Park, A. L., Galán, C. A., & Wang, C. X. (2023). Culturally responsive cognitive behavioral therapy for ethnically diverse populations. Annual Review of Clinical Psychology, 19, 51-78.

[12] Beck, A. (2019). Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy. The Cognitive Behaviour Therapist, 12, e8.

[13] Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. The Cognitive Behaviour Therapist, 12, e22.

[14] Samuel, N. K., & Simonds, L. M. (2025). Disclosing racial trauma in psychological therapy: Exploring the experiences of racially minoritised people in the UK. Psychology and Psychotherapy: Theory, Research and Practice.

adversity, poverty, discrimination, and trauma[15]. For Black children in particular, behavioural difficulties are more likely to be interpreted through racialised stereotypes of aggression and adultification, resulting in disproportionate surveillance, punishment, and exclusion. Research from the Youth Endowment Fund highlights that significant racial inequities persist in the UK's criminal justice system, with children from some ethnic minority backgrounds, particularly Black children, being vastly over-represented.[16] While Black children aged 10-17 make up 4% of the general population, they account for 15% of arrests, 18% of stop and searches, and a stark 29% of the youth custody population. This disproportionality, which has worsened over the last decade even as overall youth justice involvement has fallen, is mirrored in victimisation, where 33% of Black children were victims of violence in the last 12 months, compared to 13% of White children and 11% of Asian children. It is crucial that novel interventions for this population address the shortfalls of existing CBT interventions, including acknowledging and targeting racial inequalities explicitly.

MindWorks is a systemic, CBT-based programme developed by Anna Freud to support young people aged 11-16 who exhibit behaviours labelled as aggressive and disruptive. The individual-level intervention is designed to be delivered by qualified practitioners. This includes Education Mental Health Practitioners (EMHPs) and Children's Wellbeing Practitioners (CWPs), who possess existing CBT training, or mental health practitioners (such as social workers or nurses) with CBT experience. All practitioners will receive additional bespoke training in the intervention (see later section on practitioner training). MindWorks combines evidence-based CBT practices (such as cognitive restructuring, problem solving and social skills training) with systemic and relational approaches. The intervention aims to validate and empower the young person by addressing risk factors in their environmental context, rather than locating the problem solely within the individual.

The MindWorks evaluation operates within a policy context that requires explicit engagement with racial equity, particularly acknowledging that if schools fail to understand behaviour through a trauma-informed lens, recognising racism and structural inequality, they risk restricting a young person's education and future opportunities. For example, behaviour labelled as aggression may in fact be an expression of emotional distress, a survival mechanism, or an act of resistance against oppressive systems. When perceptions of behaviour are filtered through a racialised lens and misperceived as violence, this leads to disproportionate disciplinary action. The result is that rates of exclusion and suspension are

[15] Armstrong, D. (2018). Addressing the wicked problem of behaviour in schools. International Journal of Inclusive Education, 22(9), 997–1013. https://doi.org/10.1080/13603116.2017.1413732

[16] youthendowmentfund.org.uk/wp-content/uploads/2022/10/YEF-Children-violence-and-vulnerability-2022.pdf

not merely reflections of individual student behaviour but are shaped by systemic factors located outside of the child.

The MindWorks intervention explicitly addresses this by training practitioners to support school staff in contextualising student behaviour, recognising oppression and identity, and adapting their approach accordingly. Reduced school exclusion, suspensions, and transfers are intended long-term outcomes of the programme.

We outline in this protocol a combined internal pilot and efficacy trial of the MindWorks intervention. The evaluation adopts a staged approach, in line with YEF guidance. Both the pilot and efficacy trial will consist of a cluster randomised controlled trial (cRCT) design, with randomisation occurring at the school level. Programme delivery for each young person will last one term, and be delivered in a school setting. The initial internal pilot phase is designed to assess the programme's deliverability, acceptability, and evaluability to ensure it is ready for a larger-scale trial. If the pilot meets the pre-defined progression criteria, the evaluation will proceed to a full efficacy trial to determine the intervention's impact on key outcomes. This will comprise an impact evaluation and an implementation and process evaluation (IPE). Data from the pilot will be pooled with data from the efficacy trial.

This document details the rationale, design, and methodology for this evaluation of the MindWorks programme.

Study context and co-design

MindWorks is a new intervention, built on:

- Existing psychological models including CBT and the AMBIT[17] model.
- Extensive delivery team experience delivering clinical, school-based and trauma-informed interventions with children, young people, and their wider networks
- Evidence of interventions for young people experiencing emotional regulation difficulties presenting as disruptive and aggressive behaviour.

Prior to protocol development, Ending Youth Vi olence Lab (EYVL; evaluation partner; part of part of the Behavioural Insights Team; BIT) and Anna Freud (delivery partner) conducted a period of co-design, with the following aims:

1) To refine and develop the MindWorks programme including defining eligibility criteria, recruitment protocols, and exploring feasibility of delivery in mainstream and Alternative Provision (AP) settings.

[17] Adaptive Mentalization-Based Integrative Treatment: an approach developed by Anna Freud to support teams develop systems of help around particularly vulnerable clients. It applies mentalization theory and practice in work with both clients and their system.

2) To develop and refine the approach to evaluation, focusing on key issues to resolve. These included sample size and power calculations, acceptability of randomisation and what the control arm should receive, ways to encourage participation of children and young people (CYP), school staff and parents in data collection and acceptability of questions.

3) To address concerns from YEF's Grants and Evaluation Committee (GECo) around the potential of CBT to cause harm in the long term to racially minoritised CYP by affecting their response to and lived experience of racial trauma/systemic racism and locating issues in the individual rather than recognising the impact of the system on difficulties.

4) To ensure a strong approach to fidelity across the delivery team including a clear framework for monitoring fidelity and considering how to ensure diversity in the delivery team workforce.

The co-design period consisted of the following activities:

- Four workshops with the evaluation team (EYVL), delivery team (Anna Freud) and YEF representatives. These covered:
    - **Workshop 1: Refining the Theory of Change** including the activities, outcomes, mechanisms of change, moderators and potential backfire effects.
    - **Workshop 2: Identifying measures and data collection methods** for primary and secondary outcomes, and developing a measure of fidelity.
    - **Workshop 3: Evaluation design** including randomisation, recruitment, business as usual offer, control arm offer, how to engage schools, young people and parents in the programme and trial and agreed pilot to efficacy progression criteria.
    - **Workshop 4: Risks and mitigations, timelines and progression criteria,** including development of the risk register and shared Gantt chart.
- Each workshop had the attendance of at least one Race Equity expert (Dr Jalissa Clarke, Dr Jessica Davies). They provided input from a Race, Ethnicity, Diversity, Inclusion (REDI) lens, ensuring that all conversations were held with equity and inclusion in mind.
- Paper on Race Equity considerations in CBT for young people produced by Anna Freud (Appendix 1)
- Stakeholder engagement sessions including the following:

Stakeholder	Activity	n	Topics covered
Representatives from mainstream schools	90 minute focus group	5	• Randomisation acceptability & control arm offer • Tracing students between schools

Representatives from AP schools	90 minute focus group	3	• Understanding BAU • How to engage schools with evaluation
Young people	90 minute focus group	3	• Appeal of the programme and how it is presented • Randomisation acceptability & control arm offer • BAU offer • Data sharing • Survey design & support
Parents/carers	90 minute focus group	2	• Appeal of the programme and how it is presented • Randomisation acceptability & control arm offer • Data sharing • Survey design & support

Appendix 2 includes a summary of the topics covered in these engagement sessions and the stakeholder feedback. In line with best practice in stakeholder engagement, we have fed back directly to all stakeholders on how their views have influenced our trial protocol.

Intervention

MindWorks is a systemic, youth-focused CBT intervention developed by Anna Freud, designed to support young people exhibiting significant difficulties with emotional regulation presenting as disruptive and aggressive behaviours. It integrates core CBT principles within a systemic framework informed by the AMBIT model. The following section covers the target population, activities, outcomes, moderators and potential backfire effects. **The graphical Theory of Change is included in the Mechanisms and Outcomes section of this document.**

Rationale for the intervention

Conduct problems within UK schools are widely prevalent, with research indicating that rates in diverse inner-city London schools are approximately 16%, three times higher than the 5-6% reported in national studies[18]. These difficulties are often rooted in social and economic contexts with young people exposed to racial discrimination twice as likely to develop conduct problems. While national initiatives such as Mental Health Support Teams (MHSTs) in schools use Cognitive Behavioural Therapy (CBT) to address behavioural issues, individual clinical

[18] Blakey, R., Morgan, C., Gayer-Anderson, C., Davis, S., Beards, S., Harding, S., Pinfold, V., Bhui, K., Knowles, G., & Viding, E. (2021). Prevalence of conduct problems and social risk factors in ethnically diverse inner-city schools. BMC Public Health, 21(1), 849. https://doi.org/10.1186/s12889-021-10834-5.

interventions are often unsustainable without a systemic approach[19]. Conversely, while systemic approaches such as School-Wide Positive Behaviour Support (SWPBS) shift the focus to the entire school environment, they can fail to address individual needs[20]. MindWorks addresses this lack of integrated support by combining evidence-based CBT with a systemic framework to provide an alternative approach to ineffective or punitive disciplinary models.

Target population

Primary:

The intervention targets young people aged **11–16 years** who are in secondary education (mainstream or Alternative Provision (AP) schools) who are experiencing significant difficulties with emotional regulation and behaviour, particularly in the context of their relationships with others. This might include:

- Getting into verbal or physical conflict with family members, friends or school staff
- Damaging property
- Challenges with following rules

The participants section of this protocol sets out inclusion and exclusion criteria for the study.

Our target population includes Year 11 pupils, but we expect relatively low recruitment due to GCSE pressures. Where possible, we will concentrate Year 11 recruitment in the autumn term, when there is more capacity for delivery and pupils may be more motivated to seek support as exam-related stress builds. We will not deliver MindWorks to Year 11 students during the summer term.

We are targeting young people in both mainstream and AP cohorts. We believe it is important to include both school types in the project for a number of reasons. Firstly, to generate more generalisable evidence on the efficacy of MindWorks across school settings. Secondly, students in alternative provision schools are much more likely to reflect the young people who struggle the most with the difficulties targeted by the MindWorks programme. Individuals who attend AP schools or pupil referral units (PRUs) are far more likely to be involved with the criminal justice system and receive a custodial sentence[21]. As such, AP schools are likely to be a setting in which the MindWorks programme can target the highest need young people who are most likely to be later involved in the criminal justice system.

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[19] March, A., Stapley, E., Hayes, D., Town, R., & Deighton, J. (2022). Barriers and facilitators to sustaining school-based mental health and wellbeing interventions: A systematic review. International Journal of Environmental Research and Public Health, 19(6), 3587. https://doi.org/10.3390/ijerph19063587

[20] Armstrong, D. (2018). Addressing the wicked problem of behaviour in schools. International Journal of Inclusive Education, 22(9), 997–1013. https://doi.org/10.1080/13603116.2017.1413732

[21] www.ons.gov.uk/peoplepopulationandcommunity/educationandchildcare/articles/theeducationandsocialcarebackgroundofyoungpeoplewhointeractwiththecriminaljusticesystem/may2022#absence-and-exclusions

Finally, the mechanisms through which the MindWorks intervention is hypothesised to work are likely to transfer across setting types, so it is feasible to include both mainstream and AP schools.

We will monitor the experience of recruitment, engagement and data collection in mainstream and AP settings as part of the pilot trial. If significant issues are found in one or other school type, we may transition to recruiting only from a single school type for the efficacy trial.

Secondary:

The secondary targets of the intervention are the parents or carers of young people, school staff and other trusted adults in the young person's network. The MindWorks programme is explicitly designed around a systemic framework, recognising that while the primary recipient is the young person, the intervention's success is fundamentally dependent upon the engagement and adaptation of the secondary target populations. This approach is informed by the robust evidence that conduct problems are most effectively conceptualised and addressed within a systemic context, ensuring that therapeutic gains are sustained outside of individual sessions.

Activities

Programme activities

MindWorks will be delivered in mainstream and AP schools over the course of one academic term. There is flexibility in how the intervention is delivered based on the needs and availability of the young person and key network members. Sessions will predominantly take place in school, scheduled to accommodate young people's individual timetables and preferences, as well as the constraints imposed by room availability. This can mean sessions take place at any time of day, and in some cases, at the end of the school day. Practitioners can also conduct sessions in community settings or online where this is more appropriate for the young person and their network. As noted in the table below there are typically 6-8 individual sessions with each young person, in addition to 4-6 network sessions (including with teachers and parents) over the course of a delivery term.

The MindWorks intervention is delivered in three phases: start-up, active intervention, and sustainability. The fidelity markers (defined in the fidelity section) provide the minimum requirements for content and dosage.

Programme phase	Duration/Dosage	Core content and procedures

Start-Up phase (Assessment, Relationship-building)	1 session (minimum 30 minutes)	Collaborative, strengths-based assessment; formulation; relationship and rapport building; explicit goal setting with the young person; identification of trusted adults in the young person's network.
Active intervention phase (individual sessions)	6–8 sessions (extendable to 10 sessions).	Individually delivered CBT-informed sessions focused on skill-building. Sessions cover topics based on the individual's formulation and goals, but will include some of the following: ● Anger management & Emotional regulation ● Problem-solving skills ● Cognitive restructuring ● Social skills training ● Peer influence and pressure ● Identity and self-worth.
Active intervention phase (network sessions)	4-6 sessions/contacts with network members.	Systemic engagement with the young person's network (parents/carers, school staff). Practitioners share goals, discuss the young person's challenges and strengths, identify how behaviour is currently being responded to, and collaboratively generate alternative responses to behaviour.
Sustainability phase (embedding gains)	1 session (minimum 30 minutes)	Focus shifts to embedding gains and scaffolding relationships. This final session must include reviewing initial goals, reviewing trusted adults for ongoing support, discussing future challenge responses, and creating a written action plan to be shared with the young person and their network.

Maximising engagement

Practitioners will be highly flexible in their efforts to build successful engagement with young people and their network. Practitioners will seek to have weekly contact with young people, which may involve making several attempts within a week in order to secure a meeting. Practitioners are also aiming for weekly contact with the network, which may be by phone,

email or in person depending on the focus. All contacts/attempts to meet will be recorded within the clinical record. These data will be used for the IPE analysis.

If a young person or adult participant misses a session, practitioners will follow up with persistence and sensitivity. Typically (at least) three follow-up attempts will be made per missed session, using varied modes of contact (e.g. in person at school, phone, text, school liaison) and varied times of day for the adults.

Where appropriate, these 'make-up' sessions may be combined with other planned contacts or restructured to maintain therapeutic momentum. This flexible and proactive stance reflects the "whatever it takes" ethos of the MindWorks model, recognising the complex and often unpredictable nature of engaging young people with significant social and emotional challenges.

Practitioners will be recruited for their experience of carrying out outreach/therapeutic work with this population, so that they come with skills and qualities that will aid this assertive approach to engagement, which will be further attended to through the Mindworks training. Practitioners will also use existing trusted relationships as vehicles to support their own trust building with the young person.

To support young people, parents/carers, and school staff in achieving the minimum required number of sessions, we will implement several additional strategies tailored to the context and participant group. These reflect both preventive and responsive approaches, and are adapted where appropriate to the differing dynamics of AP and mainstream settings.

Young people (all settings):

- Early, personalised engagement to co-design goals and preferred working styles, increasing intrinsic motivation.
- Clear messaging about the flexible and collaborative nature of the work.
- Rapid scheduling of initial sessions to establish momentum.
- Use of school-based sessions where possible to minimise disruption to academic attendance.
- Use of visual tools, brief check-ins, and short sessions where attention or distress limit engagement.

Parents/Carers:

- Emphasis on value of their perspective and non-judgemental approach to past experiences of services.
- Multiple routes of contact (e.g. phone, video, school meetings, home visits if appropriate).
- Persistence and openness throughout, not just at intake.

- Inclusion in goal-setting and review processes to maintain relevance.

School staff:

- Flexibility in when and where meetings take place (e.g. fitting around timetables).
- Framing of sessions as building on existing support roles rather than 'adding extra work'.
- Liaison and scheduling support from the practitioner and engagement lead.
- Where needed, team-based involvement so that more than one adult may contribute.

Additional for AP settings:

- Recognising greater volatility in student attendance, practitioners will coordinate closely with pastoral staff to identify and capitalise on windows of availability.
- Sessions may be shorter, more frequent, and responsive to the young person's mood or behaviour on a given day.
- Additional practitioner visibility (e.g. more informal presence on site) to maintain continuity.
- Closer collaboration with staff to jointly plan support for each session.

Additional for Mainstream settings:

- Coordination with school timetables and protected intervention slots.
- Strategic communication with senior leadership teams to facilitate access and reinforce priority.
- Support in negotiating quiet spaces and time allocation for practitioner meetings.

These layered strategies reflect the anticipated challenges and past experience of engaging a complex cohort and are designed to increase the likelihood of session completion.

Adaptations for neurodiversity

There are anticipated higher rates of neurodiversity amongst this population than average rates in the wider student body. Mindworks is committed to being an approach that is trauma-informed, culturally sensitive and adapted to each young person's intersecting identity and needs. A neurodiversity-informed approach within Mindworks ensures that practitioners consider neurodivergence, both identified and not formally identified, within their assessment, formulation and intervention. This includes understanding and attending to the relevance of factors such as:

- Sensory load (noise, crowds, lighting, transitions)
- Processing differences (processing speed, demand avoidance, working memory challenges)
- Emotional experience differences (alexithymia, rejection sensitivity, hyperarousal)

- Social communication differences (literal interpretation, difficulty reading intent)
- Demand sensitivity/avoidance (the extent to which meeting the demands of the environment feels safe and possible and the nervous system response to this)
- Executive functioning (planning, shifting, inhibition)
- Masking and burnout (the extent to which the young person feels able to show up authentically in school and the cumulative nervous-system cost of functioning in environments not adapted to their neurotype)

MindWorks' focus is on developing a shared understanding of the young person's strengths, preferences and needs and exploring how these may be contributing to expressions of distress that present as disruptive or aggressive behaviours.

These would form key areas of focus for parent/school sessions. Rather than locating the "problem" within the young person or placing sole responsibility on them to change their behaviour, the emphasis is on adjusting environments, relationships and expectations so they better fit the young person's neurotype.

Young people would be actively involved in thinking about how situations could be managed differently and supported to develop, practise and strengthen skills that promote safety, regulation and positive connection with others.

For all young people, including neurodivergent young people, the aim is for this to be an empowering process that aligns with their goals and aspirations and builds on their strengths and interests, rather than a corrective one.

Resources and sessions will be adapted accordingly so that they support each young person's engagement, participation, regulation and progress.

Anna Freud has a strong track record of developing and delivering training that is focused on supporting professionals to develop their understanding of neurodiversity, neurodivergence and neuro-affirming approaches (e.g. National Autism Trainer Programme, Anna Freud[22]).

Currently, Anna Freud also hosts Autism Central - England's Peer Education Programme, which is the National Peer Education Programme for families and support networks of autistic people of all ages in England. The programme is delivered by Anna Freud and commissioned by NHS England. Through this, they offer families education, coaching and connection through co-produced resources, one-to-one peer support from peer guides with lived experience and community events.

[22] https://www.annafreud.org/training/health-and-social-care/national-autism-trainer-programme/

The Mindworks practitioner training will include materials developed within these programmes and one of the MindWorks trainers, Nana Owusu, is a facilitator within Autism Central and will be involved in developing the content and delivering the training in this area.

Within the IPE interviews, we will explore the impact of neurodiversity on engagement and experience of the MindWorks programme.

Safeguarding

There may be safeguarding incidents raised during the delivery of the MindWorks programme. The limits of client confidentiality will be clearly explained and documented in all initial agreements with the young person and their family, notably the need for disclosure where risk to self or risk to others has been identified.

Safeguarding advice and support will be available at all times to practitioners while direct work is taking place, with a senior practitioner named each day as the safeguarding contact. In the event of a disclosure of current risk during MindWorks delivery, practitioners will notify their supervisor or safeguarding lead for further advice and a plan will be put in place including notifying the Designated Safeguarding Lead (DSL) at the young person's school and family members where appropriate. A safety plan will then be agreed with the young person with oversight from the Head of Service and form part of the ongoing intervention. The co-director of the programme is the DSL for Anna Freud who will be available for urgent advice throughout the programme.

Practitioners and recruitment

The programme will be delivered by practitioners selected based on competencies, rather than formal roles. We know that particular qualities, alongside therapeutic competencies, are required to engage disenfranchised communities. These include resilience, optimism and ability to adapt therapeutic interventions to fit the particular needs of the young people. Competencies around engagement, core CBT expertise and the skillset to work with trusted adults, including experienced professionals, will be expected. We anticipate the MindWorks team to include Education Mental Health Practitioners (EMHPs) and Children's Wellbeing Practitioners (CWPs), who possess existing CBT training, as well as mental health practitioners (such as social workers or nurses) with CBT experience. Professionals qualified to at least MSc level in psychology or a related degree, alongside relevant prior practical experience (e.g., assistant psychologists, research assistants, youth workers), will also be eligible.

Anna Freud's recruitment process will use positive action to encourage applications from practitioners from ethnic minority backgrounds so that the clinical delivery team will reflect the diversity of the young people recruited for the RCT, whilst following best recruitment practices and ensuring regulatory compliance. Demonstrable experience in race equity will

be included as an essential characteristic to the job description and consideration will be given to lived experience.

Practitioner training

10 day Mindworks core training

All practitioners must complete 10 days of MindWorks training with senior members of the Anna Freud clinical team including input from Dr Lesley French (Co-Director), Dr Laura Talbot (Training Development Lead), Liz Cracknell (Training Delivery Lead), Dr Jalissa Clarke (EDI Consultant) and the Anna Freud Head of Clinical Services, Nana Owusu. This training team includes an EDI consultant and senior clinicians with lived experience, ensuring that the training is grounded both in expertise and authentic perspectives.

Training will cover core CBT methods, race equity, motivational interviewing, and systemic and trauma-focused elements. It will also include a specific focus on culturally-adapted practices and recognition of the impact of structural discrimination on mental health and behaviour.

MindWorks specifically aims to avoid the potential harm of "culture-blind CBT," which risks locating the problem solely within the individual. The intervention avoids blaming the young person and situates difficulties within environmental and structural realities, ensuring normal stress reactions to racism (e.g., hypervigilance or mistrust) are not pathologised. The programme draws on robust evidence that CBT is effective for diverse youth when delivered in a culturally responsive way. Adaptations include using culturally adapted CBT practices that emphasise cultural pride, racial socialisation, and strengths-based approaches drawing on the following specific components:

- Self-reflection and bias awareness (Hanna, Talley, & Guindon, 2000)
- Creating safe, trusting therapeutic spaces (Williams et al., 2023)
- Open, respectful dialogue about race and culture (Hanna & Cardona, 2013)
- Integration of social justice principles into clinical practice (Hanna & Cardona, 2013)
- Knowledge of race-related mental health research (Metzger et al., 2021; Williams et al., 2023)

MindWorks practitioner training is intentionally designed to extend beyond the parameters of conventional NHS CBT training, specifically for practitioners who are already qualified in low-intensity CBT-based interventions (e.g., CWPs, EMHPs). Rather than re-teaching foundational therapeutic models, MindWorks focuses on developing systemic competencies and integrating relational, network-oriented ways of working that are not typically emphasised in standard CBT training. This marks a shift from individual-focused clinical work to a more contextually sensitive and responsive approach.

Practitioners will be expected to draw on the knowledge and experience they already hold about taking an anti-racist stance in their work and to actively apply this throughout their training. Tutors will facilitate structured role play exercises that allow practitioners to demonstrate their practice using a race equity lens in realistic scenarios and receive constructive feedback. Training will combine workshops, case-based practice, and reflective supervision to ensure that cultural humility and anti-oppressive practice are consistently applied. Ongoing supervision and consultation will sustain this stance.

Dedicated race equity training

Ahead of the 10 day Mindworks training training, Anna Freud will provide a two day workshop dedicated to race equity led by senior clinicians with lived experience. This workshop will be supported by a reading list of self-study materials to help practitioners strengthen their core understanding of racism ahead of the training programme.

Quality assurance

Quality assurance will be maintained through the following activities:

Post-training reflections

After completing the two week programme each practitioner will have an individual session with the race equity adviser and senior clinical tutors to reflect on their learning, explore areas for further development and identify specific aspects of practice to strengthen. This early and ongoing connection with the race equity adviser helps to build their relationship with practitioners from the outset. It also serves to create the conditions for them to hold race equity as a central consistent consideration across all aspects of the work.

Practice observation

Where possible, practitioners will be observed by supervisors in early sessions of the programme as part of monitoring fidelity to the model and assessing cultural safety. Where practitioners are not meeting minimum standards, these will be addressed by the supervisor and additional support or training will be provided if required.

Weekly individual supervision

Each practitioner has weekly supervision with their team leader, who is a senior clinician, who will also be available to offer ad hoc support outside of these times (i.e. safeguarding, risk management, debriefing support). Team leaders access individual supervision fortnightly with Deputy Heads of Service, who themselves have fortnightly supervision with the Head of Service.

Weekly group supervision

Practitioners attend a weekly supervision session (60-90 minutes) in small groups with the senior training supervisor (who developed/delivered the Mindworks training) allocated to their team. This space is intended to support fidelity to MindWorks, through offering opportunities to bring live casework dilemmas and to think these through in a shared group space with reference to core MindWorks theory and practice tools. Opportunities to reflect on practitioner stance in terms of sustaining a trauma-informed, culturally sensitive and anti-oppressive approach will also be provided within the space. Good practice can also be surfaced and exchanged between peers and themes requiring further practice development can be identified. A monthly group supervision for team leaders is also facilitated by one of the senior training supervisors.

EDI individual consultation

The EDI consultant will provide specific individual consultation to practitioners to support them in addressing cultural or equity-related aspects of their work on an ad-hoc basis. For instance, if a practitioner feels stuck or uncertain how to proceed with a case involving significant racial trauma, an individual session with the EDI consultant can be arranged either via the practitioner or supervisor. The culture of the team encourages practitioners to proactively seek 1:1 support whenever needed; it is normalised as good practice rather than a sign of difficulty. This support can be accessed by practitioners, team leaders and Deputy/Head of Service.

EDI group consultation (group)

In addition to standard clinical supervision, teams benefit from a dedicated equity-focused consultation and reflective space, provided by the EDI consultant. Practitioners can bring material specifically related to culture, diversity and inclusion in their casework or reflect more generally on a related theme. The EDI consultant's group consultation creates a safe space for practitioners to explore their own biases, seek guidance on cultural adaptations and strengthen their anti-oppressive practice. This offer signals to practitioners that equity (including race equity) is a sustained priority and that specialist support is available continuously. This ensures that challenges around delivering culturally responsive care are identified and addressed in real time, to promote fidelity to the programme's race-equity stance.

Continuing Professional Development (CPD) offer

To supplement the initial training, MindWorks provides ongoing CPD opportunities, including refresher and booster training during school holiday periods. These can be tailored to emerging development needs as well as being opportunities to exchange good practice. The aim is to foster a learning community including all MindWorks teams where practitioners and

leaders continuously grow their expertise. These are mandatory sessions for all members of the MindWorks delivery teams.

Monitoring client experience

Practitioners will address potential harms by rigorous attention to the engagement of the young person and their presentation in each session. Therapists will invite feedback throughout the programme from young people, school staff and family members. This will include use of the (Child) Session Rating Scale[23] which will be administered at the end of each session to get real-time feedback about the therapeutic alliance so that problems can be addressed. There will also be a separate form provided for feedback to be given outside of the direct therapeutic relationship. If there is any breakdown in the relationship the young person can request an alternative practitioner. Any young person who withdraws from the programme will be asked for feedback about their reasons. Practitioners will be informed of any feedback and worked with to address the issues raised and to ensure practice is corrected.

Consideration of racial, ethnic and other minoritised groups

MindWorks is explicitly designed to be sensitive to and appropriate for racially, ethnically, and other minoritised groups, integrating race equity and anti-oppressive practice at every stage. Programme design to date, and ongoing programme delivery, has and will continue to be informed and challenged by the organisational EDI commitments and infrastructure of both the delivery partner and evaluator.

Anna Freud's EDI strategy outlines their commitments in domains of: representation; inclusion and belonging; continuous learning and cultural humility; and community wellbeing. The EDI ecosystem ensures EDI is embedded across all projects and programmes, according to the EDI strategy. As well as having recruited dedicated EDI Leads from both organisations, everyone working on the project will remain responsible for the active consideration of EDI throughout delivery.

The intervention operates from the foundational belief that young people's mental health challenges often arise from systemic and structural inequalities, including the disproportionate impact of poverty, discrimination, and trauma. It recognises that racially minoritised young people are disproportionately affected by exclusion and systemic discrimination.

[23] The Session Rating Scale is a 4 item visual analogue scale which assesses clients' perceptions of: respect and understanding, relevance of the goals and topics, client-practitioner fit and overall alliance. The Session Rating Scale is used for those aged 13 and over, and the Child Session Rating Scale for those aged 6-12. https://www.corc.uk.net/outcome-measures-guidance/directory-of-outcome-measures/session-rating-scale-srs/

Race equity advisors have been part of the co-design stage and will continue to be involved throughout the MindWorks evaluation process to hold the evaluation team and delivery team accountable to considerations of race and diversity. The Anna Freud team have produced a separate paper on cultural and race considerations in CBT, which provides a comprehensive overview (with relevant references) of how MindWorks will implement a culturally informed approach, available in Appendix 1. These approaches to race equity already form a core part of Anna Freud's routine clinical delivery in community settings.

Template for Intervention Description and Replication (TIDieR)

This intervention description uses an adapted version of the TIDieR framework.[24]

Item	Description
Intervention name	**MindWorks**
Why does the programme exist?	**The need** Emotional regulation difficulties expressed as disruptive and aggressive behaviours by young people presents a significant challenge within schools, with persistent conduct problems resulting in disciplinary action including school exclusion. While Cognitive Behavioural Therapy (CBT) is effective for addressing conduct problems, traditional models focus on individual skills and often fail to understand contextual factors or involve the young person's wider system. When schools fail to view behaviour through a trauma-informed lens, they risk misinterpreting emotional regulation difficulties as simple misconduct. This leads to higher rates of exclusion and restricted future opportunities for young people who are struggling with conduct symptoms. **The goal** To improve emotional regulation and behaviour in young people aged 11–16 by delivering a systemic, trauma-informed CBT intervention. The programme aims to support young people through a combination of evidence-based CBT practices and systemic and relational approaches, understanding their behaviour within their social context. MindWorks supports school staff and carers in contextualising student behaviour, working closely with the young person's wider network to ensure environmental consistency, aiming to ultimately reduce

[24] Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D., Macdonald, H., Johnston, M., Lamb, S.E., Dixon-Woods, M., McCulloch, P., Wyatt, J.C., Chan, A-W., & Michie, S. (2014). Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide. BMJ, 348.

	school exclusions, suspensions, and future involvement in violence and the criminal justice system.
Who is the programme for?	The intervention targets young people aged 11–16 years who are in secondary education (mainstream or Alternative Provision (AP) schools) who are experiencing significant difficulties with emotional regulation and behaviour, particularly in the context of their relationships with others. This might include: ● Getting into verbal or physical conflict with family members, friends or school staff ● Damaging property ● Challenges with following rules The programme recognises a primary target (the young person) and secondary targets (parents/carers, school staff, and other trusted adults). A core requirement for participation is the active involvement of the young person's wider network to ensure therapeutic gains are sustained outside of individual sessions. **Inclusion criteria (as identified by school staff):** ● Scoring 4+ on the Strengths and Difficulties Questionnaire (SDQ) conduct subscale (teacher-rated). ● OR Scoring 3+ on the SDQ conduct subscale, plus at least one of the following: ○ Identified as at risk of exclusion in the next academic year. ○ History of school exclusion or 2+ suspensions in the last two academic years. ○ History of involvement in the criminal justice system. ● At least one school-based adult must be willing to be involved in the intervention. ● English language skills sufficient to access a verbally based psychological intervention. ● Minimum school attendance of 40% in the previous term. **Exclusion criteria:** ● Currently receiving CBT or other psychological interventions specifically focused on emotional regulation difficulties expressed as disruptive and aggressive behaviours ● Identified by school staff as being at risk of suicide.
What (materials)	**Practitioner training and supervision materials** ● MindWorks training modules: Practitioners must complete 10 days of MindWorks training. This includes specific modules on core CBT methods, motivational interviewing, systemic and trauma-focused elements, and race equity. In addition, practitioners must complete 2 days of race equity training.

	● Culturally-adapted frameworks: Manuals and resources focusing on culturally-adapted practices, self-reflection and bias awareness, and the integration of social justice principles into clinical practice. ● AMBIT model guidelines: Materials for implementing the systemic framework informed by the AMBIT model, used to support teams in helping clients who experience multiple disadvantages. ● Quality assurance checklists: Supervisors use a half-termly checklist form to rate delivery against quality standards. **Screening and referral tools** ● Strengths and Difficulties Questionnaire (SDQ): Specifically, the conduct subscale used for identifying eligible young people. ● Light-touch referral form: A shared, secure excel sheet used by schools to refer participants and provide demographic details. **Direct delivery and participant materials** ● Individual session resources: Materials focused on core intervention topics including anger management & emotional regulation, problem-solving skills, cognitive restructuring, social skills training, peer influence, and identity & self-worth. ● Network engagement tools: Resources to facilitate sessions with parents, carers, and school staff to co-generate alternative responses to behaviour. ● Written action plans: Created during the Sustainability phase to be shared with the young person and their network to address future challenges. ● Informational packs: A pre-read pack with detailed programme information for young people/parents/carers.
What (procedures)	The MindWorks intervention is a systemic, youth-focused programme that integrates cognitive behavioural therapy (CBT) with the AMBIT (Adaptive Mentalization-Based Integrative Treatment) model. All practitioners delivering the intervention undergo 10 days of bespoke training, 2 day race equity workshop, and receive 90 minutes of weekly small-group clinical supervision, plus individual supervision and consultation. **The programme is delivered in three distinct phases:** ● Start-up phase: ○ Practitioners conduct a collaborative, strengths-based assessment and formulation. ○ The phase involves explicit goal setting with the young person and the identification of trusted adults within their network.

	● Active intervention phase: ○ These focus on CBT-informed skill-building tailored to the individual's goals. Core topics include anger management, emotional regulation, problem-solving, cognitive restructuring, social skills training, peer pressure, and identity/self-worth. ○ Practitioners engage systemically with parents, carers, and school staff. They share the young person's goals, identify current responses to behavior, and collaboratively generate alternative, more supportive responses. ● Sustainability phase: ○ The final session focuses on reviewing initial goals and trusted adults for ongoing support. ○ Practitioners work with the young person and their network to create a written action plan for future challenges.
Who delivers the intervention?	The programme is delivered by a multidisciplinary team from Anna Freud, organised into a clear clinical and oversight hierarchy. **Wellbeing practitioners** The primary deliverers of the intervention. They provide direct 1:1 support and facilitate the systemic work with families and schools. These are likely to include Education Mental Health Practitioners (EMHPs) and Children's Wellbeing Practitioners (CWPs), who possess existing CBT training, or mental health practitioners (such as social workers or nurses) with CBT experience. Each practitioner would typically see 6-8 young people per term/school. **Senior practitioners** Provide direct supervision and clinical guidance to the wellbeing practitioners. They will provide weekly supervision typically for 18-24 cases per term. **Deputy Head & Head of Service** Provide strategic leadership and clinical governance. The Head of Service is overseen by two part-time **Co-Directors**. They are also responsible for managing and delivering the CPD offer for schools within the control arm of trial. The Deputy will also focus on embedding teams in their local area in relation to local safeguarding and network involvement. **Project Manager** Coordinates delivery activities and logistics. **Training Development Lead and Delivery Leads** Oversee the initial and ongoing professional development of the staff. **Schools Relationship Manager (UCL)** Leads on school recruitment and maintains high-level institutional partnerships.

How	The intervention is designed to be flexible and adaptive to the needs of the young person and their network. **Mode of delivery:** ● Sessions take place predominantly in-person within school settings. ● Practitioners have the flexibility to conduct sessions in community settings or online (via internet/video call) when more appropriate for the participant or their network members. **Format of delivery:** ● Individual sessions with the young person. ● Network sessions with the young person and their wider network. This includes, where possible, parents, carers, school staff and other trusted adults to ensure therapeutic gains are supported outside of sessions.
Where	MindWorks is delivered within secondary schools (Mainstream or AP). Sessions will take place predominantly in school, scheduled to accommodate young people's individual timetables and preferences, as well as the constraints imposed by room availability. This can mean sessions take place at any time of day, and in some cases, at the end of the school day. Practitioners can also conduct sessions in community settings or online where this is more appropriate for the young person and their network.
When and how much	The MindWorks intervention is designed to be delivered over the course of one academic term. There are typically 6-8 (minimum 4) individual sessions with each young person and 2-6 network sessions (including with teachers and parents) over the course of a delivery term. The programme is delivered in the following phases: ● **Start-Up phase -** one session, minimum of 30 minutes. ● **Active intervention phase -** 6–8 (minimum 4) sessions with young people, with the flexibility to extend to 10 sessions if required. Also involves 2–6 sessions or contacts with network members, such as parents, carers, and school staff. ● **Sustainability phase -** one session, minimum of 30 minutes.
Tailoring	The programme is flexible in how it is delivered based on the needs and availability of the young person and key network members, both in terms of the

	practical elements of the mode of delivery and the content of the intervention using a trauma-informed and race-equity lens. **Cultural responsiveness** Adaptations include open dialogue about race and culture, ensuring the therapy fits the young person's specific identity and experiences. **Contextualised formulation** Instead of a one-size-fits-all approach to conduct issues, the practitioner tailors the intervention to address the specific environmental stressors affecting the young person. **Systemic flexibility** The level of engagement with parents or school staff is adjusted based on the specific network available to the young person. Each teacher would typically be expected to support 1 -3 young people during the intervention. This is not a fixed limit, but a flexible guideline informed by the school's capacity and staff roles. Some teachers may only be involved with one young person, while others, especially those in pastoral or SENCO roles, may work with several. MindWorks builds around staff's existing relationships with the young people.
How well (planned)	Fidelity is defined as the "minimum level of activities/input that need to occur for a young person to be considered to have received MindWorks". The Fidelity framework has the following specific markers: ● Practitioners must complete all 10 days of MindWorks training, the pre-training race equity workshop and receive at least 90 minutes of weekly small-group supervision. ● The start-up phase requires a minimum of one 30-minute session involving structured assessment, goal setting, and identification of trusted adults. ● The active intervention phase requires a minimum of four 30-minute sessions covering at least three of the six core CBT-informed topics (e.g., problem-solving, social skills) and a minimum of two 30-minute sessions with at least one member of the young person's network to co-generate alternative responses to behaviour. ● The sustainability phase requires a final 30-minute session to review goals and create a written action plan shared with the network. Other strategies to improve and maintain fidelity include: ● Data collected via practitioner logs, supervisor checklists, and administrative programme data to calculate the proportion of participants who meet the minimum fidelity standards.

	● Interviews and focus groups with practitioners, school staff, and the school relationship manager to identify barriers and facilitators to adherence. This includes exploring how school context (e.g., buy-in, culture) or systemic factors (e.g., discrimination, neurodiversity) impact delivery. ● Quality is also maintained through a robust clinical and REDI (Race, Equity, Diversity, and Inclusion) framework including training that combines workshops and case-based practice to ensure cultural humility remains a constant standard and weekly supervision for practitioners by senior staff with an explicit focus on bias awareness and self-reflection.

Mechanisms and outcomes

The Theory of Change developed for the MindWorks programme is shown below in Figure 1. This details the activities, outcomes and mechanisms for the programme.

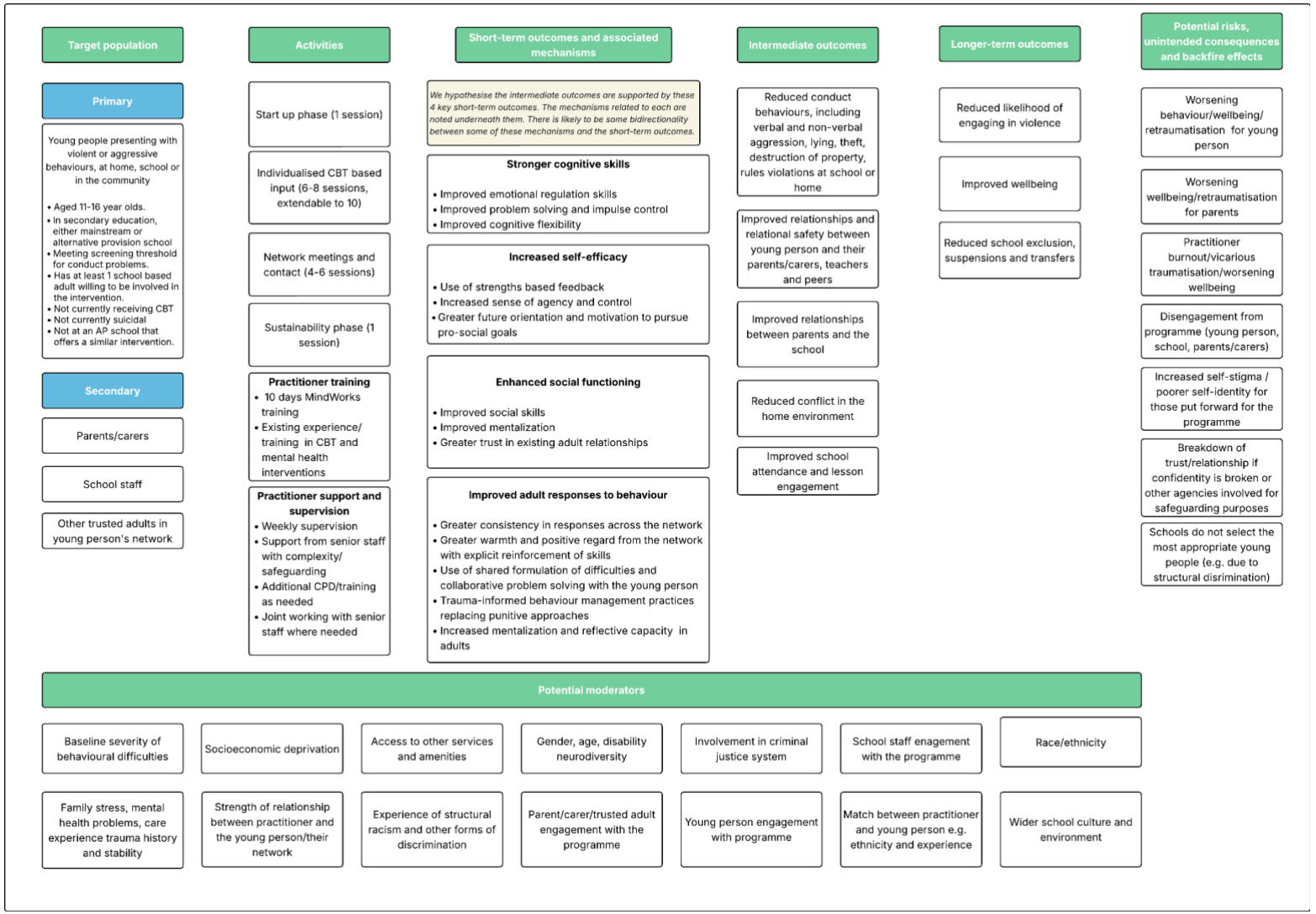


Figure 1. MindWorks Theory of Change (please follow link for high quality version)

Short-term outcomes and associated mechanisms

Via the co-design work, we have identified four key short-term outcomes, each driven by a set of mechanisms. These are outcomes we would expect to change during the programme delivery window, over the course of one school term. There is likely to be some bidirectionality between some of these mechanisms and the short-term outcomes.

Education systems traditionally rely on a "manage-and-discipline" model that disproportionately disadvantages students with disabilities or mental health difficulties, as many students experience emotional regulation difficulties that manifest externally as disruptive or aggressive behavior[25]. MindWorks addresses this by offering evidence-based CBT practices, such as cognitive restructuring and social skills training. These activities have a robust evidence base for enhancing cognitive skills including emotional regulation skills ***(secondary outcome)*** in young people by improving emotional regulation strategies, problem-solving ability, impulse control, and cognitive flexibility[26]. MindWorks also has a key focus on improving the mentalization capacity of young people, considered to be a key mechanism of change for the intervention. This focus, along with a focus on social skills training and developing a trusted adult relationship with the practitioner is hypothesised to enhance the young person's social functioning ***(exploratory outcome).***

When teachers perceive behavioural difficulties as within-child deficits rather than by-products of poorly met needs or social stressors, students can be left with a diminished sense of control[27]. MindWorks addresses this by utilising strengths-based feedback to foster an increased sense of agency and a greater future orientation. These mechanisms are hypothesised to lead to increased self-efficacy and a higher motivation to pursue pro-social goals.

Crucially, when support structures fail to bridge the gap between individual needs and systemic change, relationships between the student, family, and school often break down. MindWorks addresses this through a systemic and relational approach that validates the young person's context. By working with the wider network to increase mentalisation and reflective capacity in adults, the intervention aims to replace punitive approaches with trauma-informed behaviour management and shared formulation. These mechanisms are

[25] Armstrong, D. (2018). Addressing the wicked problem of behaviour in schools. International Journal of Inclusive Education, 22(9), 997-1013. https://doi.org/10.1080/13603116.2017.1413732

[26] Kendall, P. C. (Ed.). (2011). Child and Adolescent Therapy: Cognitive-Behavioral Procedures (4th ed.). Guilford Press.

[27] Blakey, R., Morgan, C., Gayer-Anderson, C., Davis, S., Beards, S., Harding, S., Pinfold, V., Bhui, K., Knowles, G., & Viding, E. (2021). Prevalence of conduct problems and social risk factors in ethnically diverse inner-city schools. BMC Public Health, 21(1), 849. https://doi.org/10.1186/s12889-021-10834-5)

assumed to lead to improved adult response, marked by greater warmth and consistency and enhanced social functioning.

Intermediate outcomes

Our intermediate outcomes are those which are hypothesised to change over the course of the MindWorks programme, and increase in magnitude across the follow-up period.

MindWorks hypothesises that the work with the young person to develop cognitive skills and social functioning will lead to an intermediate reduction in primary conduct behaviors ***(primary outcome)***, including verbal and non-verbal aggression, lying, theft, and rule violations at school or home, by equipping young people with alternative strategies to manage their emotions. This is also hypothesised to help reduce conflict at home and improve school attendance ***(secondary outcome)*** as the young person is better equipped to manage these challenges across environments. These intermediate outcomes are also supported via the improved adult responses to behaviour, enabling adults to better support the young person and respond consistently and appropriately to their needs. Together, the short-term changes for both the young person and their network help improve relationships and relational safety between the young person and their parents/carers, teachers and peers ***(secondary outcome)***. The intervention focuses on increasing self-efficacy using strengths-based feedback and increasing agency and control also ensures the young person achieves their personal identified programme goals.

Longer-term outcomes

Longer-term outcomes are those that we might expect to change due to changes in the intermediate outcomes, but are unlikely to be seen during the term-length intervention period itself. Improved behaviour at school, combined with the network's improved response to behaviour is hypothesised to reduce the risk of exclusion, suspension and transfers ***(secondary outcome).*** These are also hypothesised to support the young person's wellbeing as they feel more supported and better able to manage at school and at home, reducing the experience of emotional difficulties ***(exploratory outcome)***. In the long-term, these improvements in individual capabilities, relationships and school experience are hypothesised to reduce the risk factors for involvement in violence. This will be investigated using longer-term follow up using YEF's data archive.

Moderators and potential backfire effects

The successful operation of this model is subject to assumptions and external factors. Potential moderators influencing effectiveness include the following:

1. Gender
2. Race/ethnicity
3. School type (mainstream vs. alternative provision)
4. Socioeconomic deprivation
5. Age
6. Baseline severity of behavioural difficulties
7. Disability/neurodiversity
8. Care experience
9. Prior involvement in the criminal justice system.
10. Family stress, mental health problems, trauma history and stability
11. Experience of structural racism and other forms of discrimination
12. Parent/carer, school staff, young person engagement with the programme
13. Match between practitioner and young person e.g. ethnicity and experience
14. Wider school culture and environment.

We are collecting quantitative data on items 1-9. We will use gender, ethnicity, and school type for subgroup analyses. These three were selected as the primary subgroups for quantitative analysis as they are expected to be the most important moderators and due to greater confidence in data quality and subgroup sizes for these variables (more details in the Data Analysis section). We will include ethnicity, school type and school location as covariates in the analysis. We will also compare all quantitative data, where possible, to national datasets to understand to what extent the MindWorks population is reflective of the wider youth justice population and if certain demographics of young people are more or less likely to enter the programme. We will explore the impacts of items 10-14 qualitatively as part of the IPE. We recognise that any psychological intervention has the potential for backfire effects and unintended outcomes, particularly one working with a vulnerable population. Key potential backfire effects that we have identified for the programme are the following:

- Practitioner burnout/vicarious traumatisation/worsening wellbeing
- Disengagement from programme (young person, school, parents/carers)
- Schools do not select the most appropriate young people (e.g. due to structural discrimination).
- Worsening behaviour/wellbeing/retraumatisation for young person
- Worsening wellbeing/retraumatisation for parents
- Increased self-stigma/poorer self-identity for those put forward for the programme
- Breakdown of trust/relationship if confidentiality is broken or other agencies involved for safeguarding purposes.

We will use a combination of demographic data, programme engagement data, formal measures, practitioner surveys and qualitative data from IPE interviews to explore the impact

of these moderators on the experience and outcomes of the MindWorks programme and the existence and impact of any backfire effects.

Participatory practice

MindWorks positions participatory practice, particularly involving young people and communities with lived experience of adversity, discrimination, and exclusion, as central to its design and delivery ethos. Obtaining input at the earliest stages of the evaluation will enable those from marginalised backgrounds to actively shape the research design, ensuring that key elements are equitable and resonate with the experiences of the target demographic. During the co-design phases, Anna Freud Young Champions and Parent and Carer Champions were consulted to discuss trial design issues, shape the content and focus of co-design workshops and provide input on evaluation design, including randomisation acceptability, the control arm offer and survey design. This enabled us to refine our approach based on direct feedback. Going forward, Anna Freud will convene two advisory groups, whereby the members of the group reflect the target population:

- Anna Freud's Parent and Carer Champions will form the Parent Advisory Group (PAG). This group is formed of parents and carers who care for young people with experience with mental health problems. They will provide parental perspectives on key aspects of the programme and evaluation, such as developing materials and engagement.
- A Youth Advisory Group (YAG) of young people (11-16 year-olds) from a network of pupil referral units (PRUs), who will provide specific, developmental-stage appropriate input on participant materials and engagement.

Participation at Anna Freud is underpinned by the rights-based model developed by Professor Lundy, based on four key concepts: space, voice, audience and influence. Through the model, and Anna Freud's dedicated Participation team, we will support the PAG and YAG to effectively engage throughout the trial.

Additionally, we will work closely with a small group of 1–3 members from the YEF Youth Advisory Board (YAB) which consists of young people (16–25 years old) from across England and Wales, leveraging their collective expertise on youth violence and systemic inequity. YEF will retain all safeguarding responsibilities and provide staff support for YAB members, as part of their existing support structures. Our team, supported by Dr Jessica Davies as a consultant, will provide the necessary additional scaffolding to help YAB members move from passive consultants to proactive and meaningful contributors.

The research team will provide choice and autonomy to the YAB, allowing their participation to be shaped by the young people themselves. Examples of the type of peer research they could be involved in include supporting the design and facilitation of a YAG workshop,

ensuring youth-facing materials are trauma-informed and culturally sensitive, and feeding into analysis and interpretation.

We aim to build a foundation of trust, belief, and mutual respect when working alongside experts by experience, enabling the development of psychological safety, which is essential for discussing sensitive topics and capacity building, where members progress from novice contributors to informed partners capable of critiquing more complex elements of the research. This involves providing options for members to be involved from the start to the end or offering rolling participation, recognising that members may be managing challenges that impact their physical or psychological capacity to engage. Recognising their existing commitments to school or work, we will offer flexible sessions and work within their existing 'monthly menu' of opportunities, typically requiring one hour of engagement per month. To further ensure involvement remains meaningful and respects autonomy, we will provide a 'menu' of different ways to participate that reflects their interests, skills and capacity. This allows members to 'dip in and out' based on their preference, preventing the experience feeling tokenistic.

Trial delivery

The pilot and efficacy trial will be delivered over six cohorts from September 2026 to July 2028, with delivery for each cohort lasting one academic term. For each cohort data collection will occur at the following points:

- Baseline data - collected pre-randomisation, after young people have been referred to the trial.
- Follow-up data - collected at the end of the term after MindWorks is delivered (approximately 3-4 months after the end of delivery)

Recruitment and delivery will occur over the following timeframe:

Pilot trial	April-June 2026	Recruitment of all year 1 schools (n= 12)
	September 2026	Delivery of cohort 1 (n= 2 intervention, n = 2 control)
	January 2027	Delivery of cohort 2 (n= 2 intervention, n = 2 control)
	April 2027	Delivery of cohort 3 (n= 2 intervention, n = 2 control)
Efficacy trial	Summer 2027	Recruitment of all year 2 schools (n= 18)

	September 2027	Delivery of cohort 4 (n= 3 intervention, n = 3 control)
	January 2028	Delivery of cohort 5 (n= 3 intervention, n = 3 control)
	April 2028	Delivery of cohort 6 (n= 3 intervention, n = 3 control)

At the start of each year of delivery, Anna Freud will recruit all schools needed for the trial in that academic year (12 in year one (academic year 26/27), 18 in year two (academic year 27/28)). Schools will then be randomised into three cohorts, for each of the three delivery terms. These cohorts will include a mix of geographical locations (to enable delivery from the Anna Freud team) and of mainstream and alternative provision schools.

Delivery locations will include London/Greater London, and potentially areas around the Southeast and Manchester. Our criteria for selecting areas include: school interest and engagement, diversity in pupil population, availability of Alternative Provision (AP) partners (e.g. Olive Academies), and areas with higher-than-average youth offending or school exclusion rates. If school response rates are more robust than anticipated, we may select areas based on school readiness and capacity to host the intervention. Regardless of the final locations chosen, we will ensure the sample reflects the diversity and complexity of the target population.

Set up for a cohort will begin the term prior to delivery (see school engagement and onboarding below). Schools within a cohort will be randomised into treatment or business as usual conditions after baseline data collection.

Business as usual will comprise the support normally available to young people with these challenges. This will include signposting to support services/programmes in the area of the school by the School Relationships Manager/Deputy Head of Service as part of the initial engagements with the school and providing parent/carer and child-facing information as part of the consent process.[28]

Schools in the control arm will have the option of receiving a financial incentive (of £500) or continuing professional development (CPD) training from Anna Freud on a topic of their choice, drawing from an extensive existing portfolio of training currently offered including: autism and well-being; supporting students managing anxiety; responding to students who self-harm; school attendance and student well-being; anti-racism and mental health in

[28] Business as usual signposting will be light touch, generic and standardised (e.g. to CAMHs and local charities), not individual referral conversations. Most schools will already be aware of these services. Business as usual activity will be captured as part of the implementation and process evaluation.

schools. Our offer will include two sets of CPD, one aimed at school staff and one aimed at parents. These will be delivered to incentivise participation in the evaluation and prevent dropout. We have chosen these incentives following feedback from our co-design work with mainstream school staff, alternative provision school staff and parents. All groups suggested that they would find CPD training to be the most valuable incentive for the control arm. CPD will be delivered after follow-up data is collected, in-person for school staff and online for parents. The evaluation and delivery team will run virtual events following the completion of the study for all participants (school staff, parents/carers, young people) to share the results and findings from the study.

Voucher incentives will be provided to all trial participants primarily to encourage survey completion. **Young people** will be offered a £10 voucher in recognition of the time taken completing the surveys (at baseline and follow-up) and £15 for participation in interviews. **Parents/carers** will be compensated with a £30 voucher for participation in interviews. These figures have been chosen to reflect the time taken (surveys will take approximately two thirds of the time of interviews, 30 minutes vs. 45 minutes). Parents are compensated more than young people due to their time being taken out of their own time versus the school day, and due to their age. These figures correspond to compensation levels that EYVL/BIT has used in previous trials.

All schools in the trial will also be offered an additional £500 incentive for supporting data collection activities. Payment of this will be linked to the following conditions:

1. **Schools facilitate one main day of data collection and one mop up day of data collection** (during which evaluation team members facilitate outcome data collection from young people, including the primary outcome).

2. **Teachers provide 80% of teacher outcome data collection** (including teacher student relationship scale, conduct behaviour, and attendance).

Delivery team staffing

In year 1 of the evaluation, Anna Freud's delivery workforce will comprise two teams, each containing 3 Wellbeing Practitioners and 1 Senior Practitioner, supported by an administrator (working across both teams). These teams will be led by 1 Deputy Head of Service and 1 Head of Service, who, in-turn will be overseen by two part-time Co-Directors (all based at Anna Freud). As part of our phased approach, considering necessary and realistic recruitment timelines, the Deputy will be recruited after the first term of delivery.

A Project Manager (funded in-kind) will help co-ordinate delivery activities. Part-time training leads (Anna Freud) will oversee staff training. A Schools Relationship Manager (UCL) will lead

school recruitment and engagement.

If the trial progresses to year 2, an additional team (3 wellbeing practitioners and 1 senior practitioner) will be recruited to deliver in the additional schools.

Please see the developer and delivery team staffing table for detailed information on delivery team roles and responsibilities.

Participant journey

Figure 2 below shows the participant journey for the MindWorks trial.

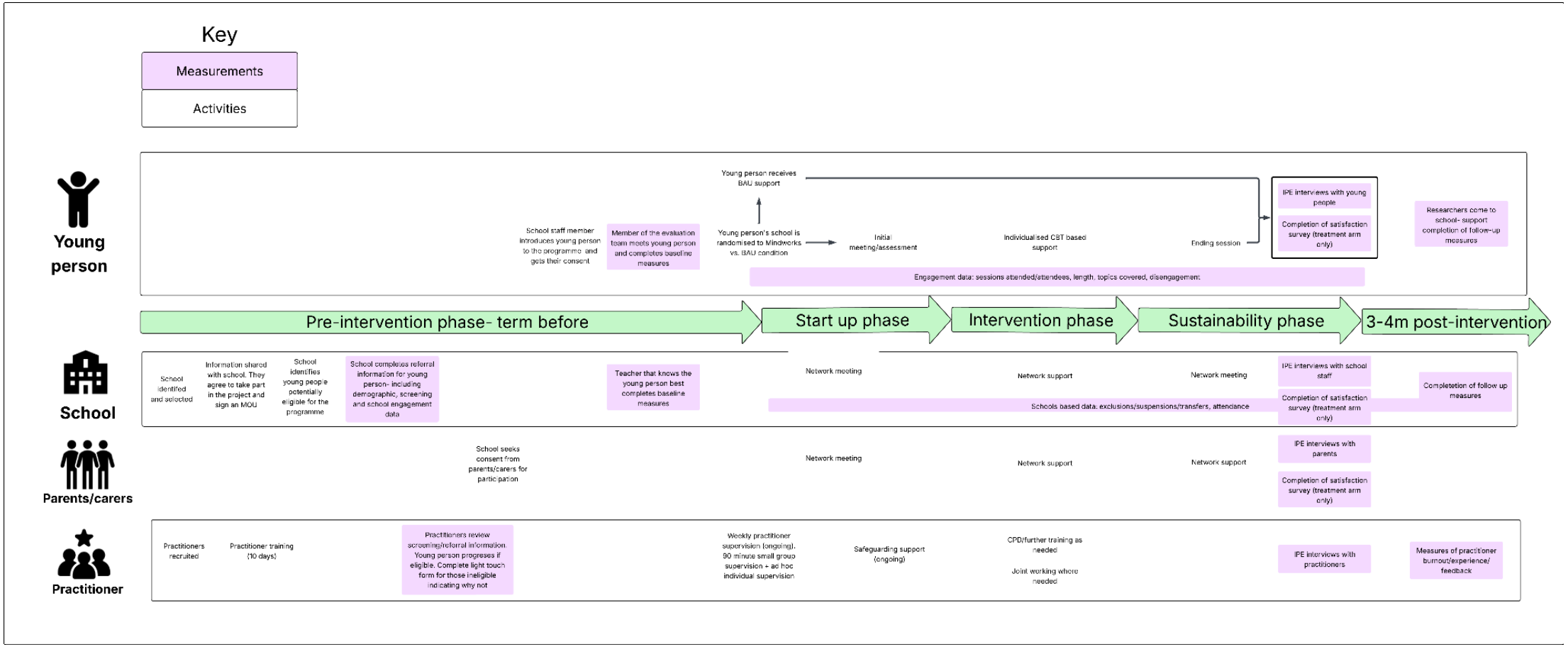


Figure 2. Participant journey for the MindWorks programme [(please follow this link for a high quality version)]

School engagement and onboarding

We are confident in our ability to recruit to target, and have a track record of achieving this. For example, Anna Freud led the Education for Wellbeing Programme, a large-scale research programme, funded by the Department for Education, involving two randomised control trials, testing mental health interventions across more than 500 primary and secondary schools coordinating baseline and follow-up data collection for more than 30,000 children and young people. BIT (the organisation in which EYVL sits) has a deep expertise in educational research and has delivered over 300 school based trials. In one recent schools based trial (One Step Ahead, funded by the EEF), we achieved an 83.8% data completion rate on a trial of 3700+ pupils which involved a high burden for teachers (30 minutes of data completion per pupil, 6 pupils per teacher). We comment further below on the strategies we will utilise in this trial that we have successfully used in previous trials to optimise school engagement and teacher data completion.

EYVL will supplement the existing expertise within the core evaluation team with expert input from Lal Chadeesingh, BIT's Head of Education Policy. Lal has 9+ years of expertise applying behavioural insights to challenges in education, and has led 20+ education projects, for organisations including YEF, the Department for Education, Ofsted, the Education Endowment Foundation, and the Department for Culture, Media, and Sport. Lal brings deep expertise in optimising data collection and evaluation in school settings for RCTs, including recent projects such as Tips by Text (143 schools), BITUP (115 schools), Grassroots (115 schools), Diagnostic Questions (160 schools) and Teacher Wellbeing (120 schools). Lal will support the development of teacher-facing materials, such as information sheets and training, ensuring that these are designed to be understandable, compelling and persuasive to encourage teachers to take part in research activities.

For MindWorks, we will recruit schools in two batches: prior to year 1 and prior to the year 2 of delivery. This phased approach reflects the project team's extensive experience recruiting schools for intervention and evaluation studies and balances the need for sufficient notice and planning with the risk of disengagement if the lead in period is too long. Recruitment will draw on a combination of established relationships and structured outreach. Through a recent research project, we have active research links with ten Alternative Provision schools, several of which operate across multiple sites and serve relatively large cohorts. These include Chiltern Way Academy, with capacity for 176 pupils at one of its three sites, Unit Education Trust Pathfinder, with 333 pupils on roll across three sites, and the Academy of Central Bedfordshire, with capacity for 140 pupils. Many of these schools have already expressed interest in continuing to collaborate with Anna Freud on future research and provide a strong initial pool for recruitment. Anna Freud also has an excellent working relationship with Olive Academies who have six AP schools across London, Kent and East of England.

To recruit additional AP schools, we will use well-established and tested methods that have been effective across multiple prior projects. This will include maintaining and reviewing a comprehensive database of AP schools in and around London and neighbouring regions, systematically rating schools against eligibility and feasibility criteria such as cohort size, staffing capacity and prior research engagement. The SRM will then approach senior school contacts, typically heads of site, SENCOs or pastoral leads, through targeted emails and follow up calls to arrange an initial meeting. These meetings will be used to clearly present the programme and evaluation, answer questions, and assess mutual fit before schools formally commit. In addition, we will leverage Anna Freud's Schools in Mind network (over 38,000 members), their UK-wide Education Panel of 30 education leaders and teachers across varied settings, and warm contacts from their research and direct work in schools

Our co-design work suggests that not all mainstream schools will have the required number of eligible students, particularly those with smaller student bodies. During the recruitment phase, Anna Freud will focus on schools that report they have at least 25 young people on their roll who would meet the eligibility criteria. See Participants section for further information.

Once a school agrees in principle, we will develop an individualised Memorandum of Understanding that sets out expectations, timelines, data requirements and staff involvement in clear and practical terms. Prior to delivery, we will also offer in person school visits both by the Head or Deputy Head of Service and School Trial Manger, to introduce the team, present the project to relevant staff, and explain both the responsibilities and the anticipated benefits for pupils and the wider school community. This early face-to-face engagement has consistently proven critical in building trust and securing buy-in in AP and mainstream contexts.

Maintaining engagement once schools are recruited will be treated as a core delivery function rather than an administrative task. The SRM will be schools' primary point of contact, mobilising schools during the term prior to delivery to support referrals, before moving to consent and baseline data collection. The Head and Deputy Head of Service will support this, building relationships prior to intervention delivery. The project team will provide clear and timely communication about expectations, deadlines and upcoming activity, so that schools can plan staff time effectively. EYVL and Anna Freud will work extremely closely together throughout the onboarding, engagement and data collection period. This will ensure an aligned participant journey and touchpoints so that participants receive input and information at the optimal time. See the participant journey section for more detail.

To optimise engagement from schools in the evaluation we will:

- Deliver training and onboarding sessions for school staff in the term prior to delivery, led by Anna Freud and EYVL, to introduce the programme and trial,

explain referral pathways and eligibility criteria, clarify the process, and address questions to build confidence and buy in.

- Following training, schools will have access to a website which will contain a recording of the webinar, information sheets, FAQs and any other relevant trial information, kept up to date by the SRM and evaluation team.
- Maintain half-termly contact with schools taking part in subsequent terms to ensure that relationships are kept 'warm' and that pre-planning logistics are completed in advance (where possible).
- Ensure that there is an in-person school visit from a senior member of the delivery team prior to programme delivery to support engagement, reinforce expectations, and address practical questions with staff.
- Establish two named key contacts in each school (as insurance against illness / staff departure), typically a behaviour lead or pastoral staff member, to act as the liaison between school staff and the delivery and evaluation teams. We will also engage the headteacher at each school with the trial, as they will be key in ensuring school buy-in and continuation of engagement across the trial period.
- Communicate clearly and consistently about the potential benefits of participation for pupils and schools, and share final results and learning with schools, parents and carers once available.
- Apply Behavioural Insights (BI) principles to all communications utilising BIT's in-house expertise to ensure that communication is optimised, friction is reduced and the call to action is clear.
- Provide advance notice of all requests on school staff time, including data collection and survey completion, to support planning and minimise burden.
- Develop individual timetables for each school to ensure that the project aligns well with individual school calendars (avoiding half terms, exams, placement days etc) and confirm this with key contacts prior to their participation.
- Integrate administrative data sharing with existing systems of data collection where possible to reduce duplication of workload.
- Ensure that surveys are brief, clear and accessible on school systems. Work with teachers in each school to trial the surveys, to ensure that they are working as expected prior to data collection.
- Provide thoughtful and clear communication about the trial to school staff and in the information shared with parents and young people, to ensure that the expectations and aims are clear, both from an evaluation and programme perspective. Particular care will be given to ensuring understanding of the randomisation element, the data collection requirements and the programme aims and delivery model.
- Deliver a webinar at the end of the evaluation where we will share the

outcomes and learning from the trial. All schools in the trial will be invited to take part and to invite the parents and young people who took part in the trial to join.

- Use additional incentives to encourage school engagement and data completion (see trial delivery section for more details).

To optimise engagement and data collection from particular teachers we will do the following:

- Early identification of trusted adults with whom the young person already has an established relationship.
- Maintaining regular communication with adult participants throughout the intervention to support their engagement.
- Using brief, low-burden tools and clearly explaining their relevance.
- For intervention delivery, in the case of staff changes or school moves, practitioners will reach out to identify a new trusted adult and continue the work with minimal disruption. Tracking of adult participants will be embedded into delivery and monitored throughout the trial. Practitioners will record all adult contacts and engagements in a structured format, and this will be reviewed in supervision.
- The SRM will maintain a list of CYP and corresponding school staff identified to complete surveys at each school. They will contact schools every half term to keep in touch and identify pupils and school staff who have moved. They will work with their contacts in the school to identify an appropriate new school staff member to complete the endline data collection in the case of transitions. With support from the school contacts, they will reach out to the new school staff member proactively to provide information about the data collection requirements and respond to any questions.
- The evaluation team will use the data collection sessions within the schools as an opportunity to support and encourage data collection from school staff. They will follow up on non-returns of surveys with the SRM and school staff, supporting re-engagement as needed.

Consent process

Schools will identify young people that they think might be relevant for the programme based on their perceived need. They will discuss any students that they are unsure about with the SRM. Schools will identify a link teacher for each student (someone who knows the young person well and is willing to complete survey data and be involved in network sessions if the school is in the MindWorks arm).

The school will then have a conversation with and share an information sheet with the young person and their parent/carer. Where possible, these conversations should occur within the context of existing conversations and channels of communication between the school and parents/carers about the young person's support needs. Information sheets will be written in clear, understandable language and a video information sheet will be provided alongside Translated materials will be offered for parents/carers who have limited English.

The language used to describe the programme will be reviewed by our PAG and YAB to ensure it is both clear, understandable and accurate without being stigmatising. The information sheet will contain contact details for the trial team and parents/young people will be invited to contact the team with questions or concerns about the programme/evaluation. It will also include information about data being stored within the YEF archive for later linkage to routine datasets. We anticipate that there may be some concerns with this and will draw on previous YEF trials to communicate this in a clear way to both groups.

School staff will be given training from the delivery and evaluation team on how to present the programme and trial to students and parents when sharing the information sheets. This will include a focus on the following:

- Identifying the benefits of the programme/trial to young people and parents
- Ensuring the programme is presented in a way that is clear, jargon free and non-judgmental and does not place the blame for the behaviour on the child or their parent/carers
- Integrating the trial invitation into existing pathways of communication if possible such as regular pastoral meetings in school
- Ensuring that the expectations of the trial are clear - both in terms of the evaluation (randomisation, chance of being in the control arm, data collection expectations) and the programme (young person/network involvement, focus of the intervention, length and intensity)

Parents/carers will not be required to provide opt-in consent for their child to take part in the intervention, but will be able to opt their child out of participating. Parents will be given at least 2 weeks to opt out (we will offer as long a window as possible, given constraints on the wider recruitment timeframe). It is our previous experience that when parents opt their children out of a programme this tends to happen within the first few days of the information being shared.

The school will follow-up one week after the initial contact with a reminder to parents. Wherever possible, this will be via a different communication channel to that used originally (e.g. text, phone call or physical letter) to maximise the chance that parents will engage with the information fully. The school will internally record the contact attempts and communication channels used. Fully anonymised data on this will be shared with the trial

team to evaluate the proportion of young people/parents declining to take part and ensuring records are kept of the information being shared with parents. The school will provide written consent for the young person to participate in the programme in loco parentis.

We have chosen an opt-out rather than opt-in consent approach for parents for a number of reasons. Previous consultations with a network of AP schools advocated use of an opt out procedure when recruiting participants for our sample of adolescents with conduct problems on a previous intervention project. Feedback from this network of schools is that parental engagement can be challenging, even for regular school matters. The network stated that lack of parental engagement should not be interpreted as an objection to research and have further made a strong case for their students being interested in being involved and student participation naturally only occurring on a voluntary basis. For this reason, the school has used an opt-out procedure when engaging with research studies in the past, including past projects with Anna Freud. Additionally, in a recent project, also involving young people with severe conduct problems, that offered schools the choice of either opt-in or opt-out parental consent, only 1 school of 20 chose opt in. This led to very low participation rates at this school, raising concerns about representativeness.

There is other evidence to suggest that an 'opt-in' parental consent approach can lead to a biased sample[29]. Studies have shown that pupils whose parents provide opt in consent were less likely to be a minority, to have behaviour problems at school or to be at risk for problem behaviour, and more likely to live in two-parent households, to have a relatively high grade average, and to be involved in extra-curricular activities (an indicator of higher household income).[30] Biased, non-representative samples would limit the generalisability and validity of the findings, undermining the value of the study and the ethical risk/benefit ratio. Furthermore, prohibiting young people without active parental consent from taking part in intervention research may lead to excluding the most vulnerable children from a potentially beneficial intervention, which is also an ethical concern. Active assent from young people will be sought and no research will proceed without it.

[29] Anderman, C., Cheadle, A., Curry, S., Diehr, P., Shultz, L., & Wagner, E. (1995). Selection bias related to parental consent in school-based survey research. Evaluation Review, 19(6), 663-674; Courser, M. W., Shamblen, S. R., Lavrakas, P. J., Collins, D., & Ditterline, P. (2009). The impact of active consent procedures on nonresponse and nonresponse error in youth survey data: Evidence from a new experiment. Evaluation Review, 33(4), 370-395; Junghans, C., Feder, G., Hemingway, H., Timmis, A., & Jones, M. (2005). Recruiting patients to medical research: double blind randomised trial of "opt-in" versus "opt-out" strategies. Bmj, 331(7522), 940; Junghans, C., & Jones, M. (2007). Consent bias in research: how to avoid it. Heart, 93(9), 1024.

[30] Anderman, C., Cheadle, A., Curry, S., Diehr, P., Shultz, L., & Wagner, E. (1995). Selection bias related to parental consent in school-based survey research. Evaluation Review, 19(6), 663-674; Tigges, B. B. (2003). Parental consent and adolescent risk behavior research. Journal of Nursing Scholarship, 35(3), 283-289.

Referral of young people to the programme

After receiving verbal assent from young people and having provided opportunity for parental opt-out, schools will then refer young people to the programme by completing a light-touch referral form that will be shared with the MindWorks delivery team (likely via a shared, secure excel sheet). This will include the Strengths and Difficulties questionnaire (used as a screening tool to identify eligible young people- see methods section for further detail) as well as demographic details (gender, age, ethnicity, FSM status, involvement with children's services, learning needs, previous involvement with the criminal justice system). The delivery team will review the referral forms and ensure that young people are eligible for the trial, speaking to school staff where needed. Referral data will be shared with the evaluation team to review referral criteria and map participant flow through the trial, including whether young people of certain characteristics are more or less likely to be referred, accepted and enter the trial.

Young person assent

At the point of baseline survey completion, a researcher will re-explain the key information from the information sheet to the young person, answer any questions and collect their written assent to take part in the trial. School staff will also be provided with an information sheet and an opportunity to ask questions to the delivery and evaluation team. Written consent will be collected from school staff at the point of baseline survey data collection.

Network engagement in the programme

Young people do not need to have both a parent/carer and a school staff member engaged for eligibility. While both are of course preferred, the presence of at least one trusted adult, typically a school staff member, is sufficient for inclusion. Our rationale is based on two key considerations:

The nature and quality of adult relationships is more important than the number of adults involved. In the delivery team's experience, a meaningful, engaged connection with one adult (whether a parent or school staff) can create the foundation for impactful work.

Mandating parent/carer involvement risks creating a binary framing, i.e., full participation or exclusion, which does not reflect the fluid and relational nature of engagement. Some parents may initially appear ambivalent, but may become more involved over time through trust-building efforts.

Practitioners are trained to engage parents/carers sensitively and persistently, acknowledging potential disillusionment with previous services and creating space for them to shape the intervention. Even if regular sessions with carers are not possible, practitioners will maintain contact around key issues (e.g. safeguarding, progress updates) and will continue to seek opportunities for deeper involvement. The invitation to participate remains open throughout,

and practitioner supervision will include reflection on barriers and strategies to promote parent/carer engagement.

Importantly, our approach aligns with the core ethos of MindWorks, which seeks to avoid individualising difficulties and instead works systemically. Therefore, while not mandatory, carer engagement is actively pursued and valued throughout the intervention process.

We acknowledge that delivery and outcomes may differ depending on the level of adult involvement. This variation is expected and will be tracked through the evaluation. Differential levels of parent and staff engagement will be explored at the analysis stage (through both qualitative and quantitative data) to better understand their potential influence on outcomes and to inform future development of the programme.

Managing school transitions

Once a young person has assented, the delivery team will take an active and structured approach to maintaining engagement throughout the trial period, recognising the heightened risks of disengagement, mobility between settings and disrupted attendance, particularly within AP settings. Practitioners will prioritise early relationship-building and continuity, using the initial phase of contact to establish trust, clarify expectations and agree flexible ways of working that reflect each young person's needs and preferences. Sessions will be adapted in length and structure, with planned breaks where needed, and practical supports such as refreshments provided where permitted, to reduce barriers to sustained participation.

Anna Freud have extensive experience of potential moves across schools in AP settings and have found that this varies considerably. In many cases the potential move is already known or predicted, and we would avoid recruiting such young people where possible. In cases where a young person moves between sites within the same Trust or local area, continuity of practitioner involvement will be maintained wherever possible. If a placement change occurs during delivery or follow up, the team will make proactive efforts to maintain contact with the young person and coordinate with the receiving setting to support continued participation and data collection, subject to consent and safeguarding procedures.

Our first step will be to make direct contact with the new setting, whether mainstream or AP, introduce the intervention, and establish whether delivery can be meaningfully continued. In most cases, practitioners will maintain contact with the young person and offer continuity through transitional sessions, either in person or remotely, depending on location and capacity.

Where a new trusted adult is needed to support the young person in the new setting, the practitioner will work with both the young person and staff to identify a suitable figure and introduce the approach in a way that facilitates buy-in. This will clearly vary on a case-by-case

basis. Recognising that new staff may have limited history with the young person, the practitioner will support this relationship-building process and provide relevant background to help ground the work and help build motivation. As in all aspects of this work, building a relationship, trust, and developing shared goals is key.

Regarding data collection, the SRM will contact schools every half term to keep in touch and identify pupils who have moved. During onboarding we will set expectations for support from schools when a student moves school. Schools will be asked to inform the SRM, identify a contact in the new school and provide an introduction between this school staff member and the SRM. We will work with this school staff member to identify the most appropriate person to complete the endline survey for the young person. At this point we will provide the individual with information about the study and highlight the data collection requested. We will monitor response from these school staff and if necessary offer incentives either during data collection or in future cohorts of data collection to support response rates.

Engagement will also be supported through consistent scheduling, advance notice of sessions, and a collaborative approach that gives young people a sense of agency over pacing and content within the intervention framework. This combination of relational continuity, flexibility and proactive coordination is designed to maximise retention over the course of the trial and support follow up data collection, even in the context of the instability that characterises many AP placements. Our extensive experience working with AP populations, and low attrition rates from a recent project which included young people at AP schools, demonstrates that these approaches are effective in meeting the challenges of delivery in these settings.

Language used to introduce the programme

We recognise that there is a delicate balance to be found in the language used to introduce the programme to school staff, young people and parents. The description of the programme needs to be clear enough to accurately identify those who are most in need of the intervention and to prioritise between potential young people who might be referred. Additionally, the reasons for referral and programme goals need to be clearly explained to young people and parents such that the data collection questions and long-term data linkage to police data do not come as a surprise or cause confusion to participants. However, we are very conscious that using stigmatising language and locating the problem in the child may lead to reduced engagement in MindWorks and risk backfire effects such as worsened wellbeing or increased stigma. As such we propose the following language is used when describing the programme. We have developed this language in conjunction with Anna Freud staff and our race equity experts, as well as via co-design work with young people and parents.

School staff

The programme is designed to support young people who are experiencing difficulties with emotional regulation and behaviour, particularly in the context of their relationships with others. This might include:

- Getting into verbal or physical conflict with family members, friends or school staff

- Breaking things

- Challenges with following rules

These difficulties should be having a significant impact on their life, and the young person should be at risk of school exclusion in the next academic year due to these difficulties (for those in mainstream schools). The programme would involve someone from Anna Freud working with the young person, their family and school staff in school for one term. They would work directly with the young person and with the adults around them to support the young person with these difficulties and to help the young person achieve goals that are important to them.

Please see the case examples below for examples of the type of young person who would be the target for this programme.

Example 1

Jason is in year 10 at school. Jason has strong social skills and a good sense of humour, however these strengths are often not noticed due to the other behaviour that he exhibits. He often gets into physical altercations with other students, over issues such as being bumped into or perceived insults due to finding it difficult to regulate his emotions. He has been suspended once this year for fighting. School staff are aware that things are difficult at home, as Jason's mum is struggling with finances and a difficult relationship and there has been historical social services involvement. Jason often talks about how he and his mum argue a lot, and he doesn't like to be at home.

Jason's difficulties are causing increasing tensions with school staff, who are finding his behaviour very difficult to manage. Jason, in turn, feels like the school staff aren't treating him with respect, and that his previous attempts at asking for help from staff haven't been listened to. His head of year is increasingly saying that she thinks Jason should be excluded from the school.

Example 2

Kathryn is in year 9. She attends an Alternative Provision school having been excluded from her mainstream school last term. Kathryn is very strong academically and shows excellent imagination and creativity in her work assignments. However, most days she becomes upset around social situations with other girls in the class, particularly when she feels left out or that others have been mean to her. This results in her yelling, being insulting and occasionally slapping others or pulling their hair. Kathryn was expelled from her mainstream school due to these social difficulties, as well

as multiple incidents of stealing the possessions of other students. When teachers speak to her about her behaviour, Kathryn struggles to be truthful, and will often blame others or say things that aren't true to explain what happened. When school staff tell Kathryn off for lying, she becomes even more upset, and it feels like this makes the problem worse.

Kathryn's parents are wondering whether Kathryn might have autism and are seeking an assessment for this. School staff however struggle to get in contact with Kathryn's parents, their previous negative experiences with her mainstream school staff mean that they now avoid contact with school due to feeling 'told off' by staff.

Parents

'*The programme is designed to support young people who are experiencing difficulties managing their emotions and behaviour, particularly in the context of their relationships with others. This might include:*

- *Getting into verbal or physical conflict with family members, friends or school staff*
- *Breaking things*
- *Challenges with following rules*

These difficulties should be having a significant impact on their life and their engagement with school. The programme would involve someone from Anna Freud working with the young person, their family and school staff in school for one term. They would work directly with the young person and with the adults around them to support the young person with these difficulties and to help the young person achieve goals that are important to them.

Young people

'*This programme is for young people who are finding it difficult to manage their feelings at school and home, and are having troubles at school, for example, getting into fights or arguments with family, friends or school staff. The programme involves someone from Anna Freud working with you and the adults in your life. The aim is to help you to understand and let other people know how they can support you and your feelings. The aim is to help you achieve the goals that are important to you.'*

Research questions

Pilot trial

Deliverability

1. Can a sufficient number of schools be recruited to participate in the study?
2. Can a sufficient number of eligible young people (CYP) be recruited to participate in the study and does this vary by mainstream vs. alternative provision schools?
3. Are the referred young people representative of the wider youth justice population[31] in terms of key characteristics? (gender, ethnicity, learning needs, socioeconomic deprivation, social care involvement)
4. Do the recruited young people and their network remain engaged in the programme?
5. Are there any differences in engagement between young people of minoritised backgrounds (gender, ethnicity, learning needs and neurodiversity, socioeconomic deprivation, social care involvement) or from mainstream vs. alternative provision schools?
6. Is the MindWorks programme being delivered with fidelity? Including training and supervision, practitioner quality and delivery of minimum programme components.

Acceptability

7. Is the programme seen as acceptable by children and young people, practitioners, parents/carers, and schools[32]?
8. Are there aspects of the programme that can be improved upon without negatively impacting the core components?
9. Are there any identified backfire effects or unintended consequences of the programme?

Evaluability

10. Do the evaluators have confidence that an RCT will produce a robust and secure assessment of impact?
11. Is the randomisation procedure feasible and adhered to?
12. What proportion of recruited young people, teachers and parents/carers successfully complete baseline and endline data?

[31] We will compare the population that was referred to, and engaged with MindWorks with youth who received a non-custodial sentence or caution according to the ONS, 2022 dataset. This is to say: Gender: 69% male, Ethnicity: 20% non-White British, Free school meals: 50% in receipt of free school meals, Social care involvement: 22% child in need, 5% looked after child, SEN status: 7% with a SEN statement (SEN E status)

[32] We define acceptability using the Theoretical Framework of Acceptability which consists of seven component constructs: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. We will explore these via surveys and qualitative data collection

13. What factors influence the completion rates of these assessments, including school type?
14. What, if any, alternative services do the control group receive?
15. Is it possible to collect the necessary demographic data that would be required to assess whether outcomes vary by key characteristics?

The descriptive analysis collected during this stage aims to assess evidence of promise by looking at proximal outcomes or causal mechanisms, rather than relying on formal hypothesis testing, which is generally not recommended for pilot trials due to expected underpowering.

Efficacy trial

The efficacy trial is designed to estimate the MindWork programme's impact, understand for whom it works and why, and assess how well the programme is implemented at scale. It will measure effects on the key outcomes, examine whether these vary across different groups, and explore implementation quality, fidelity, and acceptability, including how these may differ across schools and young people with different socioeconomic backgrounds.

The list of research questions are:

Impact evaluation

Primary research question

1. Does the MindWorks programme reduce conduct behavior among young people[33] in participating schools at follow-up (4 months post-programme end) compared with business-as-usual practice?

Secondary research question

2. Does the MindWorks programme improve the following outcomes among young people at follow-up compared with business-as-usual practice?
    - Self-reported emotional and behavioural difficulties
    - Self-reported emotional regulation skills
    - Self-reported aggression
    - Relationships between teachers and young people
    - School exclusion, suspension and transfers
    - School attendance

Exploratory research questions

3. Does the MindWorks programme improve the following outcomes among young people at follow-up compared with business-as-usual practice?

[33] Eligible young people who assent to participate and complete baseline surveys

- Self-reported pro social behaviour
- Self-reported emotional difficulties
- Self-reported peer relationships

4. Do the following potential moderators interact with treatment (as measured by treatment × moderator interaction terms) to produce different programme impacts[34]
   - Gender
   - Race/ethnicity
   - School type (mainstream vs. alternative provision)

Implementation and process evaluation

Validating the Theory of Change

1. **Outcomes** - What were the main identified outcomes of MindWorks for young people, parents and school staff?
2. **Mechanisms** - What were the perceived mechanisms of impact through which the programme was thought to generate change?
3. **Backfire effects** - Are there any identified backfire effects or unintended consequences of the programme?

Acceptability[35]

4. **Acceptability** - Is the programme seen as acceptable by children and young people, practitioners, parents/carers, and schools[36]?
5. **Barriers and facilitators to acceptability** - Are there any barriers/facilitators of programme acceptability? Are these the same/similar to those expressed during the pilot trial?
6. **Variations in acceptability** - Are there variations in acceptability across young people from different backgrounds or school characteristics?
7. **Improvements** - Are there aspects of the programme that can be improved upon without negatively impacting the core components?

[34]We are likely to not be powered to detect these heterogeneities but still believe it is important to perform this empirical analysis to understand the full extent of the impact of the MindWorks programme.

[35] We define acceptability using the Theoretical Framework of Acceptability which consists of seven component constructs: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. We will explore these via surveys and qualitative data collection

[36] We define acceptability using the Theoretical Framework of Acceptability which consists of seven component constructs: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. We will explore these via surveys and qualitative data collection

Deliverability

8. **Dosage** - What was the dosage of the MindWorks intervention for those in the treatment arm?
9. **Engagement** - Do the recruited young people and their network remain engaged in the programme, why or why not?
10. **Systemic bias** - In what ways did systemic factors such as gender, ethnicity, experience of discrimination, learning needs and neurodiversity, and socioeconomic deprivation impact on referral, enrolment and engagement in the programme?
11. **Adherence (fidelity)** - Was the MindWorks programme delivered with fidelity? Including training and supervision, practitioner quality and delivery of minimum programme components.
12. **Barriers and facilitators to fidelity** - What were the barriers and facilitators for implementation and fidelity to the intervention, and how did these change over time?
13. **Adaptations** - What factors influenced adaptations to MindWorks delivery during the trial and how might this affect learning for the future?
14. **School context** - How did contextual factors (such as the school type, location, environment, buy-in and culture) act as barriers and facilitators to the implementation and impact of the programme?
15. **Practitioner experience** - What was the experience of recruitment, selection, training and supervision for the programme practitioners?

Evaluability

16. **Business as usual** - What interventions did schools already have in place? What, if any, alternative services do the control group receive?
17. **Programme differentiation** - How does MindWorks differ from schools' usual approaches to supporting young people exhibiting disruptive and aggressive behaviours?
18. **Scaling** - What is the recommended next stage for the evaluation if the intervention is found to be effective?

Pilot trial: Success criteria and/or targets

EYVL and Anna Freud have developed a series of progression criteria and RAG (Red, Amber, Green) ratings. We will use these throughout the project for two purposes:

1. To monitor if the project is proceeding as expected, allowing the delivery and evaluation teams to adjust the approach where needed

2. To make recommendations to the Youth Endowment Fund as to whether the trial should progress to an efficacy trial at the end of the pilot trial.

We will use the progression criteria to review core data as it becomes available during the pilot trial. The data relevant for progression for each of the two pilot cohorts can be broken into three different timepoints:

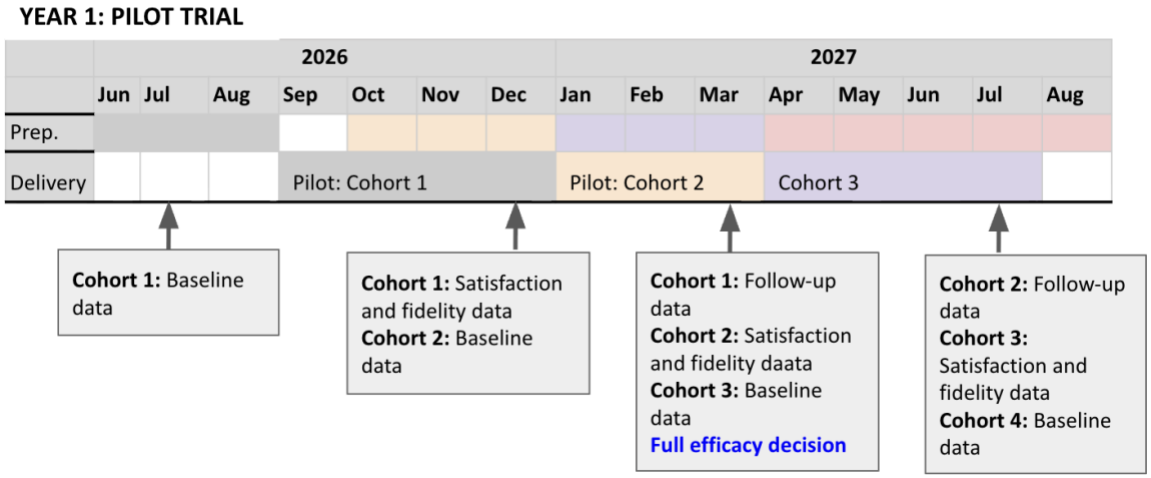
- Baseline data, including:
    - School recruitment
    - Referral and recruitment numbers
    - Proportion of young people eligible for the trial
    - Baseline data completion
    - Survey acceptability
    - Demographic data completion

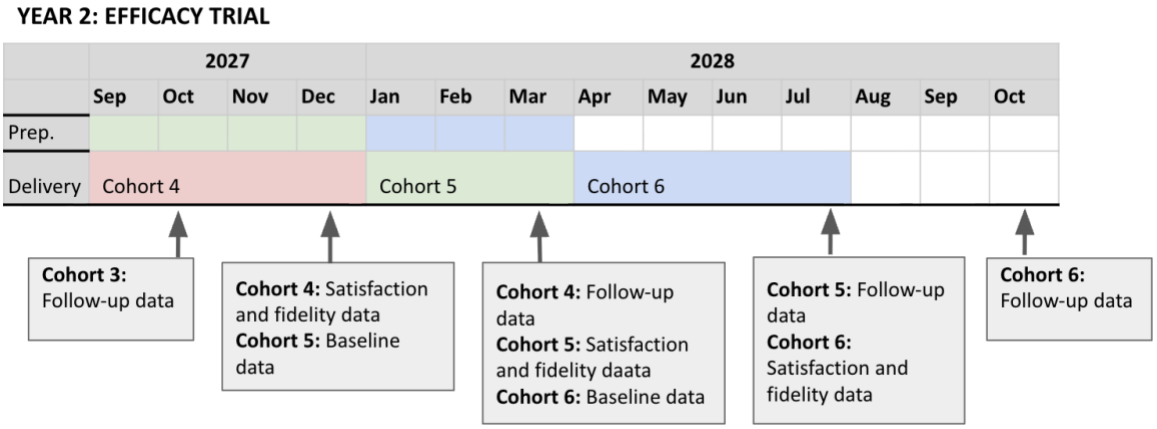
- Endline data, collected at the end of the delivery window including:
    - Retention and engagement data
    - Fidelity measures
    - Programme acceptability data via satisfaction surveys

- Follow-up data including:
    - Follow-up data completion

Figure 3 below shows the overall timeline and data collection points for the MindWorks trial:

Figure 3. MindWorks timeline and data collection points





A decision about whether to progress to the full efficacy trial will be made in April 2027. This will be made using baseline data from cohort 1-3, endline data from cohorts 1 and 2, and follow-up data from cohort 1. Given that baseline data collection and randomisation will have happened for cohort 3 at this point, even if a decision is made to **not proceed** with the full efficacy trial, delivery will still occur for cohort 3 to complete the pilot trial, however evaluation activities could be stopped at this point if YEF prefer to collect a reduced amount of data for the pilot evaluation.

We envision that:

- Criteria with Amber ratings will indicate reviewing or adjusting our approach to delivery/evaluation.
- Criteria with Red ratings will indicate that serious consideration is needed about what changes might be needed to justify moving the project to the full efficacy trial.
- If Red ratings are found for any of the continued monitoring criteria evaluation retention, enrolment, disengagement, substantive negative feedback and serious adverse events (see page 85) there would be a strong recommendation to stop.

The quantitative criteria used to monitor evaluability-related objectives are described in Table 1 below.

Table 1: Progression criteria

Research objective	Research question	Criterion	Description	Source	Timepoint	RAG scores
Deliverability	1	School recruitment	The number of schools that are recruited, consented and retained in terms 1 and 2 of the pilot trial (aim is 4 schools per term, 2 AP, 2 mainstream)		Baseline	Green: 7-8 Amber: 5-6 Red: less than 5
	2	Eligible referral volume	The number of eligible referrals received across all schools in terms 1-3 of the pilot trial as a proportion of total intended sample	School referral forms	Baseline	Green: 75-100%+ Amber: 50-74% Red: less than 50%
	2	Referrals by school	Number of schools in terms 1-3 of the pilot trial achieving at least 80% of their target number of eligible referrals (25)	School referral forms	Baseline	Green: 9-12 Amber: 6-8 Red: less than 6
	2	Enrolment in the programme	Proportion of eligible young people whose parents/carers provide assent and who consent to participate in the programme and provide baseline data	EYV Lab database	Baseline	Green: 75-100% Amber: 50-74% Red: less than 50%

	3	Referral of ethnic minority youth	The proportion of young people referred to the trial who are of an ethnic minority background.	School referral forms	Baseline	Green: 30%+ Amber: 20-30% Red: less than 20%
	4 & 5	Disengagement	Disengagement from the programme including differential attrition for ethnic minority participants	Proportion of young people identified by their therapist as disengaging from the programme - i.e. refusing to attend the remainder of sessions or asking to be withdrawn from the programme	Endline	Green: <10% of young people disengage, no differential attrition for ethnic minority groups Amber: 10-25% of young people disengage, some indicators of differential attrition for ethnic minority groups. Red: >25% of young people disengage, clear trends of differential attrition between groups.
	6	Fidelity (practitioner training and supervision)	Number of practitioners who meet minimum fidelity standards.	Practitioner/ supervisor reported data	Endline	Green: 5-6 practitioners Amber: 3-4 practitioners Red: 0-2 practitioners
	6	Fidelity (practitioner quality including cultural sensitivity)	Practitioner quality as rated by the supervisor during the fidelity assessment to include consideration of cultural sensitivity.	Supervisor rating scale	Endline	**Green:** 0 practitioners rated as below acceptable standards of delivery quality or standards of cultural sensitivity. **Amber:** 1-2 practitioners rated as below acceptable standards of delivery quality or standards of

						cultural sensitivity. **Red:** 3+ practitioners rated as below acceptable standards of delivery quality or standards of cultural sensitivity.
	6	Fidelity (delivery of minimum programme components)	Proportion of young people who receive minimum level of input as identified on the fidelity framework	Practitioner/ supervisor reported data	Endline	Green: 75-100% Amber: 50-74% Red: less than 50%
Acceptability	7	Acceptability to young people	Proportion of young people who report being satisfied or very satisfied with the programme	Young person satisfaction survey	Endline	Green: 75-100% Amber: 50-74% Red: less than 50%
	7	Acceptability to parents/carers	Proportion of parents/carers who report being satisfied or very satisfied with the programme	Parent satisfaction survey	Endline	Green: 75-100% Amber: 50-74% Red: less than 50%
	7	Acceptability to schools	Proportion of school staff who report being satisfied or very satisfied with the programme	School staff satisfaction survey	Endline	Green: 75-100% Amber: 50-74% Red: less than 50%
	7	Acceptability to practitioners	Proportion of practitioners who agree/strongly agree with the statement 'I am happy to continue to deliver MindWorks next term'	Practitioner survey at end of pilot delivery	Endline	Green: 5-6 practitioners Amber: 3-4 practitioners Red: 0-2 practitioners
	9	Increased distress or harm caused to young	Negative feedback or complaints from young people/family members	Direct feedback to delivery staff or	Endline	Green: <10% young people for whom substantive negative feedback on the

		person, family or school staff	or school staff	qualitative feedback via the feedback survey/endline satisfaction survey[37].		programme has been shared by young people/family/school staff per cohort. Amber: 10-25% young people for whom substantive negative feedback on the programme has been shared by young people/family/school staff per cohort. Red: >25% young people for whom substantive negative feedback on the programme has been shared by young people/family/school staff per cohort
	9	Serious adverse events	Occurrence of serious adverse events including a death or suicide attempt, psychiatric hospitalisation or perpetration of a serious violent crime.	Captured in real-time in case notes by therapists, shared anonymously on a termly basis with the evaluation team	Endline	Green: No adverse events that are associated with programme delivery occurring for a young person on the trial during the intervention or follow-up period. Amber: One adverse event that is associated with programme delivery occurring for a young person on the trial during the intervention or follow-up period (per term).

[37] During the development of the satisfaction survey, the EYVL team will operationalise exactly what feedback would be substantive enough to contribute towards this marker. For example, an answer of 'poor' or 'very poor' to 'how would you rate the quality of the support you received?'

						Red: 2+ adverse events associated with programme delivery occurring for a young person on the trial during the intervention or follow-up period (per term).
Evaluability	10	ICC and pre-post correlation	ICC and pre-post correlation in the primary outcome	Baseline and follow-up school staff surveys	Baseline, Follow-up	Green: ICC <=0.1 or correlation >=0.6 Amber: ICC >0.1 or correlation <0.6 Red: ICC >0.1 and correlation <0.6
	12	Completeness of baseline data collection	The proportion of respondents answering at least 80% of the questions (across young people, parents/carers, school staff)	Baseline young person, school staff, parent/carer surveys	Baseline	Green: 75-100% Amber: 50-74% Red: less than 50%
	12	Evaluation retention	Proportion of young people for whom we have a complete primary outcome (baseline and follow-up)	Follow-up young person, school staff surveys	Baseline, Follow-up	Green: ≥80% of those randomised Amber: ≥50% Red: <50%
	12	Completeness of follow-up data collection	The proportion of respondents answering at least 80% of the questions	Follow-up young person, school staff surveys	Follow-up	Green: 75-100% for each participant group Amber: ≥50% for each participant group Red: <50% for 1+ participant group
	13	Acceptability of survey questions	The proportion of respondents who report feeling 'comfortable' or 'very comfortable' answering the survey questions (across young people,	Baseline young person, school staff surveys	Baseline	Green: 75-100% Amber: 50-74% Red: less than 50%

			school staff)			
	14	Business as usual data	The number of teachers / young people in endline data who report the young person having received a concurrent, similar intervention (i.e. CBT or systemic psychological input for conduct problems)	Follow-up school staff, young person surveys	Follow-up	Green: 0-2 participants Amber: 2-10 participants Red: 10+ participants
	15	Demographic data	Proportion of young people who have data provided on all key demographics	School referral form	Baseline	Green: 75-100% Amber: 50-74% Red: less than 50%

We will not establish a deterministic rule about how many green-, amber-, and red-rated criteria would justify/prohibit progression, but instead will use the criteria to support a balanced judgement, in conjunction with other stakeholders.

In addition to reviewing the data associated with the progression criteria overall, we will also review the data broken down by mainstream and AP schools. This will enable us to understand whether recruitment, engagement, attrition or fidelity varies across the provision settings. If we find that there appears to be large systematic differences, we may decide to recruit from only one setting type for the efficacy trial.

The decision for progression to the efficacy trial will be made on follow-up data only from cohort 1, and the trial consists of rolling referrals and delivery. As such, we will monitor key data on deliverability, acceptability and evaluability termly (each time we receive a new batch of data) to identify any key issues to respond to.

In addition to the decision regarding progression to full evaluation, the three teams (YEF, Anna Freud, EYVL) will meet regularly to monitor delivery and evaluation activities. This will include:

- Mid-August 2026: Report on diversity of therapists recruited and progress on training and assessments
- Midway through Cohort 1 delivery (October 2026 half term): Report on early reflections on any emerging issues, including potential harms
- After Cohort 1 delivery (January 2027): Report on early findings from first cohort of delivery and IPE findings, including potential harms
- Transition point (April 2027): Share performance against the key progression criteria for the pilot

Methods

Trial design

Trial design, including number of arms	Two-arm cluster RCT (internal pilot followed by extended efficacy phase)
Unit of randomisation	Schools

Stratification variables (if applicable)		Type of school (AP versus Mainstream) Broad geographical area[38]
Primary outcome	variable	Conduct behaviour (school staff perspective)
	measure (instrument, scale, source)	School staff report on the Teacher Report Form (TRF) (externalising scale). Measured at baseline, follow-up.
Secondary outcome(s)	variable	Aggression (young person's perspective)
	measure (instrument, scale, source)	Young person's score on the Reactive-Proactive Aggression Questionnaire (RPAQ)
	variable	Emotional and behavioural difficulties (young person's perspective)
	measure (instrument, scale, source)	Young person's score on the strengths and difficulties questionnaires (SDQ)
	variable	Emotional regulation
	measure (instrument, scale, source)	Young person self-report on the Social Emotional Competence Questionnaire (SECQ) - self-management subscale
	variable	Relationship between teacher and the young person (school staff perspective)

[38] This is included from a practical perspective to ensure that practitioners are able to deliver the intervention. We expect the areas to be very broad (for example, North East, North West, Midlands, London) but this will mitigate against a practitioner who lives in Manchester being allocated to delivery in London for example, given it is a relatively small team.

	measure (instrument, scale, source)	School staff self-report on Student Teacher Relationship Scale (STRS)
	variable	School attendance
	measure (instrument, scale, source)	Percentage attendance in the term after the end of the intervention
	variable	Exclusions, suspensions and transfers
	measure (instrument, scale, source)	A binary measure summarising the extent to which a child or young person faced either exclusion, suspensions or transfers (measure takes 1 if experienced any of the three and 0 if experienced neither), up to the point of follow-up data collection
Exploratory outcome(s)	variable	Emotional difficulties
	measure (instrument, scale, source)	Young person self-report on the SDQ - emotional problems subscale.
	variable	Prosocial behaviour
	measure (instrument, scale, source)	Young person self-report on the SDQ - prosocial subscale.
	variable	Relationship between young person and their peers
	measure	Young person self-report on the SDQ - peer problems subscale

	(instrument, scale, source)	
Baseline for primary and secondary outcome	The baseline for every outcome is the same measure, collected prior to randomisation.	

Randomisation

Randomisation will be conducted at the school level to minimise contamination between treatment and control groups. For each academic term, the cohort of participating schools will be randomly allocated to one of two conditions:

1. Treatment Group: Schools in this group will receive the full MindWorks intervention for their referred pupils.

2. Control Group: Schools in this group will continue to provide their standard business-as-usual (BAU) support for referred pupils.

Randomisation will be conducted by EYVL on a rolling basis for each term's cohort of schools, after baseline data collection for that cohort is completed. We will use stratified randomisation, with strata defined by school location and school type (AP / mainstream), allocating schools to intervention or control [1:1] within each stratum. These variables are likely to be correlated with key outcomes, and stratifying on them at randomisation improves balance and precision.

Stratification by location is a particular priority given delivery-partner capacity constraints: in year 1 delivery teams will be in London but in year 2, each term we expect at least one delivery team in London and at least one in another location. To ensure each location-by-type stratum contains enough schools for within-stratum randomisation, we will recruit schools in pairs by location each term (i.e. at least two APs or two mainstream schools in London, and at least two in the other location, per term). In the situation a stratum contains only one school, allocation will be by simple randomisation – stratifying variables will always be included in the regression analysis to account for any such imbalance.

Randomisation will be conducted by EYVL on a rolling basis for each term’s cohort of schools, after baseline data collection for that cohort is completed. Randomisation will be conducted

using the R software using a random number generator function. This will be carried out by a team member from BIT/EYVL and quality assured by a senior BIT/EYVL colleague to ensure it is implemented correctly. At the time of randomisation, the researcher will be blinded, and will not have access to the link key between the school IDs and school name. It will not be possible to blind school staff, young people or data collectors to treatment allocation.

To avoid demoralisation for schools randomised to the control arm, all information sheets will discuss randomisation early and clearly. Information will be included on the value that the control arm provides to the research, and the additional compensation that will be provided to the control arm (vouchers for survey completion and CPD training for teachers/parents). We will contact stakeholders associated with control schools following randomisation to let them know the outcome, highlighting their importance to the research and to thank them for continuing to take part. Our co-design work with stakeholders suggested that school level randomisation (rather than individual) is likely to lead to less demoralisation due to the outcome feeling less 'personal' and having less of an ability to directly compare their experience with other students that they know.

Participants

Inclusion and exclusion criteria for CYP

Young people are considered eligible for MindWorks if they meet the following inclusion criteria, as identified by school staff:

- Scoring 4+ on the Strengths and difficulties questionnaire: conduct subscale, as rated by a teacher that knows the young person well
  OR
- Scoring 3+ on the Strengths and difficulties questionnaire: conduct subscale and having at least one of the following risk factors:
  - At risk of exclusion in the next academic year due to behaviour
  - Has experienced school exclusion due to behaviour
  - 2+ suspensions in the last two academic years due to behaviour
  - History of involvement in the criminal justice system

And:

- Aged 11-16
- Has at least 1 school based adult willing to be involved in the intervention.
- Has English language skills such that they can access a verbally based psychological intervention
- School attendance in the previous term of at least 40%[39]

[39]This threshold was chosen to ensure high risk young people are reached whilst balancing this with the need to avoid low compliance and attrition from the study. The intervention targets children at risk of disengaging from

Exclusion criteria are:

- Currently receiving CBT or other psychological intervention focused on emotional regulation difficulties expressed as disruptive and aggressive behaviours
- At risk of suicide (where known to school staff)[40]
- In Year 11 (where MindWorks delivery would occur during the Summer term)

Inclusion and exclusion criteria for schools

Inclusion criteria are:

- Mainstream or AP school for secondary school students
- Estimate that they have at least 25 children who would be eligible for MindWorks
- Willing for staff to participate in MindWorks if the school is randomised to the treatment arm
- Able to commit to supporting the evaluation activities

Exclusion criteria are:

- A school that offers a similar intervention (a CBT or systemic based psychological intervention for disruptive or aggressive behaviours)

Sample size calculations

We have estimated the required sample size for the efficacy trial using standard methods for cRCTs with a continuous primary outcome. We have included here power calculations for a sample size of 30 schools in the trial.

We conducted power calculations using R software[41] to show how the minimum detectable effect size (MDES) varies under different parameter assumptions, as outlined below.

The power calculations are based on the following assumptions:

- Significance level (two-sided): 0.05
- Power = 0.8

school, not those who have already opted out. Furthermore, the work with the child's network requires some engagement with school and while practitioners can deliver some sessions into the community the default is for school-based delivery and caseloads/resourcing are planned with this in mind. If a high proportion of students require community delivery due to school non-attendance this will significantly impact on practitioners' capacity to deliver.

[40] Staff will report on the referral form where there is a known, active suicide risk (i.e. current crisis team involvement, recent attempt). In this case, the student will be excluded from the trial and school staff will retain the safeguarding responsibility for their wellbeing. Trial team members can provide further signposting to support services if needed. If a risk of suicide is identified during MindWorks delivery, clinical safeguarding procedures will be followed, see section on safeguarding above.

[41] Using the pwr.t2n.test command.

- Cluster size = 22 CYP[42]
- Within school attrition from baseline to the primary endpoint = 20 percent
- Baseline rate of conduct problems = 0.6
- Effect size: We present results for a range of Cohen's d.

We present MDES as Cohen's d for a range of intracluster correlation coefficients (ICCs) and pre-post correlation values. Our primary scenario (Scenario 2) uses 30 schools with ICC equal to 0.05 and pre-post correlation equal to 0.7, and we also show sensitivity to higher ICC values up to 0.10.

Specifying attrition rate

We assume 20 percent attrition within schools between baseline and the primary outcome point (follow-up). We do not expect any attrition to happen at the school level.

Specifying ICC

Recent evidence from school-based cRCTs supports the ICC values used in our power calculations. A large systematic review of 65 school trials reports median ICCs of 0.031 at the school level for pupil health and well-being outcomes (Parker et al., 2023)[43], while European data on adolescent psychosocial outcomes - such as depressive mood and self-esteem, show school-level ICCs typically between 0.01 and 0.07 (Shackleton et al., 2016)[44]. For social-emotional functioning outcomes, a secondary analysis of five UK cluster trials find that most pupil-reported ICCs lie below 0.04, and although teacher-reported outcomes tend to be somewhat higher due to shared observer effects, the authors report school-level ICCs commonly in the region of 0.05–0.10 (Parker et al., 2025)[45] . Meta-analytic evidence from cluster trials of depression also estimates pooled school-level ICCs around 0.07 (95% confidence interval [CI]: 0.05, 0.09) (Bhaskarapillai, 2023)[46]. Taken together, this evidence indicates that school-level ICCs between 0.02 and 0.08 are typical for psychosocial and behavioural outcomes. Within this context, our preferred ICC assumption of 0.05 is both

[42] We assumed a cluster of 22 for delivery on average to 20 CYP assuming some attrition between baseline and programme starting.

[43] Parker, K., Nunns, M., Xiao, Z., Ford, T., & Ukoumunne, O. C. (2023). Intracluster correlation coefficients from school-based cluster randomized trials of interventions for improving health outcomes in pupils. *Journal of Clinical Epidemiology, 158*, 18-26

[44] Shackleton, N., Hale, D., Bonell, C., & Viner, R. M. (2016). Intraclass correlation values for adolescent health outcomes in secondary schools in 21 European countries. *SSM – Population Health*, 2, 217-225.

[45] Parker, Kitty, et al.Patterns of intra-cluster correlation coefficients in school-based cluster randomised controlled trials of interventions for improving social-emotional functioning outcomes in pupils: a secondary data analysis of five UK-based studies.*BMC Medical Research Methodology* 25.1 (2025): 120.

[46] Bhaskarapillai B, Malo PK, Kishore MT, Joseph A, et al. Intraclass Correlation in Cluster Randomized Controlled Trials: A Meta-Analysis of Studies on Major Depression. *Indian Journal of Psychological Medicine*. 2024

realistic and well aligned with the empirical literature, while our sensitivity analyses up to 0.10 ensure adequate robustness.

Specifying pre-post correlation

Because the primary analysis adjusts for baseline TRF externalising scores, the gain in precision depends on the correlation between baseline and follow-up measures. Evidence from the TRF, the CBCL, and earlier teacher-reported behaviour profiles consistently shows moderate to high stability for externalising behaviour over periods comparable to a school term or school year. The ASEBA[47] manuals report strong test–retest reliability for CBCL and TRF broadband scales, including Externalising Problems, with stability estimates commonly falling in the 0.80–0.90 range (Achenbach & Rescorla, 2001)[48]. Earlier work on the teacher version of the Child Behavior Profile, a precursor to the modern TRF, also found substantial short-term stability for behaviour-problem scales, with coefficients around 0.60–0.75 across two- to four-month intervals (Achenbach & Edelbrock, 1978, 1983)[49]. Taken together, this evidence suggests that pre–post correlations in the 0.60–0.80 range are realistic for TRF Externalising in school settings. We therefore adopt 0.70 as our preferred assumption and 0.60 as a conservative value in sensitivity analyses.

Justification for target effect size

An MDES of 0.30 on the TRF externalising scale is substantively meaningful and consistent with the wider literature on cognitive behavioural and psychosocial interventions for aggression and conduct problems. A meta analysis of CBT for anger related problems in children and adolescents reported an average effect size of d = 0.67. Another meta analysis of individually oriented CBT for severe aggressive behaviour in adolescents found positive effects on aggression, with effect size up to d = 1.1. Since MindWorks is intensive, systemic, and targeted at young people who exhibit disruptive and aggressive behaviours, and it is cost and resource intensive for schools and services, in this context a true effect size of 0.30 represents a meaningful improvement in externalising behaviour that is likely to be noticeable in the classroom and to have downstream benefits. Additionally, designing the trial around detecting effects much smaller than 0.30 would increase the required sample size

[47] An ASEBA manual is a handbook for the Achenbach System of Empirically Based Assessment (ASEBA), a set of questionnaires used to assess a person's behavior and emotional functioning.

[48] Achenbach, T. M., & Rescorla, L. A. (2001). Manual for the ASEBA school-age forms & profiles. University of Vermont, Research Center for Children, Youth, & Families.

[49] Achenbach, T. M., & Edelbrock, C. S. (1978). The classification of child psychopathology: A review and analysis ofempirical efforts. Psychological Bulletin, 85(6), 1275–1301. Achenbach, T. M., & Edelbrock, C. S. (1983). Manual for the Child Behavior Checklist and Revised Child Behavior Profile. University of Vermont, Department of Psychiatry.

considerably while targeting changes that may be less important in practice for such a resource intensive intervention.

Taken together, the empirical evidence and the policy context support the view that an MDES of approximately 0.30 on the TRF externalising scale is an appropriate target. Our power calculations show that a design with 30 schools provides sufficient power to detect effects of this magnitude, even under conservative assumptions regarding ICC, attrition and pre-post correlation. Only a scenario with a conservative correlation and ICC will lead to an MDES of greater than 0.3.

Table 3: Sample size calculations

Scenario		**1**	**2 (preferred)**	**3**	**4**	**5**
Minimum Detectable Effect Size (MDES), at randomisation		0.275	0.223	0.308	0.250	0.228
MDES, accounting for 20 percent attrition		0.285	0.236	0.319	0.264	0.242
Pre-test/ post-test correlations	**level 1 (participant)**	0.7	0.7	0.6	0.6	0.7
	level 2 (cluster)					
Intracluster correlations (ICCs)	**level 1 (participant)**	0.1	0.05	0.1	0.05	0.05
	level 2 (cluster)					
Alpha		0.05	0.05	0.05	0.05	0.05
Power		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
Average cluster size (if clustered)		22	22	22	22	20
Number of clusters	**Intervention**	15	15	15	15	15
	Control	15	15	15	15	15

	Total	30	30	30	30	30
Number of participants	**Intervention**	330	330	330	330	300
	Control	330	330	330	330	300
	Total	660	660	660	660	600

Our evaluation comprises two complementary components:

1. Impact evaluation: a quantitative study designed to assess the causal impact of the MindWorks programme through an RCT.

2. Implementation and process evaluation: a multi-methods study that explores how the programme is delivered, participants' experiences, and factors influencing fidelity, engagement, and acceptability.

Impact evaluation

Methods and data collection

Data collection is as follows:

1) Young person outcome surveys: Young people will be invited to complete outcome surveys at two time points - prior to randomisation (baseline) and at the end of the term following delivery, approximately four months after the end of delivery (follow-up). Surveys will be administered in person, in schools, using tablets or computers with the support of an evaluation team member. Surveys will be completed either 1:1 or in small groups. Teachers will advise on student needs in advance so that the experience can be tailored to them (for example, individual vs. small group data collection, support with reading the questions, completion of the questionnaire privately or spoken through with the evaluator, need for breaks). Further detail on how surveys will be administered to encourage participation and comfort is included in Appendix 3.

All proposed full-scale measures are validated for use in this population and have been used in evaluations of interventions for similar difficulties previously. In selecting the measures to collect we considered: the balance within the survey of positive and negative questions, a completion time of 10-15 minutes and REDI factors, which have been considered by our expert advisors. We will monitor survey length and seek input from CYP on length prior to the

start of the evaluation and continue to monitor experience throughout the 6 terms of delivery and evaluation. As part of the co-design process, a group of young people reviewed the proposed survey questions and data collection strategies, and many of the above considerations come from their input. Young people will be offered a £10 voucher in recognition of the time taken completing the surveys.

Evaluation team members administering the measures will be experienced in administering surveys with this population. A designated school staff member will be on standby to support any immediate difficulties, and urgent safeguarding issues will be escalated in line with the school's safeguarding procedures. School staff will be asked to be mindful of the survey contents, and offer young people a break if needed before returning to class.

We recognise that the population of young people targeted by MindWorks may be more likely than others to be absent from school. We will ask the school to support facilitating survey data collection for young people who are absent from school on the day of data collection, and/or offer a video call to support young people to complete the surveys. We appreciate this is an ask on teachers' time and therefore the evaluation team will offer in-school 'mop-up' days of data collection for schools where there are lots of absent students at each timepoint.

Annex 2 describes how data collection will be supported with young people.

2) **School staff outcome surveys:** The designated link teacher—a school staff member who knows the young person well (for example, a head of year, tutor, or pastoral lead)—will complete surveys at baseline, and follow-up. These surveys capture outcomes relating to the young person's conduct behaviour (the primary outcome), emotional and social functioning, and the quality of the student–teacher relationship. The data will be collected via an online survey platform. We will encourage schools to ensure that a range of teachers complete the surveys where possible and we will monitor how many different teachers complete data in each school, as too many surveys completed by the same teacher may influence our ICC and therefore the evaluation's power. We will also monitor how many follow-up surveys are completed by a different teacher from the baseline survey. Although inter-rater reliability is moderate-to-strong for the TRF this may influence the pre-post correlation and therefore the evaluation's power.

The teacher who completes the data collection would also be involved in the intervention itself. We recognise that there is therefore a risk of social desirability bias, where the teacher may overestimate the treatment effect. However, using blinded staff that do not know the young person well is likely to lead to inaccurate data as they lack the context of the young person's typical behaviour. We will mitigate the risk of this bias by using a multi-informant approach (young person and teacher) and also including objective measures (exclusion, suspensions and transfers) to better understand the impact of the intervention on behaviour. The training delivered to teachers when onboarding them to the trial will also include a focus

on helping teachers to understand the purpose of the intervention and the need for accurate reporting.

We will require completed baseline surveys from young people and school staff for inclusion in the study.

3) **Administrative data:** Administrative data from schools will supplement survey data and provide objective indicators of attendance and outcomes such as exclusions, suspensions and transfers. Our co-design work with mainstream school staff suggested that this data is stored in accessible electronic systems and that it would be a simple task to retrieve this data for the pupils referred to the programme. We envision a shared excel sheet between EYVL and each school, held on a secure server, where they can add administrative data.

Outcome measures

Baseline measures

At baseline, we will collect measures for each outcome variable prior to randomisation. In addition, we will use the referral form to gather data on student demographics (including gender, age, race/ethnicity, and disability), socio-economic status (as indicated by eligibility for free school meals) and history of involvement with the criminal justice system. These data will be used to explore potential backfire effects and moderators.

In accordance with the theory of change, we focus on short-term and intermediate psychological and relational outcomes that act as precursors to long-term behavioural change. Our specific outcome measures are detailed in Table 4.

Primary Outcome

The primary outcome is conduct behaviour, measured using the Teacher's Report Form (TRF) externalising scale (Achenbach, 2001[50]). This reflects an intermediate outcome in the theory of change, capturing behavioural improvements expected to emerge after changes in underlying attitudes and competencies as well as relationships. The TRF externalising scale consists of 34 items rated on a 3-point scale (0 = Not True, 1 = Somewhat True, 2 = Very True), generating scores from 0–68 (higher scores imply greater behavioural difficulties). The TRF is a psychometrically robust instrument with high internal consistency and test-retest reliability (Achenbach & Rescorla, 2001).

While a number of YEF evaluations utilise the Strengths and Difficulties Questionnaire (SDQ) as a primary outcome, our considered view is that the TRF is more appropriate to capture

[50] Achenbach, T.M., & Rescorla, L.A. (2001). Manual for the ASEBA School-Age Forms & Profiles. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

change in the MindWorks evaluation. The SDQ Conduct Problems subscale contains only 5 items, which may lack the sensitivity and granularity required to detect incremental change in a targeted intervention; this is particularly pertinent as psychometric analyses have found the self-report conduct scale to have the lowest internal consistency of the SDQ subscales (Cronbach's α often around 0.5 in adolescents; Hagquist, 2007). In contrast, the TRF's 34 items specifically target aggressive and rule-breaking behaviour, providing greater content validity and statistical power to identify significant intervention effects. The SDQ is included as a secondary outcome.

We will monitor acceptability of data collection as well as completion rates, the percentage of young people for whom baseline and follow-up surveys are completed by different teachers, and the number of young people each individual teacher completes measures for.

Secondary Outcomes

Secondary outcomes comprise key short-term outcomes or mechanisms identified in the theory of change. This includes:

- Aggression (RPAQ) - the main outcome of the intervention, captured from a young person's perspective
- Emotional and behavioural difficulties (SDQ) - A broad reflection of the emotional and behavioural difficulties a young person is experiencing.
- Emotional regulation (SECQ - self management subscale)- a key short-term outcome of the intervention
- Relationship strength between young person and teachers from a teacher perspective (STRS[51]) - a key short-term outcome of the intervention
- Exclusions, suspensions and transfers - a key longer-term outcome of the intervention and a non-self reported data source.
- Attendance - an intermediate outcome which is less closely aligned with the theory of change

Exploratory outcomes comprise the following:

- Emotional difficulties (SDQ - emotional symptoms subscale)- a longer-term outcome which is less closely aligned with the theory of change

[51] To minimise burden on young people, this measure is captured from a school staff perspective only

- Peer relationships (SDQ - peer relationships subscale) - an intermediate outcome which is less integral to the intervention compared to adult relationships
- Prosocial behaviour (SDQ - prosocial subscale) - a short-term outcome.

Table 4: Outcome Measures

Type of outcome	Outcome measured	Instrument	Completed by	Number of items	Subscales to be used	ToC Element	Scoring	References
Primary	Conduct behaviour	Teacher's Report Form	School staff self-report	34	Externalising scale (which includes the aggressive subscale and the rule breaking subscale)	Intermediate outcome	A score from 0 to 68 is generated by summing across all 34 items in the externalising scale. Each item is rated by the teacher on a 3-point scale: ● 0 = Not True (as far as you know) ● 1 = Somewhat or Sometimes True ● 2 = Very True or Often True Higher scores imply greater prevalence of misconduct behaviour.	Achenbach, 2001[52]
Secondary	Aggression	Reactive-Proactive aggression questionnaire	Young person self-report	23	Reactive aggression and proactive aggression sub-scales	Intermediate outcome	A score from 0 to 48 is generated by summing across all 23 items in the two sub-scales. Each item is rated by the young person on a 3-point scale: ● 0 = Never ● 1 = Sometimes ● 2 = Often	Raine, 2006[53]
Secondary	Emotional and behavioural difficulties	Strengths and difficulties questionnaire	Young person self-report	25	All	Intermediate outcome	Each item in the questionnaire is coded on a 3-point scale: ● 0 = Not at all true ● 1 = Somewhat true ● 2 = Certainly true	Goodman,1997 [54]
Secondary	Emotional regulation	SECQ - self-management	Young person	5	NA	Short-term outcome	Items are assessed on a 6-point Likert scale ranging from 1 (not at all true of me) to 6	

[52] Achenbach, T. M. (2001). *The Teacher's Report Form for Ages 6–18*. Burlington, VT: ASEBA, University of Vermont.

[53] Raine, A. (2006). The reactive-proactive aggression questionnaire: differential correlates of reactive and proactive aggression in adolescent boys. Aggressive Behaviour, 32, 159-171.

[54] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.

		subscale	self-report				(very true of me). Overall, higher scores indicate greater difficulties in self-management.	
Secondary	Teacher-young person relationship	Student Teacher Relationship Scale (STRS)	School staff self-report	15	Both subscales (closeness subscale and conflict subscale)	Intermediate outcome	Each item is answered on a 5-point scale ranging from *1 (definitely does not apply)* to *5 (definitely applies).* Scores are computed separately for each subscale by summing responses to the relevant items. A higher Closeness score indicates a more positive teacher–child relationship, while a higher Conflict score indicates greater tension in the relationship.	Pianta, 2001[55]
Secondary	Exclusions, suspensions and transfers	Admin data	School-level administrative data	NA	NA	Long-term outcome	A binary measure capturing the likelihood that the CYP faced either exclusion, suspensions or transfers (faced any of the three issues = 1; 0 otherwise). Combined measure as likelihood of any of these events is low.	NA
Secondary	School attendance	Admin data	School-level administrative data	NA	NA	Long-term outcome	Percentage attendance over the school term after intervention ended.	NA

[55] Pianta, R. C. (2001). Student–Teacher Relationship Scale: Professional manual. Odessa, FL: Psychological Assessment Resources.

Exploratory	Prosocial behaviour	Strengths and Difficulties Questionnaire (SDQ)	Young person self-report	5	Prosocial subscale	Short-term outcome	Each item in the questionnaire is coded on a 3-point scale: ● 0 = Not at all true ● 1 = Somewhat true ● 2 = Certainly true **Prosocial Score:** A score from 0 to 10 is generated by summing across the 5 items that comprise the prosocial behaviour subscale. In this case, higher scores imply better social behaviour.	Goodman,1997 [56]
Exploratory	Emotional difficulties	Strengths and Difficulties Questionnaire (SDQ)	Young person self-report	5	Emotional symptoms subscale	Intermediate outcomes	Each item in the questionnaire is coded on a 3-point scale: ● 0 = Not at all true ● 1 = Somewhat true ● 2 = Certainly true	Goodman,1997 [57]
Exploratory	Peer relationships	Strengths and Difficulties Questionnaire (SDQ)	Young person self-report	5	Peer problems subscale	Intermediate outcomes	Each item in the questionnaire is coded on a 3-point scale: ● 0 = Not at all true ● 1 = Somewhat true ● 2 = Certainly true	Goodman,1997 [58]

[56] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.

[57] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.

[58] Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.

Young people are asked to complete 53 questions as part of the evaluation at baseline and follow-up. We estimate this will take approximately 15 minutes based on estimates for time completion of the various components (e.g. the full SDQ is estimated to take 5-10 minutes to complete). School staff are asked to complete 129 questions at baseline and follow-up, we estimate this will take approximately 15-20 minutes.

Data analysis

Main effect outcome analysis

The approach will differ for the pilot and efficacy phases of the trial.

For the pilot phase, the analysis will be primarily descriptive. We will focus on summarising key progression criteria, including recruitment rates, data completeness, and participant retention, and on producing preliminary estimates of the ICC and the pre-to-post correlation. The pilot trial will therefore inform the decision on whether to proceed to the full efficacy trial, as well as provide more reliable inputs for estimating effect sizes.

If the project progresses to efficacy, outcome data from both the pilot and efficacy phases will be analysed together to determine the impact of the programme. The analysis will follow a pre-specified Statistical Analysis Plan (SAP) to be finalised prior to the commencement of data analysis. The SAP will be drafted after the collection of baseline data from cohort 4 (i.e. Autumn term 2027) when baseline data will be available for 60% of schools and endline data for 26%. All outcome data will be analysed using an Intention-to-Treat (ITT) analyses, including all randomised participants in their assigned groups regardless of the level of intervention received. Given the cluster-randomised design (randomisation at the school level with outcomes measured at the pupil level), the primary analysis will utilise Multilevel Models to ensure valid statistical inference. For the majority of our outcomes, which are continuous variables, we will use the Linear Mixed-Effects Model (LMM). For secondary outcomes that are binary (e.g., probability of suspensions/exclusions), we will use the Generalised Linear Mixed-Effects Model (GLMM) with a logistic link function. We will use Satterthwaite-corrected clustered standard errors to account for the small number of clusters (anticipated to be under 30 clusters).

For each outcome, we will include the corresponding pre-intervention value of that outcome as a covariate in the regression model. This maximises statistical power and adjusts for baseline imbalances and regression to the mean. Additionally, we will control for baseline characteristics at two levels. The Pupil-level covariate will be ethnicity. School-level covariates will include school type and school location (the stratification factors).[59]

In line with standard practice for clustered education trials, we did not explicitly model individual covariates in the power calculations. Instead, precision gains were incorporated via

[59] It is usual to include controls for variables you have stratified and checked balance on. In a perfectly balanced experiment the estimated treatment effect will be the same regardless of whether a stratified variable is included in the regression, but stratifications are rarely perfect due to stratum sizes not being perfect multiples of the number of arms, and can become unbalanced during the trial due to attrition or non-compliance.

the assumed pre–post correlation between baseline and endline outcomes, which captures the majority of variance reduction typically achieved through adjustment for baseline outcomes and related pupil characteristics. The demographic covariates listed will be included in the analysis model, but we did not assume additional power gains from them beyond that captured by the baseline–endline correlation.

The mathematical specification for the LMM regression model for pupil *i* in school *j* is defined as:

$$Y_{ij} = \alpha + \beta_1 * Treatment_j + \beta_2 * Control\ vector_{ij} + u_j + \varepsilon_{ij},$$

Where: Y_{ij} is the measure of the outcome at the primary analysis point as per Table 4; $Treatment_j$ is the indicator variable for the treatment arm; $Control\ vector_{ij}$ represents the vector of fixed effects for all pupil-level and school-level covariates; u_j is the random intercept associated with each school mean, and ε_{ij} is the residual error term. The GLMM regression model will be constructed, modelling the log-odds of the binary outcome (in case of secondary outcomes that are binary). Given our sample size is sufficiently large, Cohen's d and Hedges' g are numerically almost identical (correction factor ≈ 0.999). We therefore report Cohen's d, which is equivalent to Hedges' g in this context.

Subgroup analysis

In addition to the primary analysis, we will conduct pre-specified exploratory subgroup analyses to explore whether the effects differ by school type, ethnicity and gender. This will be done by adding an interaction term between the treatment variable and the subgroup variables to the primary analytical model.[60] The three subgroup variables were selected on theoretical and empirical grounds. Evidence suggests that boys and girls differ in the prevalence, expression, and trajectory of conduct and behavioural difficulties, with boys more likely to exhibit externalising behaviours and girls more likely to present with relational aggression (Berkout, Young & Gross, 2011).[61] With respect to ethnicity, UK research indicates that Black and minority ethnic young people may follow different developmental pathways of conduct problems than white peers, shaped in part by structural inequalities including disproportionate school exclusions and institutional racism (Gutman et al., 2019).[62] Finally, young people in alternative provision represent a substantially higher-need population, with

[60] The other moderators will be analysed qualitatively as part of the implementation and process evaluation. School type, ethnicity, and gender were selected as the primary subgroups for quantitative analysis as they are expected to be the most important moderators and due to greater confidence in data quality and subgroup sizes for these variables.

[61] Berkout, O.V., Young, J.N. & Gross, A.M. (2011). Mean girls and bad boys: Recent research on gender differences in conduct disorder. *Aggression and Violent Behavior*, 16(6), 503–511.

[62] Gutman, L.M. et al. (2019). Do conduct problem pathways differ for Black and minority ethnic children in the UK? *Journal of Youth and Adolescence*, 49, 321–335.

an estimated 1 in 2 having social, emotional and mental health difficulties compared with 1 in 50 in mainstream schools (Gill et al., 2017).[63] Note that these subgroup analyses are exploratory and the study is likely to be underpowered for interaction analyses; findings should therefore be interpreted with caution. Note that these subgroup analyses are exploratory and the study is likely to be underpowered for interaction analyses; findings should therefore be interpreted with caution.

Compliance analysis

In the event of non-compliance, we will estimate the Complier Average Causal Effect (CACE) on the primary outcome, in line with the YEF analysis guidelines.[64]

Additional stopping rules

We will monitor termly data on the completeness of survey and administrative data in both arms (combined), any identified harms or backfires, and implementation of MindWorks and retention of CYP in the intervention.

Potential harms in this context include the following:

- Young people or their family members feeling blamed for the young person's behaviour and internalising this- particularly for those of minoritised backgrounds.
- Young people or their family members feeling misunderstood or not heard by their therapist, particularly with regards to their lived experience of structural inequalities and cultural background.
- Young people or their family members feeling stigmatised by their inclusion in the programme or the programme's contents or approach
- Young person, family member or school staff distress due to the programme contents or approach
- Serious adverse events due to distress caused by the programme contents or approach such as hospitalisation, self-harm, suicide, criminal behaviour or death.

Any harms identified will be discussed within the delivery and evaluation teams within the clinical supervision and appropriate clinical pathways (delivery team) or regular project meetings (evaluation team).

Key items from the pilot progression criteria will continue to be monitored termly throughout the trial. This includes:

1. Evaluation retention
2. Enrolment rates

[63] Gill, B., Quilter-Pinner, H. & Swift, D. (2017). *Making the Difference: Breaking the Link Between School Exclusion and Social Exclusion*. IPPR.

[64] YEF Analysis Guidelines

3. Disengagement rates
4. Increased distress as measured via substantive negative feedback
5. Serious adverse events

Any of these criteria meeting the 'amber' threshold would be escalated to cross-party meetings (Anna Freud, EYVL and YEF). These would then be discussed and a mitigation or adaptation plan agreed if needed (for example, changing the programme approach or increasing therapist training). Any red criteria indicate the point at which we expect the trial and delivery would be paused entirely, and the teams would discuss whether to halt the study permanently or continue with significant modifications and mitigations in place.

Implementation and process evaluation

In recognition of the ongoing and iterative nature of implementation, the methods and data collection for quantitative and qualitative research activities have been separately described. Insights from the pilot trial will be used, where appropriate, to adapt methods for the efficacy trial.

Throughout both quantitative and qualitative data collection, we will take a theory-informed approach that is guided both by the programme theory and the Theory of Change, as well as an implementation approach guided by implementation theory. This will ensure we are able to understand and explore the effects of structural factors on the experiences of young people and parents and school staff.

Research methods

We are taking a mixed methods approach to data collection for the IPE with themes explored through both qualitative and quantitative data collection methods. Findings will be triangulated across methods to answer research questions.

Qualitative methods and data collection

Each term during the pilot and efficacy trial, we will conduct interviews with practitioners (n=2; 1hr), school staff (n=2; 1hr), young people (n=3; 45m) and carers (n=3; 45m) within one 'case study' school which is receiving or has just completed the intervention to understand deliverability, acceptability and evaluability as well as the perceived mechanisms and outcomes. Over the full efficacy trial, we will aim to include an equal number of mainstream and AP schools in our qualitative research. We will purposively sample from the young people within each cohort to maximise diversity of views, including engagement with the programme, SRS scores, ethnicity and gender. We will purposively sample schools across the trial period to ensure a balance of school type. We will also seek to conduct additional IPE interviews within the same case study school wherever possible with young people/family

members who were poorly engaged or disengaged from the programme in cohorts 1 & 2 (up to 3 young people and 3 family members per cohort). These interviews will aim to understand why these participants disengaged and any harms experienced.

Following the first term of delivery, we will deliver an additional case study visit. We will visit one mainstream school and one AP school in order that learnings from both types of school are gathered early in their trial and represented in our findings and decision making for progression. Interviews with young people, school staff and practitioners will be conducted in person where possible during a visit to the school but we will also offer telephone or online platform interviews for adults not available during the visit and for parents/carers.

During the pilot trial we will also conduct two online focus groups, one with practitioners (n=3-5; 1hr) and one with school staff (n=3-5; 1hr) to identify problems and solutions for the efficacy stage. These focus groups will include participants from multiple schools. We will conduct further focus groups twice during the efficacy trial to identify learnings across the trial as a whole. These will also consist of practitioners and school staff involved in the most recent term of delivery.

In conjunction with each of the sets of focus groups, we will conduct an interview with the SRM based at Anna Freud, focusing on themes of delivery, recruitment, setup and programme administration.

We will consult with the YAG, YAB and YEF's Race Equity Associate regarding the content of the topic guides and how structural issues are addressed within them. This ensures that lines of inquiry are culturally sensitive and do not inadvertently reinforce deficit narratives. Specifically, we will seek input on how to frame questions regarding adversity to ensure participants feel safe discussing systemic barriers rather than focusing solely on individual behavioural traits.

Trained researchers will collect qualitative data. To ensure cultural competence and safety, these researchers will receive specific input from the Race Equity Associate, including with development of a trauma informed interview schedule, and be guided by the YEF YAB on how to build authentic rapport and navigate power dynamics. Dr Jessica Davies, the Race Equity Associate, will also hold termly 1 hour sessions with researchers collecting qualitative data, to reflect on researcher positionality, potential bias and researcher approaches to data collection from an equity perspective.

To further support young people to feel comfortable in the research space, we will move beyond standard formats by employing creative, trauma-informed tactics. This includes offering fidget toys to aid regulation, incorporating drawing or writing tasks to allow for non-verbal expression, and ensuring flexibility for breaks throughout the session. We will also employ a 'traffic light' system, using coloured cards, to give participants a physical, non-verbal

way to pause or skip questions, giving them tangible control over the interview process. Prior to the interview beginning, the researcher will speak to the young person to brief them on possible content which may arise and normalise the emotions that this may evoke. Researchers will discuss what the young person would like to happen in terms of managing any distress, and naming researcher positionality.

Quantitative methods and data collection

During the **pilot and efficacy trials** we will conduct the following quantitative IPE research activities:

1. **Young person, parent/carer, school staff satisfaction surveys:** We will distribute a short survey (aiming for <5 minutes completion time) to CYP, parent/carers and school staff in the treatment arm in the final MindWorks session at the end of the term of delivery. The survey will be short and accessible to ensure active engagement from participants from diverse backgrounds. CYP will be able to complete surveys independently or with support from the practitioner or a school staff member. Participants will be assured during the process that their responses will remain confidential, and opinions will not be attributed to any individuals. We will pilot the CYP and parent survey with the YAG and PAG during the mobilisation phase to gain feedback on aspects of survey design, survey length, question design, question language and question content and we will refine the survey based on this feedback. The survey will measure participant views on fidelity components, expectations and feedback on the intervention, quality of support received, and overall acceptability of the intervention and trial. The approach to survey completion (e.g., supported vs. independent) will be adapted using a test-and-learn approach based on findings from earlier delivery terms.
2. **Practitioner satisfaction surveys:** We will invite practitioners to complete an online survey at two timepoints, once during the pilot and once during the efficacy trial. The survey will focus on practitioner's experience of delivery, acceptability of the programme, adaptations made and practitioner wellbeing (a key potential backfire effect).
3. **Demographic data:** Demographic data (including gender, age, ethnicity, free school meal status, EHCP status[65], social care status and involvement in the criminal justice system) will be collected at baseline from school staff members as they refer young people to the programme. This data will be used to monitor differences in referral,

[65] We recognise that EHCP provision is limited in its ability to capture the range of experiences of young people. Young people, particularly of racialised backgrounds, may have their behaviours attributed to other causes than learning needs or neurodiversity. Additionally, waiting lists for EHCP and neurodiversity assessments are known to be extremely lengthy, and as such young people may not have received a formal assessment or EHCP plan at the point of trial entry, despite difficulties being identified.

recruitment and engagement with the programme and outcomes across sub-groups of CYP and the representativeness of the overall sample of the wider youth justice population.

4. **Programme engagement data,** including number of sessions, medium of sessions, length of sessions, location of sessions, topics covered, attendees and SRS[66] scores will be collected throughout delivery. This data will be used to understand the proportion of participants engaging and disengaging, characterise engagement with the programme and explore how involvement of the network moderates programme outcomes. This data will also be used as part of the fidelity assessment (see section below). Anna Freud practitioners will collect Goal Based Outcomes as part of their clinical work with young people receiving MindWorks. These data will be used to understand mechanisms for impact of the intervention.
5. **Business as usual data:** From all control schools and children in the control arm, we will collect (survey / administrative) data on what other therapeutic interventions CYP receive during the trial period (to follow-up data collection timepoint).

Table 5 below summarises each of the data collection methods for the IPE and the research questions they will explore.

[66] The SRS is scored by summing the marks made by the client to the nearest centimeter on each of the lines of the four scales. Maximum score is 40, a score <36 or <9 on any scale suggests a concern.

Table 5: IPE methods and research questions overview

	Interviews					Surveys				Admin data		
	Practitioner	Young person	School staff	Parent/ carer	SRM	Practitioner	Young person	School staff	Parent/ carer	Demographics	Programme data	BAU data
RQ1- Outcomes	X	X	X	X		X	X	X	X			
RQ2 - Mechanisms	X	X	X	X		X	X	X	X			
RQ3 - Backfire effects	X	X	X	X		X	X	X	X			
RQ4 - Acceptability	X	X	X	X		X	X	X	X			
RQ5 - Barriers and facilitators to acceptability	X	X	X	X		X	X	X	X			
RQ6- Variations in acceptability		X		X			X		X	X		
RQ7 - Improvements	X	X	X	X	X	X	X	X	X			
RQ8 - Dosage											X	
RQ9 - Engagement	X	X	X	X	X	X	X	X	X		X	
RQ10 - Systemic bias	X	X	X	X						X	X	
RQ11 - Adherence (fidelity)						X					X	
RQ12- Barriers and	X				X							

	Interviews					Surveys				Admin data		
	Practitioner	Young person	School staff	Parent/ carer	SRM	Practitioner	Young person	School staff	Parent/ carer	Demographics	Programme data	BAU data
facilitators to fidelity												
RQ13 - Adaptations	X		X		X							
RQ14 - School context	X		X		X							
RQ15 - Practitioner experience	X				X	X						
RQ16 - Business as usual			X									X
RQ17 - Programme differentiation		X	X	X								X
RQ18 - Scaling	X		X		X							

Fidelity

We will take a number of approaches to measuring compliance and fidelity in the MindWorks trial (IPE pilot trial RQ9 & efficacy trial RQ11). Fidelity in this case means, the minimum level of activities/input that need to occur for a young person to be considered to have received MindWorks. This is particularly important to define in an adaptive and person-centered model such as MindWorks. As part of the success criteria, we will review fidelity following the pilot phase at the point of deciding whether to progress to the efficacy trial.

The fidelity markers we will use are the following:

Category	Fidelity marker	Minimum fidelity standard	Compliance level	Data source
Training and supervision	Practitioner training	Practitioners complete all 10 days of MindWorks training	Practitioner	Practitioner survey
	Practitioner supervision (frequency)	Practitioners receive a minimum of 90 minutes weekly small group supervision + additional 1:1 supervision as required	Practitioner	Practitioner survey
	Practitioner observation (frequency)	Practitioners are observed a minimum of twice a term during delivery sessions by their supervisor or other senior practitioner.	Practitioner	Practitioner survey
	Practitioner supervision and training (quality)	Practitioners provide feedback on their views of the amount and quality of their training, supervision, support in joint working/safeguarding and additional CPD. Minimum fidelity standard will be if at least half of practitioners report each item to be 'acceptable' or above.	Practitioner	Practitioner survey
Quality	Practitioner quality	Supervisors rate practitioners as meeting minimum quality standards as determined by their experience of supervision and joint working/observations. Quality factors will include ratings of cultural sensitivity. The full framework for this will be developed in collaboration between the EYVL and Anna Freud teams as part of the mobilisation phase, with input from the lived experience panels (YAB, YAG and PAG) where appropriate.	Practitioner	Termly checklist form, completed by supervisors. Exact items and minimum expected standard will be determined in the mobilisation phase, but may include items such as 'practitioner brings appropriate topics to supervision', 'practitioner escalates safeguarding issues appropriately', 'practitioner brings a mentalizing stance to their work'.

Delivery of minimum programme components	Caseload size	Practitioners have appropriate caseload size (6-8 young people per term)	Practitioner	Case notes
	Start-up phase	1 session with young person of a minimum 30 minutes contains the following elements: ● Use of structured assessment questions ● Goal setting ● Enquiring about trusted adults in YPs network ● Relationship and rapport building	Participant	Practitioner self-report as part of case notes for session
	Active intervention phase (individual sessions)	● Minimum of 4 [67] sessions of 30 minutes each ● Young person and practitioner present (plus additional trusted adult if the young person requests this) ● Sessions should cover a minimum of 4 of the 6 core topics across the intervention: ○ Anger management / emotional regulation ○ Problem-solving skills ○ Cognitive restructuring ○ Social skills training ○ Peer influence and pressure ○ Identity & self-worth	Participant	Practitioner self-report as part of case notes for session
	Active intervention phase (network sessions)	● Minimum of 2 network sessions, 30 minutes each with at least 2 members of the young person's network ● Across the sessions, the practitioner must: ○ Share the young person's goals for the programme with the network ○ Discuss the young person's challenges and strengths	Participant	Practitioner self-report as part of case notes for session

[67] This threshold aligns with the 6-8 session models used in Anna Freud's community teams and remote service which see a change in outcomes including goal setting.

		○ Identify how the young person's behaviour is being responded to by the network ○ Co-generate alternative responses to behaviour		
	Sustainability phase	● Final individual session with the young person, of a minimum of 30 minutes ● This session should include: ○ Reviewing the initial goals for the programme ○ Reviewing the trusted adults in the system and how they can support the young person going forward ○ Discussing how the young person can respond to future challenges and who can support them ● Creation of a written action plan, shared with the young person and their network	Participant	Practitioner self-report as part of case notes for session

Data analysis

We will use the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2022), to inform data collection and analysis, particularly the analysis of barriers and facilitators. This involves looking at factors in the inner and outer context as well as the individuals involved in the intervention, to understand barriers and facilitators to implementation.

We will analyse data from each element of the IPE separately, then triangulate and integrate, identifying areas of difference and reinforcement, and using different data sources to substantiate and explain findings. This includes data to test the Theory of Change and the hypothesised mechanisms.

Quantitative IPE data

We will assess fidelity to the model through the criteria set out above using practitioner logs, supervision data and programme administrative data. We will comment on what proportion of practitioners / young people met each fidelity criteria, and qualitatively explore the reasons for any deviation.

We will explore change in Goal Based Outcomes for young people in the MindWorks arm between baseline and endline. Additional quantitative data (survey responses, engagement data etc.) will be reported descriptively. We will additionally provide descriptive statistics on how these data vary across key demographics (gender, ethnicity) but expect the sample size to be too small to make any statistical inference about differences between these groups.

Qualitative IPE data

Qualitative data will be analysed using a version of the framework approach, which is widely used in applied social research. Framework analysis will be undertaken to examine and interpret qualitative data, with themes developed both deductively and inductively to include unexpected issues. Framework analysis facilitates systematic theme-based comparison within study populations (e.g. between different groups of CYP) and between study populations (e.g. comparing the views of practitioners, parents, school staff, and CYP), as well as within case analysis (e.g. exploring how the particular school context impacts on feasibility and perceived outcomes).

We will also utilise the insights of Dr Jessica Davies, YEF Race Equity Associate and advisory boards when approaching qualitative sub-group analysis, and qualitative analysis more broadly. Specifically, Dr Jessica Davies will provide consultation on how structural factors and researcher positionality may influence the themes that are extracted. This will further ensure the positionality of the research team is considered, and an equitable approach to analysis is

fostered throughout.

Integrating YEF's YAB, along with consulting the YEF Race Equity Associate during the analysis phase, enables members to function as peer researchers. This collaboration supports the research team in identifying biases or hidden subtext. This ensures findings and interpretations are culturally sensitive and not pathologising. To ensure meaningful involvement, the research team will provide accessible orientations to the framework analysis process, allowing members to review either anonymised data extracts or emergent thematic findings. The insights from young people will directly shape the findings by refining coding frameworks and adjusting thematic language. In instances of differing interpretations, we will engage in meaning-making dialogues, supported by Dr Jessica Davies. If a consensus is not reached, both perspectives will be represented in the final report to ensure the evaluation remains transparent and respects the expertise of lived experience.

Cost data reporting and collecting

We will report the cost of delivering the intervention in the final report, following YEF costing guidance.

We will:

- Use a bottom-up costing approach and break costs down into: staff; programme procurement; buildings and facilities; materials; and incentives for taking part.
- We will report the total cost for a typical single school receiving the intervention for one round of delivery and the costs per participant for one round of delivery, assuming full compliance.
- We will not consider evaluation activities
- Depending on heterogeneity in costs across schools, we will either report average costs, or select a case which we think is most representative of the costs we expect to be incurred in future, typical rounds of delivery. If costs differ between mainstream and AP schools we will present costs separately for these.

Anna Freud is the key delivery partner for this evaluation however schools also incur costs to provide the intervention which would be covered under YEF's costing guidance. To report cost at the end of this study, we will produce a template for Anna Freud and a sample of 6 schools (3 AP and 3 mainstream) to complete, covering staff costs, equipment/materials costs, programme procurement costs, and buildings and facilities costs. We will collect this information from Anna Freud at the end of each term of delivery, across both pilot and efficacy phases and from schools at the end of their term of delivery.

Diversity, equity and inclusion

This section outlines the steps that will be taken to ensure the evaluation is accessible to all, welcoming, and inclusive. The evaluation design explicitly addresses the systemic and structural disadvantages faced by minoritised groups and those who are disproportionately affected and/or underserved by existing services or delivery:

1. **Contextualising difficulties:** MindWorks is structured to avoid pathologising the young person's difficulties, instead situating challenges within the context of structural and environmental realities, such as experiences of discrimination and socioeconomic adversity. Practitioners are trained to explicitly contextualise difficulties within the structural realities of racism and systemic inequality.

2. **Targeting high-risk populations:** The MindWorks trial focuses on young people exhibiting significant difficulties with emotional regulation putting them at significant risk of school exclusion, ensuring resources are directed toward those most likely to benefit. We will recruit schools who report that they estimate at least 25 students in their school would meet the inclusion criteria, and wherever possible will recruit schools that are in areas of high socioeconomic deprivation or have a high proportion of racially minoritised students. We will also sample participants (for our qualitative and stakeholder engagement work) to capture a range of backgrounds and perspectives and ensure that there is the space within interviews and focus groups to explore specific equity and diversity issues.

3. **Accessible language and materials:** All information documentation provided to young people will be accessible and written in plain English. Parental information sheets are written in clear, understandable language. All written material will be reviewed by the PAG and the YAG to ensure clarity and non-stigmatisation. Information sheets will contain a QR code, phone number and email address so parents, young people and school staff can speak about the programme and the trial with the trial team.

4. **Accessible, inclusive and culturally sensitive material and survey design:** Broad survey content has been reviewed by our Race Equity advisors, and will also be reviewed by our YAG and PAG prior to the pilot phase beginning. Multiple tactics will be used to ensure that data collection for both young people and parents is flexible and accessible such as the choice of having questions read aloud, movement opportunities, translation services and offering breaks (see data collection section for further details).

5. **Compensation and incentives:** Both young people and parents/carers will be compensated for their time and expertise in completing surveys and engaging in interviews, promoting fairness for their contribution to the research.

6. **Minimising power imbalance:** In qualitative data collection, we will use an approach which includes tools and techniques to minimise the power imbalance between researchers and

participants, such as ensuring inclusive facilitation through displaying empathy and respect. We will use accessible language, give young people choice and control over data collection and respect them as the experts in their own experience.

7**. Contextualised and sensitive reporting:** Findings will be interpreted through a collaborative process with our youth advisory boards, YEF's Race Equity associate, Dr Jessica Davies, and expert REDI advisor, Dr Jalissa Clarke. This will ensure our final report goes beyond simply presenting numbers, by fully accounting for the racialised context of youth justice, explaining data limitations, and communicating findings in a sensitive and impactful way.

Participatory approach

The principle of participatory practice is central to our research approach, ensuring the amplification of voices of young people and communities with lived experience of adversity, discrimination, and exclusion. The co-design stage has involved stakeholder engagement with young people, parents, AP school staff and mainstream school staff. Views, ideas and experiences have been actively integrated into our evaluation design (see Appendix 2 for the full findings of these engagements). The pilot and efficacy trial will continue to engage young people via a youth advisory group. This will be held at four key points during the trial with a group of young people that represent the target group for MindWorks. We will also create a parent advisory group that will be convened at a similar frequency.

We will utilise our advisory groups as active participants in the research journey, recognising that it is easy to only include stakeholder input as tokenistic input after research decisions have been made. Instead, we will involve our advisory group throughout the research, inviting them to input on key trial decisions such as how consent is sought, how the evaluation and programme is presented, offer, provide feedback on information sheets and other materials, provide insight into any issues with delivery or evaluation that occur during the trial, assisting in interpreting findings, and helping to shape final recommendations.

Our approach will involve engaging two specialised advisory boards of young people, who will meet regularly with evaluators, as well as one advisory board of parents/carers. Where possible, we will leverage the Youth Endowment Fund Youth Advisory Board to harness the collective expertise of young people (aged 16 - 25) or engage with peer researchers from another local organisation, impacted by youth violence, in addition to the Youth Advisory Group (ages 11 - 16) recruited by Anna Freud and the Parent Advisory Group (Parent and Carer Champions). This approach is designed to dismantle traditional power hierarchies in research by embedding the lived experience of adversity, discrimination, and exclusion into the evaluation architecture.

We will hold in mind the social context and respect the boundaries of participants, ensuring the psychological safety essential for discussing sensitive topics is maintained alongside

flexible contribution. We will aim to provide options for how those within the advisory boards can contribute, ensuring involvement is meaningful and shaped by individual preference rather than predecided by researchers. This approach considers power dynamics and accessibility and ensures the benefits of involvement are defined by the participants themselves. Crucially, experts by experience will be fairly compensated, acknowledging systemic inequalities and the current cost of living crisis.

An example of how we could involve experts by experience include offering opportunities for co-designing meeting agendas which ensures that issues prioritised by minoritised communities are central to the evaluation, rather than peripheral. Similarly, allowing members to select their preferred engagement methods (e.g., virtual vs. in-person, written vs. verbal) respects the diverse logistical realities of families from marginalised backgrounds.

Another example of an option we hope to explore is for YEF YAB members to act as peer intermediaries, attending Youth Advisory Group sessions and supporting recruitment, for example, by providing explanations to families. This aims to increase the perceived safety of the space and encourages genuine engagement. It is important to note that these are only examples of potential ways of working alongside peer researchers as the ways in which we work with them in reality, will where possible be shaped by the peer researchers themselves.

Recruitment diversity

Schools will put forward young people for the programme that they feel would most benefit. We recognise that there is a risk of this perpetuating selection biases, for example young people from certain subgroups being less likely to be put forward as school has 'given up' on them, or behaviour being interpreted differently through a racialised lens. In both the pilot and efficacy trials, we will review the characteristics of young people referred to the programme, consented to the programme and disengaged from the programme/trial. We will evaluate whether characteristics of these groups (such as gender, age, ethnicity, FSM status, additional educational needs, social care involvement) are reflective of the wider youth justice population. If not, further information on this issue will be sought, via IPE interviews, administrative data or informal conversations with school, practitioners, parents and young people to try and understand the reason for this, and to adjust the approach to the evaluation or programme delivery to better meet the needs of minoritised young people.

Evaluation team experience

The evaluation team has extensive experience working with vulnerable and marginalised communities. EYVL has considerable expertise in violence reduction interventions and evaluating psychologically informed programmes with vulnerable groups. Our team members have been involved in multiple projects focused on working with marginalised communities including the YEF sponsored Summer Jobs feasibility study, looking at the impact of

employment on young people vulnerable to violence (Tom McBride, Dr Clare Tanton), an evaluation of a YEF funded Boxing intervention for young people at risk of involvement in violence (Tom McBride), an evaluation of a coaching intervention for young care leavers (Dr Clare Tanton, Dr Akanksha Vardani and Dr Emily Gray), and a feasibility study of a school-based mentoring programme for young people at risk of becoming not in education, employment or training (Dr Clare Tanton, Dr Emily Gray).

All staff conducting qualitative interviews will have completed training in inclusive and trauma-informed qualitative research processes, local safeguarding procedures, NSPCC's Introduction to safeguarding and child protection training, and interviewing best-practice. Our IPE lead (Dr Emily Gray) is a Clinical Psychologist with experience delivering psychological interventions and assessments with vulnerable and marginalised individuals. We recognise that researcher positionality will impact on qualitative data collection, such as researcher ethnicity, educational experience, gender and class. Dr Jessica Davies (YEF Race Equity Associate) will be offering termly sessions with the evaluation team collecting qualitative data to reflect on positionality, bias and issues of equity in the data collection process.

Delivery team experience

The project team has extensive experience working with vulnerable and marginalised communities, for example:

- Leading the delivery of three school and community based clinical services across three London boroughs, delivering culturally sensitive individual and group interventions, plus additional support for e.g., neurodiverse young people, non-English speakers, and unaccompanied asylum-seeking children (Dr Lesley French).
- Co-Directing our AMBIT programme (Dr Laura Talbot). AMBIT is an approach to support teams improve how they help clients who experience multiple disadvantage, who have often also developed adaptive mistrust of professionals. Laura also has extensive clinical experience of working with marginalised adolescents and their families impacted by trauma, violence and exploitation in a range of school and community outreach settings, as a practitioner, supervisor and clinical lead.
- Consultant clinical psychologist and academic researcher, focusing on the impacts of childhood trauma, conduct problems, and subsequent pathways to mental health difficulties (Prof. Eamon McCrory). Eamon's clinical expertise is rooted in working directly with young people who have histories of trauma and who exhibit significant behavioural challenges, including severe conduct problems and sexually harmful behaviours.

More broadly, Anna Freud has considerable expertise in working with vulnerable and marginalised communities, including:

- Our Schools division worked alongside expert anti-racism groups to create new resources for schools on anti-racism and mental health.
- The UK Trauma Council, a project of Anna Freud, is the first UK-wide platform bringing together expertise in research, practice, policy and lived experience in the field of childhood trauma
- Our Applied Research and Evaluation division has significant experience of conducting research with CYP at risk of crime and youth violence, as well as their families, across youth justice, community and education settings. Advisors from this division will offer in-kind, advisory support to this project.

Ethics and registration

This trial is self-assessed as being high risk due to the inclusion of high-risk participants in the form of vulnerable young people. As a result we will seek ethical approval from an independent panel of external experts with experience of working with vulnerable children and experience with safeguarding and child protection.

The independent ethics review committee (ERC) will review the following information:

- Ethical review form.
- All participant-facing materials, including consent forms and information sheets for young people.
- Topic guides.
- Surveys.
- Safeguarding and distress protocol.

The ERC will discuss any issues raised by the research with the aim of finding solutions that meet ethical requirements. If there are substantial changes while the research or evaluation is being implemented, the ethics form will be revised and the revisions agreed with the ERC.

The pilot and efficacy trials will be registered at *www.controlled-trials.com*.

Data protection

We will follow appropriate data protection processes in accordance with BIT processes, including completing a Data Protection and Security Checklist and Data Protection Impact Assessment, which will be reviewed and approved by BIT's legal team.

EYVL and Anna Freud will store and handle all data securely and confidentially in line with requirements of the UK GDPR, and Data Protection Act (2018), including that Personal Data shall be processed lawfully, fairly and in a transparent manner that ensures the security of

the Personal Data. It is initially proposed that only EYVL and Anna Freud will have access to data collected as part of the evaluation.

EYVL and Anna Freud will be independent controllers who will also process data. The legal basis will be "legitimate interest". Article 6(1)(f) of UK GDPR states that "*processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child*." For the special category data we will be processing, the Article 9 condition we are relying on will be "scientific research purposes". For the data on involvement with the criminal justice system, as per Article 10, we will be relying on "scientific research purposes".

We determine that there is a genuine purpose to process this data. This data will inform building the necessary evidence around what works to reduce offending and build young people's social and emotional competencies. Data processing is necessary to complete a robust evaluation. The data subjects will include: at-risk youth, parents/carers and school staff.

During this trial, data will be stored on secure, password-protected and encrypted network drives (hosted by BIT). Access to the data will be restricted to the relevant members of the project team involved in this evaluation.

If a Personal Data Breach occurs despite the mitigations in place, project team staff will deal with the security incident without undue delays. All Personal Data Breaches (or suspected Personal Data Breaches) will be reported to BIT's Data Protection Officer as soon as a project team member becomes aware of one (including if this is outside of office hours) by contacting the Data Protection Officer directly and by completing a Data Incident Notification Form. Staff will not attempt to investigate a Personal Data Breach themselves but will take steps to contain the Personal Data Breach as quickly as possible. Such steps might be taken prior to reporting the incident to the Data Protection Officer where this is reasonable and necessary to protect Data Subjects and mitigate the potential impact of the Personal Data Breach.

Stakeholders and interests

Developer and delivery team

Name	Role	Role description	Institutional affiliation

Prof. Eamon McCrory	Programme Director – Strategic (0.2 FTE - funded + in-kind)	Project oversight, quality assurance and strategy. Jointly leading the delivery team, with a primary focus on strategic oversight and close working with evaluation partners. Responsible for ensuring alignment between programme delivery and trial design, supporting methodological rigour, and addressing strategic risks related to recruitment, implementation and fidelity. The key liaison contact with the evaluation team, contributing to interpretation of findings and ensuring that learning from the trial is clearly communicated to funders, policymakers and the wider sector.	Anna Freud & UCL
Dr Lesley French	Programme Director - Operational	Operational oversight of delivery teams, including safeguarding. Jointly leading the delivery team, with a primary focus on operational oversight and delivery of the MindWorks intervention. Responsible for delivery quality, risk management and overall safeguarding oversight. Line management of the Head of Service.	Anna Freud
Laura Lucas	Schools Relationship Manager	Responsible for leading recruitment of all participating schools to target and co-ordinating: engagement; participant recruitment; scheduling; intervention timetables; and liaison with school staff, building relationships to ensure successful collaboration and retention. Overseeing engagement and onboarding of new schools to the delivery timetable, including completion of MoUs. Holding responsibility for school recruitment KPIs, including active networking with schools and school leaders to secure engagement and maintain momentum. Line management of the Project Manager.	UCL
Harriet Phillips	Project Manager	Supporting the coordination of all delivery activities, with a focus on supporting the SRM to recruit, engage and sustain relationships with mainstream and alternative provision schools.	UCL

Dr Laura Talbot	Training Development Lead	Overall responsibility for training development, delivery and ongoing supervision in the MindWorks model. Leading training delivery for all delivery teams.	Anna Freud
AMBIT team	Training Delivery Leads	Supporting training development and co-facilitating training for delivery teams. Ongoing support and supervision in the MindWorks model and supporting AMBIT model throughout delivery.	Anna Freud
To be recruited (TBR)	Head of Service	Working closely with the SRM to coordinate recruitment activity, manage the recruitment pipeline, and ensure we meet agreed recruitment targets and timelines. Overseeing delivery of the CPD offer for schools in the control arm of the trial, including planning, coordinating, and delivering training, and maintaining engagement with those schools throughout the trial period. Holding responsibility for implementation issues within local systems and resolving operational barriers to delivery. Managing operational risk, including safeguarding oversight, escalation pathways, and operational issue resolution. Line management and supervision of the Deputy Head of Service, and overall accountability for ensuring issues are addressed promptly and safely.	Anna Freud
TBR	Deputy Head of Service	Line manages the Senior Practitioners and provides expert clinical guidance across the teams, including consultation on individual cases (there will be approximately 60 active cases in a typical term). Overseeing clinical staff appraisals and performance reviews. Ensuring consistency in practice, including maintaining a culturally sensitive and appropriately adapted approach across the caseload and workforce. Identifying team training needs and ensuring these are promptly addressed through targeted support and development.	Anna Freud

		Managing initial safeguarding concerns, including triage and appropriate escalation.	
TBR	Senior Practitioners	Line manages three wellbeing practitioners, overseeing workload, priorities, and day to day problem solving. Providing weekly 1:1 supervision for each practitioner, with oversight of 18-24 active cases per term. Offering on-the-spot clinical consultation to support case planning, engagement, and effective delivery, with the young person and wider system including teachers and parents. Troubleshooting and resolving on-the-ground delivery challenges with schools and families, escalating where needed. Coordinating and line-managing the admin support to ensure smooth scheduling, communication, and timely documentation. Maintaining consistent, culturally sensitive practice across the team and feeding training needs and themes to the Head of Service.	Anna Freud
TBR	Practitioners	Delivery of intervention. Expected caseloads: 6-8 children and young people each over a given term. One team of 3 Practitioners would deliver N=18-24 cases per school per term. Delivering direct work with young people, including assessment, goal setting, structured sessions, and review, adapting approaches to be culturally sensitive and appropriate to the young person's context and needs. Delivering the MindWorks intervention in line with the model and agreed timelines. Engaging parents and carers where appropriate, and working collaboratively with school staff to support engagement, formulation, and agreed strategies to support the young person. Identifying, monitoring, and responding to risk and safeguarding concerns, following policy and escalation	Anna Freud

		pathways, and documenting actions clearly and promptly. Maintaining accurate, timely case records and contributing to required monitoring and reporting, including session logs, outcomes measures, and any trial-related documentation. Participating in weekly supervision and team meetings, using feedback to strengthen practice and maintain consistency of delivery across the team. Contributing to smooth day-to-day running of delivery by liaising with the team admin and schools regarding scheduling, consent, communications, and other practical arrangements.	
TBR	Administrators	Frontline liaison with families regarding appointment booking. Clinical administration and monitoring; supporting HoS with reporting.	Anna Freud
Jalissa Clarke / Irene Brown-Martin	EDI Consultant	EDI expertise throughout - including clinical consultation on race equity for the delivery team.	Anna Freud
Participation Team (TBA)	Participation Lead and Participation Officer	Leading engagement with and feedback from young people and parents throughout delivery.	Anna Freud
Profs Jess Deighton, Julian Edbrooke-Childs, Peter Fonagy, and Peter Fuggle	Academic Advisory Panel	Expert consultancy in the AMBIT model and conducting evaluations in school and crime and justice contexts, to support intervention and evaluation delivery.	Anna Freud & UCL
Academic Consultant	Prof. Essi Viding	Providing senior methodological and scientific guidance in relation to implementation and delivery. Advising the delivery team in developing a successful recruitment plan, support with existing AP network links and advice in relation to effective data collection, and storage, drawing on extensive expertise in recruitment of schools and research in young people with conduct problems. Helping advise the evaluation team as needed in relation to methodology and translation of results into	UCL

		learning that is relevant for policy, practice and future research.	
Rachel Hart	IG Consultant	Supporting the Programme team to establish IG protocols and notices, plus ongoing support throughout delivery.	Anna Freud

*** In Kind roles**

NOTE: Please see Anna Freud's team structure and budget for further information on costed and in-kind roles.

Evaluation team

Name	Role and responsibility	Institutional affiliation
Tom McBride	Project director. Responsible for ultimate project oversight and quality assurance.	The Ending Youth Violence Lab
Dr Clare Tanton	Project manager. Responsible for day to day project delivery, budget and timeline management.	The Ending Youth Violence Lab/The Behavioural Insights Team
Dr Emily Gray	IPE delivery. Responsible for delivery of the IPE aspect of the pilot and efficacy trial.	The Ending Youth Violence Lab/The Behavioural Insights Team
Dr Akanksha Vardani	Impact evaluation. Responsible for the impact evaluation aspect of the pilot and efficacy trial.	The Ending Youth Violence Lab/The Behavioural Insights Team

Risks

Please see attached risk register and mitigations for full version

Category	Risk	Risk Rating	Mitigation
Evaluation	Mindworks does not have a feasibility study for this specific population.	12 (Moderate)	Building on an evidence-based systemic CBT foundation and utilising a robust co-design phase and internal pilot to mitigate the absence of a standalone feasibility study.
Delivery	Inconsistent intervention delivery.	15 (High)	Ensuring delivery consistency through a standardized framework that tracks fidelity across four phases and provides weekly clinical supervision.

Delivery	Risk of inadequate practitioner competence and supervision.	12 (Moderate)	Managing competence through rigorous selection criteria, a mandatory training programme, and continuous oversight via weekly small group reflective supervision.
Evaluation	Distress caused to young people and families through evaluation activities such as measuring sensitive outcomes.	16 (High)	Using non-stigmatizing language, empowering participants to terminate sessions at any time, and adhering to a distress policy with school staff on standby.
Evaluation and Delivery	Assessment of suicidality if risk is identified at any point.	15 (High)	Maintaining safety by excluding actively suicidal individuals at referral and training practitioners to escalate issues through mandatory supervision.
Delivery	Safeguarding concerns may arise when working with vulnerable CYP or adults.	12 (Moderate)	Ensuring all staff undergo safeguarding training, follow institutional procedures, and operate within a trauma-informed systemic framework.
Evaluation and Delivery	Risk of physical, verbal or emotional harm to delivery and evaluation staff from participating young people.	20 (High)	Protecting practitioners and evaluators through trauma-informed training, weekly clinical supervision, and having school staff on standby during data collection.
Evaluation	Risk of increased stigma, poor self-identity and re-traumatisation for CYP and their families.	16 (High)	Shifting focus from individual blame to structural realities utilizing culturally responsive principles and practitioners trained in race-equity stances.
Project Management	Lack of clarity and communication between consortium partners.	4 (Low)	Maintaining alignment through a collaborative co-design phase and regular check-ins based on an established foundation of trust.
Evaluation	Lack of informed consent.	10 (Moderate)	Utilizing a multi-layered process with age-appropriate information sheets. Requiring child written assent and offering the opportunity for parental opt out via at least two communications.
Evaluation	Acceptability of randomisation and feeling of rejection for CYP and families.	9 (Moderate)	Utilizing school-level randomisation, compensating participants with vouchers, and offering specialized training as an incentive for control schools.
Delivery	Risk of the long term harm of CBT to minoritised youth.	15 (High)	Mitigating risks of culturally insensitive CBT by hiring a diverse workforce and providing training in racial trauma and race equity.
Evaluation	Difficulty recruiting sample size needed to power the study.	15 (High)	Monitoring recruitment feasibility through an internal pilot with contingency plans to increase school numbers or adapt eligibility criteria.
Evaluation	Risk of young people not completing the surveys.	12 (Moderate)	Encouraging engagement through incentive vouchers, transparent communication about confidentiality,

			and flexible data collection methods such as mop-up days.
Evaluation	Risk of school staff not completing the surveys.	12 (Moderate)	Reducing administrative burden with brief digital surveys and providing financial incentives and CPD training for control schools.
Evaluation	Lack of CYP and parent/carer engagement.	16 (High)	Utilizing flexible, person-centered delivery, proactively monitoring engagement issues, and confirming parental investment during onboarding.
Delivery	Delivery staff having to travel between geographical locations as a result of school randomisation.	9 (Moderate)	Managing challenges through stratified sampling, assigning practitioners to geographical 'patches', and utilizing a dedicated schools relationship manager.
Delivery	Ensuring inclusivity for neurodivergent children and young people and their families.	12 (Moderate)	Training staff to assume hidden neurodiversity and providing practical adaptations, such as fidget toys and movement breaks.
Evaluation	Identifying that a Child or Young Person (CYP) is eligible for the MindWorks intervention but lacks an adequate supporting network.	9 (Moderate)	Requiring at least one willing supporting adult for eligibility and referring participants to external programs if the network is insufficient.
Evaluation	Safeguarding risks of online data collection or home visits.	9 (Moderate)	Maintaining high thresholds for home visits, preferring public community spaces, and strictly following lone working policies and protocols.
Evaluation	Risks to treatment fidelity when scaling up.	12 (Moderate)	MindWorks implements strict workforce controls, standardizes recruitment and training to ensure practitioner competence, and conducts ongoing quarterly quality checks to protect the intervention's integrity.
Delivery	Risk of delivering intervention in a context that is not receptive and difficulty building trust.	12 (Moderate)	Requiring at least one willing school adult per referral and training practitioners to address institutional bias through collaborative problem-solving.
Delivery	Risks to sustainability due to one term delivery.	9 (Moderate)	Promoting long-term impact by embedding the intervention systemically within the school network to ensure staff reinforce techniques after the program concludes.
Delivery	Staff attrition of practitioners.	16 (High)	Mitigating attrition by assigning two practitioners per school, providing mandatory weekly supervision, and monitoring well-being.
Delivery	Delivery complexity of working across AP and mainstream schools.	12 (Moderate)	Using the pilot phase to monitor feasibility across Alternative Provision and mainstream settings to allow for targeted refinements.

Evaluation and Delivery	Risk of not meeting minimum target for diversity amongst the cohort and intervention not being provided to young people who would most benefit from it due to structural racism and inequality.	15 (High)	Embedding race equity through expert advisor guidance, advisory groups, and proactive monitoring of demographic characteristics.
Evaluation	Poorly understood or unclear eligibility criteria.	16 (High)	Testing criteria developed through extensive co-design during the pilot phase to ensure they accurately identify the target population.
Evaluation	Fluidity of the population and risk of CYP moving schools.	16 (High)	Managing retention by following students across schools, utilizing dual enrollment records, and deploying a Relationship Manager to maintain institutional buy-in.
Evaluation	Lack of school engagement.	12 (Moderate)	Requiring at least one willing school adult per referral and training practitioners to address institutional bias through collaborative problem-solving.

Timeline

Milestone	Date	Evaluation Activities	Delivery Activities
Set Up and Mobilisation	Feb 2026 - Aug 2026	• Finalising the protocol, creating data sharing agreements (DPIAs), developing patient facing information, surveys and qualitative topic guides. • Obtaining ethical approval, completing trial registration and protocol publication and designing templates for administrative data (school/practitioner) and cost data collection. • Training practitioners specifically on how to follow evaluation procedures and collect cost data.	• Gathering curriculum materials, developing bespoke training content, and refining materials. • Recruitment process including advertising, shortlisting, interviewing, pre-employment checks, and issuing contracts for practitioners. • Practitioner induction, training on the intervention curriculum, and scheduling training dates. • Establishing clinical monitoring systems to ensure the safety and quality of the practice delivered to participants.

		• Forming and engaging the youth and parent/carer advisory groups.	
Pilot Phase Cohort 1	April 2026 - Mar 2027	• School level randomisation and communication of assignment. • Baseline and follow-up quantitative data collection for cohort 1. • IPE qualitative data collection and fidelity monitoring for cohort 1. • Receiving, checking, and cleaning administrative and case note data. • Engagement with advisory boards.	• School recruitment and onboarding for all pilot schools. • Handling referrals within the schools and providing specific training to school staff on how the program works. • Consent collection and delivery of the intervention to cohort 1. • Delivery of CPD to control arm parents and school staff.
Pilot Phase Cohort 2	Sep 2026 - July 2027	• School-level randomisation and communicating assignments. • Baseline and follow-up quantitative data collection for cohort 2 • Drafting and submitting the transition decision document to enable the YEF progression decision. • IPE qualitative data collection and fidelity monitoring for cohort 2. • Receiving, checking, and cleaning administrative data. • Engagement with advisory boards.	• Handling referrals and providing training to school staff. • Consent collection and delivery of the intervention to cohort 2. • Delivery of CPD to control arm parents and school staff.

Pilot Phase Cohort 3	Jan 2027 - Dec 2027	● Randomisation and communicating group assignments. ● Baseline and follow-up quantitative data collection for cohort 3 ● IPE qualitative data collection and fidelity monitoring for cohort 3. ● Receiving, checking, and cleaning administrative data. ● Collaborative pilot phase review of lessons learned. ● Engagement with advisory boards.	● Handling referrals and providing training to school staff. ● Consent collection and delivery of the intervention to cohort 3. ● Delivery of CPD to control arm parents and school staff.
Efficacy Phase Cohort 4	Apr 2027 - Mar 2028	● Randomisation and communicating group assignments. ● Baseline and follow-up quantitative data collection for cohort 4 ● IPE qualitative data collection and fidelity monitoring for cohort 4. ● Receiving, checking, and cleaning administrative data. ● Collaborative pilot phase review of lessons learned. ● Engagement with advisory boards.	● Year 2 school recruitment, school staff training, and handling referrals for cohort 4. ● Consent collection and delivery of the intervention to cohort 4. ● Delivery of CPD to control arm parents and school staff.
Efficacy Phase Cohort 5	Sep 2027 - July 2028	● Randomisation and communicating group assignments. ● Baseline and follow-up quantitative data collection for cohort 5 ● IPE qualitative data collection and fidelity monitoring for cohort 5. ● Receiving, checking, and cleaning administrative data.	● Handling referrals and providing training to school staff. ● Consent collection and delivery of the intervention to cohort 5. ● Delivery of CPD to control arm parents and school staff.

		● Engagement with advisory boards.	
Efficacy Phase Cohort 6	Jan 2028 - Dec 2028	● Randomisation and communicating group assignments. ● Baseline and follow-up quantitative data collection for cohort 6 ● IPE qualitative data collection and fidelity monitoring for cohort 6. ● Receiving, checking, and cleaning administrative data. ● Engagement with advisory boards including dissemination. ● Drafting and submitting the final evaluation report, including managing two rounds of peer review. ● Supporting the publication process and hosting virtual events to share findings.	● Referrals within schools and training school staff for cohort 6. ● Consent collection and delivery of the intervention. ● Delivery of CPD to control arm parents and school staff.
Performance / Monitoring	Mar 2026 - Sep 2029	● Submit quarterly monitoring to the online community. ● Submission of end of project report and project budgets.	

Appendix 1. Race equity considerations in CBT for young people (MindWorks RCT)

Introduction

We appreciate the panel's feedback and would like to address concerns raised about CBT, particularly its application with racially minoritised young people. At Anna Freud we fully recognise that there are broader systemic issues that drive the overrepresentation of minoritised young people in the criminal justice system – and more broadly for many young people impacted by poverty, parental mental illness, discrimination, and trauma. We agree that all interventions should avoid locating the problem solely within the individual.

We are acutely aware of young people having to navigate the world they find themselves in, including schools/APs who are more likely to resort to sanction as a first response without seeking to understand behaviour in a trauma informed manner that recognises the impact of developmental adversity and the role of racism and structural inequality. This behaviour in such contexts significantly risks restricting their education, relationships, and future opportunities. MindWorks seeks to address the difficulties that young people are experiencing in their lives today, in order to support them in achieving better life chances. In doing so, the intervention combines evidence-based and culturally informed CBT practice with systemic and relational approaches that aim to validate and empower the young person and address risk factors in the contexts around them.

In other words MindWorks is not an individualised intervention in isolation. Nor does it replace the need for structural and sociocultural transformation to create a more equal society. Rather it addresses one level of the challenge – working with the systems around the young person, including families, schools, and communities, and is delivered by practitioners trained to contextualise difficulties within structural and environmental realities. This ensures the young person is not pathologised but instead supported in the context of their lived experience.

Anna Freud's commitment to race equity and work with minoritised young people

Anna Freud and UCL's long-standing partnership brings a shared and demonstrated commitment to equity, diversity and inclusion, which directly informs the design and delivery of the MindWorks programme. Both organisations have extensive experience working with young people from racially minoritised backgrounds who are disproportionately affected by exclusion, poverty and systemic discrimination. This collaboration enhances our capacity to deliver culturally competent, inclusive and representative interventions.

Following the death of George Floyd, Anna Freud undertook a fundamental review of its approach to Race, Equity, Diversity and Inclusion (REDI). The resulting organisational strategy, Closing the Gap, embeds REDI principles across all aspects of our work, from leadership and governance to service delivery and research. We have achieved measurable progress toward representation, with nearly one in four colleagues now identifying as from a minoritised ethnic background, including over one in five in senior roles. This structural progress is matched by a focus on inclusion and belonging, continuous learning, and participatory practice that amplifies the voices of young people and communities with lived experience of adversity, discrimination and exclusion.

Through programmes such as the UK Trauma Council and the National Autism Trainer Programme, we actively involve people with lived experience in training, research and service design, ensuring that our interventions reflect and respond to the realities of those they serve. This participatory approach is central to MindWorks and our race-equity stance in the delivery of CBT-based interventions.

MindWorks: An overview of race equity and cultural responsiveness

As we outline below we are embedding race equity at every stage of the programme. This includes:

- Co-design and input from race equity experts and young people from diverse backgrounds
- Training practitioners to create space for young people and their parents and carers to discuss experiences of racism and discrimination, ensuring that this conducted in a trauma-informed these experiences are validated and integrated into therapeutic work
- Training practitioners to support school staff in a) understanding behaviour through a mentalizing lens, with explicit attention to how oppression and intersecting aspects of identity influence student behaviour and shape responses to it and b) considering how they (school staff) can adapt their approach and responses to the young person and their family based on this understanding
- Using culturally adapted CBT practices that emphasise cultural pride, racial socialisation, and strengths-based approaches
- Ongoing reflective supervision to ensure fidelity to these principles.

MindWorks and the nature of CBT

MindWorks is a systemic, youth-focused CBT intervention. Our approach to race equity in CBT is grounded in the recognition that young people's mental health challenges often arise from systemic and structural inequalities. We fully agree that there is potential harm if CBT were to "locate the problem" in the young person, for instance, pathologising a normal stress

reaction to racism – rather than acknowledging environmental, systemic and societal contributors. The MindWorks intervention explicitly avoids blaming the young person. Instead, it situates their difficulties in context (for example, experiences of discrimination, socioeconomic adversity) while still providing access to an evidence-based treatment.

There is robust evidence that CBT can be effective for racially and ethnically diverse youth when it is delivered in a culturally responsive way. Meta-analyses show that racially minoritised young people benefit as much as their non-minoritised peers when CBT is appropriately adapted to their lived experience (Huey et al., 2023; Smith et al., 2011). Programmes such as Coping Power and Multisystemic Therapy have demonstrated consistent efficacy across ethnic groups, including among African American and racially diverse UK youth (Lochman & Wells, 2002; Butler et al., 2011).

However, as Andrew Beck (2019) emphasises, therapists must understand and address racism as part of assessment, formulation and treatment. Experiences of racism are cumulative risk factors for poor mental health, and ignoring them risks alienating service users and misrepresenting the source of distress. Beck's framework provides practical guidance for therapists on incorporating discussions of racism and cultural context into CBT formulations, building rapport and trust, and ensuring therapy acknowledges the real social environments young people inhabit. This approach aligns closely with the design of MindWorks, where practitioners are explicitly trained to integrate awareness of racism, discrimination and cultural identity into assessment and treatment, validating young people's lived experiences rather than pathologising their responses to systemic inequality.

Potential risks of a culture-blind CBT approach

While the extant evidence noted above suggests that CBT as a therapeutic approach is sound, applying it without cultural adaptation or sensitivity can pose risks. Standard CBT focuses on individuals' cognitions and behaviours, which, if delivered in a vacuum, may inadvertently send the message that the problem lies solely within the young person, rather than in the injustices they have experienced in their daily lives.

An exclusively individual-focused CBT approach with marginalised clients can overlook systemic influences and make clients feel blamed for their difficulties (Steele, 2020). Clinicians have noted that ignoring oppressive social-context factors in therapy can lead to disengagement, dissatisfaction, or early dropout (Hanna & Cardona, 2013; Rathod et al., 2019).

For example, a Black adolescent describing anxiety or anger stemming from repeated experiences of racism could feel invalidated if a therapist were to reframe their thoughts without acknowledging the reality of discrimination. A "culture-blind" CBT intervention risks pathologising a young person's natural responses to racism (such as hypervigilance or

mistrust) instead of validating and seeking to understand their experience. This potential harm is precisely what we would seek to avoid and why MindWorks has taken from the outset a systemic approach. By design, our intervention frames the young person's difficulties in the context of systemic racism, community violence, and other environmental stressors rather than as personal failings.

Effectiveness of CBT for minoritised youth

Taking a broad view, the general evidence base indicates that CBT is generally effective for racially minoritised groups across a range of mental health problems (Huey et al., 2023). A review of randomised trials concluded that CBT produces meaningful benefits for ethnic minority clients, with no significant differences in effect size compared to White clients (Huey et al., 2023). In some cases, evidence-based interventions have shown equivalent or even greater efficacy in minority youth relative to majority populations (Smith et al., 2011).

In the domain of conduct problems, multiple studies have included high proportions of racially minoritised youth and found no diminution of treatment effects. The Coping Power programme – a CBT-based group intervention for youth with aggressive and disruptive behaviour – improved delinquency outcomes in both African American and White boys, with no moderation of efficacy by ethnicity (Lochman & Wells, 2002). Similarly, systemic interventions that incorporate CBT techniques have proven effective in diverse populations. Multisystemic Therapy (MST), a family- and community-based CBT intervention for serious conduct problems, has yielded significant reductions in re-arrest rates and antisocial behaviour in multiethnic samples, primarily African American youth (Henggeler et al., 1998; Timmons-Mitchell et al., 2006). Notably, trials of MST in the UK have also demonstrated positive outcomes for youths from ethnically diverse backgrounds (Butler et al., 2011).

In summary, there is little direct evidence that CBT is inherently less effective for racially minoritised young people. On the contrary, when delivered appropriately the evidence suggests it has the potential to benefit these young people as much as their non-minoritised peers. However, the concern which we share is how CBT is delivered: a culturally blind approach may disengage, harm or alienate clients; a culturally attuned approach is essential to avoid such outcomes, and enhance.

Culturally responsive CBT: adapting the model to lived experience

Beck (2019) highlights that many therapists lack confidence in asking about race, ethnicity and experiences of racism, fearing they might get it wrong. Yet, evidence shows that openly and sensitively exploring these topics can strengthen the therapeutic alliance and improve outcomes for racially minoritised clients. MindWorks incorporates these principles directly into practitioner training and supervision to ensure that practitioners are equipped to:

- Confidently and respectfully ask about culture, ethnicity and faith once trust has been established
- Explore experiences of racism as part of the young person's lived reality and psychological formulation
- Integrate these insights into case formulations and maintenance cycles
- Use supervision to reflect on their own biases and emotional responses when engaging with issues of racism and discrimination.

Our systemically embedded CBT approach is flexible and can be adapted to incorporate clients' cultural identities and experiences of oppression (Rathod et al., 2019; Huey et al., 2023). MindWorks draws on established practices and evidence for culturally adapted approaches in the following way:

- Addressing internalised oppression: CBT can help young people recognise and challenge negative beliefs that stem from racism. Steele (2020) highlights how internalised racism can produce core beliefs of inferiority or shame; culturally attuned CBT explicitly reframes these as products of external oppression rather than personal truth.
- Contextualising cognitive techniques: Therapists are trained to distinguish between cognitive distortions and adaptive vigilance shaped by real-world racism. Williams et al. (2023) stress that techniques like cognitive restructuring must be applied in ways that validate the reality of discrimination while supporting adaptive coping.
- Leveraging cultural strengths: Adapted CBT often integrates racial socialisation, cultural pride, and family strengths, which have been shown to buffer against negative outcomes (Yasui & Dishion, 2007; Metzger et al., 2021).
- Models for racial trauma-focused CBT: Williams et al. (2023) describe a structured CBT approach for stress and trauma due to racism, emphasising phases of cultural assessment, stabilisation, healing, and empowerment. Metzger et al. (2021) show how integrating racial socialisation into Trauma-Focused CBT for African American young people can enhance engagement and outcomes.

These adaptations help to ensure that CBT validates and empowers minoritised young people, locating difficulties within systemic contexts rather than in the individual.

Practitioner workforce diversity

We recognise the importance of a diverse and representative practitioner workforce. Anna Freud has a strong track record in attracting, recruiting, and supporting practitioners from a range of backgrounds, and we will take proactive steps to ensure MindWorks draws from and reflects this experience. Our recruitment strategy will emphasise positive action to attract a broad and diverse applicant pool.

Practitioner training and preparedness

Delivering MindWorks with fidelity to a race-equity stance will involve comprehensive practitioner training that includes the following components, including:

- Self-reflection and bias awareness (Hanna, Talley, & Guindon, 2000)
- Creating safe, trusting therapeutic spaces (Williams et al., 2023)
- Open, respectful dialogue about race and culture (Hanna & Cardona, 2013)
- Integration of social justice principles into clinical practice (Hanna & Cardona, 2013)
- Knowledge of race-related mental health research (Metzger et al., 2021; Williams et al., 2023)

Training will combine workshops, case-based practice, and reflective supervision to ensure that cultural humility and anti-oppressive practice are consistently applied. Ongoing supervision and consultation will sustain this stance (Rathod et al., 2019).

The evaluation

Given the disproportionate impact that youth violence has on marginalised and minoritised communities EYVL always seeks to ensure that issues of diversity and inclusion are at the heart of our evaluations, and we will work with YEF's Race Equity associate Dr Jessica Davies and our expert advisor Dr Jalissa Clarke to ensure REDI issues are fully embedded in our approach.This will include ensuring that young people from marginalised backgrounds are given the opportunity to comment and critique our evaluation methods and tools through our Young Person Advisory Group, and ensuring as well as drawing on experience from other projects to ensure there is a focus on inclusivity in recruitment, data collection and analysis and ensuring there is a strong focus on safety and wellbeing during surveys and interviews.

Conclusion

MindWorks integrates cognitive behavioural principles with systemic, culturally responsive practice to support young people whose lives are shaped by adversity, exclusion and racism. It recognises that mental health challenges are not solely individual difficulties but are often rooted in social and structural inequalities. MindWorks therefore aims to strengthen young people's sense of agency and resilience while working with the systems around them, including families, schools and communities, to create conditions that enable change.

The approach is grounded in the evidence that CBT, when delivered in a culturally responsive way, can improve outcomes for racially and ethnically diverse young people (Huey et al., 2023; Beck, 2019). It builds on the partnership between Anna Freud and UCL, whose shared commitment to race equity, representation and participation underpins the design and delivery of this programme. Practitioners are trained to address issues of culture, racism and

discrimination as integral to assessment and formulation, rather than as secondary considerations. This ensures that therapy validates lived experience, avoids pathologising normal responses to racism, and promotes engagement through trust, cultural humility and reflective supervision.

While MindWorks cannot address the wider structural causes of inequality, it offers a meaningful way of mitigating their impact on young people's mental health and life chances. Through rigorous evaluation and reflective practice, this study will contribute to the growing evidence base for culturally competent CBT and inform efforts to make mental health provision more equitable and effective. In doing so, it seeks to offer a model of practice that is both evidence-based and socially just, enabling young people to be understood and supported within the full context of their lives.

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Appendix 2: Feedback from stakeholder engagement

Alternative Provision school staff

Date: 25.09.25
Attendees: 3 representatives, 1 school staff, 1 head of academy, one senior trust role (previous head of academy)

Stakeholder views:

- They were generally very positive about participating in the programme/evaluation- appreciated a systemic programme designed with AP schools/needs in mind and felt this would fill a gap in provision, particularly with reduced statutory support over the last few years
- Felt that a high proportion of their students would fulfil criteria
- YP tend to stay at AP schools for 1 year, can come suddenly but the school tends to be full for the year by mid-October, so outreach work into mainstream after that.
- All YP at an AP school are 'dual enrolled' so have a named mainstream school that they are working towards re-engaging with. We should ensure we collect this data in order to track YP as they transition back to mainstream education.
- Some YP are part time in AP schools and part time in mainstream- we will need to consider implications for data collection and network engagement in this case
- AP school students will have a staff member that works closely with the young person and with home, and would be a natural fit for data collection/participating in network meetings.
- Staff felt additional compensation wouldn't be needed on top of programme provision, but that CPD from Anna Freud for control schools would be welcome
- Staff agreed with our proposed approaches to data collection- already do a lot of data collection/surveys to monitor progress and impact of interventions

Mainstream school staff

Date: 5.11.25
Attendees: 6 representatives from 3 schools, mainly teaching staff with additional pastoral/mental health/behavioural role

Stakeholder views:

- Staff again positive about engagement in the programme/trial
- Lots of services available both within school and outside, but can be difficult to access. Most focus on young people only, and don't take a network or systemic approach.
- Happy with the description of the programme- suggest that framing to parents will need careful consideration to ensure their buy-in.

- Keen for CPD for control schools- also wonder whether CPD for parents would be possible (e.g. webinars or virtual training)
- It's rare for students to move out of school via exclusion. If they move to AP they will still be having regular communication with their mainstream school so can be followed up easily.
- Teachers felt confident they could answer the survey questions and would feel comfortable to do so.
- Contact teacher for programme delivery and questionnaire- likely 5 across the cohort of 20, mainly behavioural leads/pastoral leads.
- 2 schools suggested 5 YP/year who would be relevant, 1 felt 5 across the school
- Happy to be involved in a trial
- Stressed clear communication about expectations from the beginning both for staff and young people/parents
- Potential challenge of 'selling' the programme to YP/parents and then being randomised to control- schools will need to consider what BAU they would offer instead in these instances

Young people

Date: 21.10.25
Attendees: 3 young people, female, teens and early 20s

Stakeholder views:

- Positive about need for programme
- Clear communication needed when selling the programme-
    - Reduce any mental health jargon
    - Integrate into existing meetings/communication
    - Programme as a response to behaviour that is causing difficulty at shool
    - Don't give impression that there is something 'wrong' with the YP
    - Focus on the potential benefits
- Other students will know who gets taken out of class- this might add to stigma if programme is seen negatively
- YP flagged that they would potentially have felt 'deeply offended' or singled out and defensive if invited to a programme like this.
- YP likely willing to take part in the trial if they understood it clearly and the benefits to them
- If YP are picked out, onboarded and then offered nothing- drop out from surveys is very likely. Can other BAU support be offered?
- Voucher reward would be good
- Risk of randomly picking buttons, how to make sure they complete accurately?

- Risk of control group not finishing the survey because they're not interested in this/doesn't benefit them.
- Use of creative approaches in IPE interviews could be useful- writing feedback, drawing, play- opportunities for both group and individual feedback
- Would like to know more about survey content in advance- not exact questions but broad topics so YP can feel prepared.
- Having option of knowing trial outcome at end would be good- not all YP would want this but good to have the offer.
- Small group data collection may be tricky- more 'school like', less honesty.
- May wish to please researcher and so also not be honest.
- Concern about data sharing- schools access to data, sharing of survey responses- YP may have had previous experience of safeguarding involvement.
- Content of questionnaires
    - With potentially triggering topic offer sensory support - breaks, games, fidget toys, crafting activities if they want a break from the questionnaire, people on hand to support e.g. playing scrabble. Allowing desensitising
    - Visual indicator of how far through you are
    - Opportunity to save at a certain point and take a break
    - Staff to be aware that someone has done the survey
    - Disclaimer that this can be a difficult thing to speak about, speak to a trusted adult
    - Share in advance that the questionnaire is about getting a more holistic picture of you, but it's not all of you- not defined by your answers to these questions.

Parents

Date: 12.11.25

Attendees: 1 parent of 2 children in AP school, 1 parent of 2 children in (private) mainstream school. Both have experience with similar difficulties to the target population of MindWorks.

Stakeholder views:

- Feel this programme could be beneficial, getting parents fully involved is crucial to support the programme
- Will one term be long enough to deliver and embed the learning?
- Young people need to see what's in the programme for them- learning emotional regulation/reducing conflict may not be a meaningful outcome. Something more concrete might be better (e.g. missing a particular lesson, a physical reward).

- Also frame the programme around things the young person values such as aspirations, 'tools to be a better grown up', work out what you're good at.
- Definite risk of young people not being willing to do the programme, particularly if they have to miss class for it and other students know that they're going out for a programme like this.
- The programme needs careful framing by Anna Freud- parents need to feel like the school will shift on things, not just the young person/parent needing to change.
- Parents feel they should have a conversation with school about this programme before child is told, think about when and how to speak to them about it.
- Parents would want pre-read pack with detailed information about the programme, what it will involve from them etc.
- Parents may be sceptical of the work and have negative response due to previous experiences e.g. social work, feeling blamed. May feel that the problem is for the school to solve. Need to demonstrate value for parents to engage them.
- Need to ensure good buy in from school staff body- one teacher attending the network meetings for all young people is unlikely to create change.
- Think having the training for parents/school staff would be a good control arm offer. Becomes training vs. intensive programme rather than programme vs. nothing. Also more powerful evidence.
- With young people surveys, need to make it not feel like an exam- online rather than pen and paper, verbally completed.
- Surveys should be easy, online and clear. Include a clear window in which to respond, tell parents how long it will take.
- Sessions for parents to come together who are on the programme may be useful for sharing learning and a sense of peer support
- It would be useful for parents to be able to see what responses they gave to questionnaires at the start of the programme so they can compare over time. Also to receive a report at the end showing their progress/change over time.
- If children know their parents are completing questionnaires they may want to know content, needs to be private and the data sharing clear.
- Linkage to police dataset raised significant concerns amongst attendees. Both in terms of being clear about how data is shared (i.e. from whom and which data) and also giving consent on behalf of their child for something that will happen in the future when they are an adult. Also concerns around data privacy.

Appendix 3. Data collection strategies

Young person surveys

The adult supporting the young person will:

- Remind them of the key information around the programme and evaluation that was included in the information sheet. The information sheet will have already contained information on the data collection processes, purposes and the types of question that will be asked.
- Explain the purpose and confidentiality of data collection- reminding young people that the survey data collected is anonymous and will not be shared with family or school staff, being mindful of young people's potential mistrust of sharing personal information due to past experiences of safeguarding.
- Explain that the questions about the young person are a snapshot of some of the things that they find easier and harder, and won't represent everything important about them and their lives
- Take written assent for entry into the trial and completion of the measures. This will be integrated into the online survey process and stored separately to the survey responses, matched with a unique identifier.
- Offer breaks during data collection including the opportunity to play with fidget toys or other sensory items
- Provide a visual indicator of how far through the survey the young person is.
- Complete the measures in a way that feels comfortable for the young person (e.g. sitting vs. walking, young person reads the items vs. the adult reads the items to them vs. they listen to an audio version of the questionnaire using a headset).
- Welcome feedback and views on survey questions that the young person might want to share.

Parent/carer surveys

The evaluation team will encourage participation in the surveys via the following:

- Designing the survey questions with recognition of the fact that parents/carers are likely to have experienced similar discrimination and trauma as their children
- Making surveys accessible on phone and other devices, giving a clear time frame for survey responses and telling parents how long it will take.
- Reviewing the contents of the survey with a parent focus group to identify any concerns with the particular questions included
- Having questions reviewed by our REDI expert advisor
- Reassuring parents of the confidentiality of their responses
- Advising parents that they can opt out of the survey or particular questions if they feel uncomfortable

- Ensuring questionnaires can be completed on a private link and it is clear to parents that their answers won't be shared with their child
- Offering telephone or video call support with completing the survey

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