My View

Intervention Developer	British Refugee Council
Delivery Organisations	British Refugee Council
Evaluator	Ipsos MORI and Centre for Evidence and Implementation (CEI)
Principal Investigator	Karl Ashworth
Protocol Author(s)	Karl Ashworth, Claudia Mollidor, Raynette Bierman (Ipsos MORI) Eleanor Ott, Georgina Mann (CEI)
Type of Trial	Non-blinded parallel two-armed randomised control trial with UASC individually randomised to a treatment or waitlist control group (on rolling basis)
Age or Status of Participants	Unaccompanied Asylum Seeking Children (UASC) aged 12 to 18 (at the start of the intervention)
Number of Participating Sites	5: 4 physical sites, 1 remote intervention site
Number of Children and Families	280
Primary Outcome(s)	Endline YP-CORE total score (difference in mean score, intervention vs control group)
Secondary Outcome(s)	Endline SWEMWBS (difference in mean score, intervention vs control group)
Contextual Factors	

Summary

The My View therapeutic intervention for unaccompanied asylum seeking children (UASC) will be delivered by the British Refugee Council for 11 months between June 2021 and May 2022. It will be delivered by trained therapists in four physical (London, Kent, Birmingham, Leeds) locations and one therapist will operate remotely. In total, 280 UASC aged c. 12 to 18 at the start of the intervention will take part. My View contains either one to one therapeutic intervention over 12 one-hour long sessions (to be accessed by c. 190 young people), group therapy (to be accessed by c. 57 young people) or crisis intervention (to be accessed by c. 33 young people). The therapeutic interventions are supported by individual case work for each client, where relevant. For the purpose of the evaluation, the intervention period is 3 months.

The primary aim of the intervention is to improve the psychological and emotional wellbeing of UASC. The primary outcome measurement will be the YP-CORE, which will measure psychological distress at baseline and follow-up 3 months later. The secondary outcome measurement will be SWEMWBS, which will measure mental well being at the same time points as the YP-CORE.

The three elements of the evaluation are a randomised controlled trial, an implementation and process evaluation and a cost analysis. The evaluation will take place from June 2021 to June 2022.

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Background and Problem Statement

Unaccompanied Asylum Seeking Children (UASC) arriving in the UK often have complex psychological needs not only due to the trauma they are likely to have experienced, but also in relation to resettling in a foreign environment. Papadopoulos (2000b, 2001a,b) explains that:

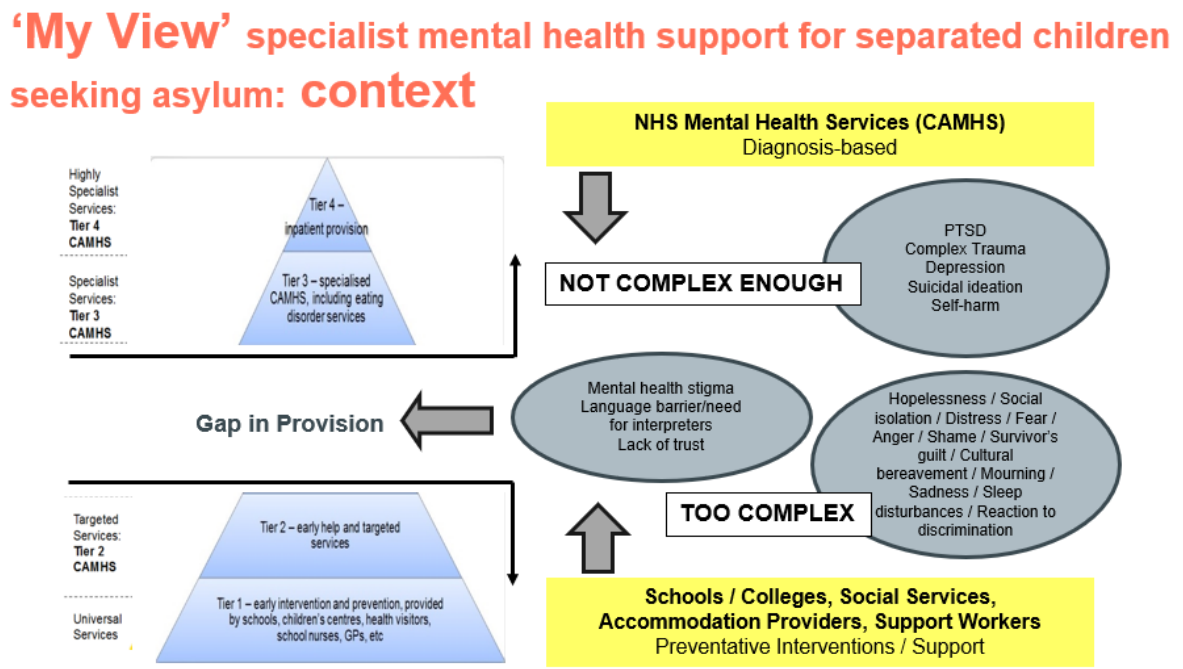
[…] the 'refugee trauma' discourse tends to be restrictive because it emphasizes only one segment of the wide spectrum of the refugee experiences. This spectrum could be divided into at least four phases which have been identified as:

1. Anticipation: when people sense the impending danger and try to decide how best to avoid it;
2. Devastating events/adversity: this is the phase of actual violence, when the enemy attacks and destroys, and the refugees flee;
3. Survival: when refugees are safe from danger but live in temporary accommodation and uncertainty; and
4. Adjustment/Integration: when refugees try to adjust to a new life in the receiving country

Many UASC are said to fall through the gaps of existing CAMHS provision, or the provision provided lacks the necessary sensitivity to their circumstances. Davies Hayon and Oates's 2019 literature review[1] on the mental health service needs and experiences of unaccompanied asylum-seeking children in the UK identified high levels of needs. The review also highlighted barriers to using mental health services include lack of cultural awareness as well as young people's mistrust and stigma and highlighted the importance of mental health services being available in spaces commonly used by UASC.

The British Refugee Council (BRC) has developed a programme to provide specialist therapeutic support to UASC, 'My View', as described in Figure 1.

Figure 1: Gap in provision filled by My View



Source: British Refugee Council presentation to WWCSC, Ipsos MORI and CEI, 8 April 2021

[1] Davies Hayonm T. & Oates, J. (2019). The mental health service needs and experiences of unaccompanied asylum-seeking children in the UK: a literature review. *Mental Health Practice* 22(6), 13-20.

Intervention and Theory of Change

Background

The 'My View' intervention, provided by the British Refugee Council, is a specialist therapeutic service for separated young people and designed to fill the gap in mental health provision detailed above. It is a short-term intervention which aims to stabilise psychological/ emotional wellbeing and better position clients to access longer-term interventions should it be needed via facilitated referrals to mainstream or longer-term specialist services.

The therapeutic care model has been tailored to meet the unique cultural and experiential needs of the client group, including being trauma-informed. Therapists employ creative/ play techniques and non-scriptocentric activities to ensure the service is accessible to non-English speaking clients. It also takes a holistic, biopsychosocial approach to considering client needs, recognizing that practical challenges with issues such as foster placements, housing and asylum claims will exacerbate mental health issues. The intervention involves one to one, crisis and group therapeutic interventions, with casework provided by the therapist as needed.

Staff and staff training

The overarching model is the trauma-informed Refugee Council Therapeutic Model in providing holistic (psychosocial) therapeutic support. My View has a team of therapists from various disciplines and backgrounds. These include dramatherapy, play therapy, counselling, integrative therapy and art psychotherapy. Therapists use their skills and expertise in order to meet each individual client's needs. All therapists are Health & Care Professions Council (HCPC) or British Association for Counselling and Psychotherapy (BACP) registered.

Before working with My View clients, all therapists receive five training sessions, with a total duration of 14 hours; the content is outlined in Table 1.

Table 1: My view staff training schedule

Topic	*Audience*	Detail of session
WWCSC: New Procedures – 3h	*Compulsory for everyone (staff and volunteers)*	1. Introductions 2. External evaluation 3. Flowchart of activities and RCT 4. Evaluation and feedback 5. Targets 6. Focus on changes: referral procedure / times / waiting lists 7. Focus on changes: YP CORE 8. Focus on changes: contact with Evaluator and Funder
Therapeutic Care model – 3h	*Compulsory for everyone (staff and volunteers)*	1. The Refugee Experience & Implications for Separated Children 2. Adolescence, Migration, Trauma: The intersection 3. Refugee Council Therapeutic model (Therapeutic relationship, Bearing witness, Psychoeducation) 4. Toolkit of interventions 5. Preventing burnout and self-care
In-Form Induction / refresher – 2h	*Compulsory for new starters and open to everyone (staff and volunteers)*	1. Recording of 1:1 (IA, other, final, DNA) 2. Recording of group session (first and other, DNA) 3. Recording workshop / outing 4. Recording group feedback / YP CORE 5. Recording communication with clients/stakeholders 6. Recording referral to external service 7. Change in client's details (agencies)

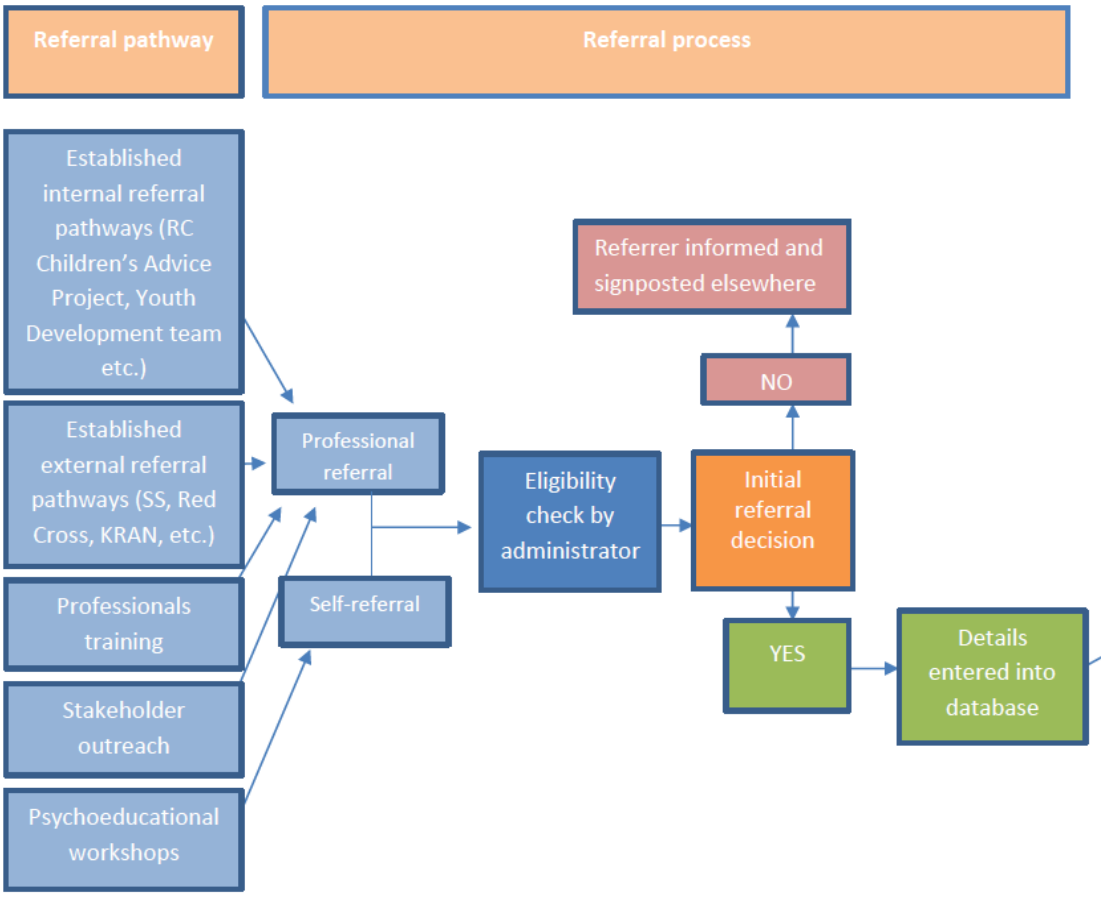
Safeguarding Training – 3h	*Compulsory for everyone (staff and volunteers)*	1. Risk and classification of risk 2. Self-harm: assessment & management 3. Emergency management 4. Risk from others / risk to others 5. Procedures: respond – record, refer 6. Exploration of examples & case studies
Admin & Life at the Refugee Council Induction – 3h	*Compulsory for new starters and open to everyone (staff and volunteers)*	1. Key processes (Team drive, Team folder, Team calendar) 2. Annual leave, toil and how to request 3. Expenses claim 4. Interpreter timesheets and Big Word 5. Client Data Spreadsheets & Weekly waiting lists 6. Other procedures & changes

Who (recipients): The target population and ultimate beneficiary of the programme

The target population is Unaccompanied Asylum Seeking Children: those who have arrived in the UK alone without parents or guardians and are in the care of Local Authorities. The British Refugee Council supports young people regardless of the status of their asylum claim (not yet made, pending, granted). While new referrals must be 18 or under at time of referral, the Council will continue support for those who've had their 18th birthday.

The referral pathway is summarised in Figure 2:

Figure 2: Referral pathway



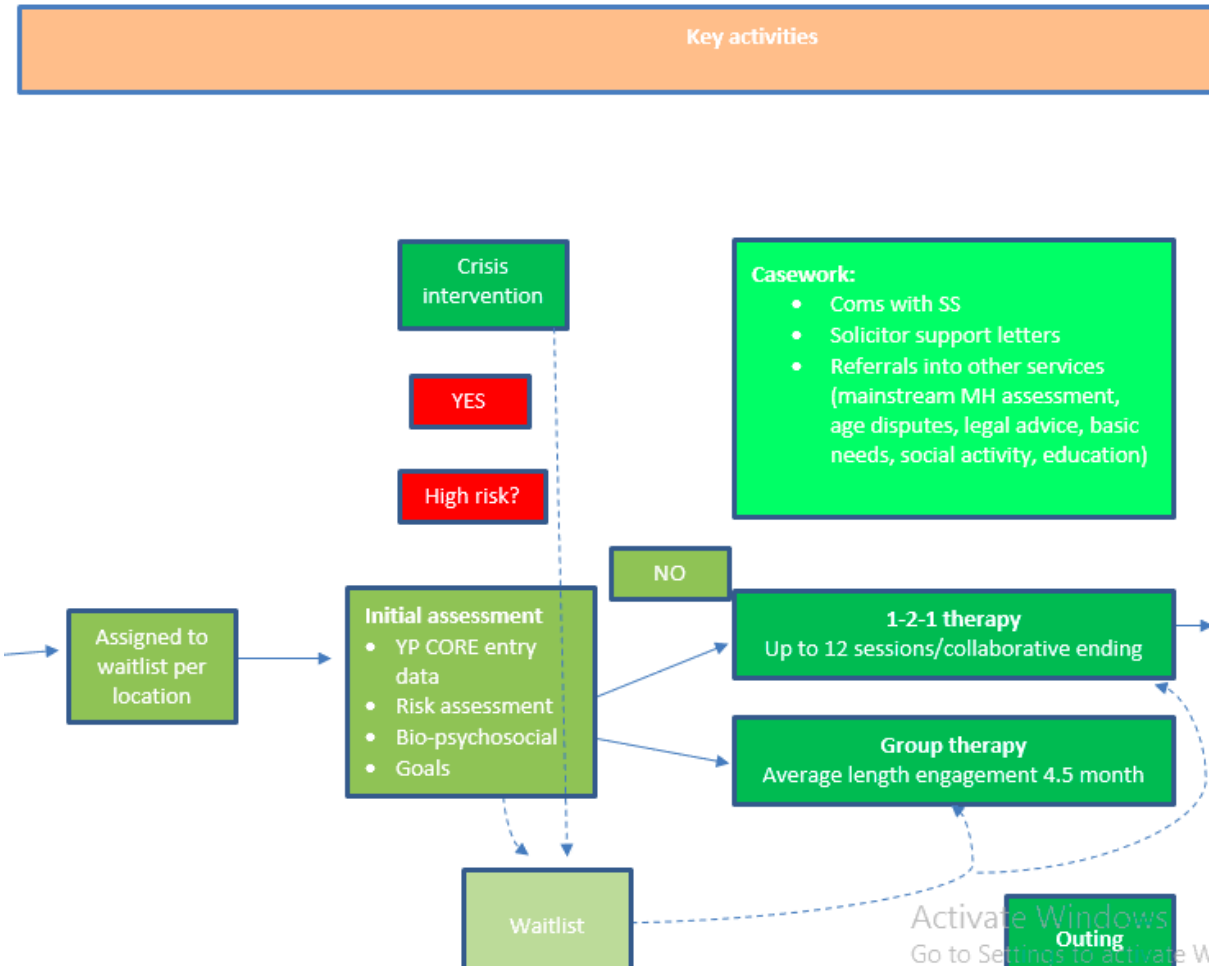
What (procedures): the activities involved in delivery of the programme/intervention

The intervention sees trained therapists working within the Refugee Council's trauma-informed therapeutic care model through the following interventions:

- A holistic initial assessment exploring the bio-psycho-social needs of the client as well as any practical issues that may be exacerbating their difficulties (e.g. asylum claims)
- Up to three crisis intervention sessions for young people with urgent needs (excluded from the evaluation)
- Up to 12 one-to-one counselling sessions with extensions in exceptional circumstances
- Group therapy sessions to build peer support networks and normalise their experiences e.g. dramatherapy, art therapy, music therapy
- Group psycho-educational workshops to help young people better understand mental health and the symptoms they may be experiencing such as flashbacks, disturbed sleep etc. (excluded from the evaluation)
- The Refugee Council also engages in informal clinical consultations with a young person's social worker and foster carer to establish informed onwards referrals pathways (i.e. casework)

The key activity flows are depicted in Figure 3:

Figure 3: My View activity flow



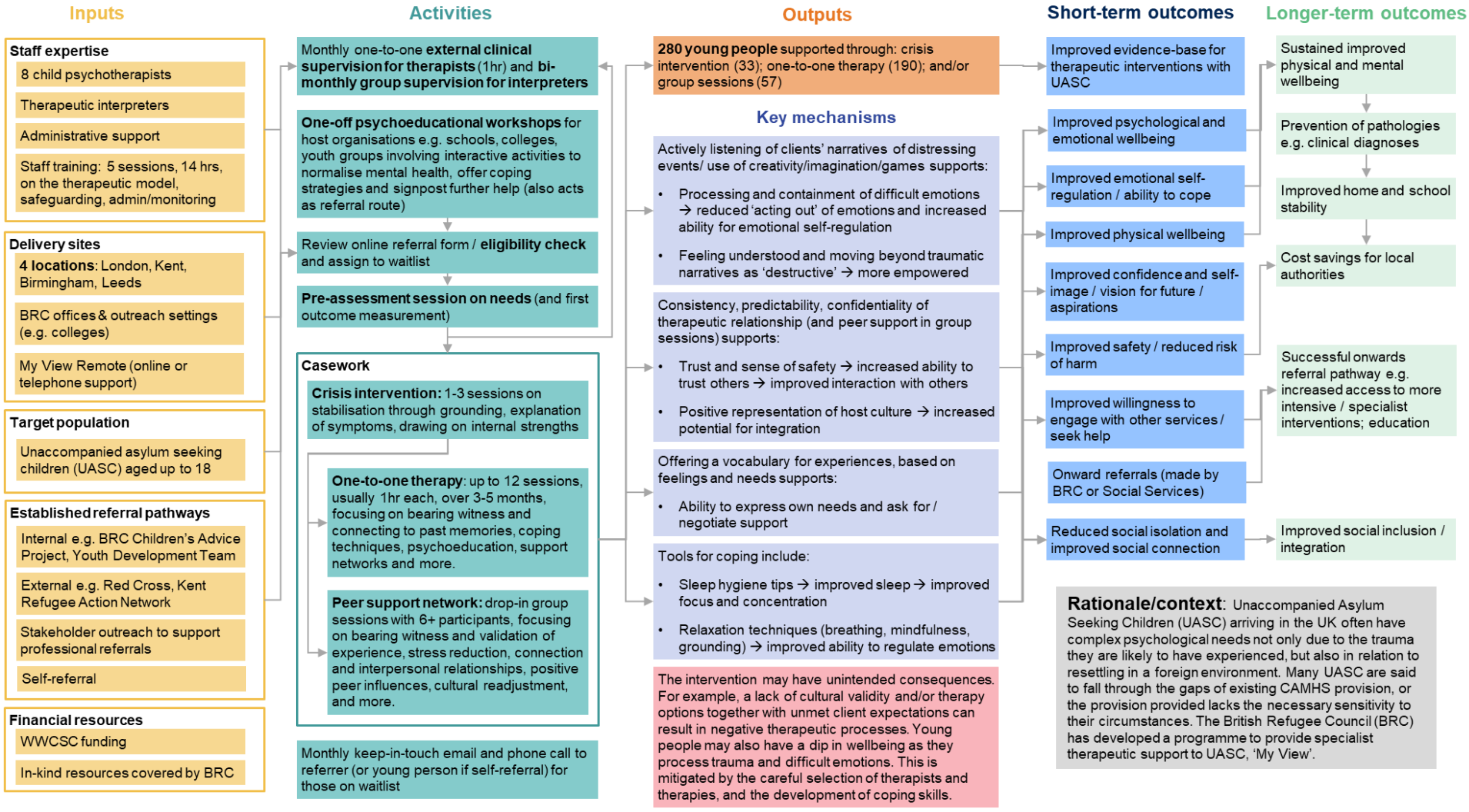
Where (location): the delivery setting

The service is typically delivered face-to-face from one of the British Refugee Council

service hubs (London, Kent, Birmingham, Leeds), whether their own offices, outreach locations such as further education colleges and Reception Centres in Kent or through forums provided by other service providers (e.g. British Red Cross youth groups). However, during the Covid-19 crisis the service has moved to remote delivery with sessions held over the telephone and video calls, where engagement has continued to be high. One ‘remote’ intervention location will remain in place as part of the evaluation.

Theory of change

Figure 4: My View Theory of Change



Inputs

To deliver the intervention, the BRC received funding from WWCSC and recruited 8 therapists (one to provide virtual therapy, one each in Leeds and Birmingham, two in Kent and three (accounting for 1.4 FTE) in London). Therapists receive 5 training sessions in the therapeutic method (as outlined in Table 1).

Clients are referred via internal or external pathways (e.g. Refugee Council Children's Advice Project, Youth Development Team, Red Cross, social services, KRAN) or can self-refer (see Figure 2 above).

Activities

The young person's eligibility for the intervention is checked by a Refugee Council administrator. If eligible, the young person's details are entered into a Refugee Council database and an assessment of whether the young person is 'high risk' is carried out.

There are three ways in which therapists conduct direct work with clients:

Crisis sessions. Up to three of these are offered to clients with urgent immediate need for therapeutic support, classified as 'high risk'. If necessary, clients will be offered follow-on one to one therapeutic support. Therefore, they cannot be randomised as they will bypass the waitlist. Activities taking place in crisis intervention include stabilisation through grounding, explanation of symptoms, and drawing on internal strengths.

Up to 12 one to one sessions, or until there is a collaborative ending agreed before 12 sessions. These sessions last an hour each. The majority of clients will engage on a weekly basis, however may miss appointments throughout their intervention due to conflicting schedules (e.g. Home Office, college – beginning at college, termly timetable changes, social worker visits etc.), religious practices (e.g. Ramadan), sleep disturbances and other factors. This is why it takes longer than 12 weeks to complete the average intervention. For the purpose of the evaluation, a cut-off period of 3 months has been agreed to collect the follow-up measure. The structure and content of the 12 sessions is outlined in Table 2.

Group sessions. There is a minimum number of six (6) and maximum of 12 participants per group session. Group sessions are offered weekly, and attendance varies.

The format of general group sessions is as follows (and content outlines in Table 2):

- 'check-in' – gauging energy and mood levels,
- 'warm-up' activity to foster participation and engagement,
- 'main activity' – this can be a series of group exercises or one extended group activity,
- 'debrief' – to reflect or comment on activity and
- 'check-out' – to close and reflect on any take away learning etc.

The average length of engagement is 4.5 months. For the purpose of the evaluation, a cut-off point of 3 months has been agreed. We will randomise until January 2022, at which point the 'final' control group members will start receiving My View for 3 months (until April 2022).

In the summer months, the Refugee Council offers separate 'summer groups' which last 6 weeks. These groups tend to be activity focused, and operate on the basis of:

- intro to activity in session 1,
- sessions 2 to 5 engagement with activity and invitation for life/therapy connections to emerge and

- session 6 focusing on closure, reflections on takeaways and signposting to other services/1-2-1 therapy/ongoing open group.

Case work

Alongside all types of direct work outlined above, the therapists undertake case work. Case work includes communication with the client's social worker, and, where necessary:

- Writing solicitor support letters
- Legal advice
- Responding to age disputes
- Referrals into other services, such as mainstream mental health assessments, social activity, education, basic needs

Monthly clinical supervision

Each therapist will have a minimum 1h per month of external 1-2-1 clinical supervision. This is defined by BACP's Ethical Framework:

"A specialised form of mentoring provided for practitioners responsible for undertaking challenging work with people. Supervision is provided to ensure standards, enhance quality, advance learning, stimulate creativity, and support the sustainability and resilience of the work being undertaken."

Supervision offers therapists a reflective space in which to develop practice and so benefits client safety. All aspects of a therapists' practice should be open to supervision.

Psychoeducational workshops (out of scope of the evaluation)

These are one-off workshops offered to host organisations such as schools and colleges, receptions centres, existing youth groups etc. Workshops involve interactive activities to normalise mental health and symptoms, offer coping strategies, signpost for further help. They can also act as a referral route into My View.

Table 2: One to one and group therapy session structure

Sessions	Complete	Content 1:1	Content Group
1 - 3	☐ Confidentiality mandate ☐ Risk Assessment ☐ Assess and prioritise needs together, including referrals ☐ YP CORE ☐ Identify goals	☐ Trust: Therapeutic Relationship – explain role of therapist and organisation ☐ Embodiment: Breathing techniques and grounding exercises ☐ Identity/role: Creative exercises (i.e. 5 things about me, personal flag etc.) – beginning to draw out secondary narratives beyond victimhood	☐ Trust: Therapeutic Relationship – explain role of therapist and organisation ☐ Embodiment: Breathing techniques and grounding exercises ☐ Identity/role: Creative exercises (i.e. 5 things about me, personal flag etc.) – beginning to draw out secondary narratives beyond victimhood
4 -6	☐ 6 SESSION REVIEW – YP CORE, revisit goals	☐ Psycho-Education: normalising, normal response to abnormal events ☐ Psycho-Education: Extra offer of specific tools needed ☐ Bearing witness: Projection – explore support networks, story-making to assess coping mechanisms ☐ Creative exercises and/or talking about everyday experiences: exploration of alternatives (emotional responses, ways of communication, roles/identities etc)	☐ Psycho-Education: normalising, normal response to abnormal events ☐ Psycho-Education: Extra offer of specific tools needed ☐ Bearing witness*: Projection – explore support networks, story-making to assess coping mechanisms ☐ Creative exercises and/or talking about everyday experiences: exploration of alternatives (emotional responses, ways of communication, roles/identities etc) *: by therapist and other group members
7 - 9	*Flag up ending in session 9 *explore and plan ending	☐ Bearing witness: projection - space to connect with past memories of identity and culture ☐ Bearing witness: narrative therapy exercises – reinforce secondary narratives of strength and coping ability – Tree of Life, Narratives in a Suitcase etc.	☐ Bearing witness*: projection - space to connect with past memories of identity and culture ☐ Bearing witness*: narrative therapy exercises – reinforce secondary narratives of strength and coping ability – Tree of Life, Narratives in a Suitcase etc.

		Beginning to link creative explorations and/or change within the therapy space to everyday life; noticing changes, even small.	Beginning to link creative explorations and/or change within the therapy space to everyday life; noticing changes, even small. *: by therapist and other group members
10 - 12	Session 10 – review goals, consider onward referrals Session 11 – YP CORE Session 12 – what will you take away + what will you do this time next week	Opportunity to reflect back and solidify any gains from therapy Opportunity to express and process emotions related to the upcoming (and past) endings Trust: Celebrate the therapeutic relationship and use it as a model for a new narrative about others and the world to possibly be established (if not here, then in 7-9 above) Embodiment: Use of rituals to mark and contain the experience of the ending Therapeutic relationship: invitation to internalise this and make it part of inner resources	Opportunity to reflect back and solidify any gains from therapy Opportunity to express and process emotions related to the upcoming (and past) endings Trust: Celebrate the relationships in the space and use it as a model for a new narrative about others and the world to possibly be established (if not here, then in 7-9 above) Embodiment: Use of rituals to mark and contain the experience of the ending Therapeutic relationship: invitation to internalise this and make it part of inner resources

A note on therapeutically trained translators

The general expectation is that where possible, the same interpreter is used throughout the 12 sessions. Interpreters are mostly selected out of a pool of previously identified and trained interpreters. Refugee Council has a holistic approach to therapeutic work with refugees, which is underpinned by our commitment to linguistic justice and human rights. Interpreting is an integral part of services provided to clients with little or no English language and has the potential to enhance the therapeutic work and relationship. It is now widely accepted in the refugee therapy sector that whenever there is an interpreter present, there is a three-way relationship. The interpreter has a relationship with both the therapist and the client and cannot be made invisible or reduced to 'just a voice'.

Refugee Council's Good Practice Guidelines for Interpreters and Therapists Working Together underpins all work with refugees in therapeutic services across England and Wales. These guidelines apply to work with adults, children, young people, couples, families and in group contexts. The underlying principle that is the foundation of these guidelines is that interpreting is a skilled and complex endeavour and the interpreting team are integral to the therapeutic work with refugees.

Therapists and interpreters working in partnership should continue to develop anti-oppressive practices in their work, aiming to 'find unique and meaningful ways to hear the clients' voices that do not deny them power and replicate discriminatory experiences' (Bains, 2010: 23). The process of interpreting is naturally slower than direct one-to-one communication and this can mean that the practitioner has more time to reflect and prepare for their next intervention/interaction while the interpreter is translating. Refugee Council believes that it can be therapeutic for the client to be heard and understood by both the therapist and the interpreter.

The process of the translation allows the therapist more time to think and reflect on interventions, and it can help pace a session with a traumatised individual. When the therapist is from another culture, and their approach and demeanour is new or uncomfortable, the familiarity of the interpreter's language and presence can be containing and make therapy possible in the beginning. The gentle and warm presence of the interpreter can be felt as validating and reassuring to a client. When the trust in the therapist grows, the presence of two caring and supportive individuals being alongside an individual in pain can be affirming and therapeutically significant.

It is Refugee Council's commitment to offer a bi-monthly supervision group to interpreters who are regularly working within therapeutic services. A supervision group can be a helpful forum as it allows the facilitation of mutual support and learning between interpreters and creates a team that can support each other within their day to day work. It is useful for this to be facilitated by a therapist working within Refugee Council's therapeutic services.

Short term outcomes

In the short term, i.e. at the end of 3 months after the intervention starts, it is hypothesised that the programme will improve young people's psychological and emotional wellbeing, as well as their emotional self-regulation and ability to cope. In addition, it is anticipated that the intervention will result in:

- Improved social connection and reduced social isolation
- Improved confidence / self-image
- Improved aspirations / view of future
- Improved physical wellbeing
- Improved safety / reduced risk of harm
- Increased willingness / openness to seek support / engage with other services
- Onward referrals to other services (made by BRC or Social Services).

The final two outcomes focus on the willingness of young people to engage with other services and whether referrals have been made but do not include actual access to other services. This is because the 3-month timeframe is often too short to see young people going on to access new services, which is linked to the length of time referrals can often take, for example, to CAMHS or to education i.e. a local college. Furthermore, while the British Refugee Council records onwards referrals to other services on their database, it is not possible to record whether or when this referral has been accepted or successful. Furthermore, the Refugee Council do not collect data about the referrals made by Social Services following the My View intervention, which are more common than referrals made by the Council.

It is also anticipated that the evaluation will improve the evidence base on what works for therapeutic interventions with UASC.

Medium and long-term outcomes

In the medium and longer term, the intervention aims to achieve:

- Sustained improved wellbeing, which is anticipated to support the prevention of pathologies (i.e. clinical diagnoses) and improved home and school stability
- Successful onward referral to more intensive therapeutic intervention (which heavily depends on local waitlists)
- Successful onward referral to education (to the extent that there are local college places which can be accessed by clients)
- Improved social inclusion / integration.

Through the achievement of these outcomes, it is anticipated there will be cost savings for local authorities typically associated with, for example, placement or school changes and mental health and social care services.

Impact Evaluation

Research Questions

In line with the logic model, we hypothesise that children and young people who take part in the My View intervention will have better psychological and emotional wellbeing. Our impact evaluation research questions are:

- What is the effectiveness of the My View intervention for UASC in terms of their psychological distress (as measured by Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) measure[2]), compared to a waitlist comparison group?
- What is the effectiveness of the My View intervention for UASC in terms of their mental wellbeing (as measured by the SWEMWBS[3]), compared to a waitlist comparison group?

These questions are relevant for children and young people participating in either one-to-one therapy (over 12 sessions) or group therapy, or a mix of both. The comparison group will include young people who will wait three months before receiving the intervention. During this time, they will not receive any intervention delivered by BRC. However, it is possible that these individuals may receive support from elsewhere, which may vary.

Design

Table 3: RCT design details

Trial type and number of arms		Non-blinded parallel two-armed randomised control trial with UASC individually randomised to a treatment or waitlist control group (on rolling basis)
Unit of randomisation		Young person
Stratification variables (if applicable)		Overall, 6 strata will be used, comprising of one high-risk stratum and five moderate risk strata defined by the British Refugee Council locations, which include four with physical geographical boundaries and a fifth with virtual boundaries. Allocation rates are 50 : 50 for UASCs in moderate risk strata and 66: 34 in high risk strata.
Primary outcome	Variable	Continuous variable – scores ranging from 0 to 40
	Measure (instrument, scale)	Mean intervention group YP-CORE score compared to mean control group YP-CORE score collected at endline (3 months from start of intervention) by delivery staff i.e. therapists
Secondary outcome(s)	Variable(s)	Continuous variable – scores ranging from 7 to 35
	Measure(s) (instrument, scale)	Mean intervention group SWEMWBS score compared to mean control group SWEMWBS score collected at endline (3 months from start of intervention) by delivery staff i.e. therapists

Randomisation

Young people will be allocated to their trial arm status after their eligibility check but before their initial assessment (see Figures 2 and 3, above). A random stratified allocation

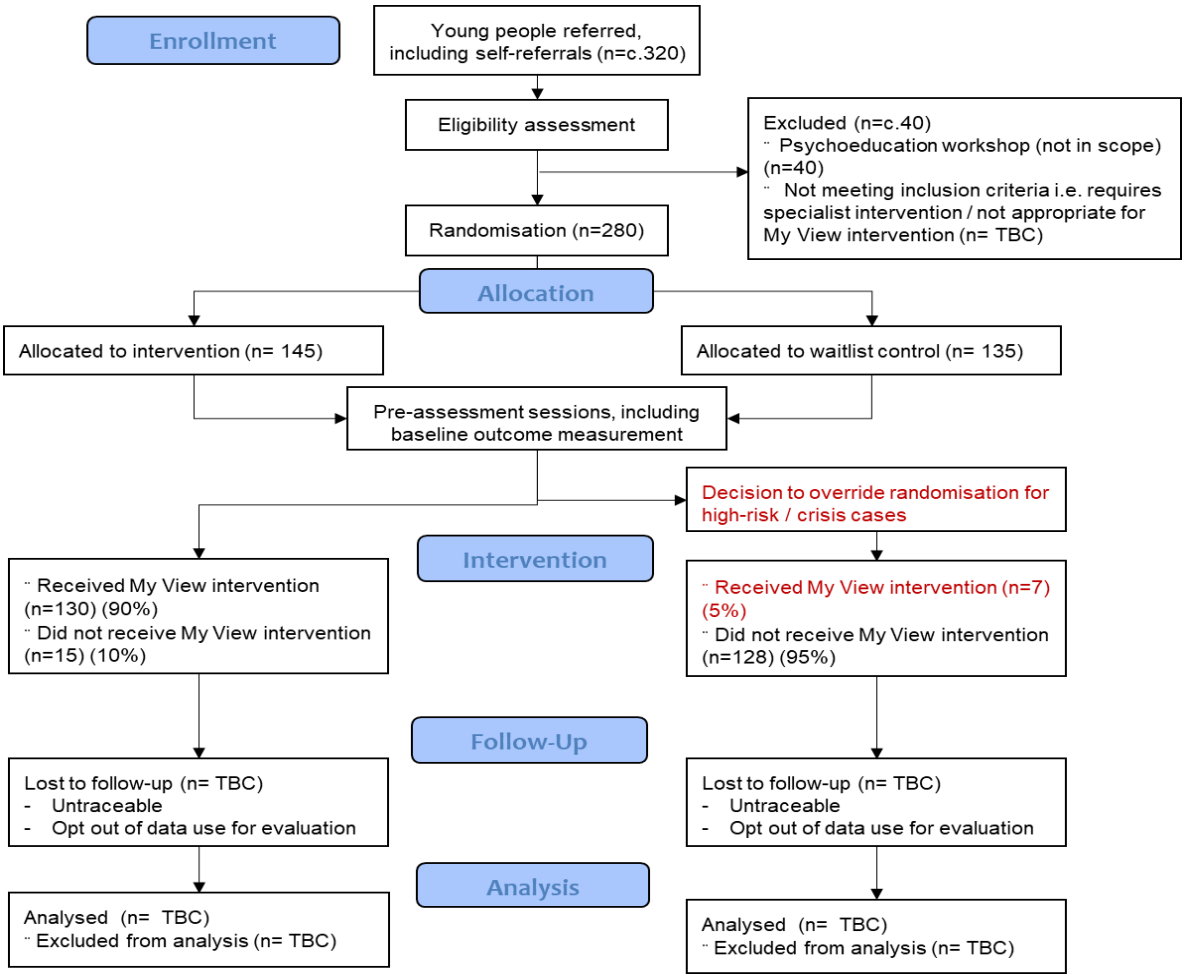
[2] https://www.corc.uk.net/outcome-experience-measures/core-measurement-tools/

[3] https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale-swemws/

procedure will be used. Random numbers will be generated separately for each stratum allowing UASCs to be assigned to treatment as they enter the study, using the random number function within the R statistical programming software package. Different random number seeds will be used for each stratum and we propose to generate blocks of random numbers of size 6, i.e. 3 in the treatment arm and 3 in the control arm. This procedure will reduce the risk of randomly generated long run sequences of allocation to any one of the groups, potentially upsetting the balance between numbers in the treatment and control groups. The random number allocation will generate the allocation lists with a 50 : 50 probability of assignment to treatment and control for moderate-risk strata.

For high risk strata, a probabilistic allocation rate of 0.64 will be assigned to treatment group, with a corresponding probability of 0.36 to the control group. This higher probability of assignment to treatment group for high-risk cases has been requested by BRC to ensure fewer high-risk cases are held back from receiving the treatment than are moderate risk cases. In addition, BRC retain the right of over-riding allocation to group for cases deemed to necessitate immediate treatment. It is possible that some of the high-risk cases identified at referral could be converted to low-risk after initial assessment. Similarly, some cases initially identified as moderate risk could be converted to high-risk. Young people will remain allocated to their strata and analysis will treat them as intention-to-treat on the basis of their original allocation. The implications of the override are further discussed below under the sensitivity analysis.

Figure 5: CONSORT diagram



Participants

Intervention locations

The evaluation will include all four delivery sites of the British Refugee Council in:

- London
- Kent
- Birmingham
- Leeds

In addition to this, the evaluation will include an online/remote delivery 'site'.

The British Refugee Council will be responsible for communicating with delivery sites about the evaluation and how this will impact delivery (compared to business as usual). The evaluation team will join a training session in May 2021 to assist with these communications.

Eligibility criteria

The eligible population must meet the following criteria:

- **Young people who are legally defined as UASC** – young people who have arrived in the UK alone without parents or guardian and are in the care of Local Authorities. The British Refugee Council supports young people regardless of the status of their asylum claim (not yet made, pending, granted). They accept young people who have applied for asylum or have had asylum granted.
- **Aged 18 years or under at time of referral:** While new referrals must be 18 or under at time of referral, the Council will continue support for those who've had their 18th birthday.
- **Passed initial assessment –** this is a collaborative decision to determine whether the intervention is an appropriate pathway. For some complex cases, the British Refugee Council will work with stakeholders and consider further referrals.

Sample Size / Minimum Detectable Effect Size Calculations

Table 4: Minimum Detectable Effect Size Calculations

MDES (Proportion of a Standard Deviation)		0.24
Proportion of Variance in Outcome Explained by Covariates[4] (R^2)	Child	0.5
	Family	NA
	Social Worker	NA
Intracluster Correlations Coefficient (ICCs)	Family	NA
	Social Worker	NA
	Team	NA
Alpha		0.05
Power		0.8
One-Sided or Two-Sided?[5]		Two-sided
Level of Intervention Clustering		NA
Average Cluster Size (if Cluster-Randomised)		NA
Sample Size	Intervention	145
	Control	135
	Total	280

[4] This includes, and will most likely be most influenced by, a baseline measure of the outcome.
[5] By default we would recommend two-sided tests.

The sample size is determined through the resources available to deliver the intervention. Consequently, we have calculated the MDES based on the expected achieved sample sizes, a stratified random allocation design at the level of the UASC and the availability of a baseline measure, which assumes a pre-post correlation of 0.71, (i.e. $R^2 = 0.5$). The PowerUp tool was used to calculate the sample size, using the BIRA2_1f spreadsheet with 6 strata (4 local and 1 virtual Local Authority for low risk cases and one stratum for high risk cases) and an average block size of 47[6] to be allocated evenly to treatment and control groups.

It is assumed that 88% of the 280 cases will be moderate risk, i.e. 247 cases. These will be allocated 50: 50 to treatment and control, i.e. 123.5 cases per trial arm. Of the 12% assumed to be high risk (n = 33), it is assumed that 66% will be allocated to treatment (n = 22) and 34% to control (n = 11). Overall, 145 cases will be allocated to the treatment group and 135 to the control group, i.e. 52% of total cases will be in the treatment group.

The MDES is a standardised effect size, i.e. it is measured in standard deviation units. This is advantageous when dealing with power analysis when outcome measure summary statistics such as the mean and standard deviation are unknown. We are not aware of reliable studies showing the distribution of the YP-Core among the population of interest studied here. However, to give an example of the MDES, a recent study by O'Reilly et al (2016)[7] showed a mean score of 18.3, with a standard deviation of 7.6 among a sample of children aged 12-16 engaging for the first time with an intervention. Using these scores for illustrative purposes only, an MDES of 0.24 multiplied by the SD of 7.6 gives a score of 1.8. Given a control group mean of 18.3, we would require the intervention to produce a YP-Core mean score of 20.1, or above, in the treatment group to be detected using our design.

Outcome Measures

Primary outcome measure

The primary outcome measurement is the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE) measure. The YP-CORE is a measure of psychological distress and is widely used in mental health and school counselling services. It is freely available to use[8].

The baseline YP-CORE measurement will take place at the pre-assessment session for young people randomised i.e. both the treatment and control groups. Data will then be collected at the following timepoints:

- Treatment group:
    - Baseline at the pre-assessment session
    - After six My View sessions (midpoint)[9]
    - After three months of My View (endline / post-treatment)
- Waitlist control group:
    - Baseline at the pre-assessment session
    - After three months of being on the waitlist (endline) – this will be at a second pre-assessment session before the young person starts My View
    - After six My View sessions (standard practice, not included in the evaluation)
    - After three months of My View (standard practice, not included in the evaluation).

[6] We have used 47 cases per block as an approximation to the 280 total required (i.e. 47 x 6 = 282).

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6860299/

[8] https://www.corc.uk.net/outcome-experience-measures/core-measurement-tools/

[9] If, for any reason, the midpoint questionnaire (after 6 sessions) gets delayed and therefore becomes close to the endline questionnaire (to be completed after three months), therapists may decide to only collect the endline.

The measure is brief, with just 10 items covering anxiety, depression, trauma, physical problems, functioning and risk to self. As such, this covers the following short-term outcomes included in the programme's theory of change:

- Psychological and emotional well-being
- Emotional self-regulation
- Safety and risk of harm

For each item, the respondent selects one response to indicate how they have been feeling over the last week:

- Not at all
- Only occasionally
- Sometimes
- Often
- Most or all of the time

Each of these responses has a score between 0 and 4 (some are reverse scored), meaning each question has a score between 0 and 4. The clinical score is calculated by multiplying the total mean score (total of all item scores divided by number of items completed) by 10. However, because the YP-CORE has 10 items, this calculation is identical to simply adding the raw score of all 10 items, providing all 10 items have been completed[10]. This gives a simpler and quicker way for practitioners to arrive at the clinical score. The clinical score is the total out of 40.

Figure 6: YP-CORE scale

The administration of the YP-CORE measure should be done consistently so that potential deleterious effects of changes in administration are minimised. It will be collected by the therapist using translated versions to ensure consistency. The British Refugee Council already collects the YP-CORE meaning this outcome measure is already embedded in practice for the one-to-one therapy. However, we are aware that a different measure is used for group sessions – this will need to be adapted to ensure consistent outcome measurement across participants.

[10] Where there are missing data, the clinical score is calculated by multiplying the total mean score by 10. Re-scaling the clinical score is not recommended if more than one item is missing.

Secondary outcome measures

The secondary outcome measurement is the short version of the Warwick–Edinburgh Mental Wellbeing Scale (SWEMWBS)[11]. The SWEMWBS is a measure of mental wellbeing and therefore provides a secondary measure of the programme's short-term outcome relating to improving the mental and emotional wellbeing of young people.

The SWEMWBS has been validated for populations of young people aged 15 -21 (McKay & Andretta, 2017; Ringdal et al., 2018). It uses seven of the WEMWBS's 14 statements about thoughts and feelings, which are positively worded. Similar to the YP-CORE, each statement asks how the young person has been feeling over the last two weeks (instead of one) and has five similar response options:

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

The SWEMWBS is free to use following completion of a registration form[12].

The SWEMWBS will be collected at the same timepoints as the YP-CORE. Young people will complete the SWEMWBS with the support of an interpreter where needed and this will be collected by therapists. The SWEMWBS has also been translated into a number of languages and some of these have been validated both psychometrically and qualitatively[13].

To score the SWEMWBS, each statement has a score between 1 and 5 and all seven scores are summed. Scores range from 7 to 35 and higher scores indicate higher positive mental wellbeing. The total raw scores need to be transformed into metric scores using the SWEMWBS conversion table[14].

[11] https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale-swemws/

[12] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/non-commercial-licence-registration/

[13] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/translations/

[14] https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/howto/swemwbs_raw_score_to_metric_score_conversion_table.pdf

Figure 7: SWEMWBS scale

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5

Analysis Plan

Primary Analysis:

The primary and secondary impact analysis will use regression models to establish impact. For the primary outcome, the YP-CORE summary score will be the outcome variable. A binary indicator identifying whether the UASC was allocated to treatment (scored as unity) or control (scored as zero) will be included as a main effect in the model. The coefficient for this variable will carry the impact effect as the average difference in the YP-CORE outcome between the treatment and control group. The coefficient will be significance tested with a two-tailed alpha of $P < 0.05$, to establish the significance of the impact effect. Additionally, further variables will also be included in the regression, including the baseline measure of YP-CORE and an identifier for the stratification group. A single level OLS regression model with an identity link and Gaussian error term, will be used, given the lack of clustering in the data and the continuous nature of the YP-CORE outcome score.

$$\hat{Y} = a + bD + \sum_{j}^{J} z_j X_j + e \qquad (1)$$

Where $\hat{Y}$ is the predicted outcome score, *a* is the intercept, *b* is the coefficient carrying the impact effect, *D* is the binary indicator equalling unity for the treatment group and zero for the control group, and z_j represents coefficients for the baseline measure and the 5 stratum group indicator variables, with X_j representing the baseline score and the binary indicator variables for the 5 stratum indicator variables, and e is assumed to be normally distributed. *J* runs from 1 to 6, with 1 representing the mean centred baseline score and 2-6 the 5 stratum indicator variables. The excluded 6th stratum will be represented in the intercept.
j
Residuals from the regression model will be checked for heterogeneity and adjusted using a Huber-White approach, if required. Checks for heterogeneity will include a visual inspect of the plot of the residuals against the fitted values and Leven tests.

There is the potential to increase the statistical power of the analysis further by including other predictor variables in the regression model. However, calculation of the standardised effect size will use the conditional total variance of the impact effect in its calculation. Using a minimum specification for the model means that the standardised effect size will only be conditioned on the baseline measure and the design variables. Consequently, the effect size

can be used in a meta-analysis study without concerns over comparability caused from effect sizes adjusting for different variables across different studies.

The impact estimator will be calculated using an intention to treat (ITT) analysis to maintain the integrity of randomisation in the allocation stage. This is the fundamental test of the success of the impact effect for this study. This ITT average treatment effect (ATE), however, is based on an 'offer to treat'. In some circumstances, especially voluntary schemes, it is possible that some people offered the treatment do not participate in the treatment (non-compliers). In such cases, the ITT effect is diminished by those who have not participated. We can calculate the size of the impact effect on those who have participated using formula (2) below, which will be greater than or equal to the ITT average effect. It is also possible that some people in the control group actually receive treatment. This cross over is likely to happen in this particular study because of the over-ride option for young people in the high-risk stratum. In this case, the control group is contaminated by treatment, lowering the ITT estimate of the average treatment effect. Formula (3) below shows how we will adjust for this circumstance of dual cross overs, where the local average treatment effect is calculated as a weighted average of treatment compliers across the treatment and control groups.

in order to adjust for the presence of non-compliers in the treatment group, and assuming we can collect outcome scores for these people, we will also calculate the treatment on the treated, following equation 8 in Bloom (2006), as:

$$TT = \frac{\bar{Y}_t - \bar{Y}_c}{\bar{D}|Z=1} \qquad (2)$$

Where the denominator is the proportion receiving treatment in the treatment group

There is also the potential for cross-overs from the control group to the treatment group arising from the enforcement of the over-ride option from the BRC. Consequently, we may have cases who were allocated to treatment and either received treatment as intended or, through non-compliance, did not. Similarly, we may have people allocated to the control who, as intended, received no treatment, but also those with through the override option, received treatment. In such a situation, we will also include an estimate of the Local Average Treatment Effect (LATE), also described by Bloom (2006; equation 11):

$$LATE = \frac{\bar{Y}_t - \bar{Y}_c}{\left(\bar{D}|Z=1\right) - \left(\bar{D}|Z=0\right)} \qquad (3)$$

Where the denominator is the difference in treatment rate between the treatment and control group.

These three impact effect estimators offer different perspectives on the success of the intervention. In practice, the LATE probably comes closest to capturing the impact which might be expected in a roll-out, given that the control group is likely to include a potentially influential minority of high-risk young people receiving treatment who consequently increase the baseline measure of no impact in the ITT estimator.

We note that this approach assumes the average impact effect for moderate risk cases is equal to the average impact effect for high risk cases, given that we anticipate cross-over from control groups only through the over-ride option in the high risk group. There is also the possibility that all cases in the high risk strata are overridden. If the over-ride option is exercised, we will test for the influence of the high-risk strata through sensitivity testing our results, as described below.

In addition to the estimators described above, we will provide a standardised impact effect (Glass' Δ). With only one primary outcome, there is no need to adjust for multiple significance testing, in line with WWCSC recommendations.

Secondary Analysis

Analysis of secondary outcome follows the same approach as described above for primary outcomes. The secondary outcome will be regressed onto the treatment indicator, controlling for the appropriate baseline measure and stratification membership. The secondary outcome will be treated as continuous and an OLS regression model will be used, assuming a Gaussian error distribution. Checks for normality of errors will be made and a Huber-White adjustment made if there is any evidence of heteroscedasticity. We will also mirror the ITT average treatment effect, treatment on the treated and local average treatment effects described above and provide a standardised impact effect (Glass' Δ). In line with WWCSC recommendations, we will not adjust for multiple significance tests for three (or less) outcomes.

Analysis of Harms

There is a high level of heterogeneity of interventions and measures when it comes to therapeutic intervention with unaccompanied asylum seeking children, however, evidence suggests positive impacts of such interventions (Children's Society, 2018). However, there is some evidence that therapy can have harmful consequences. The Experiences and Needs of Refugee and Asylum Seeking Children in the UK Literature Review (2005) discusses the possibility of pathologising and stigmatisation of young people's as possible harmful impact of therapy. Furthermore, there are numerous sources of qualitative evidence on negative experiences of therapy, which can be potentially harmful. The findings from Curran et al.[15] suggest that "Contextual issues, such as lack of cultural validity and therapy options together with unmet client expectations fed into negative therapeutic processes (e.g., unresolved alliance ruptures). These involved a range of unhelpful therapist behaviors (e.g., rigidity, over-control, lack of knowledge) associated with clients feeling disempowered, silenced, or devalued". This remains an under-researched area using quantitative methods.

Unintended consequences of the intervention, including harms, will be explored in the IPE. Given the positive evidence around therapeutic intervention, it is not thought that My View would inflict undue harm. Some of the issues raised above will be mitigated by appropriate eligibility and assessment processes to ensure My View is appropriate for the young people, careful selection and matching of therapists and therapies for young people, and the development of the therapeutic relationship and coping skills.

Sensitivity Analysis

If all high-risk cases are rolled into the treatment group because of the over-ride, we propose to re-run the primary and secondary outcome regressions with high-risk cases excluded to check the effect this has on the impact estimate. In all other respects, the modelling procedure will follow the steps outlined above. Additionally, if the secondary outcome data are skewed, we will check the impact estimate using an ordinal regression model, again using the binary indicator to test the impact effect, controlling for the baseline score and stratum membership.

Missing Data

We anticipate that the baseline YP CORE questionnaire will be completed by all at the initial assessment interview, given the importance of the baseline in the analysis anyone not completing will be excluded from the analysis. Similarly, we anticipate the questionnaire measures of secondary outcomes to be collected at that same time. The endline primary outcome measures will be collected three months after starting the intervention with attempts

[15] Curran, J., Parry, G. D., Hardy, G. E., Darling, J., Mason, A. M., & Chambers, E. (January 01, 2019). How Does Therapy Harm? A Model of Adverse Process Using Task Analysis in the Meta-Synthesis of Service Users' Experience. *Frontiers in Psychology, 10.*

made to collect intermediate YP-CORE scores at the 6-week interval (for the treatment group only).

We anticipate that the key risks to missing data will arise with the endline outcome score. Cases without an endline score will not be imputed and will be dropped from the analysis, which will be run using complete case response data only. BRC routinely attempt to collect YP-CORE data after the first six weeks but only for the treatment group. Consequently, we cannot treat both groups equally with respect to missing endline data, so will not attempt to use the 6-weekly score for imputation purposes.

If there is evidence of differential attrition between the treatment and control groups in terms of socio-demographic characteristics, we will construct a weight to account for differential attrition and include a weighted version of the primary and secondary outcomes in the sensitivity analysis to check on the stability of the impact estimate.
If there is no evidence of differential attrition, no weighting will be undertaken.

It is possible, however considered highly unlikely, that young people may give partial responses to the baseline and/or outcome data and, if this occurs, item responses may be imputed to enable a more complete summary score.

Exploratory Analysis

Additional analyses can be conducted after the trial is completed that are not specified in the trial protocol. However, it is useful to specify areas of potential future interest here.

Regression models will be used to explore compliance with the treatment status, using binary logistic regression to predict:

- Any gains in YP CORE scores based on types of treatment (group therapy, 1-21 session)
- Dose response, i.e. including a measure of the number/proportion of sessions into the regression model to explore effect on YP CORE growth (baseline versus outcome)
- Sociodemographics – A suite of socio-demographic and other variables, collected from the administrative data, will be included into the impact regression models to test for differences in the YP CORE. These include:
    - Age
    - Gender
    - Country of origin
    - Length of time in UK
    - Relationship status
- Where feasible, i.e. group sample sizes permitting, selected interaction terms will subsequently be investigated to provide exploratory hypotheses for further research.

Contextual Factors Analysis

A key contextual factor in this trial is the nature of treatment delivery virtually and in the four authorities. Administrative data will be available on the flow process of UASCs referred for treatment and these numbers will be compared across the different treatment centres alongside caseload, levels of engagement of the young people and so forth. The analysis will include basic descriptive statistics of the administrative data accompanied by evidence from interviews undertaken in the process evaluation.

Implementation and Process Evaluation

Aims

The implementation and process evaluation (IPE) aims both to answer distinct IPE questions and to create understanding around implementation outcomes that are useful for complementing and understanding the findings from the RCT impact evaluation. This knowledge is important for understanding the programme, its implementation in this evaluation, and creating knowledge for a potential scale up of the programme. As such, the key research questions addressed by the IPE will focus on the implementation outcomes that are a precursor to positive intervention effects[16] and appropriate to understanding 'My View' intervention which is still developing and being refined. These research questions build upon the pilot evaluation published by the British Refugee Council, for example by looking at the appropriateness and fit of the programme, acceptability, and cultural barriers to engagement. At the same time, the research questions also acknowledge the importance of revisiting and specifying the current intervention further, including understanding the mechanisms for change, specifying the intervention activities that have taken place, and examining new elements such as the online delivery.

Critical in the IPE data collection activities will be the understanding of the context of mental health for UASC and the context of delivery for partners. Although we are specifying our plans here, we will be flexible to the needs of delivery of the intervention and the needs of the populations served by the intervention, and we may modify sample sizes and data collection activities accordingly (e.g., for example, by allowing flexibility in the interview and bringing in more arts-based methods rather than semi-structured interviews or by not recruiting young people with particularly vulnerable mental health at the end of the intervention).

Logic Model development

An important component of both the RCT and IPE is specifying the logic model (LM). WWCSC facilitated an initial LM workshop at the launch and this was followed up with several other workshops and revisions led by the evaluation team. The logic model development focus on identifying the key target activities, implementation outcomes, mechanisms of change, outcomes, and assumptions. We will subsequently refine the LM in the light of study data.

Research Questions

We have grouped key IPE questions around Proctor et al. (2011)'s conceptual model that categorises implementation outcomes and distinguishes these from service and individual outcomes. The data collection proposed is shown alongside these in the table and described further in the design section.

Research questions:

1. **Mechanisms of change:** What are the perceived mechanisms of change for 'My View' to intended outcomes for young people? What are the perceived changes in outcomes?
2. **Adoption:** What is the programme reach? How many took up the service? What kinds of activities did they do, and what referrals were made and followed upon?
3. **Acceptability:** How acceptable do participants and staff find 'My View' (e.g., content, comfort, number of sessions, online nature)? Is it viewed as an improvement on services as usual by young people, delivery partners, and social workers? What adaptations have been made to make the programme more acceptable and culturally acceptable to participants?

[16]Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., et al. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2)

4. **Appropriateness:** Is 'My View' seen as a good fit with professional/service norms (e.g. counselling co-location, therapy, psychoeducational services) and with needs of UASC (e.g. addressing mechanisms for change)?
5. **Feasibility**: What are viewpoints on the feasibility of implementing 'My View'? What barriers and enablers were encountered, and how were these addressed?
6. **Implementation strategies:** What implementation strategies were used to recruit UASC, establish the service, and train / support 'My View' staff?

Design

Table 5 below provides an overview of the indicator, output, or frame of analysis for each research question and how we intend to collect this data.

Table 5: IPE design table

IPE Design Table	
Indicators, output, or analysis	**Method**
1. Mechanisms of change: What are the perceived mechanisms of change for 'My View' to achieve the intended outcomes for young people?	

• Logic model diagram
• Perceived changes in service and client outcomes including unintended consequences and risks of harm
  ○ Perceived changes in services and access to services (e.g. access to education and housing, timeliness in services)
  ○ Perceived impacts on young people (e.g., symptomatology, negative peer influences)
	• Logic model workshops
	• Interviews with staff
	• Interviews with young people

2. Adoption: What is the programme reach? How many took up the service? What kinds of activities did they do, and what referrals were made and followed upon?	

• Number of referrals
• Number of eligible referrals
• Numbers taking up
  ○ One-to-one therapy
  ○ Group therapy
• Number of sessions completed within the 12 weeks 'treatment period'
  ○ Mean, median, mode
  ○ Percentage reaching threshold of 'treated'
• Description of services and activities undertaken
• Number of young people who were overridden allocation from the RCT
• Justifications for overriding RCT allocation
• Number and types of onwards referrals made
  ○ Any data on referrals accepted
	• Individual-level administrative data – Records by the British Refugee Council

3. Acceptability: How acceptable do participants and staff find 'My View' (e.g., content, comfort, number of sessions, online nature)? Is it viewed as an improvement on services as usual by young people, delivery partners, and social workers? What adaptations have	

been made to make the programme more acceptable and culturally acceptable to participants?	
• Perceived acceptability • Perception of cultural acceptability	• Interviews with children and young people • Interviews with staff members, including therapeutically-trained interpreters • Interviews with stakeholders (e.g., KRAN, other refugee-serving organisations, CAMHS, foster carers, accommodation workers)
4. Appropriateness: Is 'My View' seen as a good fit with professional/service norms (e.g. counselling co-location, therapy, psychoeducational services) and with needs of UASC (e.g. addressing mechanisms for change)?	
• Perceived appropriateness	• Interviews with children and young people • Interviews with 'My View' staff members • Interviews with stakeholders
5. Feasibility: What are viewpoints on the feasibility of implementing 'My View'? What barriers and enablers were encountered, and how were these addressed?	
• Perceived feasibility • Perceived barriers and enablers • Perceived strategies for overcoming barriers and facilitating enablers	• Interviews with 'My View' key staff members • Interviews with intervention trainers and facilitators • Administrative data on implementation
6. Implementation strategies: What implementation strategies were used to recruit UASC, establish the service, and train / support 'My View' staff?	
Implementation strategies classified using the Expert Recommendations for Implementing Change (ERIC) compilation of 73 commonly identified and clearly defined implementation strategies in human services[17]. We will pay particular attention to the implementation strategies around engaging young people, adapting and tailoring to context, and supporting clinicians.	• Interviews with 'My View' Workers • Analysis of documents about the programme • Administrative data on workshops and recruitme

Methods

Sample and Recruitment

Administrative data will be pseudonymised individual-level data and aim to comprehensively cover all referrals and participants and will be shared with appropriate data protection safeguards, data protection impact assessments, and using data sharing agreements.

Interview participants will be purposively sampled across the four geographic sites and remote delivery per the target numbers below under data collection. We will recruit by providing information sheets through the British Refugee Council for interviews via an opt-in basis. We will provide information on the evaluation in the training for British Refugee Council and provide support for recruitment throughout the evaluation. For adult stakeholders, we may also recruit through networks and publicly available contact information.

[17] Powell, B.J., Waltz, T.J., Chinman, M.J., Damschroder, L.J., Smith, J.L., Matthieu, M.M., Proctor, E.K. and Kirchne, J.E. (2015) A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project *Implementation Science 10:21*

Interviews with children and young people after completion of the programme, so as not to interfere with counselling or intervention outcomes (n=40), with purposive sampling across the 4 sites and amongst participants who completed the 1:1 session, who did group sessions, who had crisis support, and a few who were offered the programme but decided not to participate. The exact sampling frame will be decided in consultation with the programme when distribution of participants and their demographics are better understood. We will not aim for a representative sample, but we will aim to sample purposively for a diversity of experiences and information, while ensuring that participation is entirely voluntary and that there is understanding in order to be able to consent to participation. Information sheets and consent forms will be translated into appropriate languages. We plan to compensate participants £20 for 1-hour of their time for interviews and to provide interpreters and translation of information and consent sheets where appropriate.

Data Collection

Administrative data collection will build off the British Refugee Council's extensive existing data collection systems.

We will use semi-structured interview guides for all interviews. We anticipate that most, if not all, of the interviews will take place over the phone and or video conference (per the preference of the interviewee).

Data collection will take place with the target sample sizes and time points in the data collection schedule (Table 6) below.

Table 6: IPE data collection schedule

Method	Sample size	Time point
Administrative data	All referrals and participants	June 2021-April 2022
Semi-structured interviews with children and young people after completion of the programme	40 children and young people	Nov 2021-April 2022
Semi-structured interviews with key therapists and staff	6-8 therapists and key staff at 2 time points (12-16 interviews)	July-August 2021 March-April 2022
Semi-structured interviews with other staff such as intervention trainers, facilitators, and therapeutically-trained interpreters	4-6 interviews	Feb-March 2022
Semi-structured interviews with stakeholders in each location	20 interviews with stakeholders (5x4 locations)	Feb-March 2022

Analysis

All interviews will be transcribed. Qualitative analysis will begin by using coding by using a platform for data management and coding.[18] The coding framework will be developed both deductively (e.g., reflecting elements of the questions, and logic model) and inductively, including unexpected issues emerging in the data. This will be an iterative process with multiple researchers to ensure the quality of coding structures. A framework analysis will be used to chart

[18] We are still confirming whether we will use dedoose or NVivo. In the application stage, dedoose appeared to offer the best value for money, but we are confirming this.

at the key themes across the four sites as cases of implementation, thereby examining trends in findings between and across categories of interviewees and locations.

To ensure implementation strategies are uniformly classified across the four sites, we will classify them using the Expert Recommendations for Implementing Change (ERIC) compilation of 73 commonly identified and clearly defined implementation strategies in human services[19]. We will pay particular attention to the implementation strategies around engaging young people, adapting and tailoring to context, and supporting clinicians. Understanding implementation strategies is core to understanding the results of the RCT as well as for replication and improvement of 'My View.'

[19] Powell, B.J., Waltz, T.J., Chinman, M.J., Damschroder, L.J., Smith, J.L., Matthieu, M.M., Proctor, E.K. and Kirchne, J.E. (2015) A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change (ERIC) project *Implementation Science 10:21*

Cost Evaluation

The cost analysis question is: How much does it cost to introduce and run the "My View" programme?

We will collect costs from the British Refugee Council in April 2022 of delivering the programme from March 2021 until April 2022, and projected costs to June 2022. Costs for set-up (one off) and recurring costs are to be broken down by:

- staff time for delivering therapy as well as case work (proportion of FTE multiplied by salary plus other staff costs such as national insurance contributions),
- any costs associated with recruiting and training therapists,
- any costs related to case work (e.g. staff time, travel costs, use of platforms (Zoom, phone calls), postage and stationary),
- any costs related to group therapy (e.g. equipment)
- any other overheads including facilities (cost of office and venue hire associated with face to face provision) and equipment costs (based on individual needs (own resources of cards, art materials, sleep packs, stress balls, work sheets for example the tree of life or team of leaf, body outlines etc.).

We will estimate a per pilot-site cost (given the differences in volumes) and provide costs per child, per site. We will also ask the British Refugee Council to distinguish between set-up costs and day-to-day running of the programme costs. We could compare the per-child costs with published costs for similar services, such as counselling for children with mental or emotional difficulties.[20]

[20] https://www.pssru.ac.uk/pub/uc/uc2020/1-services.pdf

Risks

Table 7: Risk register

Risk	Mitigation
Low participation by young people in My View	The programme has and will mitigate against this (e.g., understanding cultural competency, well-connected, integrated into existing services). The evaluation will examine adoption and acceptability, including the programme reach and take up as well as the acceptability by participants and staff. Likelihood: Medium Impact: High
Difficulty in recruiting young people participants of for interviews	We are ensuring that the info sheet is translated, and interviews are short and concise. We are also offering small compensation/ incentives for interviews, and only recruiting for interviews after counselling completion when there will be better trust built up Likelihood: Low Impact: Medium
Staff and young people only want to report positive aspects of the service in IPE evaluation	We will mitigate this through: ● Independence of the evaluation team ● Careful discussion of consent processes and anonymity and confidentiality ● Use of interpreters where necessary ● Use of open questions, probes in semi-structured interviews Sensitively approaching data collection Likelihood: High Impact: Medium
Difficulties in carrying out My View as designed and planned by programme team (e.g., staff illness/turnover, Covid-19 regulations changing or recruitment under remote conditions, or other administrative barriers).	The programme has and will mitigate against this (e.g., virtual design, well-connected, integrated into existing services) The IPE will capture the appropriateness of the service (including fit with professional/service norms) and the feasibility of the implementation, facilitators and barriers to implementation, and implementation strategies. Likelihood: Low Impact: High
Unrealistic expectations by funder, programme, and/or partners on ability to detect impact and change	We will mitigate this through: ● Clear communication ● Strong working relationships ● Build-up knowledge to detect impact in future evaluations Sound design, measures, and understanding of the importance of randomisation Likelihood: Very low Impact: Low
Findings not applicable to future delivery in non-Covid-19 circumstances	One basis of the evaluation is that there is value in exploring online delivery of services and that many services will continue online for young people who are remote / young people more confident with technology. Efforts will be made to distinguish features of programme delivery and implementation that might vary in non-Covid-19 circumstances. Likelihood: Low/ Medium Impact: Low / Medium

Quality of the data collected by My View/British Refugee Council makes it difficult to detect impact	Therapeutic staff trained by My View programme managers. Importance of data collection re-iterated by workshop with evaluators. Baseline data to be scrutinised and additional training offered if necessary. Likelihood: Low/Medium Impact: High
Young people drop out and no post-data can be collected	Tracking of young person through referrer by therapist. Session 6 data collection to be used as fall-back. Likelihood: Medium Impact: High
Difficulty collecting data from the control group	Waitlist design means we can get accurate 'pre' recording. Monthly check-in by therapist or BRC admin with young people while on waitlist Likelihood: Low / Medium Impact: High
Contamination / crossover between the treatment and control groups	It is possible that young people assigned to the control group receive the treatment. This might be when a decision has been made to override randomisation in high-risk cases. It may also take place if, for example, a young person in the control group attends a drop-in group session (e.g. at the Kent Reception Centre). In both cases, this will be recorded so the evaluation will be aware of how often this happens, and if appropriate, undertake sensitivity analysis (e.g. conducting analysis with and without these individuals to detect any differential impact). Likelihood: Medium Impact: Medium
Timetable / delivery delays if therapists take longer than expected to recruit	Full complement of therapists currently recruited. Likelihood: Low / Medium Impact: Low / Medium
Early data collection finds negative outcomes for intervention group young people	As the programme is established and has been run before, this is unlikely to happen. This will be discussed as part of the ethics process. Likelihood: Very low Impact: Low

Ethics & Participation

We will obtain (to be updated once obtained) research ethics approval through Ipsos MORI's research ethics process in May 2021. The ethics committee will be independent and not otherwise involved in any evaluation activities. If any changes occur to the intervention delivery or evaluation, the Principal Investigator will make these known to the chair of the Ipsos MORI Public Affairs Research Ethics Committee.

Ethical considerations

In conversation with the British Refugee Council and What Works for Children's Social Care, we have considered ethical risks and trade-offs, and are satisfied that these are sufficient and reasonable. We also believe that the evaluation has merit in providing evidence on the effectiveness of My View as a therapeutic intervention for UASC.

Consent

Administrative data collection and analysis

We will not seek consent to randomisation from UASC. We plan to send therapists an information sheet for them to distribute to their clients who are randomised and those on the waitlist, at initial assessment. This will give young people an opportunity to opt out of their data being analysed for the evaluation (any opt out received will be treated as a request to also not be approached for a qualitative interview).

Interviews with therapists, trainers and other staff

We will approach staff via email, having received contact details from the British Refugee Council programme managers. We will provide an electronic copy of our information sheet and consent form. We will check and record whether interviewees consent before starting each interview.

Interviews with young people

We will approach young people via their therapists and will provide a translated copy of our information sheet (which will be young people friendly) and consent form. Before the interview we will ensure that young people have understood the information, had the possibility to have their questions answered and seek informed consent.

Participation

We will learn about any special arrangements or alternative formats from therapists (via Refugee Council programme managers) at the interview selection stage. We will make arrangements to translate information sheets and consent forms, to provide an interpreter, or arrange other support to enable interviews to take place.

Ethical considerations relating to the RCT

The use of randomisation is justified in this context

Previous evaluation of My View has not employed a robust comparison (a counterfactual), which means that we cannot be confident about causality when claims about positive impacts are made. We are in 'equipoise' meaning we are agnostic on whether the

programme is effective or not, making an RCT the logical next step, taking the evidence to the next level.

Well-planned and executed RCTs can establish that programmes lead to particular benefits for UASC, rather than other factors explaining changes. This evaluation therefore has the potential to provide the highest quality evidence to help inform future commissioning and practice.

The randomisation has been designed so as to exclude UASC who are deemed as requiring 'crisis intervention'. After the initial one to three sessions of crisis intervention, young people will not be returned to the waitlist, however, they will continue to receive treatment (if they so wish, in line with therapists' availability) immediately.

Further, at initial assessment, if a young person has been randomised to the waitlist group and the therapists believes them to require crisis intervention, the random allocation can be overwritten.

Taking part in the intervention is voluntary

We will collect data and report on whether young people attend the My View therapy sessions they are offered (as part of the intention-to-treat analysis). Young people have the option to decline the offer to take part in the intervention.

Young people in the control group (waitlist) will receive business as usual support

Young people who are randomised to be on the waitlist will receive business as usual support. This support may vary depending on their location / local authority, the source of the referral and whether any other support can be provided. Due to the waitlist design, young people in the control group will be offered the intervention three months after the randomisation.

My View may stir up issues meaning outcomes get worse before they get better

As with any therapeutic intervention, engaging in My View may bring up traumatic past experiences, which may make young people feel worse during the intervention before they start working through these experiences and start feeling better. As there is limited time available in this evaluation, some young people may only be part-way through the intervention when the post-measure is collected. Similarly, some young people may only have attended a small number of group sessions within the three months of the evaluation observation period. If data allow, we will explore statistically any trends in changes in outcomes during the available time period in relation to number of sessions attended. This will include any data collected in Session 6.

Ethical considerations relating to the interviews

Young people interviews

In terms of content, the interviews will not ask people to revisit difficult periods in their life, but will instead focus on the experience of receiving My View and related changes in the young person's life. These expectations will be clearly explained to the interviewee before the interview takes place.

Despite our focus on My View, not personal histories, some young people may be prompted to reflect on things that have happened in their pasts. Asking about My View in a research interview may make young people recall the same deep emotions and re-visit the same traumatic events as they experienced and recalled during therapeutic sessions themselves.

Some of the topics we ask about may be sensitive for some interviewees, but the context of the interviews may also trigger difficult feelings. We have plans (set out in the topic guides) for what to do if an interviewee becomes upset.

During interviews we will be flexible and use open questions and take a friendly and encouraging approach. We will be willing to take breaks and explore topics of interest to the child rather than being bound by the topic guide. To build rapport, we will use questions to check understanding; combining verbal and non-verbal communication to facilitate understanding; and allow plenty of time and tailored support for a young person to make a decision about participation or answering individual questions.

Risk of confusion between intervention and evaluation

Our interviews will represent an additional interaction with a professional adult stranger, which UASC going through a difficult time may not appreciate. The materials and interactions we have with young people will make clear that we are independent evaluators who do not work for the British Refugee Council, and that participation is voluntary. We will work with individual therapists who know their clients with the aim of achieving a soft, tailored introduction to young people (in terms of timing, style and mode) which explains our role and aims clearly.

Risks to researchers

The content of the interviews may cause distress for members of the evaluation team. Although each interview is different, members of the evaluation team interviewing UASC will have previous experience in doing so. We will hold debrief discussions after each interview and signpost to employee assistance programmes as appropriate.

In the case of in-person interviews, researchers will assess the risk of each interview in advance, planning outbound and return travel, and making plans to report back to another team member following each interview. Risk assessment will take into account factors such as time of day, location, and mitigations may include interviewing in pairs or via video conference.

Registration

In line with WWCSC requirements we will register this trial with the Open Science Framework (OSF) and update this trial registry with results at the end of the project.

Data Protection

The data protection considerations differ for the RCT, process evaluation, and costs analysis. We believe the costs analysis will not involve personal data collection or processing. For the RCT and process evaluation Ipsos MORI and WWCSC will act as joint data controllers, and Ipsos MORI will act as data processors.

For the interviews and survey of professionals, we rely on the legal basis of consent for processing interviewee and survey respondent data. For the administrative data request, we rely on legitimate interests as our legal basis for data processing. This includes demographic data (including gender and ethnicity), child's legal status, YP-CORE scores and SWEMWBS scores. The additional condition for processing the special category data on ethnic group is Article 9(j) of the DPA 2018 (Archiving, research and statistics). We are aware that such processing is subject to appropriate safeguards. We plan a number of steps to ensure data

minimisation. We consider the admin data will be pseudonymised. The data will be transferred to WWCSC's data archive on completion of the project.

All Ipsos MORI's research operations are governed by the Market Research Society Code of Conduct. We also hold the following international quality standards covering quality management systems, interviewer quality and information security: ISO 20252:2006, ISO 9001:2008 and ISO 27001:2005.

Our data security processes meet the standards outlined in the Data Protection Act 2018. Ipsos MORI has the Cyber Essentials standard. Any personal data will be held securely on our UK servers, and securely destroyed at the end of the project. Any enhanced sample data will be encrypted and sent over our secure file transfer system, Ipsos Transfer. All projects that involve personal data processing are required to complete a data flow and post a privacy policy online for respondents, using standardised templates.

Data protection statement

This Ipsos MORI Study and your personal data

- What Works for Children's Social Care/BRC My View Evaluation 21-032899

This Privacy Notice explains who we are, the personal data we collect, how we use it, who we share it with, and what your legal rights are.

About Ipsos MORI

- Market & Opinion Research International Limited is a specialist research agency, commonly known as "Ipsos MORI". Ipsos MORI is part of the Ipsos worldwide group of companies, and a member of the Market Research Society. As such we abide by the Market Research Society Code of Conduct and associated regulations and guidelines.

About What Works for Children's Social Care

- WWCSC were commissioned by the Department for Education to work alongside CASCADE at Cardiff University. Engagement and co-design are central to our approach and we are working in close consultation with leaders, practitioners, children and young people, families and researchers across the sector to:
    - Identify gaps in the evidence, and create new evidence through trials and evaluations
    - Collate, synthesise and review existing evidence
    - Develop, test and publish tools and services that support the greater use of evidence and inform the design of the future Centre
    - Champion the application of robust standards of evidence in children's social care research

What is Ipsos MORI's & What Works for Children's Social Care legal basis for processing your personal data?

- Ipsos MORI & What Works for Children's Social Care ("client") require a legal basis to process your personal data. Ipsos MORI's & the client's legal basis for processing is your consent to take part in this study and your consent to pass your personal data to the client. If you wish to withdraw your consent at any time, please see the section below covering 'Your Rights'.

How will Ipsos MORI use any personal data including survey responses you provide?

- Firstly, responding to this survey is entirely voluntary and any answers are given with your consent.

- Ipsos MORI will keep your personal data and responses in strict confidence in accordance with this Privacy Policy and you will only be identifiable if you consent to Ipsos MORI passing back your personal data at an identifiable level to What Works for Children's Social Care
- Ipsos MORI and the client will use your personal data and responses solely for research purposes.

Who we share your data with

- Ipsos MORI will be using certain supplier organisations to assist us in running the study and we will need to disclose your personal data to these supplier organisations for that purpose. These supplier organisations include:
- Centre for Evidence and Implementation
- Translation Agency (tbc)

How will Ipsos MORI ensure my personal information is secure?

- Ipsos MORI takes its information security responsibilities seriously and applies various precautions to ensure your information is protected from loss, theft or misuse. Security precautions include appropriate physical security of offices and controlled and limited access to computer systems.
- Ipsos MORI has regular internal and external audits of its information security controls and working practices and is accredited to the International Standard for Information Security, ISO 27001.

How long will Ipsos MORI retain my personal data and identifiable responses?

- Ipsos MORI will only retain your data in a way that can identify you for as long as is necessary to support the research project and findings. In practice, this means that once we have satisfactorily reported the research findings to the client, we will securely remove your personal, identifying data from our systems 12/2022.

Your rights.

- You have the right to access your personal data within the limited period that Ipsos MORI holds it.
- If you want to contact the client about data they hold about you, please see the client's contact details below.
- Providing responses to this survey is entirely voluntary and is done so with your consent. You have the right to withdraw your consent at any time.
- You also have the right to rectify any incorrect or out-of-date personal data about you which we may hold.
- If you want to exercise your rights, please contact Ipsos MORI at the details provided below.
- If you have any complaints, we would appreciate it, if you give us the opportunity to resolve any issue first, by contacting us as set out below. You are, however, always entitled to the UK's Information Commissioner's Office (ICO), if you have concerns on how we have processed your personal data. You can find details about how to contact the Information Commissioner's Office at https://ico.org.uk/global/contact-us/ or by sending an email to: casework@ico.org.uk.

Where will my personal data be held & processed?

- All of your personal data used and collected for this survey will be stored and processed in the United Kingdom

How can I contact Ipsos MORI & Client about this survey and/or my personal data?

Contact Ipsos MORI: Email: compliance@ipsos.com with "21-032899 BRC My View Evaluation" in the email subject line

Post: 21-032899 BRC My View Evaluation, Compliance Department
Market and Opinion Research International Limited
3 Thomas More Square, London E1W 1YW, United Kingdom

- **Contact What Works** for Children's Social Care: Email: Programmes@whatworks-csc.org.uk

Post: 21-032899 BRC My View Evaluation
The Evidence Quarter
Albany House; Petty France
Westminster
London
SW1H 9EA

Personnel

Delivery team

Table 8: My View delivery team

Name	Organisation	Roles and responsibilities
Sasha Nemeckova	British Refugee Council	Operations Manager, Therapeutic Services. Lead BRC contact (0.5FTE)
Theodoros Kostidakis	British Refugee Council	My View National Manager (FT)
Sam Mitschke	British Refugee Council	Project Admin Coordinator (FT)
Therapist 1	British Refugee Council	London delivery*
Therapist 2	British Refugee Council	London delivery*
Therapist 3	British Refugee Council	London delivery*
Therapist 4	British Refugee Council	Kent delivery (FT)
Therapist 5	British Refugee Council	Kent delivery (0.6 FTE)
Therapist 6	British Refugee Council	Birmingham delivery (0.8 FTE)
Therapist 7	British Refugee Council	Leeds delivery (0.8 FTE)
Therapist 8	British Refugee Council	Remote delivery (0.8 FTE)

*The three therapists in London account for a total of 1.4 FTE

Evaluation team

Table 9: My View evaluation team

Name	Organisation	Roles and responsibilities
Karl Ashworth	Ipsos MORI	Principal investigator
Claudia Mollidor	Ipsos MORI	Day-to-day evaluation lead for Ipsos MORI
Raynette Bierman	Ipsos MORI	Lead on quantitative data gathering and local authority liaison
Ellie Ott	CEI	Lead on implementation and process evaluation
Georgina Mann	CEI	IPE support
Emma Wills	CEI	IPE support

Timeline

Table 10: My View evaluation timetable

Dates (w/c)	Activity	Leading
5 April	Kick-off meeting	All
12 April	Customer journey / programme delivery meeting	IM / BRC
19 April	Theory of change and risk register meeting	All
19 Apr-10 May	Governance, contracts	IM / CEI / WWCSC
19 Apr-10 May	Data sharing agreement	IM / BRC
19 Apr-10 May	Protocol development	IM / CEI / (WWCSC)
10 May	Milestone 1	IM
17 May	First draft protocol to WWCSC (Milestones 1 and 2)	IM / CEI
24 May	WWCSC to review protocol	WWCSC
24 May	Call with WWCSC about protocol	All
24 May	Ethics board	IM
24-31 May	Protocol changes	IM / CEI
24-31 May	Development of randomisation tool	IM
31 May	Protocol changes agreed	IM / WWCSC
7 June	Protocol uploaded (Milestone 3 and 4)	IM
7 June	Randomisation set-up meeting	IM / BRC
7 June	Programme launch	BRC
7 June	First randomisation (Milestone 6)	IM
Mid-June – Apr 2022	RCT data collection	IM
Mid-June – Apr 2022	Administrative data collection	IM
Jul / Aug 2021	Interviews with key staff (Milestone 5)	CEI
Nov 2021-Apr 2022	Interviews with young people	CEI
Dec 2021	Interim report (Milestone 7)	IM / CEI
Feb-Mar 2022	Interviews with other adult stakeholders & staff	CEI
Mar-Apr 2022	Interviews with key staff (Milestone 8)	CEI
Mar-Jun 2022	Analysis (interviews, multiple methods) (Milestone 9)	IM / CEI
Apr-Jun 2022	Cost analysis	IM
Jun 2022	Final report (Milestone 10)	IM / CEI