PILOT TRIAL PROTOCOL

Remedi Restorative Mentors: a Pilot for a Randomised Control Study

University of Birmingham

Principal investigator: Professor Siddhartha Bandyopadhyay

YOUTH ENDOWMENT FUND

Pilot trial protocol template (includes a control group)

Evaluating institution: University of Birmingham

Principal investigator(s): Professor Siddhartha Bandyopadhyay

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Project title[1]	Remedi Restorative Mentors: A Pilot for a Randomised Control Study
Developer (Institution)	Remedi
Evaluator (Institution)	University of Birmingham
Principal investigator(s)	Prof Siddhartha Bandyopadhyay
Evaluation plan author(s)	Prof Siddhartha Bandyopadhyay, Dr Ioannis Karavias, Dr Livia Menezes, Prof Julie Taylor, Dr Shola Apena Rogers, Prof Eddie Kane, Dr Emily Evans.
Evaluation setting	Community and family homes
Target group	CYP aged 10-17 who have displayed violent behaviours and/or have committed a violent offence referred to Remedi via the police and youth justice services.

[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).

Number of participants	CYP referred to Remedi from the police and youth justice services. Target sample size: treatment group – 210, control group - 254.
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Protocol version history

Version	Date	Reason for revision
1.4 [*latest*]	6/9/2022	Feedback from YEF
1.3	21/6/2022	Feedback from YEF
1.2	5/5/22	Feedback from YEF
1.1	21/3/22	Feedback from YEF
1.0 [*original*]	20/12/21	*[leave blank for the original version]*

Any changes to the design need to be discussed with the YEF Evaluation Manager (EM) and the developer team prior to any change(s) being finalised. Describe in the table above any agreed changes made to the evaluation design, research questions and approach, and the rational for these.

Intervention

The Remedi intervention is a restorative mentoring programme for children and young people (CYP) to be used as a means of diversion from the criminal justice system (CJS). Diversion can occur at the point of arrest or as a formal out of court disposal (OOCD) once a person has been charged with an offence. Point of arrest diversion allows people to avoid a criminal record in exchange for completing a community-based requirement. An OOCD will feature in a criminal record. Point of arrest diversion, or a referral to a diversionary service at an even earlier point, aims to reduce the negative consequences of formal criminal justice sanctions while allowing practitioners in relevant services to focus resources on addressing the behaviour. For CYP diversion is aimed at reducing the number of those drawn into the CJS, and the poorer life outcomes associated with this. These can include labelling of CYP as 'offenders', interruption to education, training and employment and a criminal record. Indeed, contact with the CJS can itself be criminogenic, deepening and extending CYP's criminal careers, the further they progress into it (Robin-D'Cruz and Whitehead, 2021). As such, there has been increased interest in diversion in recent years with strong and ever-growing evidence that youth diversion reduces reoffending, lowers costs, and leads to better outcomes for CYP (Ely, Robin-D'Cruz & Jolaoso, 2021).

The nature of diversionary activities vary as do the way they are provided nationally. For example, the Centre for Justice Innovation found significant variation in practice regarding requirements on CYP to plead to or admit guilt, in defining eligibility (including which offences were excluded, when it would be offered and how CYP were assessed as eligible) and also in outcomes monitoring (Lugton, 2021). This variation is linked to a lack of national guidelines for the operation of these schemes, along with rules for recording the work done and clear funding for them (Lugton, 2021). In particular, it can exacerbate racial disparities in criminal justice outcomes for CYP, due to the different ways in which racial groups are policed. Robin-D'Cruz and Whitehead (2021) note that access to diversion is in part affected by previous contact with the police, with greater levels of contact able to exclude CYP from diversion, as it can indicate less possibility of or capacity for reform. This means BAME CYP may not referred for diversion or not be eligible for it. Contact with the police tends to be more common for those from BAME communities, which are policed to a greater extent, in turn increasing the likelihood of arrest. Furthermore, a lack of trust in the police can make it less likely that BAME people who are arrested are less likely to plead guilty, again barring them from diversion.

In general, youth diversion schemes tend to involve short assessments of arrested CYP and quick referrals into light-touch, voluntary programming. In this way the diversion intervention

provided by Remedi with which this study is concerned is different, in that it aims to offer a more intensive and comprehensive service to referred CYP and their families.

Remedi is a third sector organisation primarily providing restorative justice (RJ) services to adults and CYP across the UK. This includes community and custodial settings and working with individuals as well as families.

The Restorative Mentoring (RM) project provided by Remedi aims to deal with significant levels of violent behaviours and violent crime committed by CYP in the Greater Manchester area. In particular, the intervention focuses on CYP aged 10-17 who have displayed violent behaviours and/or have committed a violent offence but who are not subject to an order higher than OOCD level. These CYP will be referred to Remedi via the police and youth justice services. Remedi reports that these CYP frequently have low levels of awareness / understanding / empathic awareness regarding the impact of their behaviours, have problematic issues within their familial setting and face varying levels of challenges regarding their mental and/or emotional health. In the experience of Remedi, if unsupported these behaviours often result in greater degrees of violence/criminality[2].

Intervention Group

The RM project consists of three components, to provide intensive one to one support for children and young people. All young people in the intervention group will receive the mentoring component but what, if any, other component they receive will be determined by an initial needs assessment. The three components are:

i. **Mentoring**: 'Action Plan' agreed with young person with Specific, Measurable, Achievable, Relevant and Time bound (SMART) goals and expectations established, one to one support with lower-level mental health needs (confidence building etc). This element will last for around 12 weeks, based on 3-4 sessions per week.
ii. **Restorative Justice (RJ)**: Provision of full Restorative Justice intervention with harmed individuals identified (if desired by harmed/victim). RJ will be offered and mentioned during the mentoring work to give many opportunities to take part – using Remedi's empathic thinking work during the mentoring.
iii. **Restorative based family work**: where the referring professional, the CYP or the Remedi mentor identifies that familial support is required this will be offered with the aim to address conflicts/improve communication and support etc. The support will be

[2] Remedi restorative mentoring case studies: http://www.remediuk.org/case-studies-restorative-mentoring/

based on a family plan including family circle work, Remedi's 'Together Families' programme and work towards a family agreement/exit plan.

Further information about the journey of the CYP through the project and its different component can be found in Figures 1-4.

There is evidence that mentoring can significantly reduce delinquency outcomes, considering both administrative and self-report data (Blattman et al., 2017; Heller et al., 2017). In addition, it can support better long-term educational outcomes (Falk et al., 2020; Rodriguez-Planas, 2012), with more limited evidence for reductions in aggression and drug use (Tolan et al., 2013). Tolan and colleagues conducted a systematic review of mentoring for CYP involved in offending and delinquency. The review considered 46 studies and undertook the first systematic evaluation of key processes to explain how mentoring helped CYP. This analysis showed stronger effects when the mentoring offered emotional support and advocacy. These are reflected in the plan for the Remedi project, for example, through the inclusion of family support and going beyond signposting CYP to relevant services. It further found evidence that the motivation of the mentors can moderate the effect of the intervention, but unexpectedly found only limited detailed evidence of what the mentoring programmes actually consisted of and how they were implemented. Hence, the authors state that further studies are required to understand which components of mentoring are having the observed effects.

As with mentoring, there is good evidence that RJ interventions can lead to positive and cost-effective outcomes regarding offending, especially in the case of violent offending, as opposed to property crime (Strang et al., 2013), which is the focus of the current Remedi intervention. The systematic review produced by Strang and colleagues also found that RJ approaches have better victim satisfaction outcomes compared to standard criminal justice processes. Of the 10 face-to-face RJ conferencing interventions included in the study, only three included people aged under 18 (one of which included only those aged under 14), with a further intervention including those aged under 30. Findings from those RJ interventions concerning offences with personal victims which included only juvenile offenders showed a smaller effect size then those with adult offenders. The authors note that this is unexpected as it is generally thought RJ works better for younger offenders.

This evidence includes a review of an RJ intervention delivered by Remedi (Shapland et al., 2008), however the three RJ interventions considered in this study all involved adult participants. There is therefore a lack of evidence regarding the experience and effectiveness of RJ with CYP, which this study will help to address.

Shapland and colleague's review of these three RJ schemes showed that one key predictor of the 'success' of RJ regarding subsequent offending was the way in which the offender

experienced the intervention. For example, the extent to which the offenders felt the intervention had made them realise the harm done by their offending; the extent to which the offender was observed to be actively involved in the intervention; whether the offender wanted to meet the victim; and how useful offenders felt the intervention had been (2008: iv). The authors link these findings to the way in which RJ interventions can support an offender's motivation to desist or cease offending. It will be important to gather data on these factors in the current study to help understand the findings. Overall they found high levels of satisfaction with RJ from both the victims and offenders who took part (Shapland et al., 2007). The majority of victims received an apology and they reported that RJ helped lessen the negative effects of the offence. Dissatisfaction revolved around disputes between victim and offender regarding the offence, or difficulties in communication.

There is limited evidence of the effect of the type of family support the Remedi intervention will involve. There is some evidence that youth mentoring is more effective when combined with additional support services (Kuperminc et al., 2005), and with family support (Taylor and Porcellini, 2013). This is mainly because CYP eligible for mentoring programs often face several disadvantages, ranging from problems at school, harmful peer connections, and parental conflicts (DuBois et al. 2002). This very much mirrors the organisation and intentions of the Remedi intervention.

There is good quality evidence regarding similar interventions, although these do not take exactly the same approach Remedi will take. For example, the Early Intervention Foundation provide evidence regarding functional family therapy (FFT) and multidimensional family therapy (MDFT) in which trained therapists work with families in need for a period of time. This shares some characteristics with the Remedi intervention, but it is provided by a practitioner with different training although with similar aims; to help improve the relationships within and functioning of the family.

Studies of FFT have found it to have a short-term positive effect on CYP. CYP aged between 10 and 18 years who are involved in serious antisocial behaviour and/or substance misuse and their families were referred to learn strategies for improving family functioning and addressing the CYP's behaviour. FFT's effect has been assessed through a small number of rigorously conducted RCT (Waldron et al., 2001) or QED (Darnell et al., 2015) studies and is supported by the findings of less rigorous studies mostly conducted in the USA. However, another RCT in the UK had more mixed results (Humayun et al. 2017), with FFT found to be no more effective than standard support provided to families and to have a negative impact on observed child/parent interaction. The authors note that this was unexpected and may be linked to the quality of the standard, 'management as usual' condition provided to all families in the study.

Regarding MDFT, studies have shown it to have positive effects for the CYP involved, regarding their use of substances and their involvement in offending and anti-social behaviour, including at 12 and 18 month follow up points. A number of the studies of MDFT have focused solely on the outcomes regarding substance use. Those which focused on outcomes regarding involvement in offending include two RCTs. Schaub and colleagues (2014) conducted an RCT in a number of European countries. They found reductions based on both self-report measures and those completed by parents and improvements in family conflict as reported by the CYP. Dakof and colleagues (2015) conducted a RCT in the USA. They found reductions based on both self-report measures supported by analysis of administrative data on arrests.

Control Group

CYP in the control group will receive Restorative Choices (RC) training, a short mentoring scheme. This tends to consist of four sessions usually lasting 1-2 hours (depending on the attention abilities of participants). The sessions take place over a period dictated by the availability of the CYP; they can all take place during a week or at most over four weeks.

Both RC and RM will be delivered by Remedi.

Restorative Mentoring Theory of Change

WHY	***Problem Observation***	There are significant levels of violent behaviours and violent crime committed by children and young people (CYP) in the Greater Manchester area.
	Need	A number of these CYP frequently have low levels of awareness / understanding / empathic awareness regarding the impact of their behaviours, have problematic issues within their familial setting and face varying levels of challenges regarding their mental and/or emotional health. If unsupported these behaviours frequently result in greater degrees of violence/criminality.
WHO	***Target Population***	CYP aged 10-17 who have displayed violent behaviour OR have committed a violent offence, capped at the level of an OOCD sanction. Referred via Youth Justice Services and Police Planned scale: 210 CYP engaged with the restorative mentoring service (the control group will consist of 254 CYP receiving Restorative Choices).
HOW	***Intervention Activities***	Provision of a dedicated, trained team of 10 full-time practitioners providing intensive one to one support for children and young people with 3 primary focuses: 1. Intensive Mentoring- including supported engagement with specialist mental health services 2. Restorative Justice 3. Family support The above team working in a collaborative partnership with referring agencies. Following referral and initial suitability check CYP are offered: • ALL: ○ Initial introduction and needs assessment ○ Supported referral on and direct support to access wider specialist mental health services. ○ Impact assessment and evaluation ○ Mentoring: 'Action Plan' agreed with young person with SMART goals and expectations established, one to one support with lower level mental health needs (confidence building etc). Will last for around 12 weeks, based on 3-4 sessions per week.

		• RJ: Provision of full Restorative Justice intervention with harmed individuals identified (if desired by harmed/victim). RJ will be offered and mentioned during the mentoring work to give many opportunities to take part – using REMEDI's empathic thinking work during the mentoring. • Restorative based family work: to address conflicts/improve communication and support etc. will be based on a family plan including family circle work, REMEDI's 'Together Families' programme and work towards a family agreement/exit plan.
	Intervention Mechanisms	**Mentoring** • Increased self-esteem, confidence and resilience, better able to cope with life crisis points • Increased understanding consequential thinking skills • Increased empathic thinking skills • CYP less socially isolated **RJ** • Victim satisfaction/benefits regarding coping and recovering, feeling safe and less fearful, improved health and sense of wellbeing **Family support** • Improved familial relationships • Improved familial communication • Families better equipped to address future challenges **Overall** • Increased access/ engagement with mental health services
WHAT	***Short Term Outcomes***	• Reduced violent behaviours • Reduced levels of aggression • Reduced weapon carrying (where applicable) • Reduction in displayed 'behavioural problems'
	Medium Term Outcomes	• Reduced involvement in violent and non-violent criminal offences • Reduction in gang involvement

		• Improved relationships with friends
	Long Term Outcomes	• Reduced levels of crime • Reduced demand on other statutory services • Reduced community tensions • Improved mental/physical health of CYP

Procedures

Figure 1 Restorative mentoring overview

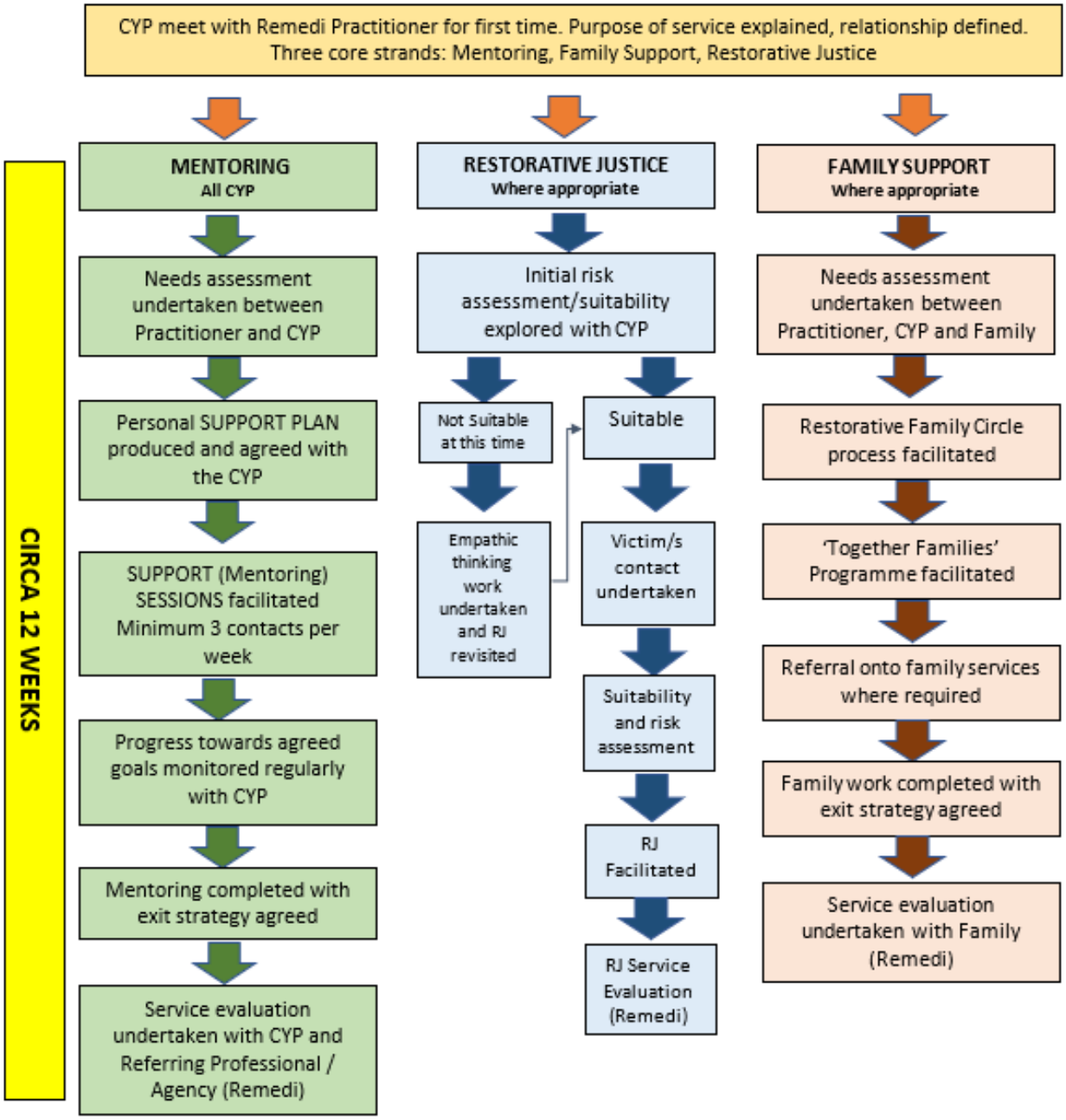


Figure 2. Mentoring component process

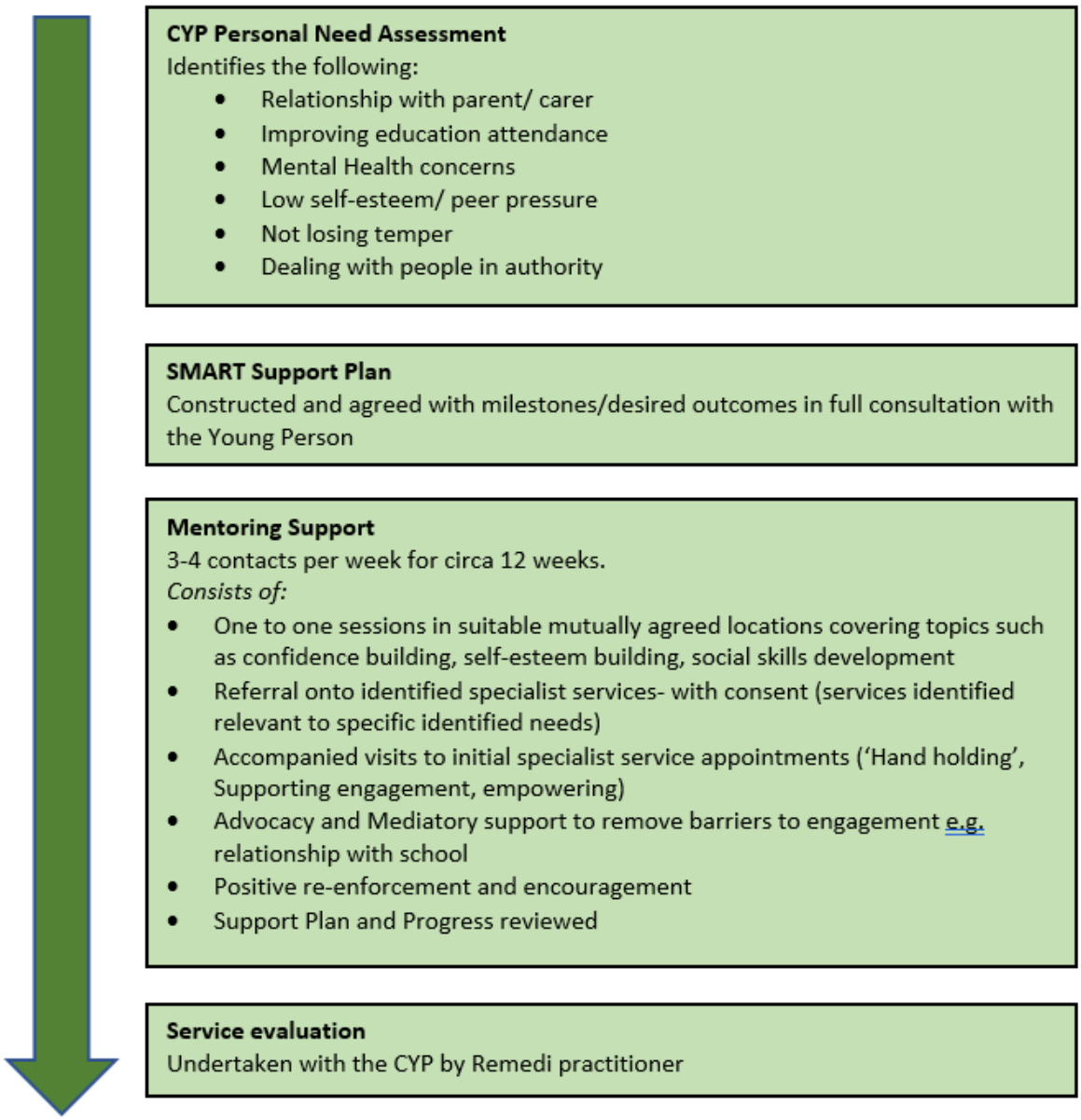


Figure 3. Restorative Justice component process

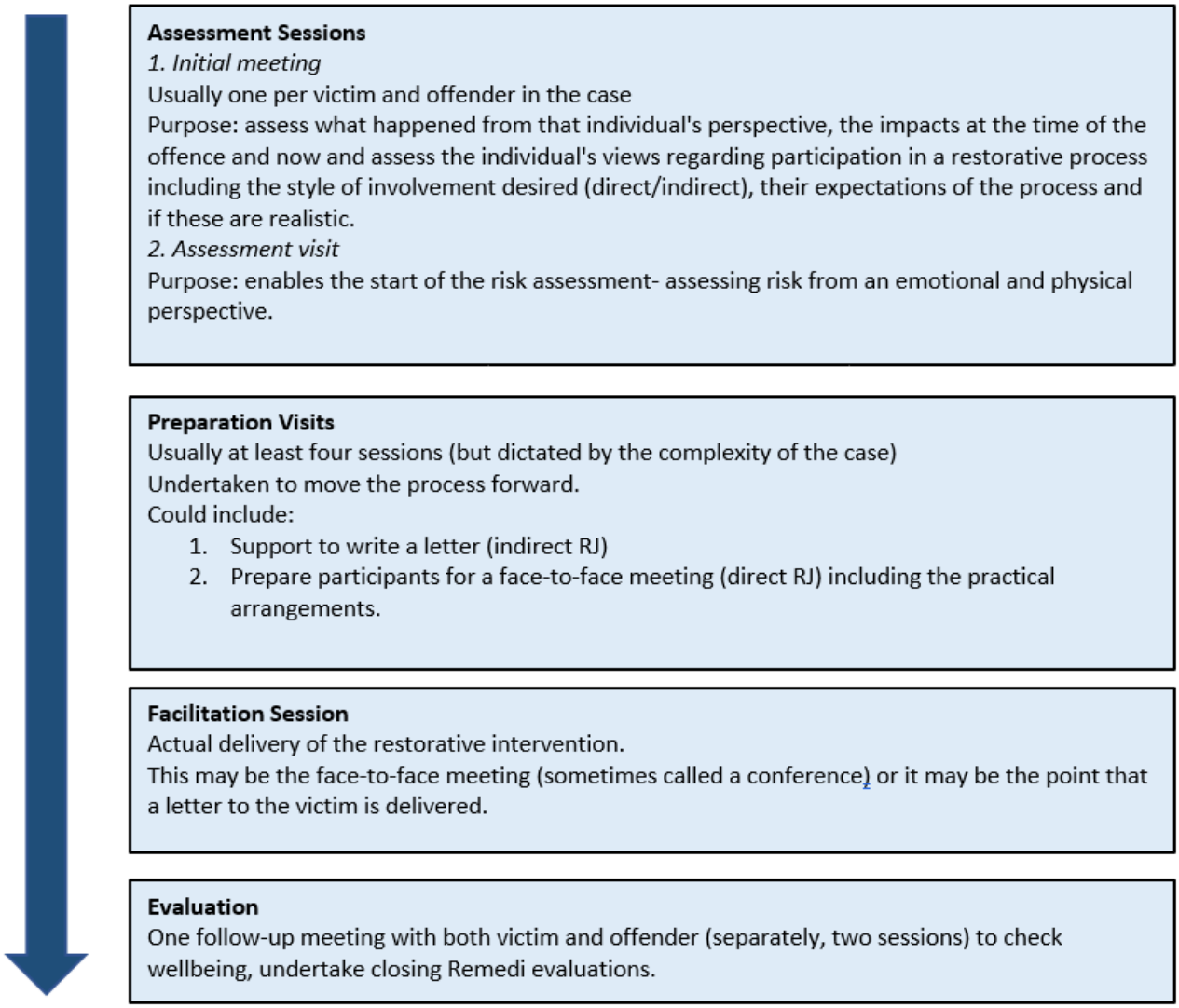
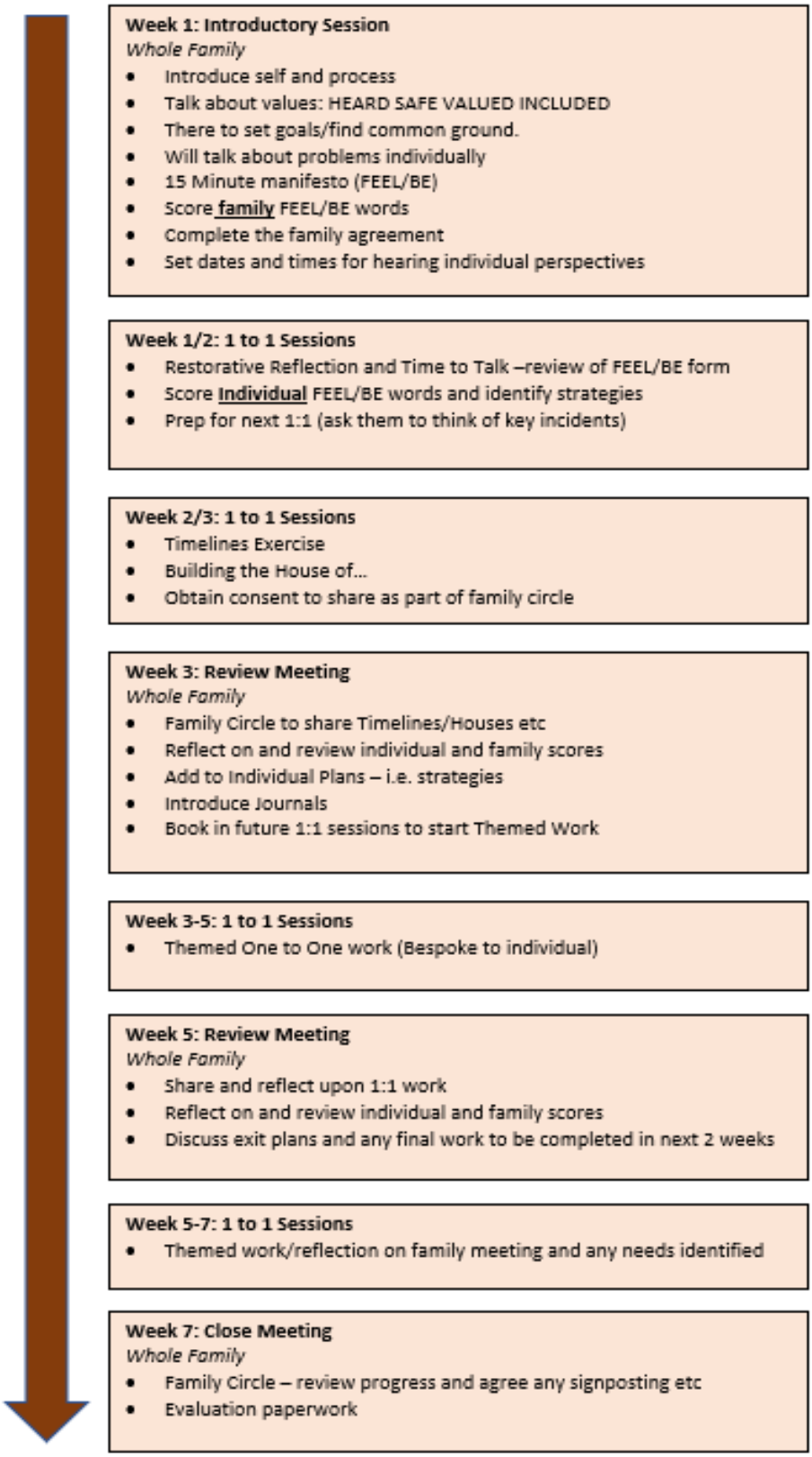


Figure 4. Family component process



Providers

Both RM and RC will be delivered by a dedicated, trained team of 10 full-time practitioners. This team will work on a fully collaborative basis with referring agencies. It is anticipated that the majority of Remedi staff working on the project will be graduates with a background in Criminology and Psychology.

All Remedi staff receive an initial training package comprised of general training (i.e., on policies and procedures, data protection, safeguarding) and training on the three components of the intervention: restorative justice skills (4 days), mentoring (4 days) and restorative family training (3 days). All providers additionally access skills development training (internally and externally), additional safeguarding training accessed via local authority, local partner agencies and advanced skills training (sensitive and complex case training for example).

Materials:

Remedi have created a series of in-house resources to support their work for this project. All procedural and service users resources are made available to personnel via secure online systems.

They are outlined below:

Mentoring:

- Mentoring Handbook *(Remedi developed resource: Core of training and available online to all Remedi personnel via secure staff portal)*
- Mentoring initial needs assessment document
- Mentoring agreement and Mentoring support plan
- Case management record
- Mentoring evaluation documentation/procedure

Restorative Justice: Restorative Justice Handbook, an in-house training course (4 days), plus an additional package focused on enhanced skills development for sensitive and complex cases (e.g. sexual offences, cases involving death, vulnerable service users etc.; 2 days), a list of RJ procedures covering risk management, case management and Standards of Practice and ways in which to evaluate RJ interventions.

Family Work:

- 'Together Families': A documented 7 session family support programme based around restorative principles/approaches. Documentation: child/young person assessment

process; parent/carer assessment process; initial needs and support plan; structured exercises to undertake on an individual and family basis; exit strategies including 'Family Plan' and evaluation process.

- Restorative Family Skills training (3 days) Building on the above Restorative Justice training and exploring all aspects of delivery regarding the Together Families programme.

Format of delivery

The majority of service delivery takes place face to face with service users, although telephone contacts may be undertaken within the context of the mentoring component as support becomes less intensive or in order to check in. In addition, in response to the Covid-19 pandemic, Remedi has developed virtual methods of service delivery for all of their operations that can be adopted as required should there be any further lockdowns or should a service user be unable to meet face to face due to having to self-isolate. Initial meetings with service users will be undertaken in suitably secure venues as close to the service user as possible. These venues will be sourced via Remedi's partnership networks and may include-community centres, schools, local authority venues and police stations. These locations will be pre-assessed to ensure confidentiality can be maintained and to ensure they are suitable to meet the diverse needs of the service user. Initial meetings will incorporate risk assessment and discussions regarding the venues of future meetings. Where home visits are appropriate, Remedi operates a lone working protocol to ensure the safety of colleagues.

Frequency and dosage

For the RM project, support will be provided over a 12-week period, although the length and frequency of the three different components differ depending on the features of the individuals, families and cases involved. The details of each strand are outlined in Figures 2-4 above.

All contacts/sessions will be arranged to meet the availability of service users and will include evening and weekend sessions as required.

Primary outcome

The primary outcome of interest in this study will be contact of the CYP with the police or youth justice services, including reoffending, rearrest or involvement as a perpetrator, victim or witness. Data on this will be taken from administrative records as well as captured in the Self-Report Delinquency Scale (SRDS, see Huizinga and Elliott, 1986) completed by

CYP at the start and end of the intervention as specified by the funder. In addition, the study will capture changes in behavioural and emotional problems through the Strengths and Difficulties Questionnaire (SDQ-a behavioural screening questionnaire, see https://www.sdqinfo.org/a0.html), also specified by the funder.

While these are the main outcomes, Remedi believes that the intervention has a series of short, medium and long term outcomes which are outlined above in the theory of change for the intervention. Most of these cannot be quantified within the evaluation period, though the process evaluation will capture some of the subjective measures.

Logic Model

A logic model has been co-developed with inputs from Remedi and YEF and is presented below:

Restorative Mentors, Logic Model

INPUTS	***What resources are needed?***	Provision of a dedicated, trained team of 10 full-time Practitioners providing intensive one to one support for children and young people with 3 primary focuses: 1. Intensive Mentoring- including supported engagement with specialist mental health services 2. Restorative Justice 3. Family support Skills and qualities specified in the job description: • Communication • Flexibility • Motivation • IT capabilities • Keeping safe The above team will work on a fully collaborative partnership basis with partner agencies. The intervention will also make use of written resources Remedi have created and use in other work.
OUTPUTS	***Activities*** *What needs to take place for CYP to accomplish the short term outcomes*	Following referral and initial suitability check CYP are offered: • ALL: ○ Initial introduction and needs assessment ○ Supported referral on and direct support to access wider specialist mental health services. ○ Impact assessment and evaluation ○ Mentoring: 'Action Plan' agreed with young person with SMART goals and expectations established, one to one support with lower level mental health needs (confidence building etc). Will last for around 12 weeks, based on 3-4 sessions per week. • RJ: Provision of full Restorative Justice intervention with harmed individuals identified (if desired by harmed/victim). RJ will be offered and mentioned during the mentoring work to give many opportunities to take part – using REMEDI's empathic thinking work during the mentoring.

		• Restorative based family work: to address conflicts/improve communication and support etc. will be based on a family plan including family circle work, REMEDI's 'Together Families' programme and work towards a family agreement/exit plan. Please refer to procedure flow charts for each element of the intervention for further details. The vast majority of service delivery takes place face to face with service users. However, given Covid 19, Remedi have developed virtual methods of service delivery for all of our operations that can be adopted as required should there be any further lockdown issues or should a service user be unable to meet face to face due to having to self-isolate. With regard to mentoring-telephone contacts may be undertaken as support becomes less intensive or in order to check in. All support at this stage is intended to be facilitated on a one-to-one basis. Should we, once fully operational, identify the potential for suitable small group work, we will review this at that time. Initial meetings with service users will be undertaken in suitably secure venues as close to the service user as possible. These venues will be sourced via our partnership networks and may include- community centres, schools, local authority venues. These locations will be pre assessed to ensure confidentiality can be maintained and to ensure they are suitable to meet the diverse needs of the service user. Initial meetings will incorporate risk assessment and discussions regarding the venues of future meetings. This may well be the family home. In all instances of home visits Remedi operate a lone working system to ensure the safety of colleagues.
	Participation *What outputs must be achieved for the short term outcomes to be achieved.*	CYP aged 10-17 who have displayed violent behaviour OR have committed a violent offence, capped at the level of an OOCD sanction. Referred via Youth Justice Services or the Police Planned scale: **Year 1:** 210 CYP engaged with Restorative Mentoring (supported and evaluated) and 254 CYP engaged with Restorative Choices (supported and evaluated).
OUTCOMES	***Short Term Outcomes***	○ Reduced violent behaviours ○ Reduced levels of aggression ○ Reduced weapon carrying (where applicable) ○ Increased self-esteem, confidence and resilience ○ Reduction in displayed 'behavioural problems'

		○ Increased access/ engagement with mental health services
	Medium Term Outcomes	• Reduced involvement in violent and non-violent criminal offences • Reduction in gang involvement • Improved familial relationships • Improved familial communication • Improved relationships with friends • Increased understanding consequential thinking skills • Increased empathic thinking skills
	Long Term Outcomes	• Reduced levels of crime • Victim Satisfaction/benefits (re coping and recovering, feeling safe and fearful, improved health and sense of wellbeing) • Reduced demand on other statutory services • Reduced community tensions • CYP able to cope with life crisis points • CYP less socially isolated • Improved mental/physical health of CYP • Families better equipped to address future challenges
UNDERPINNING ASPECTS	***Assumptions*** • There are significant levels of violent behaviours and violent crime committed by children and young people (CYP) in the Greater Manchester area. • A number of these CYP frequently have low levels of awareness / understanding / empathic awareness regarding the impact of their behaviours, have problematic issues within their familial setting and face varying levels of challenges regarding their mental and/or emotional health. If unsupported these behaviours frequently result in greater degrees of violence/criminality. • REMEDI can expect to receive referrals in from partner agencies listed above. ***External Factors*** • The family, social and community circumstances of the CYP using the REMEDI service. • Availability of specialist services in Greater Manchester for REMEDI mentors to refer on to and thresholds of these organisations.	

Research questions and/or objectives

The overarching objective is to conduct a pilot randomised control study, defining outcomes and a full evaluation method that will assess the parameters for conducting an efficacy evaluation. This pilot will form the first part of an efficacy study, and the data gathered may contribute to the final analyses. Set progression criteria will determine whether the pilot proceeds to the efficacy study.

Objectives of the pilot trial:

- Co-develop a ToC in partnership with Remedi and YEF to:
  - Clarify how the different components of the programme (i.e. mentoring, RJ, and family support) operate in practice, both individually and in combination including the presumed channels by which these produce outcomes for CYP.
  - Clarify the expected short, medium, and long-term outcomes.
- Understand how the intervention is experienced by all stakeholder groups (CYP, families/carers, victims, Remedi staff, referring organisations).
- Establish a feasible way to measure the outcomes of interest or their proxies. In addition to the two core YEF measures (SDQ and SRDS), identify, and if necessary and appropriate, co-design outcome measures with Remedi, YEF and stakeholders such as police, youth justice services and CYP.
- Consider the possibility of unexpected adverse outcomes. While the literature on RJ, family support and mentoring do not record any such adverse outcomes, the mentor will note any adverse outcomes and if significant, will refer to the Steering Committee which oversees the study for assessment whether the outcome is related to the intervention.
- Establish sufficient target population - assess if there is a sufficient enrolment of the target population to run a pilot and an efficacy study.
- Ensure Remedi can recruit the planned number of mentors and that they have a well-defined referral pathway (i.e., a criminal justice pathway with multiple referral organisations – e.g., police, youth offending service).
- Develop a design that provides robust impact evaluation, and explore capturing key differences in sub-groups of interest, with a contextual and theoretical underpinning. A 'realist RCT' (Bonell et. al, 2012) would be the preferred methodology, allowing for both statistically robust results and an understanding of the causal pathway. This enables us to understand 'what works, for whom and under what circumstances'.

The Youth Endowment Fund contributed and agreed to all aspects of this study's design. They control the final decision on whether this study will enter its efficacy stage which involves larger treatment and control groups, that facilitate statistical inference. It will not have any role in the collection, analyses, or interpretation of the data, or in the decision to submit results.

We will be required to provide monitoring information to the funder quarterly on the progress of the study.

Any changes to the protocol will be logged in a change log following discussion with the provider and funder.

Success criteria and/or targets

The pilot will measure the consistency of delivery and whether staff and CYP believe the intervention meets the needs of CYP and is appropriate. Our experience suggests that an RCT can only be implemented with the support of the staff and CYP. We suggest, therefore, that the following measures are included, with the percentages indicative:

1. Project implementation
    a) Baseline SDQ and SRDS survey of all involved CYP has at least 60% response rate; anything below that is case for concern (Yellow) with a need to pause (Red) if the response is below 40%.
    b) Intervention actions aligning with the ToC were chosen after needs assessment; if there is misalignment it will be necessary to re-visit the ToC, there is in general no need to stop the intervention but rather understand why the two diverge.
    c) 75% of actions in an agreed action plan with CYP were implemented in a collaborative process involving staff and children; if this falls below 60% (Yellow), we need to discuss why this divergence is occurring and if it reaches 50% (Red) we will re-sample over the remaining period.
    d) Case management system indicates that staff implemented the intervention as planned; this will be reviewed by UoB team and significant divergence will be reviewed with Remedi and YEF.
    e) Personnel records show mentors received adequate supervision and support; this will be reviewed by UoB team and significant divergence will be reviewed with Remedi and YEF.

2. Recruitment and retention

a) Recruitment on to the intervention and into the control group is at least 60% of planned numbers within the pilot period. Anything below that is case for concern (Yellow) with a need to pause (Red) if the response is below 40%.

3. Measurement
   a) Administrative police/youth justice contact information
   b) Results from SDQ/SRDS

   It will be important to see how easily data can be matched between GMP and Remedi records. Not being able to match at least 80% of referrals is cause for concern and needs to be discussed (Amber), anything below a 60% match is serious cause for concern (Red) and may require us to revisit this method of capturing data.

   For SDQ/SRDS, we will monitor completion rates and anything below 60% is cause for concern (Yellow) and below 40% (Red) implies the viability of capturing such data needs to be discussed with the funder and Remedi.

   Some key data issues such as incomplete/missing data or noncompliance or higher attrition rates than expected need to be considered. A certain level of missing data can be handled using statistical techniques, but quarterly audits should prevent this from becoming a serious problem.
   These ratings relate to the feasibility of the methods of data collection of the pilot. Failure to meet success criteria, does not necessarily mean that the main evaluation should be abandoned, but will suggest that the proposed design or methods require revision. Provided the above are met or feasible alternatives can be found, we will recommend that we proceed to an efficacy trial. YEF will then reflect on the evidence the evaluation provides before a decision is made about the transition to the efficacy study.

Methods

Pilot trial design

The pilot trial will be a two-armed (RM and RC) individually randomised controlled internal pilot trial. Upon referral to Remedi, CYP who have committed a violent offence will be randomly assigned to RM (the treatment group) or RC (the control group) on a 1:1 basis. Outcomes will be measured at the individual level using administrative data and through the administration of questionnaires. Measures will be obtained prior to randomisation, at post-test and at a 6-month follow-up for CYP that completed the intervention in the first six months of the pilot. Additionally, one month before the end of the pilot, police administrative data on CYP recidivism will be collected. The full process appears in the table below:

Table 1: Pilot trial protocol

Step 1:	CYP is referred to Remedi
Step 2:	Remedi assesses eligibility. Ineligible cases are excluded.
Step 3:	Informed consent/assent is provided by eligible CYP.
Step 4:	Data on CYP are collected (SDQ, SRDS questionnaires).
Step 5:	Randomisation done by the University of Birmingham: CYP is assigned to RM or RC.
Step 6:	CYP receives RM or RC.
Step 7:	Right after the intervention is completed, data on CYP are collected (SDQ, SRDS questionnaires) for short-term outcomes.
Step 8:	For CYP completing the intervention in the first six months of the pilot, follow-up SDQ and SRDS questionnaires will be collected.
Step 9:	One month before the pilot ends, police administrative data are collected from the Police National Computer.

Randomisation

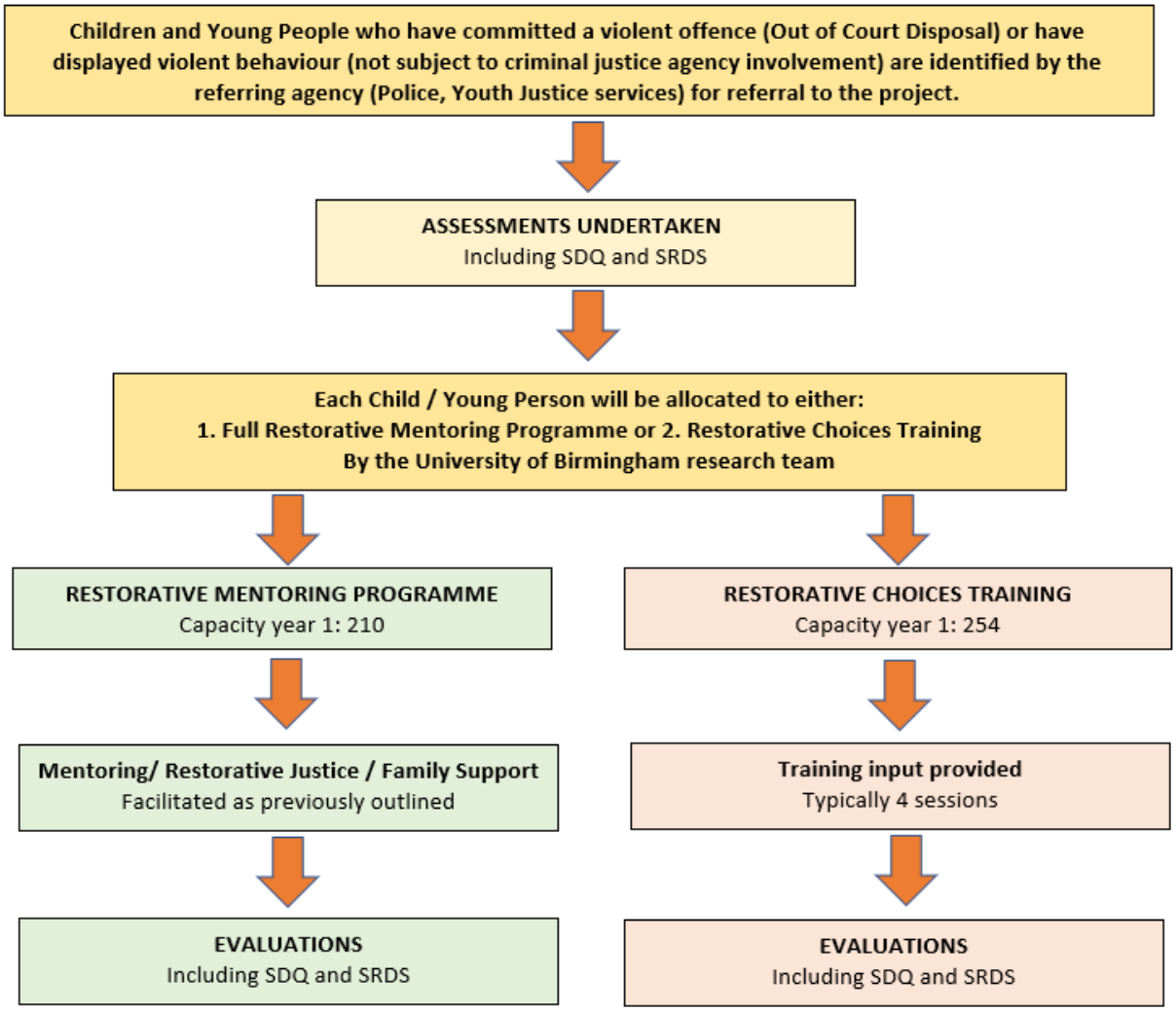
The "simple" randomisation method (Suresh, 2011) will be used, which is a robust method against selection and accidental biases. We will use the statistical software package Matlab to implement the randomisation. Automated randomisation will ensure that the process is transparent and reproducible. Allocation concealment will be ensured because Matlab will be operated by University of Birmingham researchers, who will not release the randomisation outcome until the CYP has been recruited into the trial and gone through the initial questionnaire phase (Step 4 in Table 1), which takes place after all baseline measurements have been completed. Central randomisation will be used as the Remedi administrators, who are involved in CYP recruitment, will have to contact University of Birmingham researchers to receive the allocation of the CYP. Participants and mentors will be blind to the randomisation procedure, while the University of Birmingham staff responsible for the randomisation will be blind to the questionnaire answers in Step 3 of Table 1. Finally, the member of staff responsible for the follow-up questionnaire measurements will not know whether the CYP measured will belong to the treatment or the control group.

Because several of the evaluation outcomes are self-report and may be susceptible to bias, (for example SDQ and SRDS), we will blind participants with respect to the true hypothesis that the RM intervention is better than RC. We will only let them know that we are interested in testing two different types of interventions.

Participants

The intervention will be offered to CYP aged 10-17 who have committed a violent offence or have displayed violent behaviour identified by the police and youth justice services. The diagram below provides a summary of the stages of the intervention and anticipated numbers of CYP participating in the intervention.

Figure 5. Intervention and control group process summary



The following inclusion and exclusion criteria will be used. Referrals will consist of any young person (10-17) in receipt of any out of court disposal (at any level) that has committed a violent offence in Greater Manchester. Once referred to Remedi, CYP must provide written, informed consent (or assent if relevant) before any study procedures occur. The same process would apply for parents/carers where CYP are living with a parent or carer. CYP who are unable to take part or who fail to engage with the intervention would be excluded from the study. In addition, CYP should not participate in other youth support programmes at the same time as the RM intervention.

We will request both CYP assent and their parents/carers' consent in line with Remedi's processes to involve CYP and their carers in the consenting process. The only exception to this would be 17-year-olds living independently, of who there are expected to be few.

Trained Remedi mentors will introduce the trial to CYP who will explain the main aspects of the mentoring programme. CYP and their parents/carers will also receive information sheets. Mentors will discuss the trial with CYP in light of the information provided in the information sheets. CYP and their parents/carers will then be able to have an informed discussion with the mentor. Mentors will obtain written assent (and consent where applicable) from CYP and written consent from parents/carers willing to participate in the trial.

Police and Youth Justice services will identify and refer CYP cases satisfying the above criteria to Remedi. The mentoring meetings, which include data collection, will take place in Greater Manchester, in the buildings of local authorities and the Greater Manchester Police. The questionnaire data will be transferred to the Remedi case management system by the mentors. The police administrative data will be collected by appropriately authorised Remedi staff that will be given access to a police computer.

Sample size

The planned number of pilot study participants is 464 CYP in its one year of implementation, 210 in the RM group and 254 in the RC group. This sample size was selected to provide information about aspects that might limit the study's feasibility (e.g., attrition, compliance as discussed above) and according to Remedi's capacity constraints. The selected sample also ensures the representativeness of the target study population, composed of diverse ethnic backgrounds and includes urban and rural areas. This will also give us an indication whether an adequately powered efficacy study can be conducted. The number or CYP successfully recruited in the pilot study will indicate if a larger scale efficacy study is feasible. The sample size is large for a pilot study, but it aims to reveal hidden capacity constraints, ahead of the efficacy study. The final number of CYP participating in the treatment and control groups will provide an indication of the expected recruitment during the efficacy study, and its power properties.

Methods, data collection and outcome measures

Our data will be a mixture of those generated from the pilot itself, those from administrative sources (police/source of referral), as well as those gathered as a result of the process and implementation evaluation.

1. Project implementation – qualitative and quantitative data

- Interviews/Focus Groups: The views of CYP, families, RJ victims, Remedi staff and other stakeholders (such as referring agencies) about their experience of the different aspects of the intervention. This will be vital to understanding how the intervention has been experienced by those receiving it, how its different parts have interacted and any unintended consequences.
    - Remedi staff - Staff will be interviewed (most probably as part of a focus group) at the start of the intervention and then again towards the end of the first year as part of the process evaluation. Participants will be those working directly on the project (project managers and all mentors). This is expected to be around 12 individuals.
    - Practitioners in referring organisations – will be around 12 individuals to cover the 10 local authority areas in Greater Manchester (most probably as in a focus group).
    - CYP aged 10 to 17 who are participating in the intervention. We will aim to interview 10-15 individuals. These CYP would be sampled purposively to reflect the different potential groups of CYP and referred into the different aspects of the intervention.
    - Parents/Carers of CYP who have received the family component (5-10 individuals), again those with identified intellectual disability and /or unable to communicate in English will be excluded.
    - Victims who have been involved in the RJ component (5-10 individuals), again those with identified intellectual disability and /or unable to communicate in English will be excluded.

  For the final three groups where only a sample of participants can be interviewed, we will seek a maximum variation sample (Schreier, 2018) to give a range of different backgrounds, experiences, referral routes, aspects of the intervention and ethnic backgrounds. Thank you tokens in the form of shopping vouchers (£20) will be offered to CYP participating.

- The completeness and relevance of the Theory of change already in place and any need for revisions
- Fidelity of the intervention across the complete process from selection to completion and follow up which will include a perusal of a sample of case notes captured on the project's case management system and the monitoring data shared by Remedi with YEF to see that the number of sessions offered and taken up and whether the treatment plan is followed
- The implementation and effectiveness of training – we will discuss with the Remedi the possibility of them using a simple validated measure they could use e.g.,

Kirkpatrick's 4 level measurement model[3]. Alternatively, we could use a series of purposive interviews with a sample of trained staff.

2. Recruitment and retention - quantitative data

- Data collected by Remedi on the operation of the intervention and stored in their case management system – information contained in referrals and collected by mentors during the programme.
- Monitoring data shared by Remedi with YEF concerning the operation of the intervention

3. Measurement and findings - quantitative data

- Initial risk assessment and mentoring plan created and updates on the CYP's progress recorded by the mentors, including changes in family and home circumstances.
- Police data regarding arrest, offending and other contact with the police as a perpetrators, victim or witness.
- YEF core measure questionnaires - the Strengths and Difficulties Questionnaire (SDQ) and the Self-Reported Delinquency Scale (SRDS).

To reduce the possibility of bias, data collection for the quantitative phase will be blinded for the analyst.

The pilot will be used to assess if the outcomes suggested for the treatment and control groups can be consistently collected and measured to inform the decision of whether to move to an efficacy study.

At the conclusion of the pilot study, we will provide the draft interim evaluation report. We recommend holding an event where we present findings to key stakeholders and then, taking account of their comments, produce the written report.

Stopping criteria

We will use the monitoring data Remedi collect and provide to YEF to judge whether there is a need to stop the study, because it becomes a source of harm to participants. These data will

[3] See https://kirkpatrickpartners.com/the-kirkpatrick-model/

be monitored during the life of the project to ensure this decision is made in a timely fashion. These criteria are separate and distinct from the success criteria defined previously which relate to the decision to move from a pilot to a efficacy study. As such we will base our decision on an assessment of those safeguarding incidents categories which concern harm to participants created by the intervention. These are as follows:

Level 1 Incidents
• Allegation of Sexual Assault (by staff of YP) • Allegation of Physical Assault (by staff of YP) • Staff or volunteer computer or device is found to contain images of child pornography
Level 2 Incidents
• Safeguarding Allegation (Against staff or volunteer) • Allegation of Sexual Assault (YP on YP) • Allegation that a trustee, staff member or volunteer has been abused by another trustee/s, staff member/s or volunteer/s • Funded organisation discovers that an employee or volunteer coming into contact with children is on the sex offenders register.
Level 3 Incidents by Broad Example Categories
• Sharing Personal Contact Details with children or young people. • Failure to Carry Out DBS Check which would have identified that a member of staff, volunteer or trustee was disqualified in law (under safeguarding legislation) from holding that position.

Methods overview

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
Quantitative	Provision of administrative data by Greater Manchester Police /local youth justice services	Administrative data on intervention and control group contact with the criminal justice system (involvement in offending e.g. arrests, charges) (N=464)	Descriptive – comparisons pre and post intervention for intervention and control group	Establish a feasible way to measure the outcomes of interest or their proxies. Establish sufficient target population.
	Questionnaires (SDQ/SRDS)	RM (N=210) RC (N=254)	Descriptive – comparisons pre and post intervention for intervention and control group	Establish sufficient target population.
	Remedi case management system / monitoring returns to YEF	Monitoring data on intervention and control take-up and operation (N=464)	Descriptive – comparisons pre and post intervention for intervention and control group	Establish a feasible way to measure the outcomes of interest or their proxies. Establish sufficient target population.
Qualitative	Interviews / Focus groups	CYP (N=10-15) Remedi staff (N=12) Referrers (N=12) Victims (N=5-10) Families (N=5-10)	Thematic	ToC development. Understand how the intervention is experienced by all stakeholder groups. Consider the possibility of unexpected adverse outcomes.

Data analysis

The pilot of the RCT will test the feasibility of implementing an RCT in this context as well as assessing Remedi's evidence of promise. No power calculation for the pilot has been performed and we not use the data for frequentist analyses.

The primary outcome will be subsequent contact with the police (taken from GMP and PNC records). This will be defined as any further contact, including arrests, being flagged for concern on police databases, calls for service and charges, given that the CYP being referred to the Remedi intervention may have only had limited contact with the police. The secondary outcome will be the children's internalizing and externalizing problems scores, derived from the SDQ test, and measures of self-reported anti-social behaviour and offending captured from the SRDS questionnaire.

Descriptive statistics such as means and percentages will be reported for all variables collected in the sample. Such variables include both demographic data such as age, gender and race and primary outcome data mentioned above. Cross-tabulations will be used to the show prevalence of delinquent acts across age, gender and other demographic variables.

The key subgroup analysis will be conducted with respect to the key demographics of age, gender and ethnicity. Missing data will not be dealt with as that would require statistical analysis. Given that this is a pilot, the reported descriptive statistics will only be based on complete cases.

For the qualitative data, all interviews and focus groups will be audio-recorded and transcribed. Data will be analysed using Braun and Clarke's (2021) thematic techniques. NVIVO will aid data analysis and interpretation. We recognise that some individuals may be reluctant to be recorded and, in those cases, a written record will be made and these notes will be analysed in the same way. Collection and analysis of qualitative data will be an iterative process, with both occurring in parallel – enabling emerging themes to be investigated in later interviews.

Outputs

The output of the pilot trial will include an evaluation report fully summarising the pilot study. It will include details on CYP recruitment, tables and figures providing the collected data, and descriptive analysis comparing the different short-term outcomes between the treatment and the control group. Due to small sample size the evaluation will avoid frequentist analysis of pre-post differences in outcomes (due to difficulties in interpreting these), but will focus on the differences between treatment and control group. Based on the progression criteria, we will make recommendations on (i) whether the pilot indicates that the main study is

feasible or not and (ii) any changes needed to make the main study feasible. If necessary, an updated logic model will be provided.

Therefore, the evaluation report will conclude with a statement of progression to the second year of the study and if feasible, an efficacy study protocol if the recommendation is to proceed to the main study.

Additionally, we will offer a presentation to Remedi and YEF on the main findings of the pilot study.

Cost data reporting and collecting

There are several organisations involved in the pilot delivery. Greater Manchester Police and Youth Justice Services will provide referrals to Remedi. Remedi will provide the interventions. Case referrals by the Greater Manchester Police and Youth Justice Services are part of their standard operation and therefore no further costs arise for these organisations. Therefore, in the following table we provide cost descriptions from Remedi's point of view. These costs will be covered by YEF.

Our approach will be based on five pillars: a) observe employees' work, b) request reports, c) employ self-monitoring tools, and d) review progress on a regular basis. The key employees in this intervention are the hired mentors. There are 10, a number which is not big, and therefore we will observe and evaluate all of them. Data will be collected by the coordinator, which is one person, and therefore will be consistent across the mentors. Both RM and RC interventions are well structured and we do not expect large cost deviations. To understand the resources needed to deliver the intervention, we need to understand the number of CYP who go through the RCT and the associated costs.

Remedi expect to work with 210 CYP in the RM intervention group and 254 CYP in the RC control group. Across Greater Manchester, Remedi will need 10 Mentors, 2 administrators, a project coordinator and a manager, as well as full support in terms of computer and travel expenses. The Remedi costs are based on their submitted bid to the funder for delivering this programme. We would seek to estimate the cost of delivering the intervention (RM), the control (RC) and combined.

We will collect cost data using the principles articulated in the YEF guidance document, i.e. a bottom up approach estimating the different components of costs for the organisation concerned. We expect to collect the data from Remedi and include labour costs (these will be the main source of costs), material (including licensing) costs, training costs, venue costs where applicable (if this is a regular fixed rental to be paid where say mentoring takes place). There is certainty about some of these costs, such as labour because the staff have already

been hired, and in the event of excess demand for the interventions, no new staff will be hired to meet this demand.

Publication Policy

The Publications Subcommittee comprised of researchers from the University of Birmingham will review all research outputs following the guidelines given below and report its recommendations to the Steering Committee.

a. Data analysis and release of results

The scientific integrity of the project requires that the data from Remedi be analysed study-wide and reported as such. All presentations and publications are expected to protect the integrity of the major objective(s) of the study; data that break the blind will not be presented prior to the release of mainline results. Recommendations as to the timing of presentation of such endpoint data and the meetings at which they might be presented will be given by the Steering Committee.

b. Review process

Each paper or abstract, as described below, must be submitted to the Publications Subcommittee for review of its appropriateness and scientific merit prior to submission. The Subcommittee may recommend changes to the authors and will finally submit its recommendations to the Steering Committee for approval.

c. Primary outcome papers

The primary outcome papers are papers that present outcome data. The determination of whether or not a particular analysis represents a primary outcome will be made by the Steering Committee on the recommendation of the Publications Subcommittee.

d. Other study papers, abstracts and presentations

All studies, other than those designated as “Primary Outcome”, fall within this category. All papers and abstracts must be approved by the Publications Committee before they are submitted. It is possible that in certain instances Remedi may be asked to contribute papers to workshops, symposia, volumes, etc.

Close-out Procedures

The trial will terminate after 12 months after the last participant has been randomised, or at an earlier or later date if the circumstances warrant. Regardless of the timing and circumstances of the end of the study, close-out will proceed in two stages:

- Interim period for analysis and documentation of study results.
- Debriefing of participants and dissemination of study results.

a. Interim

Every attempt will be made to reduce to an absolute minimum the interval between the completion of data collection and the release of the study results. We expect to take about 6 months to compile the final results paper for an appropriate journal.

b. Reporting of study results

The study results will be released to the participating mentors, third sector companies in the field of youth violence, economists, CYP in Greater Manchester, and the general society.

Topics suggested for presentation or publication will be circulated to the Principal Investigator (PI; Siddhartha Bandyopadhyay). The PI is requested to suggest and justify names for authors to be reviewed by the Publications and Writing Committee (PWC) , which is made up of all the researchers at the University of Birmingham. If a topic is suggested by a participant, the PWC will be formed as just described except that the person making the suggestion may be considered as the lead author. Disputes regarding authorship will be settled by the PI after consultation with the PWC.

The study will comply with the funder's publication policy[4]. For example, the first report published about the findings of the evaluation will be the Evaluation Report for YEF.

Ethics and registration

Research into violence and criminality and with CYP has certain ethical and safeguarding challenges. We will ensure all issues like confidentiality, safeguarding, disclosure etc. are fully considered. We have a robust ethics framework in place. The UoB has an overarching Code of Ethics and ethical approval is a requirement of the Code of Practice for Research. All research projects go through the ethical review and approval process. The process includes completion of a self-assessment form. Then, for studies involving human participants such as

[4] https://res.cloudinary.com/yef/images/v1623145471/cdn/16.-YEF-publication-policy/16.-YEF-publication-policy.pdf

the current evaluation, stage 2 is to secure ethical approval via the central research ethics committee. Application to securing approval typically takes between 6 and 10 weeks. If amendments are needed (e.g. further development of an interview schedule or the addition of another organization / group of participants to the project) then these can be submitted and processed quickly by the ethics committee.

Any modifications to the protocol which may impact on the conduct of the study, potential benefit of the CYP or may affect CYP safety, including changes of study objectives, study design, patient population, sample sizes, study procedures, or significant administrative aspects will require a formal amendment to the protocol. Such amendment will be agreed upon by the University of Birmingham, Remedi and YEF and approved by the University of Birmingham ethics committee prior to implementation. Administrative changes of the protocol are minor corrections and/or clarifications that have no effect on the way the study is to be conducted. These administrative changes will be agreed upon by the University of Birmingham, Remedi and YEF, and will be documented in a memorandum. The University of Birmingham ethics committee may be notified of administrative changes at the discretion of the University of Birmingham research group.

The study will be registered on https://www.isrctn.com/.

Data protection

The six lawful bases for processing are set out in Article 6 of the UK GDPR (one of which must apply when data is processed). A relevant basis for processing personal data here is the **'public task'** basis.

For qualitative data, the most relevant principle/basis is **consent**; the individual has given clear consent for you to process their personal data for a specific purpose. Informed Consent will be obtained – this is where participants receive information outlining the nature of the research, what they are being asked to do, their right to refuse to take part without negative consequences and their right to withdraw from the research during the fieldwork and up to two weeks afterwards.

Regarding **confidentiality**, participants will be informed prior to and post the interview process that the information they provide will be kept strictly confidential and that no identifying information will be available to anyone external to the research team. Confidentiality will be preserved (for quantitative and qualitative data) through steps such as (1) assignment of participant numbers/pseudonyms, (2) deletion of audio files post-

transcription, (3) transcripts / consent forms stored in a locked cabinet at the University, and (4) electronic data held on password protected spaces only accessible to researchers.

All study-related information will be stored securely in Remedi premises, the Remedi case management system and University of Birmingham computers. All participant information will be stored in locked file cabinets in areas with limited access. All reports, data collection, process, and administrative forms will be identified by a coded ID [identification] number only to maintain participant confidentiality. All records that contain names or other personal identifiers, such as locator forms and informed consent forms, will be stored separately from study records identified by code number. All local databases will be secured with password - protected access systems. Forms, lists, logbooks, appointment books, and any other listings that link participant ID numbers to other identifying information will be stored in a separate, locked file in an area with limited access.

All participant results will be kept strictly confidential, all counselling will be conducted in private rooms, and study staff will be required to sign agreements to preserve the confidentiality of all participants. The final trial dataset will be accessed by the University of Birmingham researchers. They can access the data for a period of 10 years after the conclusion of the trial.

No later than three years after the pilot, we will deliver the following for sharing purposes:

1. A dataset to the DfE containing only the personally identifying data (i.e. name, address etc.) for the CYP in the treatment and control groups, with a list of random references numbers.

2. The evaluation data set and random references numbers to ONS (no directly identifying data will be included)

Data Management Plan

Assessment and use of existing data and creating new data

We will analyse existing routinely collected police data and may produce new quantitative and qualitative data alongside the more sensitive individual level data. Ethics approvals will be obtained from the UOB where needed that will set out the usage, storage and governance of data. The research team will respect any conditions of usage set forward by the data owners and the informed consent sheets will set out how data that is collected will be used.

For interviews, when prior consent is received, all interviews will be digitally audio recorded. The recorded data will be saved on password-protected and encrypted computers of the research co-ordinator and lead for the study and will be either transcribed in-house or sent electronically to a transcription agency that complies with the University's data protection

policy and agreed security standards set by the funder. The transcripts will be stored on the computer of the research fellow in Word Format and will be thematically analysed by the study lead and research fellow.

Quantitative data will be stored anonymously. If any individual data is collected, participant names will be allocated a research ID number. A separate list detailing the participant name and research ID code will be stored in an encrypted file in research co-ordinator's laptop, separate from the rest of the project files. All UOB laptops have secure encryption which satisfies the requirements of the Data Protection Act 2018. All work involving matching using names will be on UOB encrypted machines by researchers under the PI's supervision.

All data collected will be for the specific purpose of carrying out the different phases of the feasibility studies and will be GDPR compliant.

Quality assurance of data

Data collection will be designed and reviewed to ensure integrity and quality. This will be achieved by having regular project team meetings and consulting research participants on an ongoing basis. Quality assurance of data will form a standing agenda item at all team meetings.

The Project manager will have ultimate accountability and oversight for quality assurance of data; however, it will be emphasised to all team members that they have a personal responsibility to produce high quality data. In order to ensure 360-degree oversight, a selection of each lead's work will also be reviewed by the co-leads and research fellow.

Quality assurance in the merged and linked data files will be ensured via the use of clear, consistent coding that will be crosschecked by members of the research team. All provided coding will be clearly annotated so that the purpose of the code is understood by any potential user. Data will also be manually examined by more than one person, either using subsets of the data for complete examination against the original data or running frequencies of the original and newly created data, for inconsistencies and errors.

Back-up and security of data

Each study lead and research fellow will store the data on their encrypted laptop. Further data back-up will be provided by using the UOB's secure network. Backup copies of data are taken at least daily or immediately if needed.

The UOB's Information Security document can be provided upon request. The project team will be mindful of not carrying/ using devices that contain sensitive data (such as personal

details of participants) in 'risky' situations e.g., all members of the project team will be made aware of the issues posed by the theft of laptops etc.

This evaluation will comply with YEF's Data Archive guidance, including the collection and long-term archiving of personal data. We have considered YEF's guidance on this and will abide by it.

Data Monitoring

A data monitoring committee (DMC) will be established, which will be independent of the study organisers, the funder and the evaluation team. The DMC will consist of two people, one of which will act as a chair. The frequency of interim analyses will depend on the judgement of the Chair of the DMC, in consultation with the steering committee. However, we anticipate that there might be one interim analysis and one final analysis.

The DMC will have unblinded access to all data and can propose the stopping of the project. The steering committee decides on the continuation of the trial and will report to the central ethics committee.

An audit is planned after six months in the pilot, which will include site visits. The audit will be conducted by the DMC committee.

Personnel

Delivery Team

The Remedi team for this project is as follows:

Remedi Director, Steve Jones: Project oversight.

Restorative Mentoring Team:

- Manager (Lacey Foster): Strategic management, liaison with all key partners, contract compliance, quality assurance
- Co-ordinator: Line management of practitioner base: professional supervision, case supervision/management

- Restorative Mentors: Direct service user support: Mentoring support, Restorative Justice facilitation, Family support, case recording, evaluations with service users
- Administrators: Initial triage of referrals, data entry, maintenance of case management system, collation of data for progress reports/feedback

Evaluation Team

- The team for this project will be led by Professor Siddhartha Bandyopadhyay (SB). He will act as overall principal investigator / project manager and will lead the impact elements of the study.
- The impact evaluation will be supported by Dr Livia Menezes (LM) and Dr Ioannis Karavias (IK).
- The process and implementation evaluation will be led by Professor Julie Taylor (JT). She will be supported by Dr Shola Apena Rogers (SAR) and Professor Eddie Kane (EK) from the University of Nottingham. Research fellows will support project co-ordination and all aspects of the evaluation:
- Dr Emily Evans (EE) will support SB in project management as needed as well as supporting the process and implementation evaluation and ToC work.
- Dr Juste Abramovaite (JA) will be the research fellow supporting the impact evaluation from design, data collection, and analysis.

The team will have a small group of experts who will advise the team and provide quality assurance, and if the senior researchers reach capacity, they are capable of taking on a more substantive role:

- Professor Paul Montgomery (PM) will advise on overall methodology.
- Dr Joht Singh Chandan (JSC) will advise on the approach for the impact evaluation.

An independent data management team will be formed to have oversight. This will comprise:

- Dr. Kausik Chaudhuri (KC) will advise on the approach for the impact evaluation.
- Dr James Martin (JM) will provide advice as a representative of the Birmingham Clinical Trials Unit.
- Professor Anindya Banerjee (AB) will quality assure the impact evaluation.
- Professor Matt Cole (MC) will quality assure the impact evaluation.

The wider team have other expertise relating to public health, econometrics, social sciences, evaluation methods, statistics, and implementation science. These members of staff and

senior researchers will form part of a 'critical friends' group to provide an independent review function as well as an advisory role as the project progresses.

Risks

To manage risk, we use a risk register and maintain an issues log. We have identified risks and provided mitigation for these.

We are particularly aware of risks related to Covid-19; the team and the university has become proficient with secure online working, including online meetings, webinars and workshops. The team has access to standard software such as Microsoft Teams for this purpose if needed.

Additionally, given the increased possibility of illness or care duties, a resilient team has been created. Each evaluation in addition to a lead, has at least two senior researchers and two research fellows associated with it. We also have a small cohort of experienced persons who have an advisory role who can step in for a team member should there be an unexpected contingency that will make them unavailable. All the senior researchers supporting the overall project lead have the ability and experience in this area to step in to become overall lead in case of anything unexpected happening that makes the project manager unable to carry on leading the project.

Our issues log will be used to collate key questions/issues and target the appropriate individual for a response which will be recorded in the log. Our risk register will identify, assess and control risks and uncertainties enabling us to improve the ability of the project to succeed. Our risk management is based on PRINCE2 principles.

We believe this is a low to medium risk project and have identified (and mitigated for) a small number of potential early risks prior to project initiation. The issues log and risk register will be reviewed weekly by the research team. Any issues and/or risks will be shared at the earliest possible opportunity internally for mitigation and where necessary, if these are viewed as major risks, these will be escalated to 'named' project contacts within YEF and Remedi.

A risk register and mitigation plan is included below.

Risk Register and Mitigation Plan

Description of Risk	Internal (I) External (E)	Impact Potential	Action To Mitigate Risk	Potential risk With Mitigation	Responsibility
Stakeholders difficult to engage in evaluation	E		Work with YEF, REMEDI and partners to devise a communication / engagement strategy directed at relevant stakeholders.		UoB in liaison with REMEDI and senior SPOCs within external agencies
Issues of confidentiality could impair the extent of information or evidence, which could have an impact upon the quality of our outputs.	E/I		We will have data protection guidance in place which outlines how we will collect, store, use and shred data. We will share this guidance with stakeholders to ensure that they are willing to share data. For qualitative data collection such as interviews we will provide confidentiality statements to make sure that participants feel safe to share views and information.		University of Birmingham – all staff to uphold requirements. Overall responsibility Siddhartha Bandyopadhyay
Stakeholders not willing to share relevant data or data is not available, incomplete, inaccessible or not produced in a timely fashion.	E		Work with REMEDI and stakeholders to identify the relevant data and agree sharing protocols. Consultation to take early action and modify project plan if necessary. Consider alternative data sources.		University of Birmingham in liaison with REMEDI and senior SPOCs within external agencies
Data quality too low for research requirement.	E/I		Data quality checks and cleaning techniques applied as standard. Potential use of missing data modelling if required.		University of Birmingham
Research participants (interviewees) unavailable due to time pressures	E		We will gather a pool of potential participants - larger than required to allow for sample attrition. We will work with the funder and intervention lead to convince the participants of value of the evaluation.		University of Birmingham
Loss of key evaluation team staff (possibly because of Covid-19)	I		Use of back up researchers to strengthen resilience. As indicated, a particularly resilient team has been built.		University of Birmingham
Not being able to do face-to-face fieldwork / interviews due to Covid-19 restrictions	E		Use video and teleconferencing and webinars. The team has familiarity with online working which includes holding small and large workshops.		University of Birmingham

			The University also has a range of software, for example, Microsoft Teams to facilitate such online work securely and safely.		
Archiving - incomplete or incorrectly formatted dataset for archive	E/I		Clear remit from YEF about specific information (e.g. variable list) and format needed for the archive. Data gathering tools to include these variables to facilitate gathering this in the correct format.		YEF and University of Birmingham

Timeline

Dates	Activity	Staff responsible/ leading
Jan–Mar 2022	Project set up – staff recruitment, training, define referral pathways, record management processes Evaluation set up – information sharing agreements, develop evaluation materials, gain ethics approval	Remedi: SJ/LF UoB: SB/EE
April 2022	Project go live – recruitment of CYP into intervention and control group, begin collecting case monitoring data Begin collecting SDQ/SRDS outcome measures	Remedi: SJ/LF UoB: SB (lead) and YK and LM and JA
May-Dec 2022	Project operation Gather quantitative data (outcome measures, case monitoring data, administrative outcome data) Gather qualitative data (interviews with staff, referrers, CYP, families, RJ victims)	Remedi: SJ/LF UoB: SB (lead) and YK and LM and JA UoB: JT (lead), EK, EE and SR
Jan 2023	Draft interim evaluation report	UoB team
Feb-Mar 2023	YEF make decision whether to progress to efficacy study	YEF
Mar 2023	Submit final evaluation report	UoB team

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TIDieR
Template for Intervention
Description and Replication

Appendix A:

SPIRIT 2013 Checklist: Recommended items to address in a clinical trial protocol and related documents*

Section/item	Item No	Description	Addressed on page number
Administrative information			
Title	1	Descriptive title identifying the study design, population, interventions, and, if applicable, trial acronym	1
Trial registration	2a	Trial identifier and registry name. If not yet registered, name of intended registry	38
	2b	All items from the World Health Organization Trial Registration Data Set	57
Protocol version	3	Date and version identifier	1
Funding	4	Sources and types of financial, material, and other support	2
Roles and responsibilities	5a	Names, affiliations, and roles of protocol contributors	1
	5b	Name and contact information for the trial sponsor	2
	5c	Role of study sponsor and funders, if any, in study design; collection, management, analysis, and interpretation of data; writing of the report; and the decision to submit the report for publication, including whether they will have ultimate authority over any of these activities	22
	5d	Composition, roles, and responsibilities of the coordinating centre, steering committee, endpoint adjudication committee, data management team, and other individuals or groups overseeing the trial, if applicable (see Item 21a for data monitoring committee)	39-42
Introduction			
Background and rationale	6a	Description of research question and justification for undertaking the trial, including summary of relevant studies (published and unpublished) examining benefits and harms for each intervention	21 & 3
	6b	Explanation for choice of comparators	7

Objectives	7	Specific objectives or hypotheses	17 & 21
Trial design	8	Description of trial design including type of trial (eg, parallel group, crossover, factorial, single group), allocation ratio, and framework (eg, superiority, equivalence, noninferiority, exploratory)	24
Methods: Participants, interventions, and outcomes			
Study setting	9	Description of study settings (eg, community clinic, academic hospital) and list of countries where data will be collected. Reference to where list of study sites can be obtained	28
Eligibility criteria	10	Inclusion and exclusion criteria for participants. If applicable, eligibility criteria for study centres and individuals who will perform the interventions (eg, surgeons, psychotherapists)	26
Interventions	11a	Interventions for each group with sufficient detail to allow replication, including how and when they will be administered	4
	11b	Criteria for discontinuing or modifying allocated interventions for a given trial participant (eg, drug dose change in response to harms, participant request, or improving/worsening disease)	30
	11c	Strategies to improve adherence to intervention protocols, and any procedures for monitoring adherence (eg, drug tablet return, laboratory tests)	NA
	11d	Relevant concomitant care and interventions that are permitted or prohibited during the trial	26
Outcomes	12	Primary, secondary, and other outcomes, including the specific measurement variable (eg, systolic blood pressure), analysis metric (eg, change from baseline, final value, time to event), method of aggregation (eg, median, proportion), and time point for each outcome. Explanation of the clinical relevance of chosen efficacy and harm outcomes is strongly recommended	17
Participant timeline	13	Time schedule of enrolment, interventions (including any run-ins and washouts), assessments, and visits for participants. A schematic diagram is highly recommended	11

Sample size	14	Estimated number of participants needed to achieve study objectives and how it was determined, including clinical and statistical assumptions supporting any sample size calculations	27
Recruitment	15	Strategies for achieving adequate participant enrolment to reach target sample size	NA
Methods: Assignment of interventions (for controlled trials)			
Allocation:			
Sequence generation	16a	Method of generating the allocation sequence (eg, computer-generated random numbers), and list of any factors for stratification. To reduce predictability of a random sequence, details of any planned restriction (eg, blocking) should be provided in a separate document that is unavailable to those who enrol participants or assign interventions	24
Allocation concealment mechanism	16b	Mechanism of implementing the allocation sequence (eg, central telephone; sequentially numbered, opaque, sealed envelopes), describing any steps to conceal the sequence until interventions are assigned	24
Implementation	16c	Who will generate the allocation sequence, who will enrol participants, and who will assign participants to interventions	24
Blinding (masking)	17a	Who will be blinded after assignment to interventions (eg, trial participants, care providers, outcome assessors, data analysts), and how	24
	17b	If blinded, circumstances under which unblinding is permissible, and procedure for revealing a participant's allocated intervention during the trial	NA
Methods: Data collection, management, and analysis			

Data collection methods	18a	Plans for assessment and collection of outcome, baseline, and other trial data, including any related processes to promote data quality (eg, duplicate measurements, training of assessors) and a description of study instruments (eg, questionnaires, laboratory tests) along with their reliability and validity, if known. Reference to where data collection forms can be found, if not in the protocol	28
	18b	Plans to promote participant retention and complete follow-up, including list of any outcome data to be collected for participants who discontinue or deviate from intervention protocols	NA
Data management	19	Plans for data entry, coding, security, and storage, including any related processes to promote data quality (eg, double data entry; range checks for data values). Reference to where details of data management procedures can be found, if not in the protocol	30
Statistical methods	20a	Statistical methods for analysing primary and secondary outcomes. Reference to where other details of the statistical analysis plan can be found, if not in the protocol	32
	20b	Methods for any additional analyses (eg, subgroup and adjusted analyses)	32
	20c	Definition of analysis population relating to protocol non-adherence (eg, as randomised analysis), and any statistical methods to handle missing data (eg, multiple imputation)	25
Methods: Monitoring			
Data monitoring	21a	Composition of data monitoring committee (DMC); summary of its role and reporting structure; statement of whether it is independent from the sponsor and competing interests; and reference to where further details about its charter can be found, if not in the protocol. Alternatively, an explanation of why a DMC is not needed	40
	21b	Description of any interim analyses and stopping guidelines, including who will have access to these interim results and make the final decision to terminate the trial	25 & 30

Harms	22	Plans for collecting, assessing, reporting, and managing solicited and spontaneously reported adverse events and other unintended effects of trial interventions or trial conduct	28
Auditing	23	Frequency and procedures for auditing trial conduct, if any, and whether the process will be independent from investigators and the sponsor	37
Ethics and dissemination			
Research ethics approval	24	Plans for seeking research ethics committee/institutional review board (REC/IRB) approval	37
Protocol amendments	25	Plans for communicating important protocol modifications (eg, changes to eligibility criteria, outcomes, analyses) to relevant parties (eg, investigators, REC/IRBs, trial participants, trial registries, journals, regulators)	37
Consent or assent	26a	Who will obtain informed consent or assent from potential trial participants or authorised surrogates, and how (see Item 32)	26
	26b	Additional consent provisions for collection and use of participant data and biological specimens in ancillary studies, if applicable	NA
Confidentiality	27	How personal information about potential and enrolled participants will be collected, shared, and maintained in order to protect confidentiality before, during, and after the trial	38
Declaration of interests	28	Financial and other competing interests for principal investigators for the overall trial and each study site	NA
Access to data	29	Statement of who will have access to the final trial dataset, and disclosure of contractual agreements that limit such access for investigators	35
Ancillary and post-trial care	30	Provisions, if any, for ancillary and post-trial care, and for compensation to those who suffer harm from trial participation	NA

Dissemination policy	31a	Plans for investigators and sponsor to communicate trial results to participants, healthcare professionals, the public, and other relevant groups (eg, via publication, reporting in results databases, or other data sharing arrangements), including any publication restrictions	35
	31b	Authorship eligibility guidelines and any intended use of professional writers	NA
	31c	Plans, if any, for granting public access to the full protocol, participant-level dataset, and statistical code	NA
Appendices			
Informed consent materials	32	Model consent form and other related documentation given to participants and authorised surrogates	Separate documents
Biological specimens	33	Plans for collection, laboratory evaluation, and storage of biological specimens for genetic or molecular analysis in the current trial and for future use in ancillary studies, if applicable	NA

*It is strongly recommended that this checklist be read in conjunction with the SPIRIT 2013 Explanation & Elaboration for important clarification on the items. Amendments to the protocol should be tracked and dated.

All items from the World Health Organization Trial Registration Data Set

Primary registry and trial identifying number: N/A

Date of registration in primary registry: NA

Secondary identifying numbers: NA

Source(s) of monetary or material support: Youth Endowment Fund

Primary sponsor: Youth Endowment Fund

Secondary sponsor(s): None

Contact for public queries: Dr Amy Wells, hello@youthendowmentfund.org.uk

Contact for scientific queries: Professor Siddhartha Bandyopadhyay, s.bandyopadhyay@bham.ac.uk

Public title: A Randomised Control Trial pilot study of restorative mentors for children and young people

Scientific title: A Randomised Control Trial of restorative mentors for children and young people

Countries of recruitment: UK

Health condition(s) or problem(s) studied: Youth violent behaviour

Intervention(s): Active comparator: Restorative Mentoring. Placebo comparator: Restorative Choices

Key inclusion and exclusion criteria: Ages eligible for study: 10-17 years; Sexes eligible for study: both;

Inclusion criteria: Referrals from police and youth justice services in Greater Manchester. Exclusion criteria: those deemed inappropriate for the intervention by the provider.

Study type: Allocation: randomized; Intervention model: parallel assignment. Primary purpose: Reduced reoffending

Date of first enrolment: April 2022

Target sample size: 464 (intervention 210, control 254)

Recruitment status: recruiting

Primary outcome(s): Decision regarding proceeding to efficacy trial

Key secondary outcomes: Reduced contact with the police (arrest, offending)

YOUTH ENDOWMENT FUND

Impetus

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The Youth Endowment Fund Charitable Trust

Registered Charity Number: 1185413