EVALUATION REPORT

Your Choice: A Cluster Randomised Controlled Trial of a CBT-Informed Violence Reduction Programme

Pilot Trial (Interim Findings)

Sarah Cattan, Monica Costa-Dias, Julian Edbrooke-Childs, Jenna Jacob, Angelika Labno, Yann Lopez, Tasnim Nodee, Harriet Olorenshaw, Emily Orchard, Imran Rasul, Emily Stapley

October 2023

IFS Institute for Fiscal Studies

Anna Freud

YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund is a charity with a mission that matters. We exist to prevent children and young people from becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activities.

And just as important is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work and we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together, we need to look at the evidence and agree on what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart, it says that we will fund good work, find what works and work for change. You can read it here.

For more information about the Youth Endowment Fund or this report, please contact:

Youth Endowment Fund

C/O Impetus

10 Queen Street Place

London

EC4R 1AG

www.youthendowmentfund.org.uk

hello@youthendowmentfund.org.uk

Registered Charity Number: 1185413

Contents

About the evaluator

The evaluation of the pilot trial of Your Choice was conducted in partnership between the Institute for Fiscal Studies (IFS) and the Anna Freud Centre (AFC).

The PI for the project was Professor Imran Rasul, who also led the IFS quantitative evaluation team. The IFS team had responsibility for designing and assessing the feasibility of a quantitative evaluation of Your Choice and the prospects of successfully moving from this pilot study to a full-scale efficacy trial. The team included Sarah Cattan, Monica Costa-Dias, Yann Lopez, Tasnim Nodee and Harriet Olorenshaw.

The AFC team was led by Professor Julian Edbrooke-Childs and had responsibility for the process evaluation. The team included Jenna Jacob, Angelika Labno, Emily Orchard and Emily Stapley.

PI email contact: i.rasul@ucl.ac.uk

About the Mayor's Violence Reduction Unit

The Mayor of London set up the Violence Reduction Unit (VRU) in 2019 – the first in England and Wales – to lead a partnership approach to tackling violence that is rooted in prevention and early intervention.

In August 2021, London's Violence Reduction Unit (VRU), secured £5m funding from the Home Office, with an additional £5M from the Youth Endowment Fund, to support the delivery of the Your Choice programme by London boroughs. Alongside this, the VRU invested £1 million in matched funding to support the transitional phase of the programme, which aimed to ensure that those young people recruited in the final stages of the Pilot trial were appropriately supported to complete the intervention and the evaluation.

The VRU worked closely with the London Innovation and Improvement Alliance (LIIA) on behalf of the Association of London Directors of Children's Services, aiming to ensure the smooth set-up and running of both the programme and its evaluation. The VRU is the commissioner of the Your Choice programme, and holds general programme oversight responsibilities, including governance and programme funding/ financial management.

The VRU's Young People's Action Group (YPAG) was involved in co-producing resources and tools for the evaluation of Your Choice and provided regular feedback to ensure a young person's perspective was central to the design and delivery of the programme.

About LIIA

Your Choice was designed by the team at London Innovation and Improvement Alliance (LIIA). Hosted by London Councils, LIIA is the capital's Regional Improvement and Innovation Alliance (RIIA) for children and young people. LIIA works with a range of partners including Department for Education, the Local Government Association (LGA), the Society of Local Authority Chief Executives (SOLACE) and the eight other RIIA across the country to promote learning, facilitate collaboration, enable governance, leverage investment and share best practice solutions for mutual benefit.

LIIA aims to facilitate collaboration that benefits children and young people. LIIA also aims to tackle agreed London-wide priorities, including Adolescent Safeguarding, that are set through the Association of London Directors of Children's Services (ALDCS).

The team at LIIA provide Your Choice programme co-ordination and aim to ensure that practice quality assurance standards are met.

YourChoice@liia.london

Executive summary

The project

Your Choice (YC) provides training for youth practitioners in cognitive behavioural therapy (CBT) techniques, who then aim to provide three sessions a week for 12-18 weeks to young people. Developed by the London Innovation and Improvement Alliance, and supported by the London Violence Reduction Unit, youth practitioners receive five days of training and an accompanying handbook and resources, followed by monthly supervision from a clinical lead. Youth practitioners' meetings with young people aim to build trusting and authentic relationships, using CBT techniques and tools to support the young person to better understand themselves, equip them with coping strategies, and empower them to disrupt unwanted patterns of behaviour. These tools and techniques can be adapted to incorporate approaches to speech, language and communication needs, autism spectrum disorder, and learning disabilities. Practitioners can also make use of a behavioural activation fund that enables the resourcing of relevant activities, such as gym memberships. Delivery is overseen by a clinical lead, a clinician with expertise and experience in the delivery of CBT. In this project, 11 to 17-year-olds assessed by a multi-agency risk panel as having a medium or high risk of harm or vulnerability as a result of extra-familial harm were referred to the programme.

YEF and the Home Office funded a pilot study of YC. The evaluation aimed to assess the feasibility of effective data collection, examine the implementation of YC, assess the adherence of local authorities (LAs) and youth practitioners to randomisation, and pilot study outcomes and evaluation methods. The evaluation used a survey of young people and practitioners before and after the programme that featured a range of measures (including the Strengths and Difficulties Questionnaire (SDQ), the Social Connectedness Scale (SCS-R), and the Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)). Session forms were also monitored, and interviews were conducted. Each LA was asked to name at least two teams of youth practitioners who work with the children targeted by YC and could be available to be trained. These two teams were then randomised to be treatment or control teams, with treatment teams receiving YC training. Once young people were identified by a multi-agency panel as requiring support, the intention was for them to be referred to the team with the most capacity at that point. Overall, 27/32 London LAs named two or more teams to participate in YC, but only 13 LAs adhered to the randomisation of teams. Pilot recruitment began in July 2022, and at the time of writing, the pilot was ongoing. So far, 65 practitioners have participated in the study and recruited 300 young people. This report represents an interim findings report.

Key conclusions
Data collection in the pilot study has proven very challenging. Although all LAs agreed to support and contribute to survey data collection, the collection of data has been slower than anticipated. This was a particular problem among control teams. Recruitment of young people was also lower and slower than anticipated. The evaluator suggests a range of measures to improve data collection in future trials.
Overall, YC was implemented in accordance with the logic model and intervention description. The training was successfully delivered to the treatment teams, and most young people selected to participate were at high or medium risk.
Implementation was facilitated by practitioners' understanding of and commitment to YC, the funding provided for delivery, the flexibility of the programme that enabled the use of creative and engaging sessions and the monthly supervision provided by a clinical lead. Implementation concerns included the lower-than-anticipated frequency of meetings and the additional workload associated with data collection.
The extent to which practitioners followed the protocol for assigning young people to teams was mixed. The design – established to ensure an 'as good as random' approach, where participants were assigned to the team with the most capacity, irrespective of their need – seems to have been broadly followed by the LAs who participated in the pilot; however, there was some evidence that some children were allocated to YC based on their perceived greater need – which would introduce systematic bias. Twenty-three per cent of control sessions also delivered YC techniques.
The measures used in the survey were acceptable. Greater concerns were raised regarding the evaluation methods. Of the LAs who delivered YC, 10 had a high, six had an intermediate and 15 had a low readiness for trial.

Interpretation

Data collection in the pilot study has proven very challenging. Although all LAs signed agreements committing to support and contribute to survey data collection, the collection of data has been slower than anticipated. For the sample of 300 young people, only 19 had provided complete evaluation data – including workbooks, survey data and session forms – by 31 March 2023; the evaluator had expected complete data from 160 by that point. Missing data was particularly prevalent among session forms and endline survey responses. Missing data was also more evident in the control teams. Qualitative analysis shows that control teams often felt disengaged from the pilot and deterred by the number of additional forms to fill in. This suggests that better communication with control teams will be crucial for the success of a larger trial. In addition, in further trials, the evaluator recommends a large information and training campaign to remind LAs of the importance of data collection, revision of the technology of data collection to make administration easier and development of a new method of endline survey data collection to happen during a meeting with a youth practitioner rather than relying on re-contact after the intervention. Recruitment of the young people was also lower and slower than anticipated. After seven months, 300 young people agreed to participate; evaluators knew of a further 133 who were invited to participate but did not – implying a maximum consent rate of 69%.

Overall, YC was implemented in accordance with the logic model and intervention description. The training was successfully delivered to treatment teams, and the majority of the young people selected to participate were at a high or medium risk of violence – although there were some instances across the 13 LAs where young people at low risk were assigned to YC. Information provided by practitioners in interviews revealed that clinical supervision was usually provided once a month, although some practitioners met with supervisors more frequently. Quantitative data on the content of sessions reveals that CBT activities, such as introducing CBT, goal setting, and working towards goals, were well represented in YC sessions. Qualitative analysis reveals that practitioners used CBT strategies in their work with young people by talking about their feelings, challenging thoughts together, and delivering calming strategies.

Implementation was facilitated by practitioners' understanding of and commitment to YC, the funding provided for delivery, the flexibility of the programme that enabled the use of creative and engaging sessions, and the monthly supervision provided by a clinical lead. The latter was considered an essential component of YC, especially for those youth practitioners who were very new to CBT techniques and for support in difficult cases. Implementation concerns included the lower-than-anticipated frequency of meetings. While session data is incomplete, where it was collected, the young people completed fewer sessions than expected at this stage; fewer than 20% received 11 or more sessions – compared to an expected 36 sessions. The additional workload associated with data collection also hindered implementation, particularly the requirement for consent forms at the recruitment stage and session forms after meetings.

The extent to which practitioners followed the protocol for assigning young people to teams was mixed. The design – established to ensure an 'as good as random' approach, where participants were assigned to the team with the most capacity, irrespective of their need – seems to have been broadly followed by the LAs who participated in the pilot; however, there was some evidence that some children were allocated to YC based on their greater needs – which would introduce systematic bias. Children in the treatment group were more likely to have a substantially higher incidence of socially unacceptable behaviour or be at significantly higher risk of involvement in violence. In addition, 23% of control team meetings delivered YC techniques. Adherence to randomisation did improve as the pilot progressed, and more information was provided to LAs on the importance of sticking to the design.

The measures used in the survey were acceptable. Greater concerns were raised regarding the evaluation methods. Of all the LAs who delivered YC, 10 had a high readiness for trial, six had intermediate readiness, and 15 were low. YEF is proceeding to fund an efficacy trial of YC. This trial will attempt to implement the range of recommendations suggested by the evaluator to improve the quality of the evaluation.

Introduction

Background

The Your Choice (YC) programme is a Cognitive Behavioural Therapy (CBT)–enhanced approach to practice, delivered through high-intensity contact within adolescent services. The 12–18-week programme is delivered by specially trained practitioners, who are trained in CBT tools and techniques and are supported by regular clinical supervision. Training for practitioners is delivered through a train-the-trainer model by clinicians with experience in the delivery of CBT.

Theoretical and scientific rationale for the YC intervention[1]

There is growing evidence that therapeutic support for unmet needs, adverse or traumatic experiences and other risk factors may prevent young people from becoming involved in crime and violence or may reduce further involvement (Gaffney et al., 2021). However, young people with the highest levels of risk factors are currently least likely to access such support in a clinical setting (Crenna-Jennings & Hutchinson, 2020). Lack of availability, poor information, inflexibility, complicated referral processes, cultural barriers, and stigma impact young people's access to clinical services (Brooks et al., 2021). Yet, due to concerns regarding risk, harm, or vulnerability, these young people are likely to be accessing support from other adolescent support or statutory agencies. The YC programme seeks to upskill those practitioners in a range of CBT tools and techniques that they can weave into their existing practice frameworks and work with young people.

Young people who meet the threshold for adolescent services are likely to have or be experiencing Adverse Childhood Experiences (ACE's) and/or childhood trauma. Neurodivergence is also common. Consequently, this cohort is more likely to find it difficult to recognise and manage different emotions and behaviours and are at increased risk of presenting in distress and developing mental health difficulties. There is also an increased propensity for 'risky' behaviours (Sweeney et al., 2015).

Cognitive Behavioural Therapy (CBT)

In the UK, the National Institute for Health and Clinical Excellence recommends CBT for the management of many common mental health difficulties. This is because it has been tried and tested with various populations for dealing with a wide range of psychological 'problems or challenges' (Butler et al., 2006).

A key concept of CBT is that an individual's thoughts, feelings, bodily sensations, and behaviours are interlinked. The 5-factor model in CBT demonstrates the connections between situations, thoughts, emotions, bodily sensations, and behaviours in the context of internal or external triggers (the situation/environment). These five factors are considered to be so closely connected that changes in any one of these can lead to changes in the other factors.

CBT describes a family of interventions. In more traditional (first and second wave) CBT, thinking and behaviour are key targets for change, as it is thought that these factors can be most readily influenced, as an individual has more control over those parts of the system. However, rather than changing the content of an individual's thoughts and inner experiences, newer third-wave CBT takes a broader approach and seeks to bring an awareness and change the relationship that an individual has with their inner world (Eels, 1997).

---

[1] See the Your Choice page on the London Innovation and Improvement Alliance website for further information on the background of Your Choice, including references.

The YC programme includes tools and techniques from traditional CBT (i.e. thought challenging) and third-wave approaches (i.e. emotion recognition and regulation).

Policy and practice context

Despite the promising evidence base, a common criticism of CBT has been an over-reliance on the mechanistic application of a set of techniques, with a lack of emphasis on the importance of the therapeutic relationship (Wenzel, 2021). Consequently, the YC programme prioritises time for investing in and nurturing relationships with young people through intensive contact. This is in acknowledgement of the needs of the cohort and that relationships that are safe, collaborative and trusting are likely to impact engagement and outcomes (Thomson et al., 2007).

In addition to being informed by the principles and practices of CBT, the YC programme is underpinned by a range of psychological theories and best practice principles relevant to working with adolescents at risk. These include attachment and developmental theory and child-first and trauma-informed principles.

In accordance with child-first principles, the Good Lives (Ward & Steward, 2003, cited in Barnao, 2022) and public health approach (Case & Browning, 2021) to reducing risk, YC is a strengths-based programme, which is responsive to an individual's interests, values, and aspirations and builds capabilities and strengths in order to reduce risk. YC emphasises the importance of behavioural activation (a core component of CBT) to promote positive and prosocial behaviour by i) providing access to positive alternatives and opportunities, ii) connecting young people with 'safe' communities, iii) disrupting and diverting young people away from unhelpful and unhealthy patterns of behaviour, and iv) empowering young people to identify with routes out of problematic or harmful behaviours or situations. Promoting prosocial behaviour is particularly important during adolescence given that this is a significant developmental phase relating to the formation of identity (Erikson, 1968).

Advances in brain imagery techniques have enabled an understanding of the significant neurological development that occurs during adolescence. This includes a significant reorganisation of the brain as it undergoes intense synaptic pruning, where neurological pathways that are used are reinforced, and those that are not are pruned away. We now know that the brain matures in back-to-front order, with the control centre (the prefrontal cortex) being the last part of the brain to develop. All the while, the reward centre is hypersensitive, which helps us understand why there is a spike in risk-taking behaviour during adolescence (Steinberg, 2008). The high-intensity contact provided through the YC programme encourages young people to engage in structured and appropriate reward-seeking behaviours alongside the mature frontal cortexes of their YC-trained practitioners.

YC is underpinned by trauma-informed principles, as evident in the infrastructure, design, and content of the programme. This is in recognition of the high prevalence of exposure to trauma for both the young people and the families that are supported through the programme but also the practitioners who are likely to be exposed to vicarious trauma through their work. Within the programme, there are practical tools to improve emotional literacy to support the recognition and management of intense emotions, which may be a consequence of traumatic exposures and experiences.

Emerging evidence relating to the short- and long-term impact of exposure and repeated exposure to vicarious trauma can inhibit practitioners' ability to provide high-quality care (Quitangon, 2019). Therefore, regular access to clinical supervision is a core requirement of YC programme delivery to ensure that practitioners have an opportunity to consider and work through the impact of exposure to trauma through their work.

Prior evidence

Evidence is needed on how best to deliver interventions aimed at supporting the development of social and emotional skills among adolescents at risk of violence, in which setting and with what sort of approaches. As there is a lack of consensus on which approach is most effective, programmes have been heterogeneous in the approaches taken.

The literature reviewed below suggests that most experimental evidence on the impacts of youth violence prevention programmes, with a focus on problem-solving and stress and emotional management, refer to US interventions. Many of the interventions were implemented at the whole-school level, given the importance of social groups and peers for this age group. Some other programmes targeted families or communities directly. In a few cases, dual universal and targeted treatments within the school and family settings were also tried.

Universal community programmes tended to deliver the least structured treatment. For instance, Big Brothers/Big Sisters is a long-running programme that pairs unrelated adults with young people from single-parent households (Hawkins et al., 2012). The programme is not targeted at solving specific problems; rather, it has a holistic approach to supporting the overall development of the child by promoting a long-term relationship with a mentor. An evaluation of this programme found it reduced aggressive behaviour significantly.

Universal school-level interventions have been developed for use at large scales and to promote school-level change. They are typically delivered in group settings, sometimes in the classroom, and often involve a range of activities that are delivered over an extended period of time, such as an entire school year. Activities can include role model adults teaching attitudes and knowledge to promote non-violent activities (e.g., Responding in Peaceful and Positive Ways [RIPP] [Farrell et al., 2001]), role-play (e.g., RIPP, Safe Dates [Foshee et al., 2014], and 'Becoming a Man' [Heller et al., 2017]), small-group activities to promote skill-building and improve anger management (e.g., RIPP, Safe Dates, and 'Becoming a Man'), and some involve interventions at various levels, with students, teachers, parents/carers, and health practitioners (e.g. Dating Matters [Vivolo-Kantor et al., 2021] or Multisite Violence Prevention Project [Simon et al., 2009]).

Some programmes borrow tools from CBT. For instance, 'Becoming a Man' (Heller et al., 2017) sought to reduce crime and educational dropout by changing the decision-making of disadvantaged youth at elevated risk for crime and violence by promoting immersive, experiential, and reflective activities; role-playing; the sharing of stories; and discussion. Two implementations of this programme lasted for 27 and 45 weeks, delivering one 1-hour session per week. Post-test results were similar in the two interventions, with small reductions in total arrests and larger reductions in general arrests for violent crimes (Heller et al., 2017).

Safes Dates has been found to be especially effective in preventing peer violence perpetration and victimisation and in reducing the carrying of weapons to school (Foshee et al., 2014). The programme is widely delivered in the US, and it includes a play performed by students, a 10-session classroom curriculum, and a poster contest on that curriculum. Findings from the original cluster randomised control trial (RCT) found significant effects one year after, including reduced peer violence victimisation (odds ratio = 0.88, 95% confidence interval (CI) = 0.78–0.99, p = 0.04), violence perpetration among minority students (odds ratio = 0.80, 95% CI = 0.69–0.93, p = 0.004) and weapon carrying (odds ratio = 0.69, 95% CI = 0.54–0.88, p = 0.005).

Evaluations of combined universal and targeted programmes have produced mixed findings. For instance, the Multisite Violence Prevention Project delivered dual teacher and student training in one experimental condition, a family intervention in a second experimental condition, and a combination of the two in a third

experimental condition (Simon et al., 2009). The school intervention delivered instruction and practice to students on socio-cognitive problem solving, avoiding dangerous situations, and asking for help; it used techniques such as behavioural repetition and mental rehearsal. In parallel, teachers were instructed on how to support students in the programme. Pupils with higher risk scores at the outset in the universal intervention schools had lower scores at the end of the school year for violence perpetration and victimisation compared to comparable pupils in the control school. However, the pattern was reversed for pupils with lower risk scores at the outset, where violence perpetration and victimisation were higher in universal intervention schools than control schools. Evidence for pupils who also received the targeted interventions was less clear. Here, pupils considered both aggressive and influential among their peers received treatment with their parents/carers in groups of families on basic parenting skills, adolescent relationships, and school and community issues. Small but significant reductions in physical aggression were found in treatment schools over time, but no effect on victimisation was found.

Over a period of seven weeks, the Iowa Strengthening Families Program delivered a brief family competency intervention to selected families of 10th-grade adolescents (15–16 years) in schools in deprived areas. Separate sessions with adolescents (problem-solving and emotion management training) and parents/carers (disciplinary practices and communication) as well as joint sessions on family conflict resolution, were delivered. At follow-up, 24.5% of adolescents in the control group reported one or more aggressive or destructive behaviours, compared to 14.6% of adolescents across the intervention groups (Spoth et al., 2000).

Parents Who Care delivered a more modest universal intervention to promote parent–child bonding, improve discipline practices and promote opportunities to increase youth contributions to the family. While treated youth reported less violent behaviour, in results that are consistent with those reported for the Iowa Strengthening Families Program, no effects were found on harm from drug use or offending behaviours (Haggerty et al., 2007).

Multisystemic therapy is an intensive targeted family- and home-based intervention for young people with high levels of antisocial behaviour. Therapists work with a family three times a week for up to five months and families have access to 24/7 crisis support. At the five-year follow-up, there were no significant differences in offending (or the majority of the secondary outcomes) compared to the young people who received management as usual (Fonagy et al., 2020).

Reviews of the literature suggest that CBT is an effective intervention to reduce reoffending in young people, with estimates of up to a 27% reduction based on the assumptions of a 50% reoffending rate in the control condition and 36.6% in the treatment condition (Gaffney et al., 2021; see also Koehler et al., 2013). Evidence also suggests large reductions in externalising difficulties, ranging from 62 to 74%, as reported in the Youth Endowment Fund (YEF) toolkit technical report (Gaffney et al., 2021; also see Riise et al., 2021). Meta-regression analysis has shown that more intensive treatments may be more effective, but the difference it makes might be small (Riise et al., 2021). Although the evidence of CBT being effective at reducing reoffending is promising, there is a gap in the evidence about how to deliver such approaches at scale and the effectiveness of such scaled-up approaches. This is the gap in the literature that the present research aims to address.

Aims of the present research

The overarching aim of the present research is to address the gap in the literature about the effectiveness of CBT-enhanced approaches in reducing reoffending and the delivery of such approaches at scale. Given the aforementioned heterogeneity in the approaches used in the literature, a pilot study was needed to

inform the plans for and viability of a full evaluation. To generate robust evidence of effectiveness, an RCT design was identified for the full evaluation. Therefore, the present pilot study also adopts an RCT design.

The aim of the pilot RCT is to examine the feasibility of implementing necessary data collection, how YC is implemented, the barriers and facilitators to implementation, and the ability of local authorities (LAs) to adhere to the RCT design. The final aim is to determine whether the full RCT can proceed. This is crucial information to establish the need for and feasibility of a large RCT for evaluating YC.

Intervention

The intervention was described using the TIDieR Framework (Hoffmann et al., 2014), reproduced below.

Item	Description
1. BRIEF NAME	Your Choice
2. WHY	Young people who get involved in violence – those most at risk – are those most in need of therapeutic support but most unlikely to access it. We need to shift how we offer support to young people by shifting the offer so they can access it within their community within a broader context of support and behavioural change. This can be delivered best through a holistic community model delivered through all relevant partners.
3. WHAT	For the purpose of this study, young people aged 11–18 years old who are assessed as at medium or high risk of harm/vulnerability as a result of extra-familial harm and have been considered by a multi-agency panel – typically multi-agency child exploitation (MACE)/pre-MACE – are eligible. YC includes three main components: • Upskilling practitioners via five days of training for youth workers – delivered in a cascading model – and providing a handbook and resources to support them in delivering training sessions. • Intensively working with children to build authentic and trusting relationships with practitioners and create a safe space where young people can explore and grow, understand and formulate their needs and goals. Specifically: - Young people in the treated arm will receive the equivalent of 3 meetings per week with a specially trained youth practitioner for 12 to 18 weeks. - The sessions will deliver an accessible clinical intervention, focusing on behavioural activation, emotional literacy, emotional regulation, understanding cognitive processes, and developing strategies for managing intense feelings.

	- Sessions will be informed by CBT tools and techniques, such as goal setting – using the Goal-Based Outcomes tool – and practical guidance to support young people in exploring new prosocial behaviours and achieving goals that hold meaning and value to them. Monthly clinical supervision will be facilitated by clinical leads, either embedded, spot-purchased by LAs, or already in post.
4. WHO PROVIDED	YC can be delivered by youth practitioners from a range of disciplines, including youth workers, social workers, youth justice workers, and gang workers, hired by the local authorities as practitioners in the teams involved in the study. Training is performed by clinical leads and service managers who were trained via a train-the-trainer model prepared and delivered by the program developer and practice lead (Dr Karla Goodman).
5. HOW	Practitioners trained in YC work intensively with each young person to support young people in working towards their identified goals and trying out new behaviours in their own communities. YC practitioners seek to identify and activate a young person's support network, who will be able to support the young person through and after the programme. This might include other professionals or the young person's family/carers, who are encouraged to support the young person to identify and work towards their goals.
6. WHERE	Sessions are provided in a range of locations accessible to the young person, so they are engaged in the places they want to be engaged: mainly community settings, such as youth centres, cafes, and gyms. Sessions may be provided in schools if that is where the youth practitioner is working. This may involve young people being taken out of school lessons, so the potential impact on education should be considered.
7. WHEN and HOW MUCH	YC is a programme intended to be delivered over a relatively short period (12–18 weeks), with an emphasis on activating a young person's own networks and communities to enable the continuation of positive prosocial behaviours, goal-setting, and achievements once the programme has finished. In recognition of the transient lives of the study cohort, the exact length of the programme is likely to vary according to individual circumstance and need. YC is an intensive programme designed to support young people in regularly rehearsing and embedding new behaviours. Over the course of the programme, young people are supported in engaging in three sessions per week. This might include engaging in activities to deepen their understanding of themselves, directly working towards their

	goals or working with their parent/carer to develop their understanding and skills through psychoeducation. The pilot demonstrated that this intensity was difficult to achieve. More realistically, the same total number of sessions could be delivered over an extended period of 20 weeks from recruitment.
8. TAILORING	YC provides a framework that can be tailored according to individual and local needs, context and practice models.
9. MODIFICATIONS	Modifications will be determined based on the pilot.
11. HOW WELL	To test fidelity monitoring during the efficacy trial, we will use qualitative interviews with practitioners and young people, as well as analyse and process data on the content of each session and the occurrence of clinical supervision sessions.

Further information about delivering the intervention can be found on the Your Choice page of the London Innovation and Improvement Alliance (LIIA) website (https://www.liia.london/). From there, practitioners trained in YC can also access a secured portal, providing them with additional tools to deliver YC.

The logic model is described below (in the section on Data Collection). It details the target group, intervention components, mechanisms through which change can occur, and classes of outcomes to consider. While Business As Usual (BAU) does vary across LAs, it can involve a lighter and less regular programme of meetings with the young people, with less structured content that is not geared towards CBT tools and techniques. It also does not necessarily include clinical supervision sessions to overview cases and practices.

Key findings from the qualitative data show that young people received varying support in the BAU condition, from support that matched closely with what YC offered (e.g. working on goals and taking part in activities) to basic check-ins. For those who received more support, the focus of sessions would be on education/employment and health and well-being, similar to YC. The young people reported having flexibility with meeting place, like in YC. Unlike the structured nature of YC, the BAU condition reported differing amounts of contact, from frequent mandated contact to occasional check-ins. Most young people in the BAU condition felt the current support was better than previous support (e.g. organised sessions and positive practitioners) except for those who received limited contact. Some young people in the BAU condition reported experiences of working with their practitioners similar to what is expected under YC, such as feeling understood, listened to, and connected with their practitioner. They were also able to progress with education and employment goals, learn new tools, and feel supported with their feelings. The interviews indicated that the amount of contact time depended on what the practitioner and young person could achieve together.

Research questions

The pilot trial aims to provide evidence to determine whether the study of YC should continue into the efficacy trial by qualitatively and quantitatively assessing the data collection, infrastructure, adherence to the RCT methodology, implementation of the intervention, and short-run impacts of YC. More specifically, the objectives of the pilot trial are:

1. To assess the feasibility of implementing an effective data collection exercise that supports the quantitative evaluation of YC.
2. To examine how the YC intervention is implemented, the fidelity of delivery, and what helps and hinders implementation.
3. To assess the adherence of LAs and youth practitioners to randomisation.
4. To pilot study outcomes and evaluation methods, assess the parameters for conducting an efficacy evaluation, assess whether operational progression criteria have been met, and, if so, develop a full protocol for an appropriately powered efficacy study.

The full pilot trial protocol is included in Annex A.

Success criteria and targets

The criteria against which the pilot trial is to be assessed and that underpin the recommendation of whether to conduct a full-scale efficacy trial follow the research questions above. In detail, the success criteria are:

A. Delivery is taking place as expected (relates to questions 2 and 3 above on implementation and adherence to randomisation)

- Teams assigned to receive YC are being trained.
- Teams not assigned to receive YC are not being trained.
- No other teams, except treated and Home Office(HO) teams, are delivering YC, and control teams are involved in the pilot.
- Young people are being recruited, and eligibility criteria are respected when recruiting young people into the study.
- Recruitment numbers are meeting pilot targets.
- Delivery of work with young people is taking place.

B. Data is being logged as it should (relates to question 1 on aspects of data collection)

- Questionnaires are being completed by young people and practitioners.
- Information about sessions is being shared through session forms for consenting young people.
- LAs are filling out their study workbook in line with instructions for consenting young people.
- Key identifiers for linkage to administrative data are being reported in the workbooks.

C. Data can be accessed by evaluators (relates to question 1 on aspects of data sharing)

- Information governance (IG) infrastructure for LAs sharing data with evaluators is being created.
- LAs are complying with the requirement to share updated versions of their spreadsheet with the evaluator monthly.

D. Verification of the design through data analysis (relates to question 3 on adherence to randomisation and delivery of the evaluation programme)

- Do young people in the treated and control teams have similar characteristics on average? Does this hold within services within LAs, as initially intended, or more broadly?
- Are young people in the control teams actually receiving BAU and not YC?
- Are young people in YC actually receiving YC?
- Are untrained practitioners using YC practices?

Ethical review

Ethics

We submitted a high-risk ethics application to the UCL Research Ethics Committee, which was approved on 30 May 2022 (Project ID 5115/013). Several amendments were submitted to modify the content of information sheets, consent forms, and questionnaires; slightly modify quantitative and qualitative data collection processes; and extend the duration of the data collection period. All amendments were approved.

Agreement to participate

Eligible young people are those allocated to be supported by teams participating in the pilot study and who met the following eligibility criteria:

a) Age 11–17 years old (inclusive) at the time of recruitment.

b) At medium to high risk of contextual harm and referred to LA services with a view to mitigating such risk. The evaluator required this assessment to be quality assured by a multi-agency risk assessment panel or by the practitioner's team manager.

Once a young person was identified as eligible for the study, agreement to participate was obtained through the following process:

- The young person's lead practitioner informed them about the opportunity to participate in the study. The practitioner showed them the recruitment video animation, provided them with a copy of the information sheet, and discussed with them the content of the information sheet and privacy notice. If the young person was 11–15 (inclusive), the practitioner also provided their parent(s)/guardian(s) with the parents' information sheet and had similar discussions with the parent.
- If interested in participating in the study, the young person was then invited by their lead practitioner to sign the young person's consent form. If the young person was age 11–15 at the time of recruitment, their parent/guardian was also invited to sign the parental consent form.
- See information sheets in Annex B and consent forms in Annex C. Information sheets and consent forms were translated into Turkish for participants in one LA (translations available upon request).

Trial registration

The trial was registered on the American Economic Association RCT registry on 12 July 2022 (AEARCTR-0009611). Details can be found here.

Data protection

The evaluation team treated data protection during the pilot trial with the utmost consideration and developed comprehensive data IG documentation to clarify data flows and outline the legal framework allowing for the collection, sharing, storing, and processing of the data gathered to meet the research objectives of the study.

The evaluation team developed a privacy notice for the young people and their parents and a privacy notice for practitioners to collect information about them through surveys and the LA workbooks. The project and evaluation teams worked with the Information Governance for London group to develop a data-sharing agreement between the LA and the evaluator to allow LAs to share administrative data on participants and practitioners through the LA workbooks. The information sheet for the young people (and their parents)

and the recruitment animation video summarised key elements of the privacy notice. Annexes B and C provide the information sheets and consent forms, respectively.

The information collected during the trial is stored by the IFS or the AFC for the purposes of this project. This data, for the most part, is not anonymous, but both organisations have strong measures in place to ensure data protection. Data is stored on the network of the IFS in a secure folder with access restricted to named researchers. The IFS information security management system is ISO27001 compliant, and the IFS has an Information Classification and Handling Policy, which sets out comprehensive guidelines for handling all types of data and information (including highly confidential information). The AFC has similar IG policies, and all information will be held on the secure AFC servers, with only approved researchers having access. All project team members will follow strict procedures in this policy and adhere to the IFS/AFC Information Security Policy when using or collecting data. All project team members have received appropriate General Data Protection Regulation training.

The only time someone other than someone in the evaluation team will see identifying information about a participant, alongside the information provided by the participant through questionnaires or interviews, is if the participant's answer to some survey questions or interview responses indicate that the participant or someone else would be at risk of harm. These detailed safeguarding procedures were approved in the ethics application and followed throughout the pilot trial.

The privacy notice also describes the complex data-sharing processes associated with a) the linkage of primary data collected during the study to administrative records from the Department for Education and from the Ministry of Justice and b) the archiving of data in the YEF data archive. In collaboration with the project team, a speech and language therapist, and the VRU YPAG, the evaluation team strove to make these explanations as accessible as possible through the use of various diagrams. See the privacy notice for more details on this issue.

Data subjects' rights

Data subjects have the right to ask for access to the personal information the evaluation holds about them and ask the evaluators to correct any personal information that is incorrect and erase personal information when there is no good reason for continuing to hold it, although there are certain time limits for requesting deletion linked to the YEF data archive. The privacy notice provides the evaluation team's contact information for participants to get in touch.

Purposes of data processing

The information sheet and privacy notice also clearly specify the purposes of data processing, as well as the parties with access to data and the reasons for access in great detail. It also states that the results of the research will be made publicly available through reports and presentations posted on the YEF, IFS, or AFC websites.

Data retention

The privacy notice also specifies that the data stored by IFS, which includes the information from questionnaires, as well as crime records from the Ministry of Justice, will be stored for a minimum of 10 years in order to allow the evaluation team to look at the long-term effects. After 10 years, the IFS will carry out a review to see if there is still useful work that can be done using the data, committing that they will delete it at any point they no longer need the data for this research project.

Data processing roles

As specified in the privacy notice, IFS and AFC were joint data controllers at the start of the study. When the study is finished in the second half of 2024, the data will be handed over to the YEF for archiving purposes, making the YEF another data controller. After 2024, AFC will no longer become a data controller.

Lawful basis

The lawful basis for processing and storing the information on young people and practitioners during the study is the evaluation team's legitimate interest in researching the best way to support the young people. By maintaining the YEF archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest, and this gives the YEF a lawful basis for using personal information. The lawful basis condition for processing Special Category Data(ethnicity and well-being/mental health data) is Article 9 (2) (j) Archiving, research and statistics. Processing crime record data in the project is done under Article 10, and the condition for processing that applies in this study is Research.

Project team and stakeholders

Our project is a partnership between IFS and AFC. Professor Rasul, as PI, has overall responsibility for the project. The IFS team leads the quantitative evaluation. The AFC team leads the qualitative process evaluation.

Rasul leads engagement with the YEF and the integration of quantitative and qualitative work streams. Cattan leads in liaising with the delivery partner. All members have been engaged in the design of the evaluation and survey instruments. Costa-Dias leads on methodological aspects and trial design. Cattan leads on data collection and administrative data acquisition. Olorenshaw quality assured, cleaned, and analysed data and oversaw the endline data procedure. Under the supervision of Cattan and Olorenshaw, two research assistants, Yann Lopez and Tasnim Nodee, cleaned data, ensured that safeguarding procedures were respected, coordinated endline data collection, and distributed vouchers.

Edbrooke-Childs acted as process evaluation lead. He co-leads engagement with the YEF alongside Rasul. Edbrooke-Childs and Stapley lead the methodological design. Jacob worked closely with the team on operational oversight, planning, and risk/issue log monitoring. Jacob supervised the researcher (Labno) and peer researcher (Orchard), who led data collection, with specialist input from Stapley and Labno throughout. Labno worked on project management; data collection, analysis, and reporting; and the Evaluation YPAG and peer researcher involvement. All team members analysed the data, with Edbrooke-Childs, Stapley, and Jacob leading the reporting and dissemination. Deighton provided ongoing critical appraisal with a view to the overall process evaluation.

The evaluation team actively engaged with the London VRU and LIIA in co-designing the evaluation design, communicating with LAs about the pilot trial, and designing a survey instrument to measure perceptions of the young people's safety.

The evaluation was funded by the YEF. The IFS used funds from the Economic and Social Research Council (ESRC) Impact Acceleration Account and the Centre for Microeconomic Analysis of Public Policy, an ESRC-funded Institute, to provide additional research support. The team declared no other potential interests.

Methods

Trial design

The pilot trial was designed as a cluster RCT whereby teams of youth practitioners were randomly assigned to either the CBT training and delivery of YC or BAU. The unit of randomisation is, therefore, LA teams of youth practitioners within an LA, and there are two trial arms: control and treatment. Teams in the control arm are called control teams throughout the report; teams allocated to the intervention arm are called treated, intervention, or trained teams interchangeably. Teams randomised out of training during the pilot trial continue offering BAU to the young people, which involves less structured and (in most cases) lighter support when compared to YC. Depending on whether an efficacy trial takes place, these teams may be offered training in YC at the end of the pilot trial, or they may enter the randomisation pool in the efficacy trial. Details on the number of teams and how randomisation happened in practice can be found in the Findings section later in this report.

The pilot design does not require that the young people be randomly assigned to teams within services. Instead, it follows the usual process of assigning the young people to teams, which is based on workload considerations in a system that works at capacity. Specifically, given their presented needs, a young person is assigned to the team that has the most spare capacity at the time they are referred to the LA services among the teams prepared to deal with the young person's specific needs. If applied strictly, this rule effectively guarantees that the assignment of the young people to teams is independent of the team status regarding YC training (though it will depend on the team's specialism, since teams specialise in different types of presented needs) because it depends only on team availability at the time the young person happens to be referred to LA services. After assignment to teams, the young people are recruited into the pilot study by their allocated practitioner, who is a designated member of the team with special responsibility for the young person. Recruited young people participate in the trial and have their data collected and shared. Rich data on childhood background characteristics and behaviour from the primary data collection and linked administrative records provides suggestive evidence that the assignment of the young person to a team and their subsequent recruitment is independent of the training of teams and that the YC intervention was effectively delivered within treated teams. However, we cannot guarantee a balance on unobserved characteristics of the young people related to their potential outcomes.

The evaluators did not plan any modification to the trial design once it started. However, over time, the evaluators learned about issues regarding the implementation of the randomisation in some LAs. We report on these issues in the Findings section.

Participant selection

Identification of teams

LAs identified teams to participate in the pilot trial among those involved in supporting the target group of young people aged 11–17 at medium to high risk of contextual harm (the young people assessed by their practitioner to be at risk of committing acts of violence or to be vulnerable to being a victim of violence outside their families) with an interest in training in and delivering YC. LAs were asked to name at least two teams seeking training. They submitted the names and services of these teams to the evaluation team through a survey in March and April 2022.

In a second step, the evaluators randomised assignment to training in YC among the teams that had been put forward for training. Randomisation was implemented at the LA level. There were two training periods corresponding to two funding batches: the Home Office phase (December 2021) and the YEF pilot phase

(spring 2022). In the five LAs that randomised the teams to be trained under the Home Office pilot, no additional randomisation of new teams took place during the YEF pilot phase.

LAs participating in the pilot signed a grant agreement with the VRU, including minimum requirements attached to their participation, such as their willingness for their teams to participate in the randomisation, their readiness to share data about participants' background information and compliance with the study, their willingness to facilitate survey data collection, and their readiness to deliver YC during the pilot. The grant agreement also included the list of teams that would participate in the pilot trial. These consisted of the randomised teams, as well as the team that had been trained in the Home Office (the latter would not be included in the experimental evaluation of YC but could provide useful data during the pilot study).

Identification of participants

Participants were selected from among the young people allocated to be supported by teams participating in the pilot study who met the following eligibility criteria:

a) Age 11–17 years old (inclusive) at the time of recruitment.

b) At medium to high risk of contextual harm and referred to LA services with a view to mitigating such risk. The evaluator required this assessment to be quality assured by a multi-agency risk assessment panel or by the practitioner's team manager.

Recruitment of young people in the study was done by the young person's lead practitioner, who is the youth practitioner bearing the main responsibility for delivering support to the young person. The practitioner provided information about the study using the information sheet and recruitment video. After discussing what participation would entail – in one or several sessions – the practitioner asked the young person to sign a consent form. For young people aged 11–15, the practitioner also involved the young person's parent in the recruitment discussion and asked the young person's parent or guardian to sign a consent form.

Rationale for the planned number of participants

Based on the results of the LA survey we ran in March and April 2022, we expected treated teams to enrol at least four new children in YC each month, on average. At the time, recruitment was planned to take place over two months. Given that we planned to have at least one trained team and one control team in each LA, this meant that we expected to recruit over 200 children in the treatment group (and at least as many in the control group). This rationale was provided in the pilot trial protocol (p. 4–5) and described in Annex A. Sample calculations for the pilot were simply based on information provided by LAs and not on any power calculations, since the pilot was not supposed to be an exercise in evaluating the impact of YC.

Further work between the evaluation and project teams was done to develop target numbers of young people to recruit in each LA, depending on the LA tier. The final target numbers communicated in the grant agreement were 10 participants in the 16 Tier 2 LAs and 20 participants recruited in 15 Tier 1 LAs, yielding a total of 460 young people across all 31 LAs.

The settings and locations where data was collected

Consent forms, as well as baseline survey data, were to be collected during meetings between a young person and their lead practitioner (and potentially their parent or guardian). These meetings could take place in a variety of settings, from the young person's home or a council building (e.g. a youth or community centre or school) to a public place (e.g., a park). Endline survey data was to be collected during meetings

between the young person and a peer researcher (who was blind to the allocation of young people to teams) either in a council building or online.

Data collection

Description of data and data collection procedures

During the pilot trial, we collected quantitative and qualitative data on study participants and on the implementation of the trial through multiple sources. In addition, we have plans for a future linkage between the quantitative data collected on each participant and their administrative records in the National Pupil Database (NPD), the Children In Need and Children Looked After censi, and records from the Police National Computer (PNC). The linkage will be pursued for the efficacy trial only and so is not further discussed in this report. Figure 1 below provides an overview of all the sources of primary data and administrative data planned to be gathered during the study. Details are also provided about who, when, and how this data was collected.

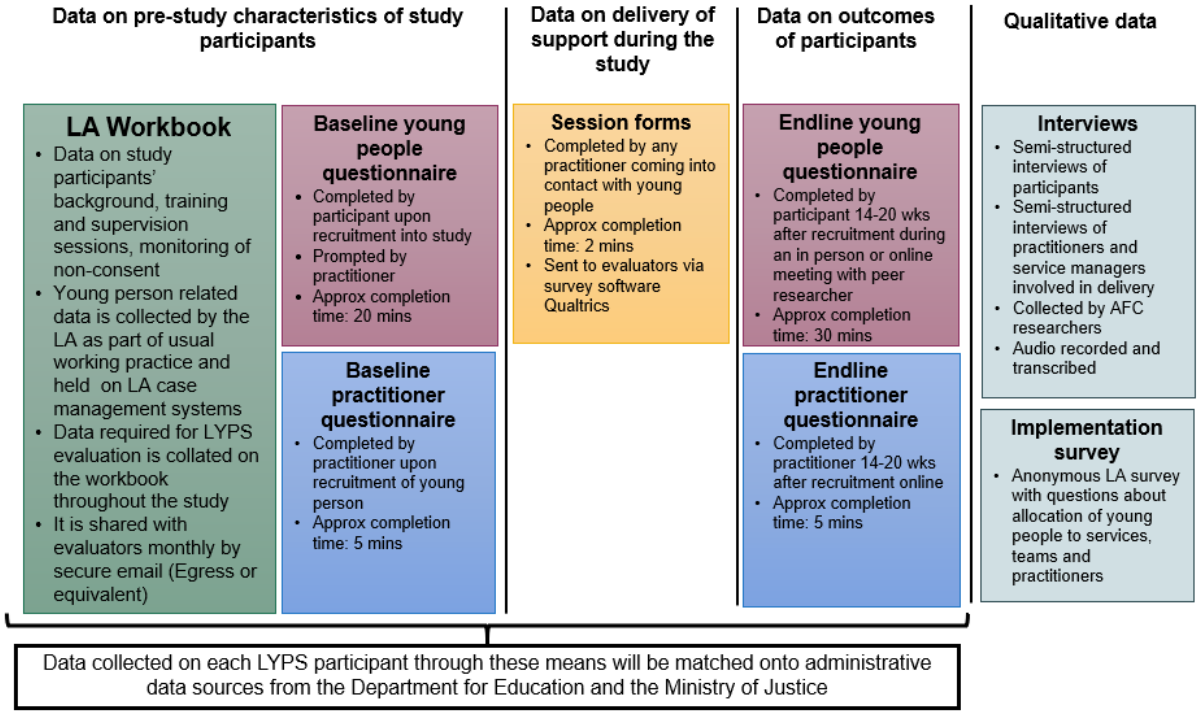


Figure 1. Data Collection

We further provide information about the content of the workbook, questionnaires, and session forms below. A copy of all questionnaires and the session form is available in Annex E.

LA workbook: The LA workbook is a spreadsheet to be filled out by the single point of contact (SPOC)/data lead of the LA to provide background information about the young person, as well as a log of training dates for practitioners involved in the study and a log of clinical supervision sessions. The background information about the young person includes date of birth, gender, ethnicity, special educational needs (SEN) status, reason for referral into the service, and any other services the young person is involved with. The workbook also includes a tab to list some basic demographic information (e.g. ethnicity, gender, and age) about the young people who were approached to enter the study but did not consent and provides an option to explain the reason (if known) for non-consent.

Baseline young people questionnaire**:** The baseline young people survey includes the Strengths and Difficulties Questionnaire (SDQ; Goodman et al., 1997) to measure emotional and behavioural difficulties, a scale developed by the evaluation and project team about the young person's perceived safety (Self-report Checkpoint),[2] the Social Connectedness Scale–Revised (SCS-R) to measure social connectedness, and a question about the young person's main activity at the time of the survey.

Baseline practitioner questionnaire: The baseline practitioner survey asks the young person's practitioner to report their risk rating of the young person and their perception of the young person's safety, using the practitioner version of Checkpoint.

Endline young person questionnaire: The endline young person survey includes the same content as the baseline young person questionnaire, plus the following scales: The Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS) to measure mental well-being, the Trait Emotional Intelligence Questionnaire – Adolescent Short Form (TEIQUE-ASF) – Self-regulation subscale to measure emotional self-regulation, and New General Self-Efficacy Scale to measure self-efficacy. These additional scales were not added at baseline to keep the questionnaire short. The endline questionnaire asks the young person some questions about their experience working with their practitioner: it asks whether they would recommend YC to someone else, it provides a free text box for any additional comments, and it asks a series of seven questions about the practitioners' approach to and practices in working with the young person. These approaches/practices were selected as those most characteristic of the practices embedded in the YC training.

The endline questionnaire was planned to be administered at the end of week 12 once the delivery period for YC had terminated. In practice, the data collection for this instrument happened at different times for different participants, in both the treated and control arms, between weeks 12 and 20 after recruitment. The delays were due to a number of factors, including a gap of up to two weeks between recruitment and the starting of sessions, a slower delivery of YC than initially planned due to difficulties in implementing the weekly intensity of meetings, and delays in following up with the young people for final survey completion.

Endline practitioner questionnaire: The endline practitioner survey includes the practitioner version of Checkpoint, as well as a series of seven questions about the practitioners' approach to and practices in working with the young person. These approaches/practices are the same as the ones asked of the young person in the endline questionnaire and were selected as being the most characteristic of the practices embedded in the YC training.

Session forms: Practitioners are requested to fill out a session form every time they conduct a session with the young person or every time a session is cancelled. The session form asks a few details about the location of the session, the young person's level of engagement, and whether the session was related to the YC programme, and, depending on the final response, offers one or two dropdown menus to describe the content of the session. The practitioner is then offered a free-text box to include any further comments on the session. If the session did not take place, the session form asks whether the reason for cancellation is known and offers a free-text box to include any other details about the session that did not take place.

[2] This report presents a number of validation analyses of this measure (see the Data Quality section), but this work has not been published elsewhere.

Pre-specified methods and measures to address research objectives

We used the data gathered throughout the study to answer the pilot trial objectives using a mixed methods approach. Below, we provide a description of which data source is used to address each of the four research objectives listed earlier in this document.

Research objective	*Data source*	*Data analysis method*
1. To assess the feasibility of implementing an effective data collection exercise that supports the quantitative evaluation of YC	- Baseline and endline young people and practitioner questionnaires - LA workbook data	Analysis of missing patterns in the workbook data and baseline and endline surveys and whether data appears missing at random or is systematically missing
2. To examine how the YC intervention is implemented, the fidelity of delivery, and what helps and hinders implementation	Session form questions about the content of sessions to be completed by practitioners	Descriptive quantitative analysis of the frequency of sessions and content of sessions and whether this closely matches the designed delivery of YC (allowing for the fact that practitioners might tailor the delivery of YC to individuals and also learn over time the most effective ways to deliver it)
	Endline survey questions about practitioners' practices with the young people, completed by the young people and by practitioners	Descriptive comparison of the likelihood of practitioners using the typical YC practices/approaches between practitioners in trained (treated) and untrained (control) teams
	Interviews with the young people and practitioners	Qualitative analysis using the framework approach to categorise the data according to the research questions and logic model and then a thematic analysis of the data by categories

3. To assess the adherence of LAs and youth practitioners to randomisation	Ongoing discussions between evaluators, the project team, SPOCs, and other LA personnel facilitated by LIIA	Qualitative analysis to form an index rating of LAs in terms of adherence to randomisation
	Implementation survey questions about frequency of meetings between young people in control teams and YC practitioners	Qualitative analysis of patterns emerging from the set of free-text responses
	Session form questions about the content of sessions	Descriptive quantitative analysis of the extent to which young people in control teams received YC sessions and of the extent to which young people in treated teams received non-YC sessions
	Baseline young people and practitioner questionnaires and workbook data	Balance the analysis between the treated and control groups of young people
4a. To pilot study outcomes and evaluation methods	- Baseline and endline young people and practitioner questionnaires - LA workbook data	- Quantitative analysis of baseline and endline data to assess data quality and reliability by comparing the distribution of SDQ scores with those obtained from the Millennium Cohort Survey at 14 years of age - Analysis of psychometric properties of the Checkpoint risky behaviour scale at baseline and endline - Analysis of correlations between measures of risky behaviour and emotional and behavioural difficulties

4b. To assess the parameters for conducting efficacy evaluation and measuring whether operational progression criteria have been met and, if so, to develop a full protocol for an appropriately powered efficacy study	- One-to-ones with LAs about their willingness and capacity to engage in an efficacy evaluation - LA surveys to list teams to include in a future efficacy evaluation and estimate numbers of eligible young people potentially recruited in each team	Combining this data in revised power calculations that also utilise information obtained from the pilot study (e.g. in terms of baseline characteristics of eligible youth)

Development of the logic model

The logic model is presented below in Figure 2. The logic model was developed following the co-design meetings. It was co-developed by the evaluation and project teams, based on the theory of change produced by the project team and the discussions about the intervention that occurred during the co-design meetings. Findings from this report will be considered in assessing whether the logic model needs revision. If it does, this will happen as part of the efficacy study. For example, there could be changes to the wording (e.g. 'well-being' to 'mental health and well-being'), or the addition of parents/carers to the target audience.

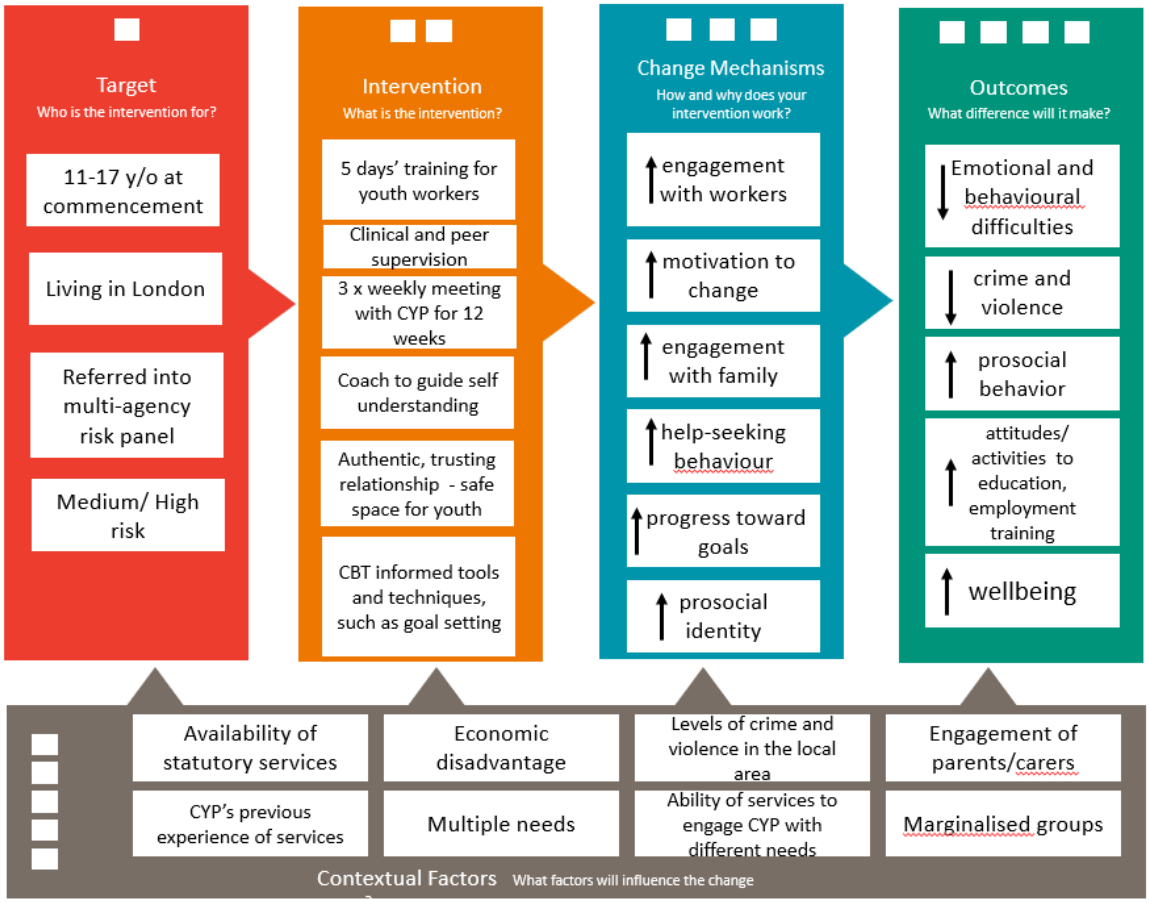


Figure 2. Logic Model

Process for developing the data collection instruments, including any piloting or validation exercises

Most survey data collection instruments are based on well-established scales: The SDQ, SCS-R, SWEMWBS, TEIQUE-ASF – Self-regulation subscale, and the New General Self-Efficacy Scale.

The evaluation and project teams and the VRU YPAG co-developed a new instrument to measure the young people's perceptions of safety, which they named '*Checkpoint: A safety scale for adolescents*'. The instrument asks the young person to rate their likelihood to engage in, be drawn into, or witness different types of risky behaviours in the next month on a scale from 0 to 5 (0 being very unlikely and 5 being very likely).

The first three questions attempt to measure active engagement in risky behaviour by asking the young person to rate their likelihood of engaging in behaviours that would i) cause distress or damage in a public place, ii) get them into trouble with the police, and iii) physically hurt other people. The fourth question attempts to measure the young person's risk of exploitation by others by asking how likely the young person thinks it is that other people in their life will try to involve them in any of the behaviours above. The fifth and sixth questions aim to measure the safety of the young person's environment by asking how likely they thought it was that they would witness a violent crime or be a victim of a violent crime in the following month.

Safeguarding concerns were raised if the young person reported it as being likely or very likely that a) they would physically hurt other people in the next month, b) other people would try to involve them in risky behaviours, or c) they would be a victim of a violent crime. In this case, the evaluation team contacted the young person's practitioner and/or the LA SPOC to inform them of the young person's answer to the baseline questionnaire. An alert for the young person was built into the questionnaire so that the young person was made aware of the escalation in the event that they reported that they were feeling unsafe.

The need for developing such a scale arose, as there were strong concerns in the project team and the VRU YPAG about the feasibility and acceptability of administering the Self-Report Delinquency Scale (SRDS) in the cohort of interest. The main concern was that the SRDS was not aligned with the principles of the child-first philosophy, the principles of the programme being evaluated, and the principles of engaging under-represented groups in the evaluation. Feedback from the VRU YPAG and practitioners was that the SRDS could cause harm to the young people in the study due to the potentially stigmatising nature of the questions, which were described as having the potential for labelling the young people as criminals through a number of questions about the perpetration of several specific criminal activities. Consequently, the measure was described as being likely to elicit inaccurate responses and disrupt the relationship between the young person and the practitioner, negatively impacting engagement in the research and YC. There was also a concern that the young people from marginalised groups may be most at risk of experiencing harm from the measure, given the increased likelihood of experiencing social and systematic inequalities and having lower levels of trust in institutional structures. These concerns were balanced against an acute awareness that increasing the diversity of participation would require the widespread adoption of well-considered and targeted approaches that actively promote and support access to research for people in under-represented groups (NHS England, 2023).

The new scale was therefore developed with the objective of lowering the potential stigmatisation and victimisation associated with asking the young people about assumed antisocial and offending behaviours. Feedback also suggested that the young people would be cautious about disclosing past and specific behaviours for fear of reprisal, resulting in unanswered or inaccurate responses. This was addressed through

the Checkpoint Scale by asking the young people about their perception of risky behaviours rather than specific or prior behaviours.

To develop the individual items, the project and evaluation teams reviewed the questions in the SRDS and other self-reported measures of antisocial or offending behaviours and attitudes to identify categories to measure antisocial behaviour, offending behaviour, harm to others, and harm from others (including exploitation). They then developed six questions asking about the young person's likelihood of engaging in these behaviours and/or being in harmful situations in the near future. The new instrument was presented to and discussed with the VRU YPAG and the Evaluation YPAG. It received positive feedback and was incorporated in both the baseline and endline young people's questionnaire.

A practitioner version was developed, asking similar questions of the practitioner about the young person. It was incorporated in both the baseline and endline practitioners' questionnaires about the young person.

While more acceptable to the young people and the LAs, there are limitations to using Checkpoint as a measure of offending behaviour. The instrument measures perceptions around safety, i.e. the perceived likelihood of engaging or being involved in violence. What this measure captures is inherently different from actual behaviour or an objective description of someone's environment. Rather, perceptions are naturally subjective concepts influenced by the young person's understanding and awareness of what constitutes violence and their own acts in that context.

Changes to the pilot trial methods or measurements after the pilot trial commenced, with reasons

The evaluation team was involved in designing the interfaces for data collection, communicating to LAs the procedures and need for rigorous adherence to randomisation, data collection and data sharing protocols, and investigating where the procedures were not applied correctly. This allowed the detection of difficulties met by LAs in collecting and sharing data and led to further communication to clarify any misunderstandings and changes in some of the methods. Specifically, we made two changes to the pilot trial methods after the pilot trial commenced. Both changes were approved as amendments to the ethics application before being implemented.

- **Changes to endline survey data collection:** We had initially planned to collect endline survey questionnaires via in-person meetings between peer researchers and the young people. Those meetings were to be arranged by the young person's practitioner, who was to be present at the beginning and end of the meetings to ensure that the young person felt comfortable with the peer researcher. For convenience, we also allowed the meetings to take place online (via Zoom). In this case, the practitioner could be part of the meeting at its start, then wait in the waiting room while the young person completed the survey with the support of the peer researcher; the practitioner could be invited back from the waiting room at the end of the session for a short debrief.

  Once the data collection of endline surveys started, it quickly became apparent that it was very difficult and resource intensive to arrange meetings outside regular sessions between the young people, practitioners, and peer researchers. This contributed to delays in the completion of endline surveys (initially planned to happen in week 12 after recruitment and eventually occurring over weeks 12 to 20). To simplify the process and ensure maximum response rates and consistency in the timing of survey responses, we modified the procedure. Specifically, we asked practitioners to administer the endline survey to the young people in a regular session in the absence of a peer researcher at week 20 after recruitment, a time closely aligned with the end of the programme in practice. Practitioners were

instructed not to interfere with the process; their role was simply to give the young person access to the online survey and read out any question that the young person found difficult to read themselves.[3]

- **Changes to the recruitment of young people for qualitative interviews:** The young people expressed interest in and provided consent for the interviews through the overall consent form. Our initial plan was to focus on following up directly with the young people who had provided this consent. While we used this approach and it was successful to a degree, it was challenging to follow up with some young people. To address this, we also followed up with practitioners of young people who had expressed interest and consented. It was made clear this was not to persuade the young people to take part in an interview but, rather, to facilitate communication between the evaluators and the young people. Often, this resulted in the practitioner checking to see if the young person still wanted to take part in an interview and, if so, helping to coordinate the meeting for the interview. These processes worked well and enabled us to reach our recruitment target.

Randomisation

The randomisation of teams into the training or control condition was stratified at the LA level and was performed by the evaluators using STATA Version 16. The procedure selected one team for each LA that named two or more teams to participate in the trial. The selection was based on the algorithm described below.

Randomisation was done in two batches; the same procedure was followed in each of the batches. The first batch took place in December 2021 in the five LAs that were willing to provide two teams to randomise into training during the Home Office–funded pilot. These LAs were Bexley, Enfield, Hillingdon, Hounslow, and Waltham Forest. The randomisation was communicated to the five LAs via email.

The second batch took place in April 2022. At that point, all other LAs provided at least two teams to randomise into training during the YEF-funded pilot. Randomisation was performed within LAs. The randomisation was communicated to the LAs via email and again in their grant agreement. In three of the five LAs (Bexley, Hillingdon, and Hounslow) where randomisation had occurred in the first batch, no additional team was provided to randomise in the second batch, and evaluators requested that the previously randomised treated and controlled teams be part of the YEF pilot trial. The final two LAs (Waltham Forest and Enfield) provided at least one additional team, which was randomised into training and control as part of the second batch. Evaluators requested that these LAs include all four teams in the YEF pilot trial.

The design of the randomisation in two stages allowed for control teams in the first phase to be randomised into treatment in the second phase. This contributes to an imbalanced final distribution of teams across randomisation arms.

Young people being referred to LA services and eligible for YC were allocated to treated and control teams based on the teams' capacity to accept one additional case at the time of referral. This assignment, if followed strictly, should be as good as random. Allocated practitioners then recruited and enrolled participants in the study. Practitioners were not blind to treatment allocation, since the treatment

[3] Update August 2023: The vast majority of the endline survey data collected so far used this procedure, which will also be adopted moving forward. Indeed, peer researchers were only present in 39 out of the 151 endline surveys completed so far. It has proved much more effective in ensuring that the young people complete the survey at the right time.

In preparation for the efficacy trial, we have also developed an audio facility to provide support for young people unable to read the questionnaire, hence further limiting the participation of the practitioner in the data collection process.

condition was defined at the team level, and the practitioner knew whether they had been trained. As part of the guidance provided by IFS to practitioners about recruiting young people into the study, the evaluators emphasised the importance of keeping potential participants blind to what their group allocation would be during recruitment.

Analysis

The qualitative and quantitative workstreams are closely integrated and designed to complement each other. Many points of detail in relation to practical implementation, assignment of the young people to teams, etc., are covered in the qualitative analysis. The quantitative analysis brings data to bear on the same issues.

Qualitative analysis

For the qualitative analysis, the overall sample size was 20 respondents, and final samples, in particular, include young people in the YC condition (n = 5), young people in the control condition (n = 5), practitioners delivering YC (n = 5), staff involved in the implementation of the London Young People Study (LYPS) (n = 2), and staff responsible for allocating young people to either the control or YC condition (n = 3). The sample size for the individual groups of respondents was deemed appropriate given the stage of the project being a pilot study with a focus on examining the implementation of the evaluation and YC. In addition, the burden on LAs was a central consideration, given that they were simultaneously implementing the RCT design, which involved teams being trained, trained teams delivering a new programme, and the young people being recruited into the trial. The staff also completed an anonymous implementation survey on the allocation process in their respective LA (n = 22).

The majority of young people who gave their consent for an interview were contacted about participation, although there were many non-respondents. When the young people were under the age of 16, their parents/carers were also contacted. In most cases, a pre-interview call was arranged with interested participants over the telephone or via Microsoft Teams to provide more details about the interview, answer any questions, and schedule the interview. Participation in the qualitative interviews was voluntary: the young people completed a consent form with their practitioner, and staff completed a consent form online or verbally. Consent was verbally confirmed at the start of the interview. At the start of their interview and throughout, participants were reminded that they could take a break or stop at any point and that they should only talk about what they felt comfortable with. Two researchers conducted each interview (one to lead and one to support), and both participated in a debrief with another senior team member after the interview to discuss safeguarding concerns, reflect on the interview, and discuss any impact on the researcher. After the interview, the young people received a £10 voucher as a thank-you for giving up their time to take part.

The team was trained in the study's safeguarding protocol. A safeguarding contact for the young person at the LA, who was the young person's practitioner of the LYPS SPOC for the LA, was identified before the interview. Participants were notified in the information sheet and again at the start of the interview that their responses were anonymous and confidential unless there was a risk of harm to themselves or others, in which case we would have to break confidentiality. The interviewer informed the participant that, should this occur, they would need to contact the Implementation and Process Evaluation Lead and the young person's practitioner. The focus of the interview was not on the reasons for the young people coming into contact with the LA or LYPS programme.

For the staff interviews, expression of interest request emails were sent initially to sites with varied experiences of the programme. This later expanded to all sites to broaden the recruitment pool. Staff were

also recruited via the YC newsletter, and some who had expressed interest in the implementation or evaluation teams were contacted directly via email.

Interviews with the young people took place on Microsoft Teams or in person at an LA hub, depending on the young person's choice. Interviews with staff took place on Microsoft Teams. Interviews were audio recorded on an encrypted dictaphone. All audio files were transcribed verbatim. The implementation survey was emailed to all LAs to be distributed internally to relevant staff.

Materials The research and programme teams jointly developed the staff and young person topic guides based on the main research questions and logic model. Subsequently, four topic guides were created: the young person, implementers/trainers, practitioners, and allocators/referrers topic guide. An open-ended implementation survey was also created to gather detailed information on the allocation and referral process from a wide range of LAs.

The Evaluation YPAG reviewed the initial draft of the young person topic guide and proposed new questions and prompts and changes to the wording of existing questions. The topic guide was revisited a few times to help overcome challenges encountered during the interviews. These changes included adding an icebreaker at the beginning to help build rapport with the young person, adding prompts to encourage the young people to elaborate on their responses, and adjusting vague or abstract language to better accommodate neurodivergent participants.

Patient and public involvement A peer researcher and the Evaluation YPAG were recruited at the early stages of the project. The Evaluation YPAG consisted of nine members (aged 16–24) from minority ethnic and LGBTQIA+ groups with lived experience of mental health, social care, youth justice (e.g. having worked with a youth worker, mental health professional, or social care worker or having had contact with youth justice/VRU), or neurodiverse groups. The group convened four times to help develop study materials, discuss recruitment issues, and interpret data analysis findings. Prior to the Evaluation YPAG, individual young people and the VRU YPAG were consulted for feedback on study questionnaires.

Analytic strategy Each transcript subgroup was analysed in NVivo 12 (QSR, 2020), drawing on the framework approach (Ritchie et al., 2003) to manage the data and conduct thematic analysis (Braun & Clarke, 2006). The transcript data for each participant was initially organised into a top-down framework composed of the study research questions and categories from the logic model. A bottom-up approach to coding and developing themes from the data was then employed to explore the data assigned to each study research question and logic model category. Findings are reported by respondent type (i.e. implementers, service managers, practitioners, the young people in the YC arm, and the young people in the control arm). Given the relatively small numbers within each respondent type, we have not included sources for quotes to address the risk of re-identification, which is increased when several quotes from the same individual are included.

Quantitative analysis

The quantitative data analysis used descriptive methods for data analysis (including means, proportions, and histograms) to characterise the extent to which LAs adhered to the data collection and delivery protocols and hypothesis testing and linear regression methods to test for balance and show preliminary estimates of effects on endline outcomes. The analysis is designed to support the four research questions set out earlier:

1. To assess the feasibility of implementing an effective data collection exercise that supports the quantitative evaluation of YC.

2. To examine how the YC intervention is implemented, the fidelity of delivery, and what helps or hinders implementation, using descriptive evidence on the delivery.
3. To assess the adherence of LAs and youth practitioners to randomisation.
4. To pilot study outcomes and evaluation methods, assess the parameters for conducting an efficacy evaluation, assess whether operational progression criteria have been met, and, if so, develop a full protocol for an appropriately powered efficacy study.

In relation to question 1, we describe the extent to which data was collected and could be utilised for the analysis. In relation to questions 2 and 3, we present descriptive evidence on the extent to which the data reveals how YC was delivered in treated teams and present checks of the baseline balance between youth assigned to treated and control groups. In relation to question 4, we present descriptive evidence on the credibility of the measures collected and some highly preliminary findings on endline outcomes based on endline surveys completed by 31 March 2023.

Timeline

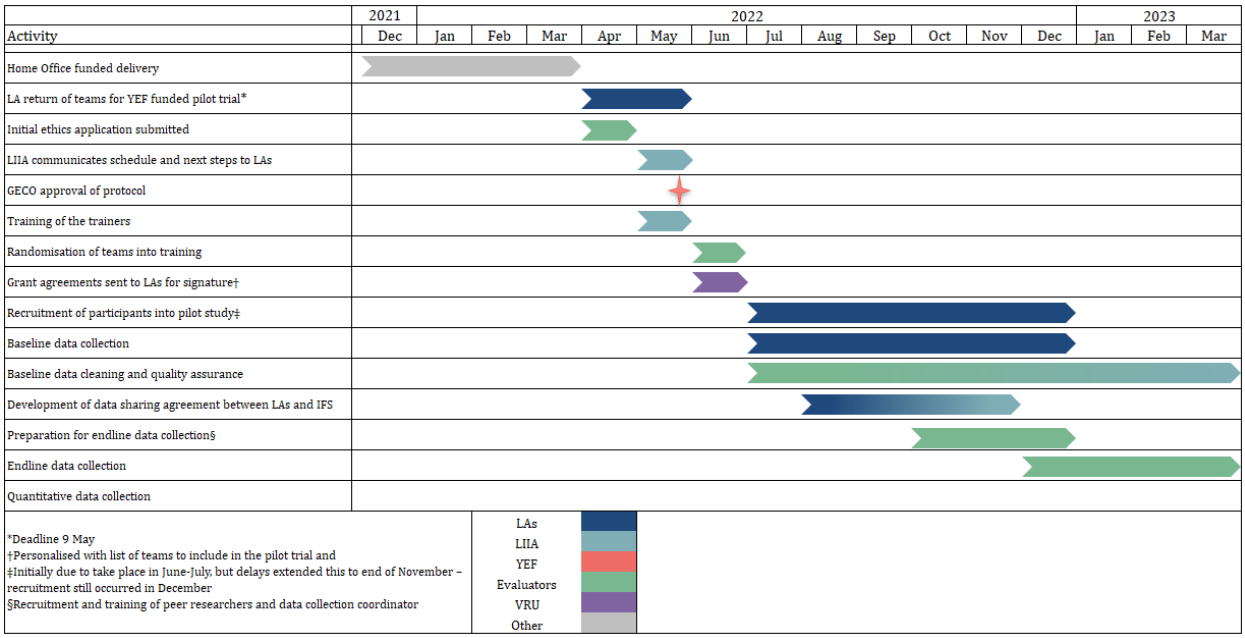


Figure 3. Pilot Study Timeline

Findings

Participants

Teams

The pilot was originally planned to include 65 teams, two per LA, equally split at the LA level between the intervention and control arms. In practice, the two-phase delivery of training, the tight deadlines imposed during the Home Office training phase, and misunderstandings on the part of LAs regarding the requirements for delivering YC within an RCT framework made this design impossible to implement at this stage. Specifically (details can be found in Table 8):

- During the Home Office training phase, randomisation was performed only for five LAs. All other LAs had teams allocated to training in a non-randomised way. This happened because the strict timeline required by the funder led some LAs to assign teams to training ahead of the randomisation.
- During the YEF pilot training phase, all LAs were invited to participate in the randomisation again. Twenty-four LAs participated, two of which had already been randomised during the Home Office training phase.
- During the YEF pilot training phase, teams proposed by LAs for randomisation into training could include untrained teams that participated in the Home Office allocation to training.
- Four LAs did not participate in randomisation in either of the two phases because they did not have enough teams for randomisation during the second phase after having a team non-randomly selected for training during the first phase.
- Of the 27 LAs that had teams randomised into YC training and control, only 13 had the randomised teams participate in the trial to recruit and support the young people in the trial. In the other 14 LAs, the treated team (two), control team (eight), or both (four) dropped out of the trial without recruiting. This happened for a number of reasons, including that the randomised teams failed to attend training and did not work with the target population.
- In 15 LAs, teams that were non-randomised participated in the trial. Of these, six also had randomised teams in the trial.

Overall, 65 teams of practitioners participated in the pilot. The two-phase randomisation – with control teams in phase one allowed to enter randomisation into treatment in phase two – and the selective dropping out of teams from the trial, which was more frequent among control teams, resulted in more teams delivering the intervention than BAU (a split of 40 to 24, with one team's status still unclear). The higher dropout rate among control teams can be partly explained by a misunderstanding of their role, with some LAs and practitioners believing they did not have to recruit into the control arm. The imbalance in the number of trained and control teams is reflected in a similar imbalance in the number of the young people recruited for the two arms. In our view, that imbalance, which resulted in more young people being recruited to the treated than to the control arm, was not biased or deliberately subverted by practitioners or LAs. Instead, it resulted from the two-phase randomisation process and initial misunderstandings of the role of control teams in the experiment.

Recruitment of participants

The pilot trial started in July 2022 and continues to date. The delivery of treatment and data collection is still ongoing, and the data presented in the analysis in this interim report is that which was available up until

the end of March 2023. Young people were recruited into the trial starting in July 2022, and recruitment continues to date; the analysis in this report refers to recruited individuals in the period up to March 2023. Figure 4 shows the timeline of recruitment up to March 2023. The series separately show the number of LAs recruiting (on the right-hand axis) and the number of young people who were recruited with consent, who completed the baseline young person survey, and who completed the young person and practitioner surveys (on the left-hand axis). We see that recruitment has been steady but initially lagged behind expected numbers, requiring a big recruitment drive that happened in November and early December 2022.

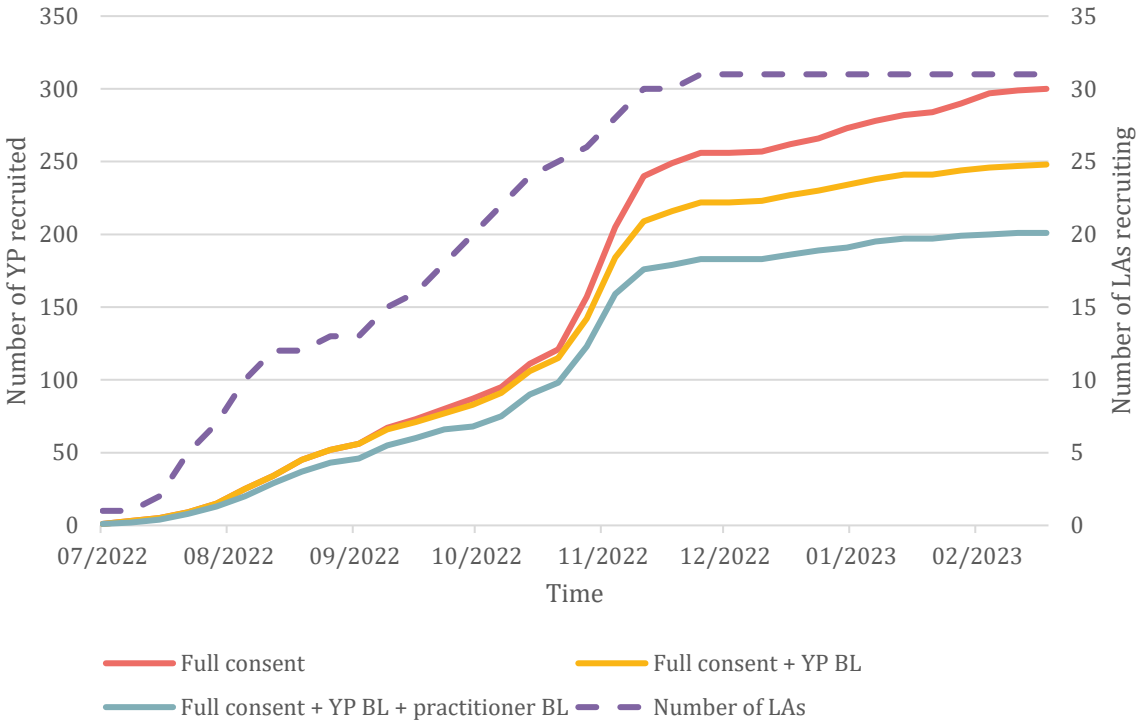


Figure 4. Recruitment and Baseline Data Collection Over Time

By the end of March 2023, the number of trained and control teams was 39 and 25, respectively. At the same time, the number of young people who agreed to participate in the trial and for their data to be used in the evaluation exercise totalled 300, split 197 and 103 between the treated and control groups, respectively. Though the young person's baseline survey was only completed for 250 of these 300 individuals, other information is available for the remaining 50 and is used in parts of the analysis that do not require baseline survey data (for instance, for checking the balance).

The figures for recruited young people are substantially lower than expected. The pilot was originally planned to last for two months, with two teams per LA, one treated and one control, totalling 62 teams overall. In terms of participating teams, the actual figure for trained teams was higher than expected due to the pre-pilot training sessions funded by the Home Office, but the trial was short of control teams, as some of the teams initially named by LAs failed to participate in the trial (and this happened disproportionately among control teams). Pre-pilot projections pointed to an average recruitment rate of four young people per team per month, which would have added up to 496 recruited young people by the end of month two, evenly split between treated and control groups. Instead, the recruitment of young people providing data for this interim report lasted for over seven months and started decelerating by the end of November 2022, as LAs were told that new recruits would not make it into this report. With 240 young people recruited by

the end of November and 64 participating teams, the average recruitment rate was 0.75 individuals per month per team, with similar rates for treated and control teams.

The most intense recruitment period was November 2022. During this month, over 130 young people were recruited. Given the efforts that were channelled into recruitment during this month, we expect it to provide an upper bound for possible recruitment rates. At those levels, two recruits per team per month would be the maximum one could expect for an efficacy trial.

Figure 5 shows data on the number of young people who provided consent to be part of the pilot and details of the baseline and LA administrative data available for them. It also shows that 300 young people have signed the form to consent to the use of their data in the study, and so the consent rate is 69% (300/433); although this consent rate could be over-estimated because only 13 LAs provided information on the number of young people they tried to recruit who did not provide consent. Consent relates to two aspects of the trial: being part of the pilot (and thus potentially receiving YC) and allowing their data to be shared. LAs reported some young people having concerns with one and others having concerns with the other.

Baseline information is missing for some young people who consented to take part in the study and for their data to be used. Figure 5 highlights the extent to which missing data sources exist for those who provided consent. Among those with full consent, only 66% (198/300) fully completed the baseline young person survey and have at least some workbook information, and only 83% (248/300) fully completed their young person baseline survey.[4]

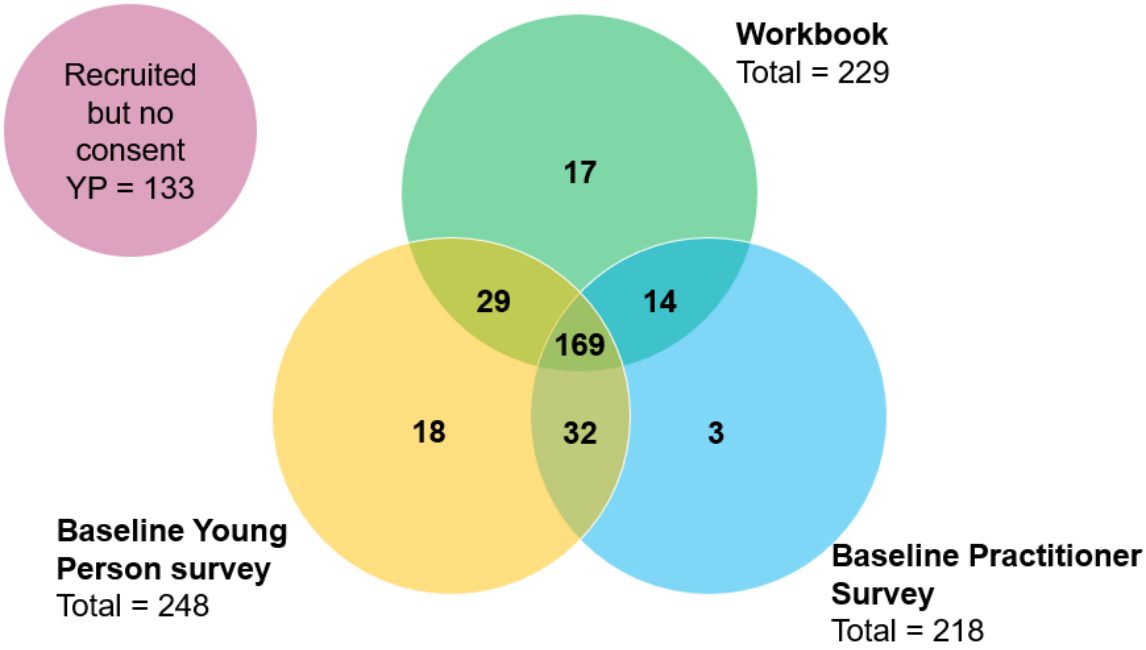


Figure 5. Final Baseline Data Collection Numbers on Pilot Participants

[4] Details of the data collection methods and how they were supported can be found in the Data Collection subsection of the Methods section under the heading 'Changes to the pilot trial methods or measurements after the pilot trial commenced, with reasons'. We further discuss where changes in design are needed under the Evaluator judgement of evaluation feasibility' heading.

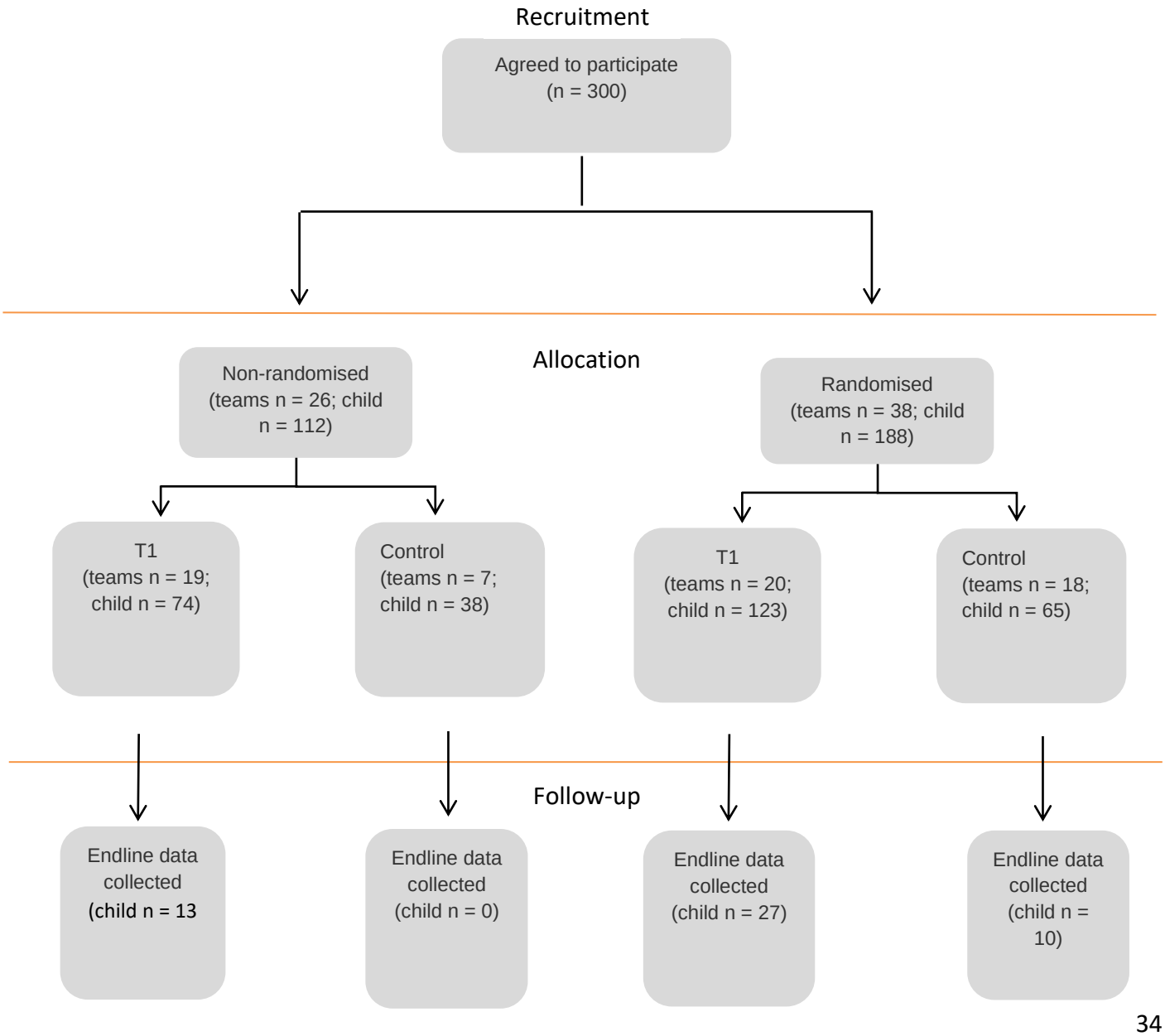
Participant flow

Figure 6 shows the flow of participants through the pilot trial.

The final sample of 300 young people was recruited into a total of 65 teams. The allocation of teams to treatment or control has been split into randomised and non-randomised teams, with more teams delivering YC than BAU 39 and 25, respectively). Recruitment into non-randomised teams came from 15 LAs that had non-randomised teams participating in the trial, sometimes alongside randomised teams. As a result, only 188 young people (66% of our sample of the young people who gave full consent) came from randomised teams. The share of the young people allocated to control or treatment teams is similar across the randomised and non-randomised teams, with 66% being assigned to a trained team.

The process of collecting endline questionnaires is ongoing. At the time of writing (April 2023), 50 young people had completed their endline questionnaires (40 from treated teams and 10 from control teams). This corresponds to a low 17% follow-up rate (50/300) and led to the re-design of the procedure used to collect endline survey data (as explained under the heading 'Changes to the pilot trial methods' in the Data Collection section).

Figure 6: Participant Flow Diagram, Two-Arm Trial



The figures below show the distribution of recruited young people by whether they have been assigned to the treatment or control groups. Figure 7 splits recruits by LA; Figure 8 splits recruits by team type (youth service).

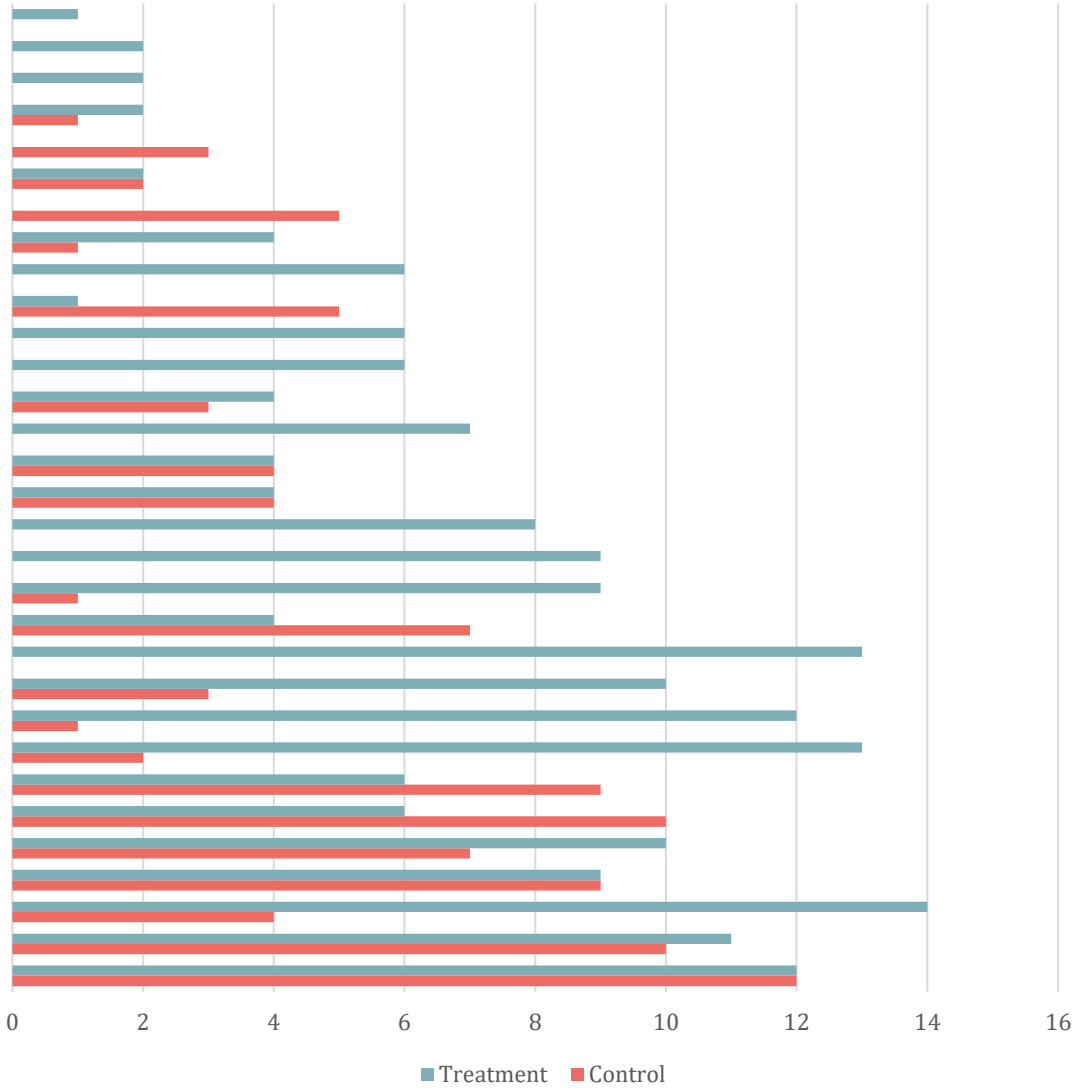


Figure 7. Total Number of Young People Recruited to Participate in YC, by LA and Treatment Status

Figure 7 plots the number of recruited young people per LA; each pair of bars shows recruitment numbers into the YC (blue) and control (red) arms. The figure reveals that a number of LAs did not recruit young people into both treatment and control groups. The dropping out of teams from the trial, described before, resulted in 10 LAs with no recruits into control teams and two LAs with no recruits into treatment teams. The remaining 19 LAs recruited young people into both treated and control teams.

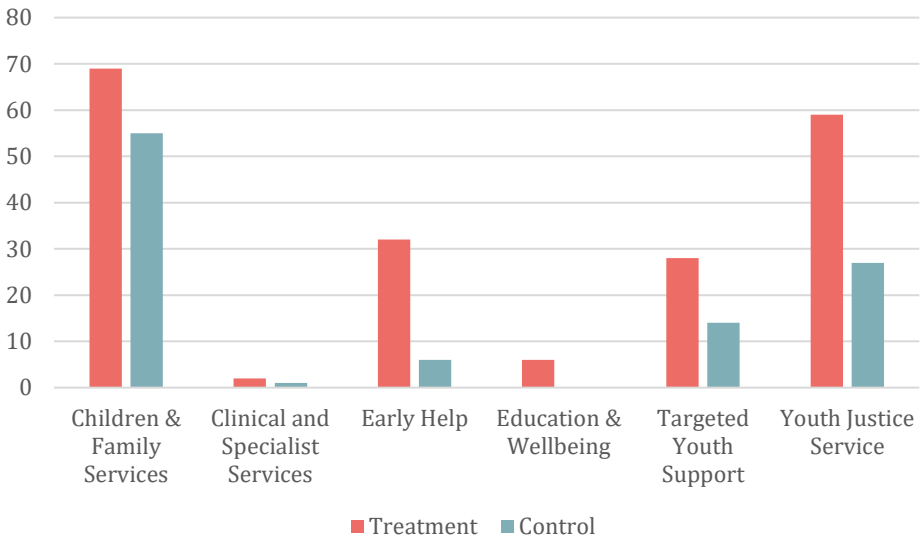


Figure 8. Total Number of Young People Recruited to Participate in YC by the Type of Service They Were Assigned to and Treatment Status

On teams participating in the trial, Figure 8 shows the majority of recruited youth are assigned to teams in Youth Justice Service and Children and Family Services, followed by Early Help and Targeted Youth Support. Fewer young people are assigned to the other teams; hence, in those teams, we do not always observe children assigned to both treated and control teams.

Baseline balance

The total number of young people included in the pilot at baseline is 300. Of these, 103 are assigned to control teams, and 197 are assigned to treated teams. The split is skewed away from the originally planned 50–50 share of the young people in treated and control teams, although the imbalance can be fully accounted for by a similar imbalance in the split of teams between trained and not trained. In total, 64 different LA teams are represented in the baseline data.

Table 1 presents the key demographic characteristics of the full sample. Tables 2–6 describe the balance at baseline of the young people assigned to the treatment and control teams. The format of the tables is the same: the first two columns show data from the control group. Column 1 shows the number of the young people in the control group and the number of different teams (across LAs) they are assigned to (in squared brackets below). Column 2 shows the average of the corresponding variable and its standard deviation (in squared brackets below). The next two columns show the same information for the treated group. We then report the difference in the standard deviation for the outcome between the treatment and control groups (the actual difference divided by the standard deviation in the control group). We do so because a rule of thumb is that standard deviation differences above 0.25 are problematic (even if the samples are statistically balanced). The first t-test reported is a simple test of equality between these values and reports the p-value of this test.[5] The final t-test controls for LA fixed effects without attempting to aggregate them in any way. In both columns for the t-test, we report p-values.

[5] We can use t-tests to check the balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure – by the law of large numbers – that the average difference is approximately normally distributed.

Deviations from the full 300 young person sample occur due to differences in rates of completion of the young person baseline questionnaire (248/300), the practitioner baseline questionnaire (218/300), and the LA workbook (229/300). There is additional variation within each survey relating to the degree of item response. The final sample size for each statistical test is recorded by treatment status.

On the whole, Tables 1–6 largely suggest that the samples are well balanced across treatment and control groups, at least in terms of observed variables, and in many cases, the standard deviation differences in characteristics are small (below the rule of thumb threshold of 0.25). Hence, at an aggregate level, randomisation protocols do appear to have been followed based on this evidence.

Table 1 focusses on baseline balance related to the demographic and background characteristics of youth. This data is collated from the LA workbooks. In Panel A, we see that the majority of youth are male (70%) and from ethnic minority backgrounds, with around 30% reporting to be White. A sizeable share of youth have special educational needs: 17% in the control group and 27% in the treated group, although this difference is not statistically significant (p = 0.129 from the simple t-test, i.e. the normalised difference is just under 0.25. Around 40% in both the treated and control groups reported having a disability. Close to three-quarters young people in our sample are in education/training/employment.

Table 1: Baseline Balance, Demographics and Background

Data Source: Local Authority Workbooks

Standard deviations are clustered at the local authority level

	Control		Treatment				
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	t-test (controlling for LA fixed effects)
Panel A: Demographics							
Gender (0/1)	76	0.289	150	0.347	-0.122	0.521	0.809
	[16]	[0.571]	[26]	[0.692]			
Prop. aged 16-17	103	0.534	197	0.437	0.195	0.333	0.753
	[21]	[1.104]	[29]	[0.833]			
Asian or Asian British	77	0.169	152	0.066	0.342	0.019**	0.0922
	[16]	[0.417]	[26]	[0.316]			
Black or Black British	77	0.325	152	0.342	-0.037	0.825	0.730
	[16]	[0.456]	[26]	[0.655]			
White	77	0.286	152	0.303	-0.037	0.856	0.824
	[16]	[0.673]	[26]	[0.616]			
LGBTQ+ (0/1)	54	0.074	95	0.042	0.141	0.464	0.530
	[12]	[0.252]	[18]	[0.251]			
Special education needs (0/1)	77	0.182	144	0.278	-0.223	0.103	0.203
	[16]	[0.397]	[26]	[0.502]			
Disability (0/1)	77	0.442	152	0.408	0.068	0.688	0.733
	[16]	[0.792]	[26]	[0.862]			
In education/training/employment when starting the programme (0/1)	71	0.761	144	0.750	0.024	0.880	0.639
	[15]	[0.642]	[26]	[0.556]			
Panel B: Background							
Looked after (0/1)	77	0.143	144	0.139	0.011	0.942	0.634
	[16]	[0.445]	[26]	[0.411]			
Involved with other council service (0/1)	42	0.714	100	0.700	0.031	0.891	0.421
	[11]	[0.606]	[19]	[0.719]			
Previously received YC treatment (0/1)	77	0.013	149	0.020	-0.054	0.770	0.822
	[16]	[0.120]	[26]	[0.240]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level. The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed.

In Panel B, we see, in terms of other background characteristics, around 14% are looked after, and the vast majority (over two-thirds) were involved with another LA service at baseline. Reassuringly, fewer than 2% reported having previously received YC.

Table 2 then provides information on the needs of youth in the pilot, again as collated from LA workbooks. We see that, in terms of the most relevant primary need, the most common needs relate to family dysfunction (over 20% in treatment and control groups) and socially unacceptable behaviour – where 21% of the control youth are classified with this primary need, and this number doubles in the treated group to 52%, a difference that is statistically different between the treated and control groups (p = 0.002). Cases other than children in need are the next most prevalent, and the samples are balanced on this dimension. We also note that around 10% of children have no stated most prevalent primary need.

Table 2: Baseline Balance, Young Person Needs

Data Source: Local Authority Workbooks

Standard deviations are clustered at the local authority level

	Control		Treatment				
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	t-test (controlling for LA fixed effects)
Most relevant primary need: N1 Abuse or neglect	70	0.000	119	0.000	N/A	N/A	.
	[15]	[0.000]	[22]	[0.000]			
Most relevant primary need: N2 Child's disability	70	0.000	119	0.000	N/A	N/A	.
	[15]	[0.000]	[22]	[0.000]			
Most relevant primary need: N3 Parental disability or illness	70	0.000	119	0.008	-0.116	0.321	0.362
	[15]	[0.000]	[22]	[0.090]			
Most relevant primary need: N4 Family in acute stress	70	0.071	119	0.042	0.131	0.476	0.607
	[15]	[0.337]	[22]	[0.197]			
Most relevant primary need: N5 Family dysfunction	70	0.243	119	0.227	0.038	0.845	0.437
	[15]	[0.723]	[22]	[0.537]			
Most relevant primary need: N6 Socially unacceptable behaviour	70	0.214	119	0.521	-0.623	0.002***	0.00772
	[15]	[0.751]	[22]	[0.958]			
Most relevant primary need: N7 Low income	70	0.000	119	0.000	N/A	N/A	.
	[15]	[0.000]	[22]	[0.000]			
Most relevant primary need: N8 Absent parenting	70	0.014	119	0.008	0.057	0.722	0.828
	[15]	[0.111]	[22]	[0.090]			
Most relevant primary need: N9 Cases other than children in need	70	0.143	119	0.042	0.372	0.220	0.330
	[15]	[0.754]	[22]	[0.326]			
Most relevant primary need: N0 Not stated	70	0.143	119	0.067	0.257	0.356	0.743
	[15]	[0.994]	[22]	[0.470]			
Safeguarding concern raised	84	0.202	148	0.230	-0.066	0.626	0.959
	[18]	[0.411]	[28]	[0.465]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level.The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed. A safeguarding concern is raised when the young person says that it is "Likely"/"Very likely" that, in the next month, they will engage in behaviour that could physically hurt other people and/or that other people in their life will try and involve them in antisocial/violent/criminal behaviours, and/or that they will be a victim of a violent crime.

Finally, on safeguarding concerns, we note that a safeguarding concern is raised when the young person says that it is likely or very likely that in the next month, they will engage in behaviours that could physically hurt other people, that other people in their life will try involving them in antisocial/violent/criminal

behaviours, and/or that they will be a victim of a violent crime. Safeguarding concerns were raised for around 20% of youth.

Tables 3–6 then present balance tables based on data collected from the young person's baseline questionnaire. In Panel A of Table 3, we focus on activities and support for young people. As expected, given the age of the target population, we see the majority go to school/college, less than 8% are in employment, and 10% are in some training programme. Twenty per cent report being primarily engaged in some other activity. Throughout, we find the absolute normalised difference in activities to be below 0.25 between the treated and control groups. These figures are largely consistent with the earlier data shown in Panel A of Table 1 from the LA workbooks.

Table 3: Baseline Balance, Activities and Support

Data Source: Young Person's Questionnaire

Standard deviations are clustered at the local authority level

	Control		Treatment				t-test (controlling for LA fixed effects)
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	
Panel A: Activities							
Main activity: goes to school/college (0/1)	86	0.663	150	0.753	-0.201	0.210	0.410
	[18]	[0.765]	[28]	[0.490]			
Main activity: works for pay (0/1)	86	0.140	150	0.067	0.158	0.397	0.378
	[18]	[0.685]	[28]	[0.407]			
Main activity: follows a training programme (0/1)	86	0.116	150	0.100	0.031	0.835	0.762
	[18]	[0.685]	[28]	[0.495]			
Main activity: other (0/1)	86	0.209	150	0.240	-0.068	0.619	0.147
	[18]	[0.566]	[28]	[0.501]			
Member of a club, sports team, church group, or other group (0/1)	84	2.429	147	2.054	0.245	0.140	0.712
	[18]	[2.226]	[28]	[1.492]			
Takes lessons in music, art, sports, or has a hobby (0/1)	84	2.631	146	2.582	0.031	0.836	0.564
	[18]	[1.806]	[28]	[1.746]			
Panel B: Support							
Support from adult at home (1-5)	85	3.951	148	4.065	-0.122	0.400	0.838
	[18]	[1.039]	[28]	[1.019]			
Support from adult at school (1-5)	35	3.421	42	3.375	0.035	0.906	0.870
	[15]	[1.680]	[20]	[1.716]			
Support from adult elsewhere (1-5)	83	3.795	148	3.999	-0.186	0.207	0.674
	[18]	[1.211]	[28]	[1.065]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level. The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed. The scores associated with "Support from adult at home","Support from adult at school" and "Support from adult elsewhere" are each generated by averaging the answers to 4 questions about the level of support the young person receives from an adult in that setting. The answers are scored on a scale from 1 to 5. They can range from "None of the time" (scored as 1) to "All the time" (scored as 5). The answers to the questions about whether the young person is a member of a club, sports team, etc., or whether they take lessons in music, art, sports, or have a hobby, are also scored on a scale from 1 to 5. They can also range from "None of the time" (scored as 1) to "All the time" (scored as 5).

In Panel B, we consider the support available to the youth. The scores associated with 'Support from adult at home', 'Support from adult at school', and 'Support from adult elsewhere' are each generated by averaging the answers to four questions about the level of support the young person receives from an adult in each setting. The answers are scored on a scale from 1 to 5. They can range from none of the time (scored as 1) to all the time (scored as 5). We see that the sample youth generally reported high levels of support from adults at home, school, and other sources (each scale lies nearly always between 3.5 and 4 for the

control and treatment groups). The magnitude of the differences in support between the treated and control groups is also small.

Table 4 then focuses on measures of difficulties across domains, with each being scored on a scale from 0 to 10. The emotional symptoms, conduct, hyperactivity/inattention, peer relationship scale problems, and prosocial behaviour scales all comprise five items. Within the treated and control groups, there is variation in each domain of difficulty, but throughout the samples, they appear well balanced, with all differences between the treated and control groups in these measures being relatively small. Finally, the last row shows scores on a prosocial scale are generally higher than on the difficulties scale.

Table 4: Baseline Balance, Difficulties

Data Source: Young Person's Questionnaire

Standard deviations are clustered at the local authority level

	Control		Treatment				
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	t-test (controlling for LA fixed effects)
Emotional symptoms scale (0-10)	84	3.667	160	3.225	0.168	0.349	0.216
	[18]	[4.203]	[29]	[3.361]			
Conduct problems scale (0-10)	84	3.595	160	3.612	-0.008	0.955	0.229
	[18]	[3.069]	[29]	[2.398]			
Hyperactivity/inattention scale (0-10)	84	5.500	160	5.537	-0.014	0.931	0.246
	[18]	[4.050]	[29]	[3.623]			
Peer relationship problems scale (0-10)	85	2.965	159	2.874	0.046	0.718	0.418
	[18]	[2.231]	[29]	[2.327]			
Total difficulties score (0-40)	84	7.012	160	6.688	0.154	0.162	0.464
	[18]	[1.433]	[29]	[1.832]			
Prosocial behaviour scale (0-10)	84	15.667	159	15.252	0.062	0.713	0.882
	[18]	[11.759]	[29]	[8.709]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level. The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed. The emotional symptoms, conduct, hyperactivity/inattention, peer relationship scale problems and prosocial behaviour scales are all comprised of 5 items. The young person can complete each item as either 'Not True', 'Somewhat True' or 'Certainly True'. The score can range from 0 to 10 if all items were completed. These scores can be scaled pro-rata if at least 3 items were completed. 'Somewhat True' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item. The total difficulties score is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40, and is counted as missing if one of the 4 component scores is missing.

Table 5 focuses on the self-assessed risks of engaging in various forms of antisocial behaviour, where we focus on the young people's reports of being very likely to be exposed to such risks in the next month (from the date of the baseline survey). We see that 9% viewed it as very likely that they would cause damage to a public place (even over such a short time horizon), and 10% viewed themselves as very likely to get into trouble with the police, with the same percentage viewing it as very likely they would physically hurt another. On these dimensions, the treatment and control groups are also balanced, showing only a small absolute difference in beliefs across them. In terms of the self-reports of others being very likely to be involved in any of the above, we find that 12% of the control group reported this, while a larger 16% of the treated group did so. Over 20% of each group reported that they were very likely to witness a violent crime, and around 6% reported being very likely to be the victim of a violent crime.

Finally, Table 6 uses data from the baseline survey administered to practitioners about the young people in the pilot, again split between the treatment and control groups. First, we consider the practitioner-assessed risks of antisocial behaviour. These questions were assessed in a similar way as in the young people baseline

questionnaire: practitioners were asked about the likelihood that a young person would be exposed to a list of risks in the following month. Across all risks, we see that, on average, a higher proportion of practitioners reported that a young person was likely or very likely to be exposed to these risks than was reported by the young people.

Table 5: Baseline Balance, Risks

Data Source: Young Person's Questionnaire

Standard deviations are clustered at the local authority level

	Control		Treatment				t-test (controlling for LA fixed effects)
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	
Prop. (very) likely to cause damage in public place	84	0.095	148	0.088	0.026	0.850	0.219
	[18]	[0.359]	[28]	[0.266]			
Prop. (very) likely to get in trouble with police	84	0.107	148	0.115	-0.024	0.852	0.915
	[18]	[0.278]	[28]	[0.349]			
Prop. (very) likely to physically hurt someone	84	0.095	148	0.101	-0.020	0.891	0.483
	[18]	[0.336]	[28]	[0.338]			
Prop. (very) likely others will involve in any of above	83	0.120	147	0.163	-0.120	0.345	0.811
	[18]	[0.284]	[28]	[0.344]			
Prop. (very) likely to witness a violent crime	83	0.229	148	0.203	0.064	0.685	0.764
	[18]	[0.511]	[28]	[0.391]			
Prop. (very) likely to be victim of violent crime	82	0.061	146	0.055	0.027	0.860	0.227
	[18]	[0.282]	[28]	[0.193]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level. The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed. Both Crime and Violence measures are generated by averaging the answers to 6 questions, which are scored on a scale from 1 to 5. The questions ask about the likelihood of the young person engaging in criminal/antisocial/violent behaviour, about the likelihood of other people involving them in these behaviours, and about the likelihood of witnessing/being victim of a violent crime, in the month following the completion of the questionnaire. The answers can range from "Very unlikely" (scored as 1) to "Very likely" (scored as 5).

We see that 25% of practitioners perceived it as likely or very likely that a young person would cause damage in a public space. In the control arm, 35% of practitioners perceived a young person to be likely or very likely to get in trouble with the police over the following month. In the treatment arm, this was 45%, but the difference is not statistically significant ($p = 0.170$ in the simple t-test. Around 20% perceived it likely or very likely a young person would physically hurt someone. We observe a larger variation between the control and treated practitioner reports of the young people being likely or very likely to be involved in these behaviours by others (36% and 58%, respectively). This difference is significant at the 1% level, even after controlling for LA fixed effects. There are no discernible differences in the final two categories, where roughly 36% and 21% of practitioners thought the young people were likely or very likely to witness or be a victim of a crime, respectively.

Finally, we focus on the practitioner risk assessments of the young people in our baseline survey. We see that on an overall risk rating score (1–4), the samples are balanced (although the normalised difference is quite high), and this is also true for the proportions of young people assigned to medium or high risk (30% and 50%, respectively).

Table 6: Baseline Balance, Practioner Risk Assessment

Data Source: Practioner's Questionnaire

Standard deviations are clustered at the local authority level

	Control		Treatment				
	N/[Clusters]	Mean/SD	N/[Clusters]	Mean/SD	Normalised difference	t-test	t-test (controlling for LA fixed effects)
Prop. (very) likely to cause damage in public place	69	0.290	144	0.229	0.140	0.399	0.506
	[18]	[0.544]	[27]	[0.360]			
Prop. (very) likely to get in trouble with police	63	0.349	144	0.451	-0.207	0.170	0.395
	[18]	[0.479]	[27]	[0.634]			
Prop. (very) likely to physically hurt someone	63	0.190	143	0.259	-0.160	0.228	0.366
	[18]	[0.351]	[27]	[0.464]			
Prop. (very) likely others will involve in any of above	69	0.348	145	0.579	-0.462	0.000***	0.003
	[18]	[0.453]	[27]	[0.608]			
Prop. (very) likely to witness a violent crime	69	0.362	145	0.372	-0.021	0.931	0.438
	[18]	[0.891]	[27]	[0.548]			
Prop. (very) likely to be victim of violent crime	63	0.206	143	0.224	-0.042	0.762	0.388
	[18]	[0.467]	[27]	[0.428]			
Risk rating (1-4)	68	2.044	139	2.209	-0.228	0.323	0.354
	[18]	[0.997]	[27]	[1.153]			
Prop. with medium risk rating	68	0.250	139	0.353	-0.219	0.305	0.296
	[18]	[0.556]	[27]	[0.697]			
Prop. with high or very high risk rating	68	0.544	139	0.482	0.124	0.422	0.291
	[18]	[0.479]	[27]	[0.553]			

Notes: ***, **, and * indicate significance at the 1, 5, and 10 percent critical level. The value displayed for t-tests are p-values for the differences in the means across the groups. We can use t-tests to check balance even though the underlying variables are not normally distributed because the samples are sufficiently large to ensure (by the law of large numbers) that the average difference is approximately normally distributed. The emotional symptoms , conduct problems , hyperactivity/innatention, peer relationship scale problems and prosocial behaviour scales are all comprised of 5 items. The young person can complete each item as either 'Not True', 'Somewhat True' or 'Certainly True'. The score can range from 0 to 10 if all items were completed. These scores can be scaled pro-rata if at least 3 items were completed. 'Somewhat True' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item. The total difficulties score is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40, and is counted as missing if one of the 4 component scores is missing . Both Crime and Violence measures are generated by averaging the answers to 6 questions, which are scored on a scale from 1 to 5. The questions ask about the likelihood of the young person engaging in criminal/antisocial/violent behaviour, about the likelihood of other people involving them in these behaviours, and about the likelihood of witnessing/being victim of a violent crime, in the month following the completion of the questionnaire. The answers can range from "Very unlikely" (scored as 1) to "Very likely" (scored as 5). The scores associated with "Support from adult at home","Support from adult at school" and "Support from adult elsewhere" are each generated by averaging the answers to 4 questions about the level of support the young person receives from an adult in that setting. The answers are scored on a scale from 1 to 5. They can range from "None of the time" (scored as 1) to "All the time" (scored as 5). The answers to the questions about whether the young person is a member of a club, sports team, etc., or whether they take lessons in music, art, sports, or have a hobby, are also scored on a scale from 1 to 5. They can also range from "None of the time" (scored as 1) to "All the time" (scored as 5). A safeguarding concern is raised when the young person says that it is "Likely"/"Very likely" that, in the next month, they will engage in behaviour that could physically hurt other people and/or that other people in their life will try and involve them in antisocial/violent/criminal behaviours, and/or that they will be a victim of a violent crime. The young person's risk rating is scored on a scale from 1 to 4, 1 corresponding "Low", 2 to "Medium", 3 to "High" and 4 to "Very high".

Implementation of YC and BAU in the pilot trial

We aimed to learn about the implementation of YC and of the BAU conditions through qualitative and quantitative methods. Qualitative analysis was based on in-depth interviews with the central implementation team of LIIA who developed and delivered YC, LA staff who work on the implementation of the programme (including day-to-day management, delivering training, and coordinating allocations to the programme), young people, and practitioners to understand how the YC programme and BAU were being implemented and delivered on the ground and what the barriers and facilitators to implementation were. Quantitative analysis was based on the session forms and aimed to log interactions between the young people and practitioners and record the content of the sessions. We summarise the findings of both strands of analyses below.

Qualitative findings on the implementation of YC

Implementers' views on how YC was implemented and delivered

Two implementers were interviewed, who were part of the central implementation team of LIIA and LA staff working on the implementation of the programme. Interviews were also conducted with service managers

and practitioners involved with implementation in practice, so we refer to implementers as being the central implementation team. Implementers' responses to this question can be categorised into three categories: perceptions of mechanisms of change, experiences of training, and experiences of supervision.

Intervention description

The implementers' descriptions of the YC programme aligned with how it was conceptualised in the logic model. We summarise the findings of both strands of analysis below. The implementers described how CBT was the core therapeutic modality underpinning the YC programme. Staff delivering YC were trained to use CBT techniques in their delivery of the programme, supplemented by skills from other therapeutic modalities, such as dialectical behaviour therapy and acceptance and commitment therapy:

> *I think that most of the youth workers, they knew some CBT techniques, so that was like a refreshing in their knowledge for them. Others, they were like first time learning them, but they found them helpful, not just for the children, but for them as well.*

Implementers indicated that the YC programme was characterised by a holistic approach to support in terms of helping the young people develop skills and strategies, as well as improving the environments that they are operating in. This could involve practitioners working to strengthen a young person's home or school environment or enabling a young person to access local amenities, manage school exclusion or avoidance, and access new extracurricular activities within their community:

> *We needed to think about food deprivation because that's quite a significant issue for some of the young people. So, we offer free food, so an opportunity to go to the café, pick up food, take it somewhere else, or have it in the café, meet with the worker.*

YC was described by implementers as a 12-week programme in which young people would meet with their practitioners up to three times per week: *'It's a high-intensity programme. It's investing time in them, to spend time with them*'. In practice, the amount of contact between the young people and practitioners varied each week.

The development of a relationship between each young person and their practitioner was considered to be at the heart of the YC programme: *'It's goal-based. It's about identifying what's the young person's agenda and working with that and then doing that in a very relational way so you don't ... it's not psychotherapeutic; it's just relational*'. The practitioners offered a consistent, frequent presence in the young people's lives.

Implementers described how, through YC, the young people were supported to find or develop new life skills and coping techniques, understand themselves better, and access new opportunities: *'It gives them an alternative to explore a different part of themselves and to understand themselves better. And to think about what some of their strengths might be, what some of their interests might be*'. Working on progression towards goals set by the young people was a key element of the programme.

Experiences of training

Implementers delivering the YC training for practitioners indicated that it was helpful to have the training materials (e.g. PowerPoint slides) provided for them to use to deliver the training. However, it was also helpful to be given scope to adapt the training sessions as necessary. They mentioned receiving positive feedback from staff attending the training: *'We've had really nice feedback. Staff really enjoyed it. I think they really enjoyed having training that gave them practical things*'. It worked well when staff had the training scheduled in their diaries in advance so they could take the time required out of their busy schedules to attend all of the sessions.

Implementers described building in time for discussion, sharing learning and experiences, breaks, and practical activities during the YC training sessions: *'I think the more we've had feedback from staff and we've had the freedom to edit it, and make it relevant locally, and make it a bit more hands-on, the better it has been*'. Use of case examples, mindfulness, and art materials were given as examples of activities that implementers had added to the training to make the content more interesting and interactive. They mentioned needing to adapt the training to close the gap between theory and practice. Changes to the training materials were also suggested, such as a shift away from the use of terminology like 'negative emotions'. Some implementers had found that four days were not long enough to deliver the training, so they had extended it to spend more time discussing particular aspects of content, such as the research process, or had included extra workshops: *'We might do a workshop session all around thought challenging or managing motivation and ambivalence. I guess our view has been that that four-day training provides the initial foundation*'.

Experiences of supervision

Clinical supervision sessions were described by implementers as an opportunity for YC practitioners to receive support to implement skills learnt through training, think about how best to help the young people they are working with, and manage any difficulties that they are experiencing in their work. Supervision sessions were seen as a necessary continuation of lessons learnt during the initial training sessions for the programme:

> *I think the best thing about it is not how to just do one-off training but how to actually sustain that through clinical supervision and a space to constantly look at their practice, develop their practice. I think that's great, and that's why I agreed to be involved in the project*.

Supervision sessions tended to take place on a regular basis, but their frequency reflected the needs of the practitioners and structures already in place within LAs.

Supervision sessions were also described by implementers as a space or opportunity for practitioners to reflect and debrief following their YC sessions:

> *That's also about our practitioners having a space to think about their own cultural competence or curiosity in their work and how that might be impacting on their work. But also a space for them to think about what they're bringing and what they're taking away from their work.*

This included, from the implementers' perspectives, practitioners' reflections about themselves and their impact on the work that they were doing with the young people or the impact the work had on them and how to manage this, such as ensuring a work–life balance and caring for themselves. Practitioners could experience trauma or triggering as a result of their work on the programme: *'We know that our practitioners are exposed on a regular basis to the traumas in the young people's lives, so thinking about the impact of vicarious trauma on the workforce*'.

Implementers' perceptions of barriers and facilitators to implementation

Perceived facilitators to implementation

Implementers described the importance of collaboration in the design and delivery of YC. Implementers referred to the importance of collaborating with, being responsive to, and listening to the young people, staff, and other key stakeholders in shaping and developing the implementation of the YC programme: '*We would always come at it at a point of collaboration. I think when they've given us feedback, where possible, we've listened to it and really named it. So, sort of,* "*You said; we've listened*"'.

Support and buy-in of service managers, identifying single points of contact within LAs, and having local 'informal champions' of the programme were also felt to be important. Implementers described helpful assets to relationship building as having an understanding of the context within which LAs operate, using the right language in communications, and using technology to enable effective communication across LAs.

Implementers indicated that the breadth of the LYPS, in terms of its involvement of 32 London-wide LAs, and the significant funding attached, contributed to its authority and success. The utility of steering group oversight of the programme and local ownership and project management was also referenced by implementers:

> *So the making it all work bit, setting up the training dates, coordinating working with the services, making sure that we've got the right number of practitioners recruited to do the training, um work very closely with the managers in [service], to make sure that they fully understand Your Choice.*

The flexibility of the YC programme, in that it is not a manualised programme but rather a 'framework' for LAs to shape to their local needs and contexts, was cited as advantageous: *'It's not a rigid manualised programme, it gives them some level of autonomy and scope to weave in their own professional and local expertise'.* The range of ways in which young people could engage with YC, including the variety of activities that they could access, was also considered a strength.

<u>Perceived barriers to implementation</u>

On the other hand, it was also acknowledged that the flexibility of the YC programme could present challenges in terms of practitioners knowing what the programme should look like in practice. Navigating tensions between project-wide requirements and needing to flex around local context needs or structures could also be challenging:

> *So, staff don't want it to be prescriptive, but then, on the other side, they will turn around to you at the end of these four days and say, 'Ok, but what do I do? You've taught all these principles, but what on earth does that look like in practice?'*

Although implementers reported that at the end of training, practitioners may have felt a lack of confidence about how to deliver YC in practice, findings from the interviews with service managers and practitioners suggested that this lack of confidence did not persist.

Irregular or sporadic communication from different individuals delivering LYPS could be overwhelming or confusing for LAs. This could be overcome by centralising communications, such as in the form of a regular news bulletin. However, sometimes it was felt that more work was needed to gain and maintain buy-in from LA staff over the course of the LYPS: *'There's another piece of work they need to do at local levels, across each borough, of meeting with manager-level staff to introduce the project, the idea, get their buy-in, because then they introduce it to staff as something positive'.* Indeed, implementers described facing resistance, particularly at the outset of implementation, when introducing the programme: *'You see these new projects coming in, and there's this new, bright, fresh idea, and they all look and sound and feel a little bit similar, but they're just rebranded as something else'.* Explaining the programme's role within the wider system was felt to be important in addressing this.

Implementers discussed challenges related to the resourcing and capacity issues that the introduction of the LYPS had presented, including needing to hit the ground running in terms of delivering and managing new demands on staff workloads. Furthermore, it was not always easy for LAs to find clinicians with the right expertise to fulfil the supervisory role within the YC programme. Some implementers mentioned commissioning clinicians from external providers to provide training and supervision: *'I think some boroughs*

have managed to get supervision from CAMHS [child and adolescent mental health services] or in-house psychologists. Other boroughs just haven't got that resource'.

Suggested improvements

Implementers suggested that the implementation of the LYPS and the YC programme could be improved in the following ways:

- Building in co-production – involve young people, their families and practitioners in the design of YC from an early stage: *'When I'm talking about co-production, you know, thinking about local authorities, thinking about young people and their families, really involving them at the earliest opportunity*'.
- Being more realistic about what can be achieved by practitioners with young people in a 12-week period: *'[The practitioners] were saying that they feel this pressure that they have to work in a certain amount of time. Apply these skills that, of course, take time to build and take time for the children also to trust the person*'.
- Ensuring that materials are kept relevant and up to date and sharing examples of good practice across LAs: *'I think it's a bit of a missed opportunity, pan-London, to have some kind of resource bank that you've got all these brilliant practitioners could be feeding stuff back into that they've tweaked and changed*'.
- Adapting materials to be more fun and age- and cohort-appropriate, including the use of online or app-based resources where relevant: *'This cohort, we know, have quite diverse needs, and so you might need to adapt things for them quite a lot ... Also, for a lot of the young people, English might be a second language, as well*'.
- Continued critical reflexivity of the model; for example, whether a train-the-trainer model is most conducive to ensuring good practice: *'It's something they might need to reflect on and think, "Well, actually, is that the best model, or should Your Choice have a team of trained, skilled trainers who support boroughs?" because I think they're compromising the quality of the training*'.

Allocators' (service and team managers) views on how YC was implemented and delivered

Among service and team managers responsible for the allocation of the young people to teams involved in the study, there were some mixed experiences of being involved in the LYPS described. Some described challenges of implementation (e.g. delay to clinical supervision, understanding the programme, and evaluation teething problems) which were generally overcome:

> *Honestly, Your Choice has been tough going, but really, really rewarding and impactful, like the outcomes have been, yeah, really impactful. But I will say, hard going for staff to, kind of, embed this new way of working, so, yeah, there are mixed feelings around it ... overall, at the end, I think going forward ... we will still continue this way of working. Because it's just added so [many] new skills to the toolbox that we ... it would be silly to then just not continue to do that.*

A related concern mentioned was the lack of funding to support young people in relation to prevention, the cost of which was contrasted with the much higher costs of, for example, state care. The resourcing provided by YC was described as an important facilitator.

Mixed views were described by practitioners about the three weekly sessions with the young people. On the one hand, practitioners described the intensity of support as being important to build and maintain authentic and meaningful relationships with the young people. A mix of sessions within a week seemed to facilitate delivery:

I'd say our main sessions, sort of, took three forms, like the practical side, activity-based. The what I'd call, more direct work using therapeutic tools. And then a, sort of, you're on my mind type of thing, you know, I'm still thinking about you as a third contact to just, sort of, maintain that relationship. Yeah, it wasn't three physical face-to-face contacts; we thought, for us, that wasn't manageable.

The flexibility of the programme enabled a range of creative and engaging activities to be used, which was described as very beneficial (e.g. go-karting, bowling, rock climbing, photography, dance classes, and cooking).

On the other hand, interviewees described concerns among their teams about the intensity of the work with the young people, especially as it could be challenging to engage a young person for even one session, or there could be competing appointments for a young person if they are involved with a number of other services. A corresponding concern for the scale-up of the study was raised regarding being able to maintain the level of intensity when supporting more young people. Interviewees suggested that the provision of YC by a greater number of teams, each with a smaller caseload, might be preferable. There was some mention that the intensity of the support was a barrier to recruitment for a small number of young people (e.g. *'We only got a few that declined to consent and ticked no. And when asked their reasoning after we'd spoken to them, it was that the three sessions a week put them off; it was, "Oh, that's a bit much"'.*

Part of this concern is related to being able to support parents, carers, or the family in addition to three sessions a week with the young person. Some also described a tension between the focus on the young people and the applicability and usefulness of the techniques learnt in YC to parents/carers:

What I didn't want to happen is that some of those three sessions a week that [were] meant to be Your Choice got, kind of, eaten away with talking to mum about her issues. Because that's not what the Your Choice programme is meant to be.

In contrast, there was some tension, albeit not insurmountable, between the individual-focused CBT tools and techniques with family work and systemic practices. The quote below highlights the challenge of supporting young people in the context of crime and violence. Although YC may support the young person and build on their strengths and prosocial identity, there is limited scope for their impact on the wider environmental, structural, and systematic risk factors for involvement in crime and violence. Addressing these wider societal risk factors is beyond the remit of programmes like YC; it should be recognised that such risk factors present a barrier to the potential impact of any individual-level programme:

Because what we feel is that if you just target the young person and try and change their behaviour but then are putting them back in the same family environment where some of those push factors that were making them gravitate towards gang culture or antisocial behaviour of youth violence. If you haven't dealt with some of those push factors, you could do some wonderful piece with the young person. But then, after 12 weeks or 16 weeks, you're then putting them back into the same home situation.

For some, incorporating families into YC had been more straightforward:

Although we've concentrated the activities on the young person, so one of them, for example, was, we went [activity], and, obviously, it was for the young person, but we actually also took the sibling. On another occasion, we actually also took the father because that young person wanted a stronger relationship with his father. So, rather than it just being the practitioner and the young person, we took the practitioner, [the] young person, and the father. And, sort of, were able to do some modelling for the father about how he could interact with the young person and doing some positive

reinforcement. So, it was an activity, but it was also, it was helping build our relationship with the young person but also then with the father. And, as I say, it was a modelling opportunity to, sort of, help people see how he could talk more positively or reframe some of his comments so that they weren't always coming out as negatives.

Similarly, some mentioned that the intensity of the support from YC and other sessions with other agencies might be overwhelming for the young people.

Practitioners' views on how YC was implemented and delivered

YC sessions took place at various locations, including outdoors, LA offices, libraries, schools, cafés, bookshops, and via telephone. Practitioners reported meeting with the young people at least twice a week, sometimes three, and one practitioner mentioned having a mix of in-person and telephone contact.

Experiences of training

Practitioners had generally positive views of the training they received. Some practitioners felt that the trainer was knowledgeable and able to tailor the training to staff needs, such as by allowing more time for discussion for specific areas of interest. Others found it helpful to receive training with a range of staff within the borough (e.g. youth justice, family support, and child protection). However, it was also felt that the training was too condensed and '*basic' – 'I wasn't impressed by the training ... it was confusing, and it wasn't very clear how the programme actually worked ... it left me with more questions than answers'* – and that the training did not provide enough guidance for how to set up the intervention in the workplace. It was suggested to allow services more time between training and recruitment to be able to set up the required resources.

Some practitioners who received the training online would have preferred some or all of it to have been delivered in person: *'I think that would really foster a sense of community and people working together on shared outcomes, and again, help with the buy-in to the programme'.* They indicated that it was less interactive and more difficult to stay focused, especially if they were joining from home.

Theme 1: initial hesitancy

Some practitioners were initially sceptical about the new intervention, assuming that it would not be different to what they already do or that it would be more like *'crisis management'* rather than supporting the *'understanding of that distress'*. However, these doubts cleared up as the intervention was put into practice.

Theme 2: practical application of learning

Practitioners felt the training gave them a good sense of the practical application of the intervention, which increased their confidence in delivering it. It was useful to receive psychoeducation about CBT and then see how different tools or strategies could be applied to real-life situations. Even those who had some background knowledge of psychology felt the training clarified how CBT techniques could be *'utilised most effectively'*. Practitioners also found it helpful to receive ideas for delivering sessions and creative strategies for engaging the young people:

Because I think a lot of the young people we work with, especially when reaching the threshold for Your Choice, are really in a stuck position. And being able to come up with actual interventions and ideas for how to move from that stuck position was really helpful.

Experiences of supervision

Practitioners described having group and/or individual supervision provided by a clinical psychologist or systemic psychotherapist. Supervision was usually held once a month, although some practitioners met with supervisors more frequently. However, it was also reported that supervision was '*missed*' because *'I don't think it was realised'* by either side.

Supervision could be seen as playing two main roles in practitioners' experiences of delivering the programme, as described in the main themes below.

Theme 1: reinforcing learning from the training

Supervision was considered '*essential*', especially for practitioners delivering the intervention for the first time. The practitioners indicated that they valued having someone to remind them of content from the training: *'I think it keeps everything fresh in your mind*'. Practitioners also felt that supervision provided them with validation that they were implementing the knowledge and tools '*correctly*'. Group supervision allowed practitioners to learn from one another and talk about the strategies that they had found helpful.

Theme 2: guidance and support

Practitioners indicated that the supervision was helpful for guiding them through the intervention and supporting them with more complex cases: 'I*t keeps you focused on the best way to deliver it for that particular young person in that situation'.* Supervisors did this by co-formulating cases, offering a new perspective on an issue, or providing relevant resources. Although practitioners had experienced supervision before, they felt that clinical supervision was useful for keeping the focus on the CBT aspects of the programme. Practitioners indicated that it was helpful to *'work in a goal-oriented way in supervision'* and to have the opportunity to reflect on one's practice.

Practitioners' perceptions of facilitators and challenges to implementation and delivery

Theme 1: administrative challenges of setup

A key challenge during implementation and delivery was managing the expectations around completing and submitting data, as described by practitioners. This included both the recruitment process (e.g. consent forms) and session data forms. Practitioners described this as *'a lot of paperwork'* for an already intensive intervention, which was in addition to completing other casework files. Practitioners indicated that changes to the process of tracking and recording data were not well communicated and that they were not able to check whether a session form was submitted, which could lead to duplicating efforts. Practitioners also felt it was difficult to access resources or information from the training and that the website was difficult to navigate. One practitioner felt that colleagues who were used to an established way of working with young people and families were '*less receptive'* to a new model being introduced.

Theme 2: increased contact time

On the one hand, practitioners described the challenges of delivering an intensive intervention. Some services were used to deliver intensive interventions, so the amount of contact was not new to the practitioners. However, most practitioners mentioned needing to have their caseloads reduced in order to meet the time demands of the intervention*: 'I think a lot of frontline practitioners would struggle to carry their normal caseload and take on Your Choice'.* They reflected that reducing caseloads might not have been practical in other services: *'I'm in a unique position to be able to do that within my role*'.

Organising a YC activity required time to scout an activity, acquire funds, travel, and complete paperwork, whereas practitioners were used to allocating around an hour to previous sessions, e.g. *'And potential for*

three contacts a week – that's the equivalent of basically three cases right there'. Expectations around one's capacity were perceived to have important implications for the young people:

> *You have to be realistic about the case numbers that you have ... and obviously, you're asking for a commitment from the young person, so you need to make sure that you've got the calendar availability to honour that commitment that you're asking from them. Because often, these are young people that have been let down repeatedly by their own… by the people around them, as well as professionals, so it's important.*

On the other hand, practitioners indicated that they liked the '*intensity*' and amount of contact, as well as the opportunity to do different activities. This was perceived to be helpful for building a relationship with the young people:

> *To work in quite a different way that also was within the remit of the work that I generally do was fantastic, and it did transform my working relationship with that young person. It strengthened it. I mean, I had a good relationship anyway, but I feel like it really strengthened it. I got to see [them] at times in quite a different environment: relaxed, interacting differently. I think [they] saw a different side of me at times as well.*

Being in regular contact with the young people allowed practitioners to check up on their goals and see how well the strategies were going: *'I feel like that has really meant that the work that I've done with them has been far more impactful, and they've made more progress by having those more contacts every week'.*

Finally, practitioners indicated that the increased contact time had been – or would have been – a challenge for some young people. Practitioners reflected on it being a *'huge commitment'* and the risk of *'fall[ing] on the danger of overwhelming a child with so much*'. They described pull factors, such as friends or criminal others, that may compete for the young people's time. Practitioners described that some young people felt like they did not need that much contact despite having a good relationship with their practitioner (e.g. *'It's a fine balance; you don't want young people to feel like you're chasing them because then that's not what the relationship should be, and that's not the way Your Choice is designed'.*

Theme 3: the context of the service

Practitioners' previous way of working, or working model, was presented as a challenge to implementation. Practitioners who worked in a systemic way with the whole family described it as *'a bit of an adjustment'* to focus solely on the young person. Others needed to adjust to the '*structure*' of YC in terms of guiding the goal-setting and strategies.

Practitioners from non-statutory services felt that working from a consent-based service, with a consent-based intervention (in contrast to statutory services), may have relieved some pressures for both sides: the young people may have felt more comfortable engaging with them, and practitioners did not have to fear that disengagement might *'feed into ... a parenting assessment or into a child protection plan'.*

> *I think there is already a bit of ... There's a distrust if it's coming from a statutory service because there is a fear of what that information is being used for and just an anxiety about, generally, social worker involvement and local authority involvement'.*

Practitioners' perceptions of suitability and the facilitators of engagement in the programme

Practitioners described the characteristics of the young people and families with whom they work. In many cases, there was disengagement from the '*system*' (e.g. education, employment, and training), a mistrust of

professionals, criminal victimisation, repeat offending, frequent *'missing'* incidents, trauma, complex needs within the family, or conflict in the home.

Practitioners described various factors that might make the intervention more suitable for the young people. They referenced the Cycle of Change model, indicating that young people need to feel *'ready to make the change'* or be at a point where *'there's been something that has caused them to have some active reflection'*. Practitioners reported that a young person who understands themselves as being a '*victim*' of coercion or exploitation would likely be more receptive and willing to engage. They also mentioned that suitable young people may need a certain level of maturity or emotional functioning to understand the intervention's concepts and suggested that older children (16–17 years old) might be better suited to the programme. Consequently, practitioners indicated that YC is *'not suitable for every young person'*. This included having *'too many push or pull factors from other areas of their life'*, significant multiple needs, or engagement with multiple agencies.

Having the young people's and their families' buy-in was described as an important facilitator of engagement in the programme. Incentives helped with buy-in, such as vouchers, funding to take part in different activities, and the prospect of revoking a statutory referral early. It was also felt that it was important to match *'the practitioner to the young person less arbitrarily and more specifically'*. Being able to adapt the intervention was also considered to be helpful for maintaining engagement.

Practitioners' views on and experiences of YC

Practitioners indicated that they had a good understanding of YC. They mentioned liking its focus on goals, thoughts, and feelings rather than just on presenting behaviours and being able to use funding for resources and activities. Practitioners reported mixed feelings about the resources and strategies used in the intervention. Some suggestions were to simplify the worksheets, add more interactive elements, and adapt them for different learning needs (e.g. SEN). One practitioner, in particular, did not find the resources for the latter stages of the YC intervention helpful, and another felt that relying too much on the worksheets might feel *'formal or official'*. Practitioners felt unsure about whether to use the goal tracker every week and cautioned that doing so might be *'too much'*. The three-column worksheet on thoughts, feelings, and behaviours was described as a *'massively useful tool'.* Mindfulness activities were also described as being too difficult for some young people: *'They lack self-esteem, and they feel self-conscious, and they feel embarrassed about it'.*

Practitioners' suggestions for improvements

There were a few who suggested improvements to the YC intervention. One suggestion was to provide training in schools so that the young people receive the same support from professionals in different settings. Another suggestion was to understand how to manage changing goals: *'[Young people] can set goals and then two weeks later be like, "I don't want to do those goals anymore"'.* It was reported that the stigma around talking about mental health, especially in minoritised communities, may be a barrier to gaining parental consent for the intervention, prompting a reflection on how the ideas and strategies can be used in a *'softer way'*.

Practitioners' perspectives on their role in supporting change (i.e. change mechanisms)

Theme 1: a meaningful relationship

> *I think that's one of the real strong points of the Your Choice programme. Those relationship-building sessions aren't just an add-on. I think they're fundamental to making the Your Choice programme different to some of the interventions that they've had previously ... and these young people, often who*

are already very disengaged from the system, they don't trust adults; they certainly don't trust professionals. So, actually, to have an adult come alongside them and say, "You're important enough for me to actually just want to spend time with you and do something that is enjoyable and get to know you".'

Practitioners indicated that building a good relationship was an essential component of the intervention and the consequent therapeutic work. They described various factors that may have helped to build this relationship:

- **Frequent contact:** Practitioners felt that the regular contact allowed them to build a relationship quicker, which then affected the young person's level of engagement and willingness to open up: *'It keeps the momentum going, and I think that I've seen a real difference in the quality of the relationships I've been able to develop*'. They also indicated that the frequent check-ins made the young people feel that they were important to the practitioners.
- **Informal or *'fun'* activities**: Practitioners described specific relationship-building activities that were different from the therapeutic sessions. These included going for walks, doing activities, such as golfing or indoor climbing, or going out to places such as shops, salons, or cafés. These also included purchasing items that supported the young people's goals, such as books. Practitioners indicated that the young people seemed more *'at ease and relaxed'*. They suggested that these activities allowed the young people to see the practitioners *'in a different light'* and feel like *'they actually care about me, and they want to invest their time with me'*.
- **Supportive characteristics**: Practitioners indicated that the young people could *'see that you're wanting to change their behaviour and support them to change their behaviour'.* Being persistent, consistent, and non-judgmental could have facilitated the young people's impressions of the practitioners' supportiveness. It was indicated that the consent-based nature of the programme, i.e. participation being voluntary, may have helped create a climate in which the young people did not feel pressured to talk about specific topics. This may have helped address the power balance, and the young people described the benefit of being able to have a choice to talk about what they felt comfortable with.

Theme 2: CBT-based strategies

Practitioners described their use of CBT strategies in their work with the young people. This involved talking about feelings more generally but also included challenging thoughts, co-formulation, exposure therapy (such as stepped activities in the community), and calming strategies (such as grounding, guided meditation, or breathing techniques). These strategies were reported by practitioners as having helped the young people with goal progression, *'physical feelings of panic'*, and seeing things from a different perspective: *'I hadn't really thought about it that way before'. (practitioner referring to something a young person had said to them)*

Theme 3: goal-oriented work

Sessions were centred around the young people's goals, which the practitioners helped plan and support: *'You're working with the young person with their goal, and they can progress towards their goal in real time'.* One practitioner reported that it was challenging to set goals that did not feel '*impossible*' and to manage the young people's expectations about achieving them.

Practitioners mentioned working on identity and values ahead of the goal-setting process. Sometimes, additional needs were identified during this process, which led to further referrals. Practitioners identified

specific activities that supported the young people's goals and accompanied them on outings related to education, employment, and community engagement.

(Intervention) Young people's views on how YC was implemented and delivered

The young people described that their YC sessions took place at school, in their homes, at community centres, or at cafés. Some young people took part in relationship-building or goal-related activities in shopping centres, food establishments, and artistic centres. Sometimes, the young people had a choice in their session locations. Sessions were held once or twice a week and ranged from 30 minutes to an hour. The young people reported that they had worked with their practitioner for between two and nine months at the time of the interview. It was noted that once a week fit better with the young people's schedules. Factors that affected session delivery and the young people's session attendance (and, consequently, progress with activities) included holidays, school revision, and the young people's and practitioners' schedules not aligning.

The young people's descriptions of the YC intervention session content and activities could be grouped into four main themes described below.

Theme 1: consequential thinking

Reflecting on behaviours and consequences was one focus of the sessions: *'We'll speak about the situation and consequences because, obviously, things just went downhill this year*'. One young person called this *'consequential thinking'.* The young people mentioned learning about different situations, sometimes in a crime or violence context, and what the consequences would be for themselves or other people.

Theme 2: self-development

Another focus of YC sessions was to learn more about oneself, reflect on issues, and develop solutions. One young person described this as *'building myself and what issues I face with myself and how I should resolve that'*. Self-development work also encompassed talking about what '*matters*' to the young people and taking part in activities '*based around my morals*', indicating some work around self-reflection.

Theme 3: relationship-building

The young people took part in informal activities with their practitioners. Such activities included going out to eat, going to the theatre, purchasing items while out (e.g. books), or doing arts and crafts together. This also included conversations about the young person's day and friends or allowing the young person to '*rant about something*'. Getting to know each other through conversations is expanded on in the next section, 'Views on and experience of YC'.

Theme 4: Progress towards goals

The young people mentioned doing activities that related to their goals, which included goal-setting as an initial activity. There was a split between the young people directly or indirectly working towards their goals during sessions. Some young people listed actions related to their goals *(*e.g. *'we went to the library' or '[the practitioner's] going to help me do my CV'*). Others mentioned *'just talking'* about goals or not having any session activities planned towards their goals. They did, however, mention working on their goals outside of sessions (e.g. attending lessons or art classes).

All young people mentioned talking with their practitioner about jobs or *'what I want to do in life'*. Working towards employment-related goals had either a more immediate focus (such as applying for a job or attending classes) or a future focus (such as aspiring to be an artist or pursuing further education or training).

(Treated) Young people's views on and experiences of YC

The young people indicated that they enjoyed talking to their practitioner about the future and goals – about anything – or life in general. The '*laidback*' nature of the sessions was appreciated. Having content planned ahead of the sessions was perceived as helpful, as was being '*free*' and able to '*lead the conversation*'. Recaps of previous sessions were perceived to be helpful.

Aspects that were less helpful included content that the young person considered to be *'basic knowledge',* in this case, relating to criminal behaviour and its consequences, and language used by the practitioner that was difficult to understand, especially for those with additional needs.

The young people tended to speak about their practitioners positively. In terms of personality traits, the young people described their practitioners as '*upbeat*', '*respectful', 'kind*', '*caring*', and '*nice*'. The young people also felt that their practitioners were helpful, encouraging, '*neutral*' (in terms of giving advice based on a situation), and '*really good listener[s]*'. The practitioners' positive personalities sometimes helped the young people to be more positive.

Most of the young people had no explicit suggestions for improving the sessions other than shortening the sessions from 30–40 minutes to 20–30 minutes.

From the young people's perspectives, YC seemed to differ from previous support the young people had received in two main ways: the activities were more interactive, and the format allowed the young people to engage in a wider range of conversations with their practitioners, e.g. being able to talk to the practitioner about '*basically everything*' and feeling heard. Previous support was generally viewed as unhelpful or less helpful when compared to YC, specifically when it came down to session activities. For example, previous support sessions included '*teach[ing] me some things*' but also *'just being talked to, and you feel like you're punished'*; whereas, doing activities and interacting might *'get someone to open up more or enjoy the meetings more'*.

Session location was discussed as having positive and negative aspects. For example, having sessions at school made it easier for the young people to attend them; however, this also meant that they would miss some school lessons. The young people did not always like their initial meeting place but were sometimes able to change it to someplace more suitable. There were perceptions of the potential stigma attached to accessing community youth services:

> *Obviously, people are going to be seeing me coming in and out of it, and it makes you feel ashamed because they're going to take a wild guess and guess correct that you're in there for something bad as a youth.*

The young people's experiences of working with their practitioners could be grouped into two main themes described below.

Theme 1: getting to know the young person

Most of the young people felt the practitioner understood or tried to get to know them. This was usually through informal conversations about things such as how their week had been, friends, or interests and hobbies and, sometimes, through showing interest in learning more about the young person's additional needs. Feeling understood was also facilitated by how much the practitioners could relate to (or understand) school stress, peer pressure, or the young person's background.

> *I feel like if I can't really relate to someone, if someone doesn't understand, like, why I've done something, it's kind of like a relationship breaker. It just feels like a huge, like, gap or a*

miscommunication because I may be saying something, but because you haven't ... you know, you can't really relate, so yeah.

This relationship-building process of getting to know each other seemed to influence how positively the young person felt towards the practitioner, which in turn facilitated session attendance or satisfaction with the sessions. It also may have given the young people a sense of being supported, '*that [the practitioner's] always here for you*'.

Theme 2: 'a safe zone for me to speak'

The young people indicated that they felt they could '*be open and speak my mind*' and *'feel free and safe to talk [to the practitioner] about anything'.* The young people indicated that the practitioners were good listeners, and being heard appeared to be a validating experience in and of itself. Aspects of good listening included not discarding what was said, taking notes, making eye contact, bringing up previous conversations, and not interrupting when the young person was speaking. Listening skills paired with a helping attitude seemed to facilitate trust and further disclosure for young people:

When I first was coming, I wasn't really comfortable and stuff like that, and I would keep things to myself that I could have told [practitioner]. But when I first told [practitioner] something, and I saw that [practitioner] was helping me, that [practitioner] was willing to help me with stuff, it made me feel more comfortable over time, to a point where I was just coming and telling [practitioner] all my situations and stuff.

However, a potential barrier to open communication was the fear of being judged by the practitioner: *'Maybe the fear of me coming and telling [practitioner] something and thinking, "Oh, [practitioner's] going to think this and that about me"'.*

(Treated) Young people's perspectives on the practitioners' role in supporting change

The young people's perspectives on the practitioner's role in supporting change through their sessions could be grouped into three main themes described below. When the young people were asked about what helped with certain changes in themselves, they talked about the conversations that they had with their practitioner and what they learnt from them during their sessions.

Theme 1: introducing new tools and techniques

The young people mentioned specific techniques they learnt that helped them change their behaviour, such as *'[de-]catastrophising'* and *'consequential thinking'.* These specifically helped with fostering school attendance and reducing harmful behaviours. There was also an indication of the young people experiencing changes in perspective-taking or mindset as they reflected on having '*a different view of seeing things in general*' or feeling more willing to take someone else's advice.

Theme 2: supporting self-development and goals

The young people reported '*know[ing] more about myself*' and '*what I want[ed] to do now, rather than before I was quite unsure*' through conversations about goals and the future. The sessions appeared to provide a space for the young people to reflect on themselves and their goals through conversation and to work on them through interactive activities, such as linking the young person with another professional to get their individual needs met. The young people spoke of problem-solving, together with their practitioner, issues they were facing, which may have helped to build confidence and *'maturity'.* Practitioners encouraged young people to think of new pathways when confronted with challenges to their goals.

Theme 3: supporting well-being

Having someone to talk to about feelings or '*vent*' to about issues was perceived as helpful for the young people and their well-being: '*... even if I'm having a hard day and I have mentoring that day, I'll still go because it's like I can vent, get stuff from my chest ... before I feel like I couldn't really vent'.* It was felt the practitioner was an extension of their support network. *'I'd say it feels like a safe space, like I'm wanting to come here and talk about something ... even if [practitioner] can't help me, just to get it out'.*

Summary of evidence

In this section, we summarise key points from the qualitative data across respondent types according to the logic model.

Intervention

All staff groups showed an understanding of the CBT principles of the intervention, such as focusing on goals, challenging thoughts, exploring feelings, and using exposure therapy. This also involved developing new skills and coping techniques, supporting new opportunities, and engaging in 'fun' activities. Interviews with practitioners confirmed that they had received training and clinical supervision, although it was less clear how long training had lasted or what peer supervision consisted of. Practitioners aimed to meet with people at least twice a week and offered different forms of contact (e.g. in person or via telephone); however, the young people reported having one to two sessions a week. All groups expressed concern about the three sessions per week: although they were viewed as important for building relationships, it was resource intensive for practitioners to coordinate them and difficult for some of the young people to agree to or fit into their schedules.

Change mechanisms

The relationship between the practitioner and the young person was thought to be an essential component of the intervention and set the foundation for therapeutic work, and this was emphasised throughout the interviews. Relationship-building was supported by frequent contact, informal activities, and the practitioners' positive traits and behaviours, such as being encouraging and trying to get to know the young person. Feeling understood and safe to talk fostered session attendance and satisfaction. The young people felt that the practitioners supported change by introducing new tools and techniques and supporting them in terms of self-development, goals, and well-being.

It was not clear if the young people or practitioners saw an increase in motivation to change, but increases in general engagement were noted. There was limited evidence that there was an increase in help-seeking behaviours in the young people. Many of the young people, however, felt more open about sharing their difficulties with their practitioners over the course of the intervention.

As the focus of the YC intervention is on the individual, few practitioners mentioned incorporating families into the programme work, thus limiting any conclusions about the role of engaging with the family as a change mechanism.

The young people worked on their goals continuously throughout the sessions with the support of the practitioners, who would identify relevant activities. Goals were often focused on education, employment, or community engagement/reintegration. Although there was no explicit mention of gaining a prosocial identity, the young people spoke about related constructs, such as reflecting on behaviours and consequences, self-development work, and values-centred activities.

Outcomes

There was strong evidence that YC impacted the young people's attitudes or activities related to education, employment, or training. The young people reported having increased school attendance, engaging in

conversations about career ambitions, and developing relevant skills for future employment. The young people also reported improvements in mental health and increased feelings of happiness and positivity, which was supported by practitioners' views. Both reported increases in confidence, self-esteem, and openness.

There was little mention of outcomes relating to crime and violence, but the young people did speak about reducing risky and health-harming behaviours, such as disengaging from peers involved in risky behaviours. The practitioners indicated reduced concerns about exploitation and the risk of reoffending. There was no explicit mention of increased prosocial behaviour, although one view is that involvement in positive activities, such as education or employment, can be considered prosocial behaviour.

Moderators

The young people used previous experiences of services, which were often described as unhelpful, as a frame of reference when describing YC. YC was thought to be more interactive, and the young people were able to talk more freely and felt heard. Relating to current support, the practitioners felt that engagement with multiple agencies would have negatively affected young people's engagement with YC.

The practitioners reflected on suitability for the programme and suggested that the young people needed to feel ready to make a change and to have a certain level of maturity or emotional functioning to understand the concepts. Multiple staff groups suggested that YC materials be adapted to meet diverse needs by simplifying worksheets or adding more interactive elements.

Allocators reported that environmental, structural, and systematic risk factors (e.g. the family environment or gang culture) presented a barrier to potential impact. The young people and practitioners noted the threat of crime and violence in the local area, especially the risk of exploitation and victimisation.

Buy-in from parents/carers was considered a facilitator of engagement, although young people did not mentioned this. Practitioners indicated that the stigma around mental health was a barrier to gaining parental consent. Practitioners were also concerned that multiple needs within a family could limit or worsen outcomes for the young person.

Qualitative findings on the implementation of BAU

Young people's views on how the control intervention is implemented and delivered

Comparisons between YC and BAU are also presented in the 'Intervention' section. The young people's descriptions of the control intervention session content and activities could be grouped into four main themes described below:

Theme 1: differing levels of support

Young people in the control condition indicated that they had received varying levels of support. The frequency of meetings or contact varied, from having contact six days a week to once every few weeks. For example, support could involve brief home visits 'to check if I'm okay', but 'we don't talk about me in specific', or it could involve mandated contact from various professionals on a nearly daily basis.

The young people indicated that they had worked with their practitioners anywhere from a couple of months to more than a year at the time of their interviews. Sessions usually took place at home, in school, Youth Offending Teams, or by phone, but everyone had at least one home visit. The young people felt that it was easy to meet close to or at home. It was indicated that they could have a choice in the meeting location.

The different frequencies of contact and support provided affected the types of activities the young people engaged in during sessions, and it also seemed to affect the young people's perceptions of how helpful the

sessions were: those with more contact seemed to perceive the sessions as more helpful and vice versa: *'[Practitioner] checks up, but if there's a problem, [practitioner] doesn't do much about it. So, basically, [practitioner] comes over for nothing, or [practitioner] checks up for nothing'.*

Theme 2: education and employment

Session activities or topics of conversation were predominantly around education and employment, and this was usually connected to the young person's goals. In a few instances, this included '*getting back into school*' after a period of absence, with the young person sometimes still waiting to be accepted by a new school. However, sometimes, there was just a check-in during sessions to see how things were going, as a young person described: '*I don't need really support for college*'.

Theme 3: social activities

Sessions sometimes had a socialising aspect to them. This included the practitioner talking with the young person about their interests or going on off-site trips to do different activities: *'Activity-wise is you go on trips and any activities they've got, I just go'.*

Theme 4: health and well-being

Some young people's sessions focused on their health or well-being, which included healthy relationships and sexual health: '*I don't really have problems with my mental state ... but they still check up on me and ask me if everything's fine', 'We sometimes talk about my mindset', and 'It's just asking questions and ticking what the good thing is, what's healthy and what's not healthy'.*

Young people's views on and experiences of the control intervention

Aspects that the young people liked about their sessions were that they were *'short and simple'*, close to or at home, and engaged them in meaningful activities (*e.g. 'my time is being spent wisely').* Aspects that the young people did not like so much included meetings being held in the morning, session content or conversations becoming *'repetitive'*, and seeing the session as not being particularly helpful (e.g. the practitioner not offering solutions to an issue).

Compared to previous support, the young people felt that their sessions were well organised *('they know what they're doing'*) or that the practitioner's *'bubbly'* personality made them more willing to meet with them. Sometimes, previous support was perceived as being more helpful than the current offer *(e.g. 'I could talk to [support worker] about anything ... basically, we built a friendship'*).

Most young people described their practitioners in positive ways. They were described as calm, nice, responsive, informative, and having good conversational skills. Body language and a positive personality were described as making the young person feel welcome.

The young people reflected on the relational aspects of their sessions, which included feeling understood, listened to, and connected with the practitioner. These aspects can facilitate trust and allow the young person to be more open, as indicated by this contrasting example: *'I never talk to him that much because I don't feel comfortable ... It's just like more about building a friendship first, I think'.*

The young people's experiences of working with their practitioner could be grouped into the three main themes described below:

Theme 1: getting to know the young person

The young people felt that the practitioners understood them individually and tried to get to know them by asking about their interests and meeting their families. Practitioners facilitated feeling understood by being

non-judgmental about the young person's background and previous behaviour (e.g. '*[Practitioner] understands where I'm coming from and the reason I done that offence or the reason why I'm here today ... I think [practitioner] understands my struggles and the people I'm surrounded with and my environment').*

Theme 2: opening up and feeling listened to

All the young people felt like the practitioners listened to them; however, not everyone felt like they could – or needed to – share information. For one young person, the barrier was a lack of relationship, leading them to feel uncomfortable, while another person did not see a need to share information: *'I don't need to tell [practitioner] anything because I'm not at risk'.* The young people indicated that practitioners needed to try to make them feel comfortable enough to be open, including having '*relaxed*' conversations, understanding their perspectives instead of just agreeing, not interrupting them, and offering support.

Theme 3: feeling connected

Building or having a connection with the practitioner was an essential component of enjoying the sessions and finding them useful. Some young people found it hard to explain why they found it easy to work with their practitioner (e.g. '*We clicked straight away'* and *'It wasn't awkward or anything ... we got on'*). It was felt that they could become more open with their practitioner after meeting more regularly.

Young people's perspectives on the practitioner's role in supporting change

The young people's perspectives on the practitioners' roles in supporting change through their sessions could be grouped into the three main themes described below.

Theme 1: introducing new tools and techniques

Practitioners engaged the young people in what they called *'consequential thinking'* or thinking about actions and their consequences and how to react differently in situations: *'Before I do anything, I think about what the consequences are'.* It is worth noting that consequential thinking also came up in interviews with the young people in the YC condition.

Relatedly, the young people worked on thinking about the future and learning about healthy versus unhealthy relationships. Using a goals worksheet was particularly helpful for envisioning pathways towards a goal: '*It made me think about things that I hadn't thought about, like in the sense that how you can map out and plan out things that you want to do in the future'.*

Theme 2: supporting education and employment

The young people spoke about significant issues with unemployment or being out of school: *'I didn't go to school ... and when I did go to school, they just piled me off to a different school that didn't touch my needs or anything*'. Practitioners supported the young people by recommending training opportunities, communicating with businesses, or working with schools and LAs to help them transition to new schools. The young people felt the practitioners were informative and helpful in their efforts, although they recognised when the solution was out of their hands (*'We haven't found a school yet, but that's more the council*').

Theme 3: supporting well-being and safety

The young people talked about their feelings and '*mindsets*' during sessions, which was not something they did often outside of sessions. They indicated that their practitioners were attuned to how they were feeling and could engage them in a conversation about it: *'[Practitioner] would bring it out of me. Yeah, [practitioner] would pick up on things if I'm worried or thinking about things. I don't know how'.* This made

them feel supported and less alone. Sometimes, the young person was also supported by other professionals working in mental health.

The practitioners were also helpful in keeping the young people safe and informed by following up with them concerning their interactions with other agencies.

Quantitative findings on the implementation of YC and BAU

To quantitively assess the implementation of YC and BAU, we collected process data from the practitioners through session workbooks. We note that this information is incomplete so far, with only 23% and 53% of the control and treatment practitioners having at least one session form completed, respectively. The low compliance with session workbook completion, particularly among teams in the control group, could relate to issues revealed by the qualitative analysis and discussed in terms of the lack of buy-in from control teams. It may also reflect that the BAU model might entail far less contact with young people than the intensively delivered YC programme, with a high incidence of zero meetings. The number of session forms for the treated and control young people is shown below in Figure 9 and indicates, for those with at least one session, that far more sessions took place under YC than under BAU.

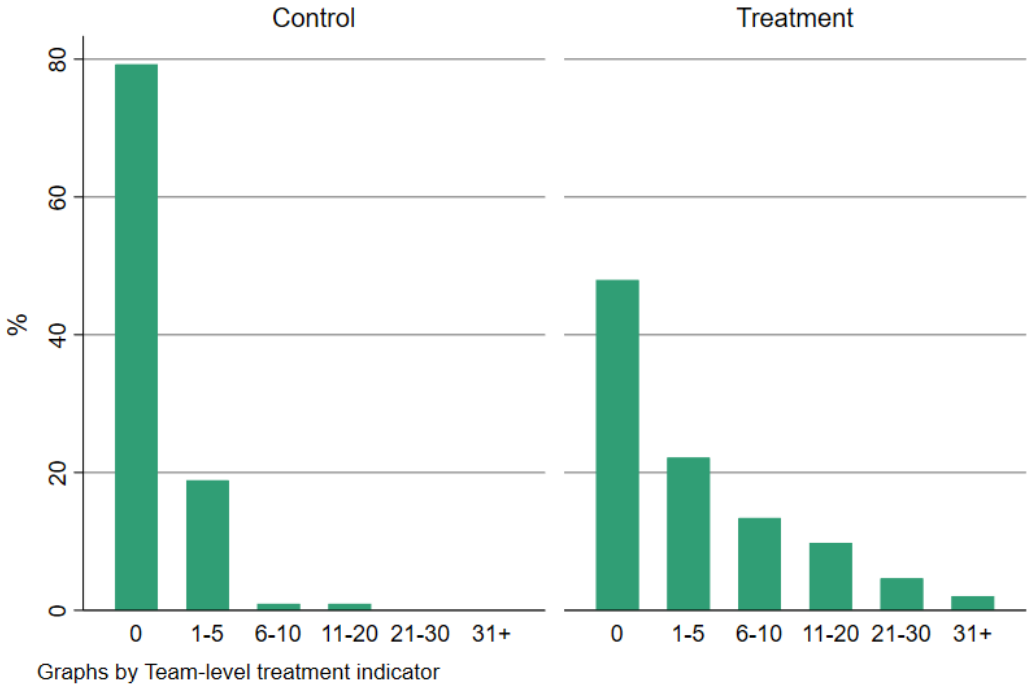


Figure 9. Number of Session Forms Completed by Control and Treatment

Narrowing in on treated young people for the sessions attended, the following figures break down the content of YC sessions. The lack of data meant that we did not do a parallel analysis for the BAU sessions. We see that many sessions covered relationship building and working towards and exploring goals. This appears well in line with the planned curriculum of the YC intervention.

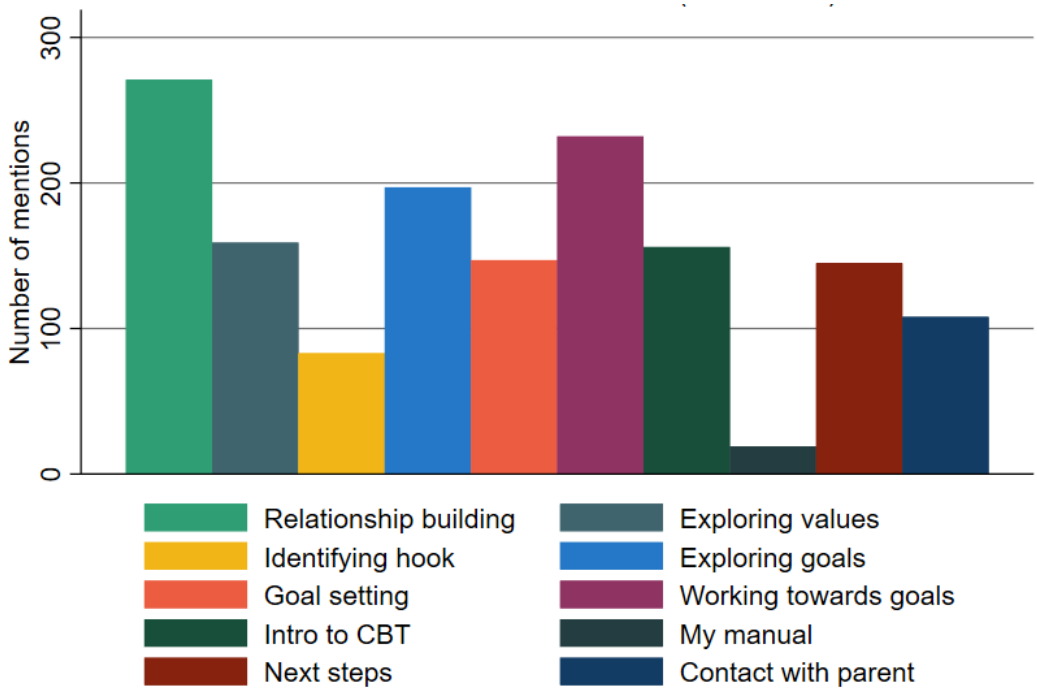


Figure 10. YC Session Content, Treated

Evaluation feasibility

Feasibility and acceptability of the evaluation design

Implementers' views on and experiences of the evaluation

Evaluation design

Implementers referenced the challenges associated with implementing an RCT design in this context in terms of managing ethical, logistical, and practical considerations, needing adequate funding, and obtaining buy-in from staff. They described addressing resistance and trying to make the value of this approach clear: *'Thinking about the ethical implications of not rigorously testing what we're doing with these young people, I think bringing that conversation to the table, I think, has been helpful*'. However, obtaining buy-in from staff, particularly in the control arm, was still felt to be challenging: *'I think there's something about them feeling a little bit more connected, particularly the control teams because they don't really get their role*'.

Recruitment

Implementers discussed difficulties in recruiting young people to take part in the evaluation, such as the short timeframe for recruitment and young people's uncertainty about their data being shared with the evaluation team:

> *Lots of people feel really unsure about that. They wonder what's going to happen with it. Does it identify them if they've been in trouble with the police or there has been any violence, domestic violence, all of those issues? People feel really unsettled.*

Evaluation materials

While the online and video materials about the evaluation were received positively by implementers, there were difficulties raised about the staff's capacity to complete all of the required evaluation work: *'We tried to sell it as "It's easy. It's quick. It's a dropdown list. It'll only take five minutes," but I know there has been … that's been difficult to get people to do consistently*'.

Suggestion for improvements

Implementers suggested that the evaluation could be improved in the following ways:

- Co-producing with LAs in terms of selecting and developing evaluation materials: *'Making sure that we have representation from our target group at the table and at decision-making stage, I think, rather than just, "What do you think of this?"'*.
- Ensuring that evaluation requirements fit with practitioners' workloads: *'I think it would have been nice if they could have just had that option to, rather than do it every session, maybe do it at the end of each week or at the end*'.
- Being able to use the evaluation materials as clinical tools: *'It would be really useful for them to be able to see their session logs when they went back on, to be able to see, to use those session logs themselves to monitor, "Well, what did I do last time? Have I entered this last note?"'*.
- Ensuring that control teams are appropriate comparators for the treatment team: *'You've got teams acting as controls who aren't necessarily appropriate, and then it's really hard to get their buy-in*'.
- Having one-to-one meetings with LAs, as well as regional meetings, to obtain buy-in: *'I think there's something about actually coming out and building up a relationship with a specified local authority*'.
- Measuring outcomes for staff, as well as the young people, and evaluating the impact of the training and supervision for staff: *'Not just the training, but what impact does the supervision and the observation and all these bits – what impact does that have on staff's confidence, on their knowledge, on their skill, on their practice?*'

What would implementers like to learn from the evaluation?

Implementers described wanting to learn about the evaluation outcomes and their use for future studies and wanting to show the value of the approach taken in the YC programme:

> *I would hope that the value that is placed on this additional activity, engaging people in different ways, not going down a traditional whatever psychotherapy, psychotherapeutic counselling model, and offering something different with practitioners that have got enhanced skills is, in lots of ways, a lot more useful ... because a lot of these families and lots of these young people would never, in a million years, work with CAMHS or voluntary sector counselling organisations in schools because there's still a lot of stigma'.*

Service managers' and allocators' views on and experiences of the evaluation

Allocators were typically service managers who were part of a multi-disciplinary panel. There was a high level of understanding by allocators of what YC and the evaluation were, including the role of randomisation of teams for training and for allocating the young people to teams. There was some question about certain eligibility criteria, such as whether family breakdown without violence was (or should be) eligible and whether the young people at the higher end of high-risk in the moderate-to-high-risk criterion were suitable, as living in highly unstable contexts would be a significant barrier to engagement.

An ongoing challenge was that not all teams could be trained and deliver YC; although, at the same time, interviewees did recognise the need for a control group: *'It's been a little frustrating that it's been quite slow, and I think there's a lot of push back on being the control group'.*

Being in the control condition, then, was described as impacting the team's understanding of the programme, the purpose of the evaluation, and its requirements, as there had been fewer opportunities to engage with corresponding staff:

I just think for the other teams who are not in the control group, they had the training quite quickly, and then they understood the programme better because they're doing it. They're doing the training. They see what they're trying to change, and I think, for my team, that's probably the gap that hasn't quite connected because they're not actually doing anything different, but they're then just getting a young person to be part of a research group but offering nothing alternative to what we normally do.

The ability of the managers and teams in the LYPS programme to discuss challenges and identify solutions locally was described as a facilitator to delivering the evaluation; for example, consistent team-meeting conversations about recruitment and why young people were not signing were identified as especially important in this process. A senior colleague observing a team member's YC session was helpful for quality assurance. The study website, with the materials readily available, was described as being very helpful. Outcome measures were described as challenging, as *'young people just don't like to do outcome measures that much. They don't see the value of it'*. There was some mention that the collection of outcome data competed with the delivery of services in terms of time..

Implementers, evaluators, and other colleagues or peers coming in to explain the programme was also described as an important facilitator to staff confidence in communicating the study to the young people. Without this, there appeared to be a lack of confidence speaking to young people about the evaluation, at least initially:

If the staff [youth practitioners] had done any training, maybe, I feel like they would have understood it better to sell it better, but because we were just like, 'These are the forms. Speak to young people', but they hadn't really got their heads around what they were offering. So, I feel like there might be a lack of confidence.

Meetings and communication with the implementers and evaluators were described as enabling a two-way conversation, and the LYPS team taking on and addressing feedback helped to show they were listening to staff on the ground:

I have been giving feedback. I mean, what is better, and it has got better as well, and they have, I think, people are more likely to own it and complete the evaluation if they see what the purpose of it is. Rather than it just being, 'Oh, [practitioner's] asking us to do x, y, or z again', you know. No, it's for a reason. And I do think, to be honest, one of the good things about what I've experienced so far is the evaluators have listened. [Implementer 2] and [Implementer 1] have been really open and listened. And they are, as much as they can, working in partnership with us and trying to work collaboratively.

(Treated) Young people's views on and experiences of the evaluation

Some young people were *'kind of excited'* and *'intrigued*' to be part of the study because of the prospect of receiving new activities and extra support. Others joined the study because their practitioner suggested it or thought that it would be good for the young person, but they did not share any reflections on this: *'I think I was told it was for research for young people, so I wanted to be a part of it because it would be helpful'.*

The young people recognised the study materials that were shown during the interview. Most young people remembered reading the information sheet and consent form, and everyone remembered completing the baseline questionnaire. The young people felt that the information sheet and consent form were clear, easy to understand, and easy to complete. They also felt that the questionnaire was '*straightforward*', understandable, easy, and quick to read and complete. Everyone also remembered watching the explainer video on the study, and one person felt that it was good at explaining what the study was about.

The young people had a range of responses to the question about randomisation in the study design. Some would like young people to *'have the choice'* to pick which group they are in or to be able to do both and see which they prefer. One felt *'lucky'* to be in the YC group because they felt they would not have liked being in the control group. Others were not sure how they felt or did not feel anything towards it. Some young people indicated that they did not necessarily fully understand this question.

None of the young people had issues with having their data stored and accessed in the way described to them in the interview. They were either happy, did not mind, did not care, or did not have feelings about it: *'It sounds safe, so I don't really care'* and '*It makes sense that they have all that information or else the research wouldn't make sense in the long run'.*

The young people generally had no suggestions for improving the study or study materials. Some felt that it was easy to take part in the study and that they had received enough information about it. One person suggested putting more tick boxes on the questionnaire but did not provide further details.

(Control) Young people's views on and experiences of the evaluation

When asked about their views on and experiences of the evaluation, the young people in the control group had some level of understanding of what the study was about or why it was conducted. One young person felt *'chosen'* because it was a good opportunity. The voucher was an influential factor in incentivising participation.

Most young people recognised the study materials (some of which were shown during the interview) or remembered completing the consent form (which was developed based on previous consent forms used in evaluations involving similar groups of young people, as well as through co-production with the LIIA, AFC, and IFS teams) and/or questionnaire. They felt that the study information sheet and questionnaire were clear, understandable, and quick and easy to complete. One young person reported that having the study materials read to them made it very easy to complete and suggested that this would be a better option for others as well. The young people generally did not suggest improvements to the study materials or to the study itself other than to have current participants recruit other young people to the study by word of mouth.

The young people were asked about their views on the randomisation aspect of the study, which prompted mixed responses. Some young people seemed confused about the question, were unsure about how they felt, or were fine with it. One young person felt that the young people should have a choice about which programme they were in, and another said they would not have a view unless they had experience with both of the interventions.

All but one young person appeared to understand the question about how their data was stored and indicated no issues with the outlined data management procedures. It was particularly important from the young people's perspectives that the data would be stored safely and securely, that it would not be linked back to them, and that it would be accessed by a limited number of people for research purposes: *'I think that's actually really cool ... I think I actually like that'.*

Adherence to and viability of the evaluation design

Throughout the pilot, we gathered qualitative information to complement the analysis of balance in the distribution of observed variables across treatment arms in assessing the LAs' adherence to the proposed evaluation design and the viability of the design to evaluate the impacts of YC on young people.

Leaving data collection and quality issues aside (see below for a full discussion), the robustness of the design hinges on the following criteria being met:

1. LAs adhere to the randomisation protocol. That is, LAs are training the teams that the evaluators have assigned to training. They are not training any of the practitioners in the control teams.
2. Young people assigned to control teams do not work with trained practitioners.
3. Young people are allocated across teams according to a process that is as good as random. This would likely take place in a system characterised by teams working at full capacity, where allocation to one team or another is determined by the team's existing caseload and team assignment in a recent spell for returning young people. It would also require that LAs not change their allocation process as a result of participating in the evaluation of YC, and that the resources in LAs can accommodate the more intense schedule of meetings required by YC.
4. Large numbers of young people consent to participate in the trial and for their data to be used in the evaluation exercise. Moreover, those giving consent are a representative sample of the group of young people receiving YC.

Below, we report the evidence we have gathered throughout the pilot on each of these three criteria:

Criterion 1: LA adherence to randomisation protocol

Table 7 compares the teams the LAs were supposed to recruit young people into for the YEF pilot trial with the team(s) the LAs actually recruited young people into. Each row in the table corresponds to one LA in London. Randomisation allocations communicated at the start of the pilot phase can be grouped into three types: Home Office randomised, YEF pilot randomised, and non-randomised.

Of the 31 LAs, 27 had teams randomised to the intervention and control arms during either the Home Office (five LAs) or YEF pilot phases (24 LAs, with two LAs having teams randomised in both phases). However, compliance with randomisation was low, with a substantial number of teams not following up to participate in the study for a variety of reasons, including that some that were randomised into teams did not attend training, some were wrongly selected from among teams that did not directly deal with the young people in the target group, and some dropped out of the trial and did not recruit (see details in Table 7).

Overall, only 13 of the 27 LAs had the randomised team trained, and both the treated and control teams participated in the trial. Among the other 14 LAs, one (10 LAs) or both (four LAs) of the randomised teams failed to participate in the trial and recruit young people. This resulted in some LAs recruiting into randomised control teams only (two LAs), while others recruited into randomised treated teams only (eight LAs). The higher participation rate of trained teams can be partly explained by a misunderstanding among LAs and control teams about the need to also recruit into that arm. This very limited compliance with the randomised allocation of teams severely compromised the validity of the randomisation.

Criterion 2: young people assigned to control teams do not work with trained practitioners

To evaluate adherence to Criterion 2, we asked allocators in the implementation survey about how often they would say that young people who were allocated to a team not trained in YC also worked with practitioners trained in YC. Their responses, shown in Figure 11, display some evidence that control observations may have been contaminated.

Table 7: Adherence to Randomisation Protocol in Pilot Trial

Data Source: Local Authority Workbooks

Protocol communicated to LAs	Implementation during pilot trial	Additional info
HO, T*, C*	HO	
HO, T*, C*	HO, T*, C*	
HO*, C*	C*	Based on HO randomisation
HO, T*, C*	T*, C*	Practitioners were allowing YP to choose whether to go into the control or treated team
HO, T*, C*	T*, C	Control recruited from non-randomised team
HO, T*, C*	T*	Originally randomised treated team no longer operating so YJS control team split into two and one half randomly selected for training
HO, T*, C*	T, C	Unsure whether randomisation was carried out as expected as LA unable to provide list of YP teams
HO, T*, C*	T, C	LA did not follow randomisation
HO*, T*, C*	HO*	
HO, T*, C*	T*, C*	
HO, T*, C*	T*, C*	
HO, T*, C*	T*, C*	
HO, T*, C*	T*, C*	
HO, C	C	Put forward two partially trained HO teams and one untrained team. Untrained team kept as non-rand control. One HO team randomly selected to be fully trained
HO, T, C	HO, T	Treated team randomly chosen from partially trained HO teams. Control team not chosen randomly.
HO*, C*	HO*, C*	Based on HO randomisations
HO*, C*	HO*	Based on HO randomisations
HO, C, T	HO, C, T	Four partially trained HO teams, one randomised to be fully trained, one randomised to stop delivering
HO, T*, C*	T*, C*	
HO, T*, C*	HO	
HO, T*, C*	HO, T*	
HO, T*, C*	C*	Treated team works with 18+
HO, T*, C*	T*, C*	
HO, C	T	Control group was not supposed to be trained yet
HO, T*, C*	HO, T*	
HO, T*, C*	HO, T*	
HO, T*, C*	HO, T*, C*	
HO, T*, C*	T*, C*	
HO*, T*, C*	HO*, T, C	LA did not follow randomisation (treated team was not treated)
HO, T*, C*	T*, C*	LA did not return YP-team matching so unsure if data collected from HO or T
HO, T*, C*	T*, C*	

Notes: Column (2) lists the teams planned to be included in the YEF pilot trial. Column (3) lists the teams that ended up recruiting participants in the pilot trial. Column (4) provides additional information on lack of adherence to pilot protocol in the LA. HO refers to team trained in Your Choice under the Home Office funding. T refers to a newly team trained in Your Choice under the YEFpilot. C refers to a control team in the YEF pilot. * indicate whether the team was randomised into treatment or control.

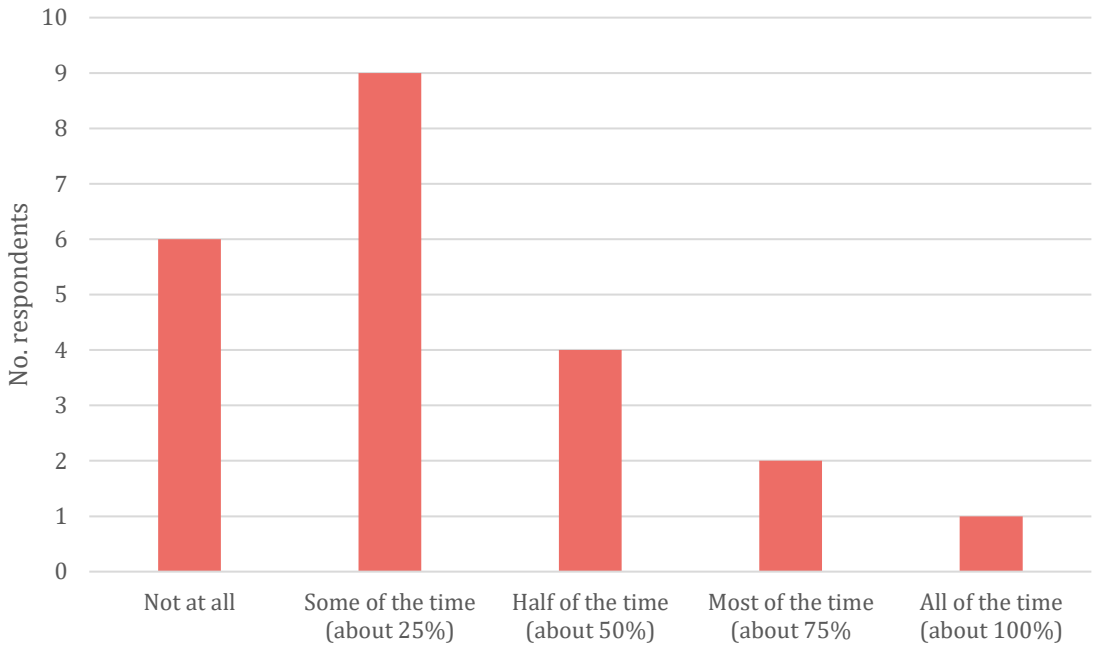


Figure 11. Frequency of Allocators' Responses to How Often They Expected Young People Allocated to a Control Team to Also Work With Practitioners Trained in YC

We can also tally these responses with the process data collected during the pilot. For those sessions for which process data is available, the next Figure shows the content of the sessions. Reassuringly, we do note that the vast majority of YC sessions were recorded to relate to YC. However, allocators reported that more than 30% of the young people in the control group met with YC-trained practitioners at least some of the time, and 23% of the control group sessions reported delivering YC. These two facts reflect a high incidence of non-compliance in delivering BAU, which, if confirmed, may strongly attenuate the effects of YC that can be estimated.

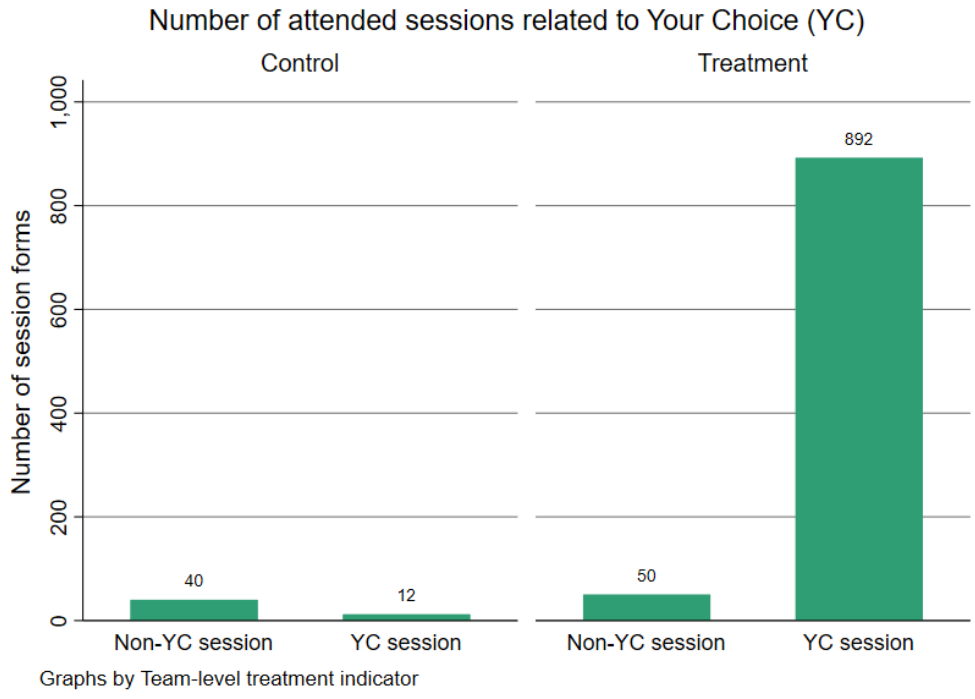


Figure 12. Number of Attended Session Related to YC, by Control and Treatment

Criterion 3: the allocation of young people to teams is as good as random

We aimed to learn about the process through which LAs allocated the young people to teams via qualitative interviews with allocators and an implementation survey for operation leads or service managers to fill in. Our findings from these two sources are summarised below.

Overall, 22 operational leads/service managers completed an anonymous survey about their experiences of allocating the young people to the YC or BAU team. The survey and interview responses are summarised below. The summaries focus on responses to the survey, with interview responses summarised where relevant; however, the questions were not the same in the survey and interviews.

Service managers/operational leads in charge of the allocation of the young people to a team of practitioners reported that the young people were screened for inclusion in the LYPS through the following processes:

- Screened by group leaders or in group supervision for programme eligibility.
- Screened by Youth Offending Service (YOS) managers or within the YOS team (e.g. after some initial work to build a relationship):
    - There was some mention of a greater expectation of staff to identify potentially eligible young people from their caseloads.
- Screened by members of this team using the MACE panel (or equivalent) or levels of risk from assessments.
- Screened during routine allocation meetings.
- Screened through other relevant services (e.g. Early Help and court) with which the young people have been in contact.
- Screened to ensure all young people in the service were eligible.

Interviewees described that allocation to teams trained in YC (or not trained) occurred by a manager - typically responsible for multiple teams - who had received the referral from, for example, MACE-type panels:

> *As new referrals came in, I would have a look at the reasons for the referral, and if they hit the, sort of, the Your Choice thing, I would give them to either unit one or unit two. So, unit one was the control, and unit two was the treatment team or delivery team, and then they would then try and get those young people signed up to the programme.*

Participants described the young people as being allocated to the teams in their service based on the following factors:

- The likelihood of co-operation and building a good relationship.
- A senior staff member's review of the capacity of teams.
- Whether or not they have previously attended sessions with a practitioner (especially within one year).
- The current staff caseload (e.g. the number of high-risk cases).
- The fit of the practitioner to meet the identified needs.
- The young person's choice of practitioner.
- A referral of a young person from a specific team being allocated to YC.

- The use of the control group to introduce the programme or the allocation of the young people to the control group if practitioners think they would benefit from YC but are not highly concerned about the young person's level of risk.
- The particular requirements of a case (e.g. court) or needs of the young person (e.g. neurodivergence, sexually harmful behaviours, mental health needs, or being on a waiting list for CAMHS [YC]).
- If via a school, the practitioner covering that school.

Some participants mentioned that all eligible young people were being allocated to YC. Similar to the survey responses, some interviewees described other factors that informed the allocation processes, such as the young person having a previous practitioner or particular needs of the young person or family.

> *If they've been in our service before, they'll be more likely to send them back to the same team because they've already got an established relationship. So, that's something that we sometimes look at. I do sometimes look at what are the needs of this family? Would they link better with a male worker or a worker from a different ethnic background or the same ethnic background? So, there are those other things that I look at.*

Still, there was an overall impression from the interviews that the allocation to teams trained in YC, or not trained, was done through processes similar to random: '*There has definitely been a couple that have gone to the control team that you would think that they would benefit from having Your Choice. But there wasn't any capacity within the Your Choice unit to take them, hence why they became a control young person'.*

We asked allocators how much information they might have on the young person at the time they make this decision. On this point, survey respondents consistently described a high level of knowledge – or available information – about a young person ahead of allocation, especially from social care or police records, assessments previously conducted by the YOS, their own records – if their team had previously worked with a young person – or their own assessment conducted at referral. Respondents mentioned that sometimes, they have little information about a young person, for example, if the referral is from the police or court and there has been less prior involvement with services.

We asked allocators to name the factors that they would take into consideration to allocate a young person to a practitioner or team of practitioners. The frequency of their responses is summarised in Figure 13. It should be noted that these reported factors may be in relation to allocating a young person to a practitioner after they have been allocated to a team, meaning they would not necessarily inform the allocation to a team trained in YC or to a team not trained.

In conclusion, there was a difference in the impressions from the analysis of the surveys and interviews, which may have been due to the interpretation of 'allocation'. In the surveys, allocation may have been interpreted as allocation to practitioners within a team, as many of the factors pertained to practitioners. In the interviews, allocation was discussed as allocation to teams of practitioners. The allocation in the evaluation design referred to how the young people were assigned to teams. The different impressions gathered for the qualitative analysis suggest that the allocation design was not always followed, a factor that compromised the evaluator's ability to assume that the allocation was 'as good as random'. Despite quantitative data showing no corroborating evidence of systematic differences in the composition of the two experimental groups, we discuss how we will further support LAs in ensuring adherence to the allocation design in the section 'Limitations and mitigation steps'.

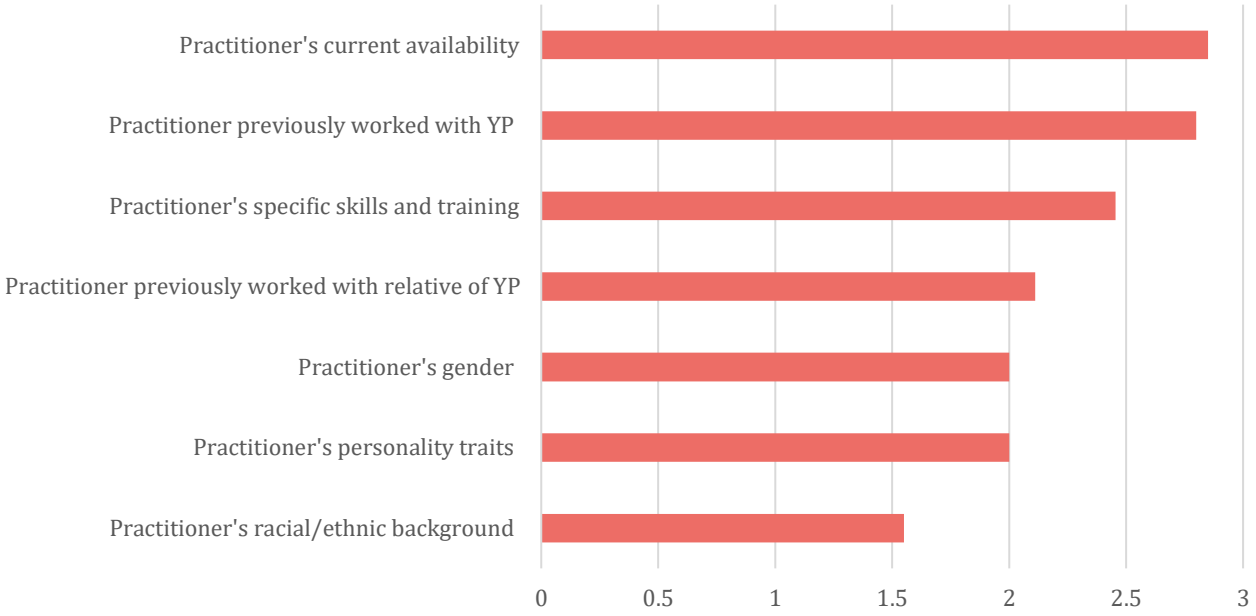


Figure 13. Importance of Different Factors in the Allocation Process of Young People to a Practitioner

Criterion 4: consent rates are sufficiently high, and the sample is representative of the target group

A big limitation on sample sizes so far – at least for the baseline data – has been the relatively lower-than-expected consent rates of young people for their data to be shared. Of course, only limited data exists for those who do not give consent to share their full data', so it is difficult to assess the representativeness of the consenting sample relative to the fully eligible sample of the young people who were assessed to be at medium or high risk. However, on the few characteristics that LAs were asked to provide about the young people they attempted to recruit but who did not consent to data sharing, the data strongly indicates that males and young people below the age of 16 are less likely to provide consent than females and young people aged 16 and above. For some young people, LAs provided an explanation for why they refused to consent. Reasons included young people being unable to participate (e.g. because they moved out of the borough), being unwilling to share data, or being uninterested in or not seeing the benefit of participating, as well as the parent being unwilling to allow the young person to participate. It is important to reiterate that this comparison is based on data from 13 LAs and, therefore, may not be entirely representative of the full sample of eligible young people who the practitioners attempted to recruit.

Further steps can be considered to increase consent rates – for example, by explaining to ensure that the purposes of the trial, the use of data (and to emphasise its anonymity), and the assurances provided in the consent forms are adequately conveyed to the young people. It might be that consent rates (the proportion of recruited young people among all who were invited to participate) have risen over the course of the pilot as practitioners gained experience in how to recruit young people but the data we have on the numbers of young people who were approached but not recruited is partial and does not allow us to confirm this.

Data quality

This section investigates the quality of the data collected for evaluation, looking in detail into the prevalence of missing data from the LA administrative records and presenting suggestive evidence of the quality of the SDQ data at baseline and endline, which are key outcomes for the study. Systematic evidence of the lack of data quality would compromise the reliability of an evaluation exercise.

Quality of LA administrative data (workbook data)

To assess the quality of the workbook administrative data, we looked at the incidence of missing information across the sample of 300 young people. Figure 14 shows how this measure of quality varies substantially by LA, with each row in the matrix corresponding to a different LA. It shows that some LAs provided near-full information for each young person they recruited (lighter rows), and others missed sharing close to 100% of the data (darker rows). We also documented variation by data type. The largest proportion of missing information occurred for the unique pupil number (UPN), unique learner number (ULN), and worker ID. While these identifiers would streamline linkages to the NPD data, they are not strictly required if names, date of birth, and, ideally, addresses are supplied; in other applications, the evaluation team has successfully linked survey data and NPD data using names, dates of birth, and postcodes only. For this reason, missing data on the date of birth, which affects 30% of our sample, is very concerning. LAs were not comfortable with sharing postcodes, so this variable was not included in the workbook.

Figure 14. Workbook Missing Data Heatmap

Quality of baseline survey data

SDQ

To assess the quality of our baseline survey data, we compared the distributions of emotional and behavioural difficulties, as measured by the SDQ, in our survey with the known population thresholds and the Millennium Cohort Study (MCS). The MCS is a nationally representative survey of children born in 2001–2002 across the UK, who have been followed every couple of years since they were nine months old. We focused on the age 14 survey, given the age range of our sample between ages 11 and 17.

Given the eligibility criteria for participating in the pilot, we expected the distribution of emotional and behavioural difficulties in the pilot sample to be heavily skewed towards a greater number of difficulties. This is what we show in Figure 16, which plots a histogram of the total difficulties scores: the total of all

items except the prosocial scale (the resultant score ranges from 0 to 40 and is counted as missing if one of the four component scores is missing). Figure 15 plots a similar histogram for the prosocial score. As expected, the distribution of prosociality in our pilot sample is heavily skewed to the left, while the distribution of the difficulties score is shifted to the right, indicating lower levels of prosocial behaviour and a higher incidence of externalising and internalising problems in the pilot sample than in the MCS age 14 sample.

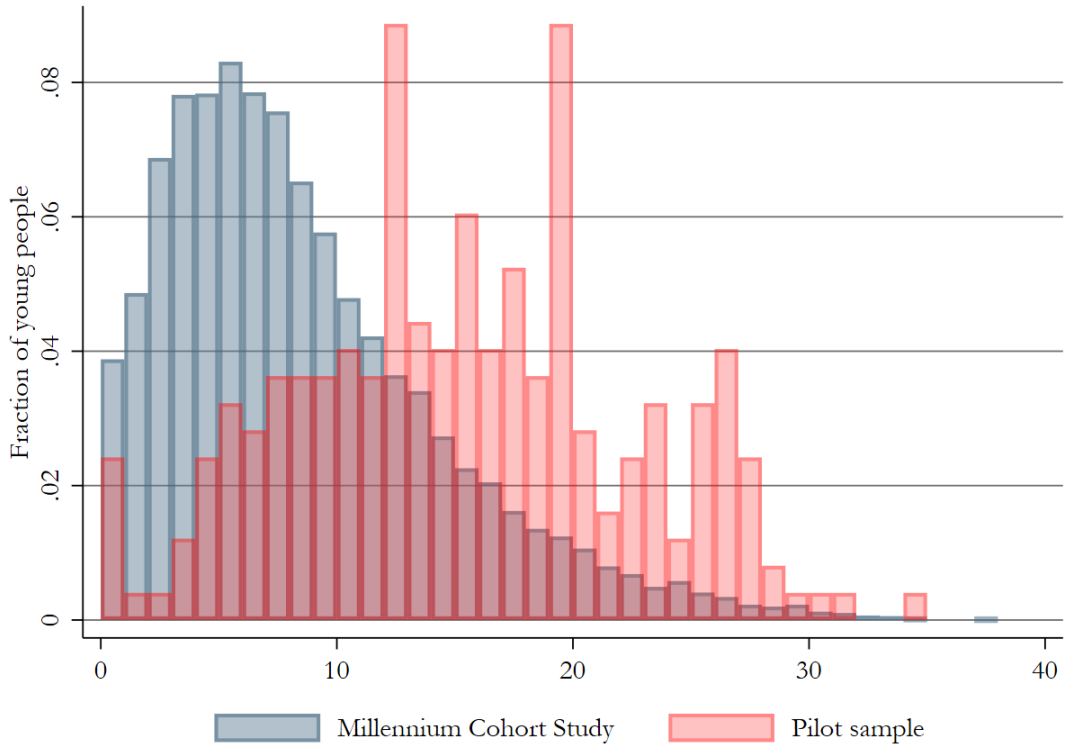


Figure 15. Distributions of SDQ Total Difficulties Score in the LYPS and in the MCS – Sample Age 14

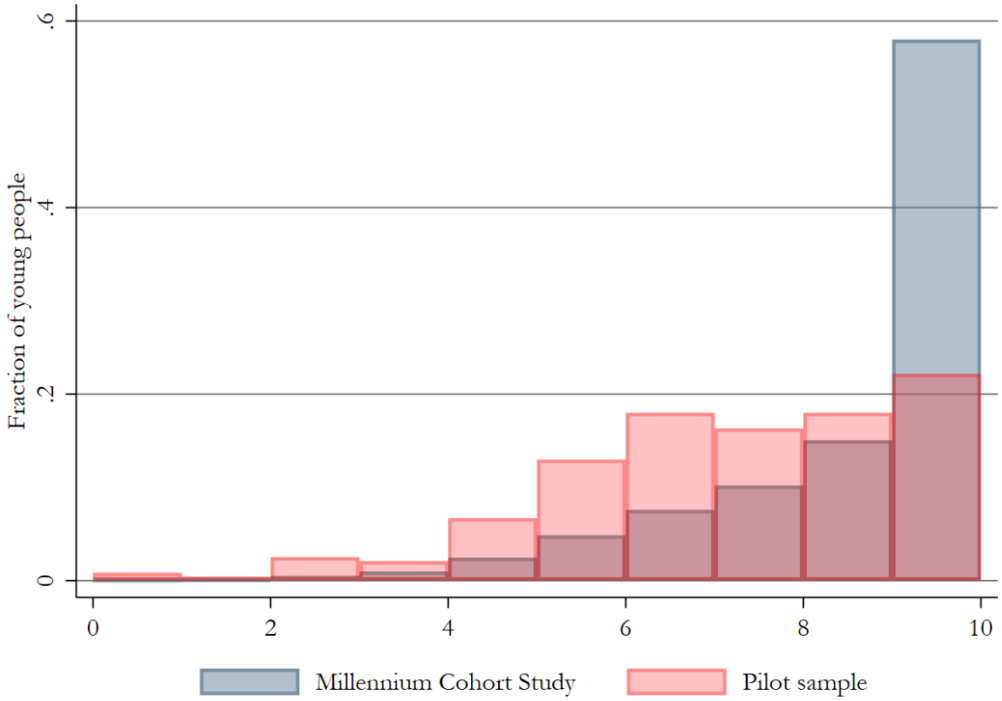


Figure 16. Distributions of SDQ Prosocial Score in the LYPS and in the MCS – Sample Age 14

While the SDQ is frequently used as a continuous score, it is also sometimes convenient to categorise scores. The initial bandings presented for the SDQ scores are normal, borderline, and abnormal. These bandings were defined based on a population-based UK survey, attempting to choose cut points such that 80% of children scored normal, 10% borderline, and 10% abnormal. In Figure 17, we compare the proportion of children in each of these three categories in our sample, in the population-based survey, and in the MCS. Note that the MCS tends to have higher proportions of children in the normal range than would be expected from the thresholds, which is likely reflective of the selective attrition that has occurred in MCS over time.

On the total difficulties score, the proportion of our sample scoring in the borderline and abnormal range is over twice as large as expected based on the thresholds and four times as large as in the MCS age 14 sample. The next two rows of Figure 18 show that this is largely driven by the high frequency of externalising problems: our sample is 3.4 times more likely to be in the abnormal range of conduct problems and four times more likely to be in the abnormal range of hyperactivity than we would expect to see in the UK population of 11–17-year-olds.

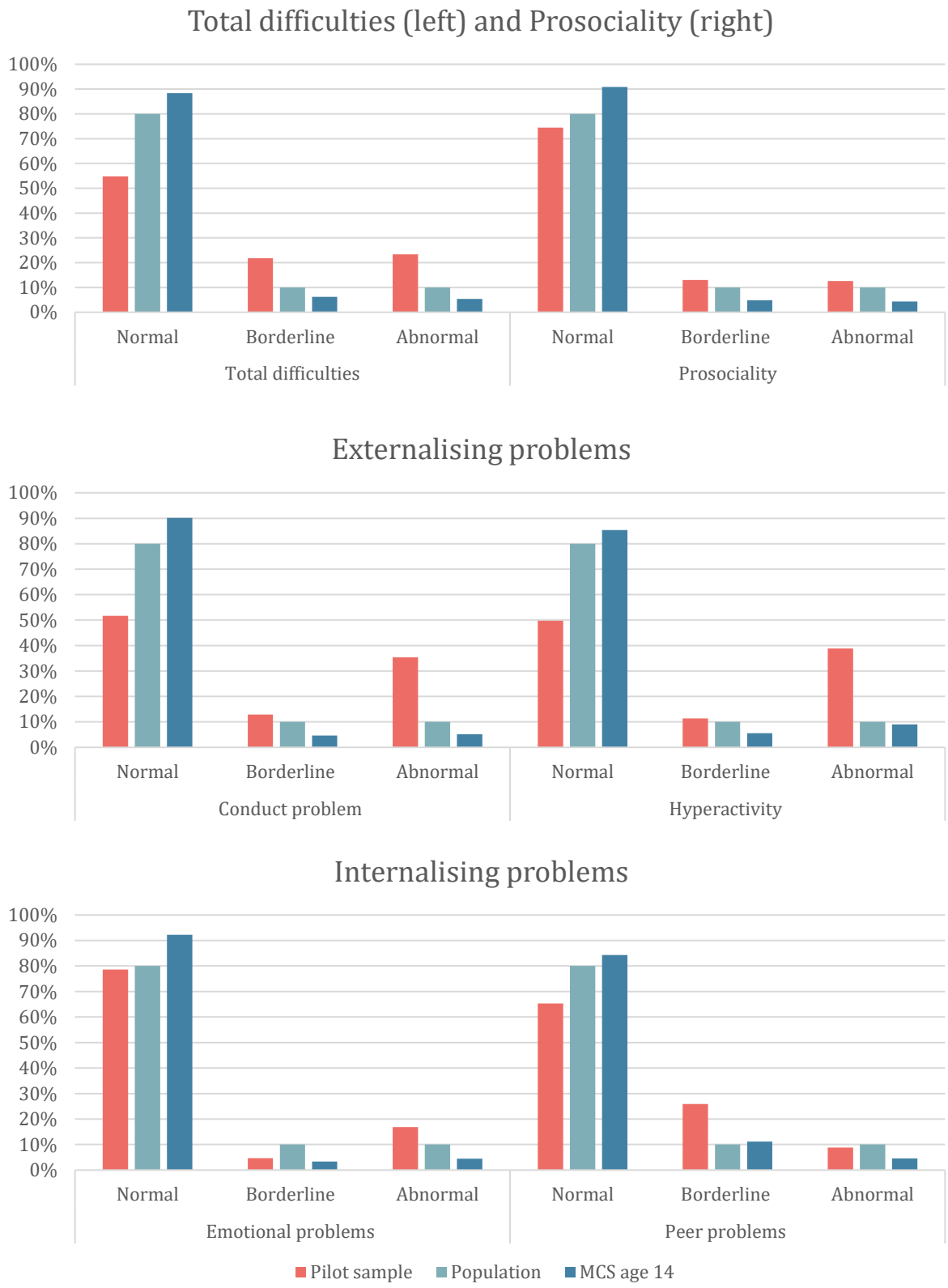


Figure 17. Proportion of Children in Normal, Borderline and Abnormal Range on Different Domains of the SDQ in the LYPS Pilot Sample, in the 11–17 Population and in the MCS

Finally, in Table 8, we report the correlation between the SDQ subdomains in our pilot sample and in the MCS. The correlations across domains are very similar in the two samples, thus providing confidence in the quality of the self-reported SDQ measure in our sample.

Table 8: Correlations in SDQ Domains in Pilot Dample vs MCS, Age 14

Data Source: Baseline Young People's Questionnaires and MCS age 14 wave

	Pilot sample				
	Conduct problems	Hyperactivity	Emotional problems	Peer problems	Prosociality
Conduct problems	1				
Hyperactivity	0.549	1.000			
Emotional problems	0.350	0.468	1.000		
Peer problems	0.138	0.230	0.361	1.000	
Prosociality	-0.288	-0.263	-0.083	-0.301	1.000

	Millennium Cohort Study Age 14 sample				
	Conduct problems	Hyperactivity	Emotional problems	Peer problems	Prosociality
Conduct problems	1				
Hyperactivity	0.546	1.000			
Emotional problems	0.367	0.350	1.000		
Peer problems	0.361	0.342	0.490	1.000	
Prosociality	-0.462	-0.369	-0.190	-0.297	1.000

Validation of the newly constructed scale to measure perceptions of safety

We investigated the internal and external consistency of the self-reported and the practitioner version of Checkpoint, the newly constructed scale to measure the perception of risky behaviour. The internal consistency of both versions is high: the Cronbach alpha is 0.81 for the self-report version and 0.89 for the practitioner version, both higher than the 0.7 threshold used to indicate satisfactory internal consistency.

To further assert the internal consistency of the two versions of the scale, we also ran an exploratory factor analysis (EFA) before running a confirmatory factor analysis (CFA). To do this, we split the sample into two random subsamples and ran the EFA on one subsample and the CFA on the other subsample. In both versions of the scale, there is clearly one eigenvalue above 1, which is strongly indicative that the co-variation between the items of the scale can be well explained by one underlying construct (Kaiser, 1960; see Figure 18).

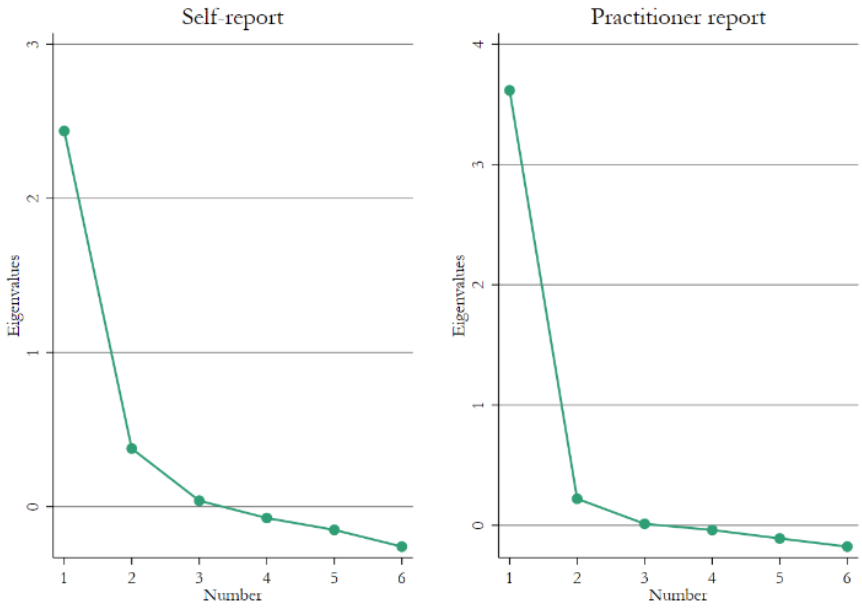


Figure 18. Eigenvalues of the Correlation Matrix of Six Items in the Self-report and Practitioner Versions of Checkpoint

Building on the results of the EFA, we ran a CFA with one factor using the other subsample. Figure 19 shows the density of the factor score predicted for the self-report version (left) and the practitioner version (right) of the scale. The distributions of factor scores obtained from the CFA are very highly correlated with a total score obtained by averaging scores across the six items (correlation coefficient = 0.96 for the self-report and 0.99 for the practitioner version). Therefore, for simplicity, we used the latter throughout our analyses.

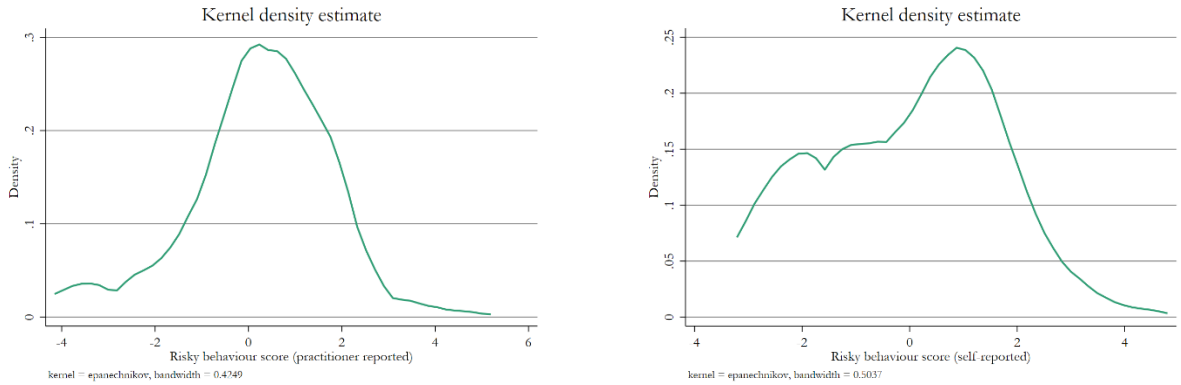


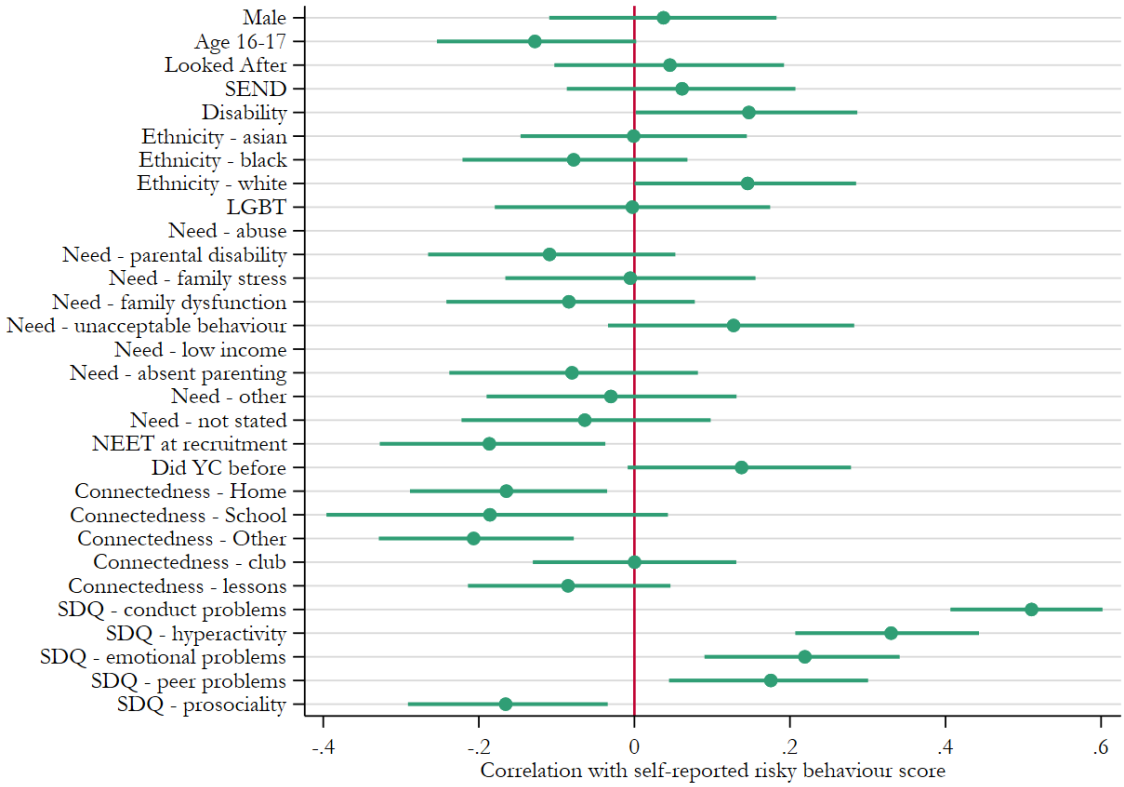
Figure 19. Kernel Densities of Factor Scores Measuring Young People's Risk From the Self-report (left) and the Practitioner (right) Versions of Checkpoint

We then investigated the external validity of the data. Figure 20 reports the bivariate correlations between the characteristics of the young person and the risky behaviour score – self-reported (top figure) and reported by the practitioner (bottom figure). These characteristics include demographic characteristics, as well as baseline survey measures of social connectedness and emotional and behavioural difficulties (from the SDQ).

Our measure of self-reported risk assessment is significantly lower for those aged 11–16 (so away from the top end of the age range of youth in the pilot study) and is significantly higher for those with disabilities, from a white background, and for those who lack supportive environments at home or from other sources.

Practitioner assessments of risk are significantly higher for male youth, those with special education needs/disabilities, and those whose most relevant primary need was identified as socially unacceptable behaviour.

The last five lines of each Figure show the correlations between the risky behaviour scores and the SDQ scores on each of the five domains. Self-reported assessments of risky behaviours are all positively correlated with all externalising and internalising domains of the SDQ and negatively correlated with the prosocial score. The positive correlations are stronger with the externalising score of the SDQ than they are with the internalising score of the SDQ, which is what we would expect. Patterns are similar for the practitioners' risk assessment, with the exception of the internalising domains of the SDQ, which are negatively correlated with risk assessment (though not statistically significantly).



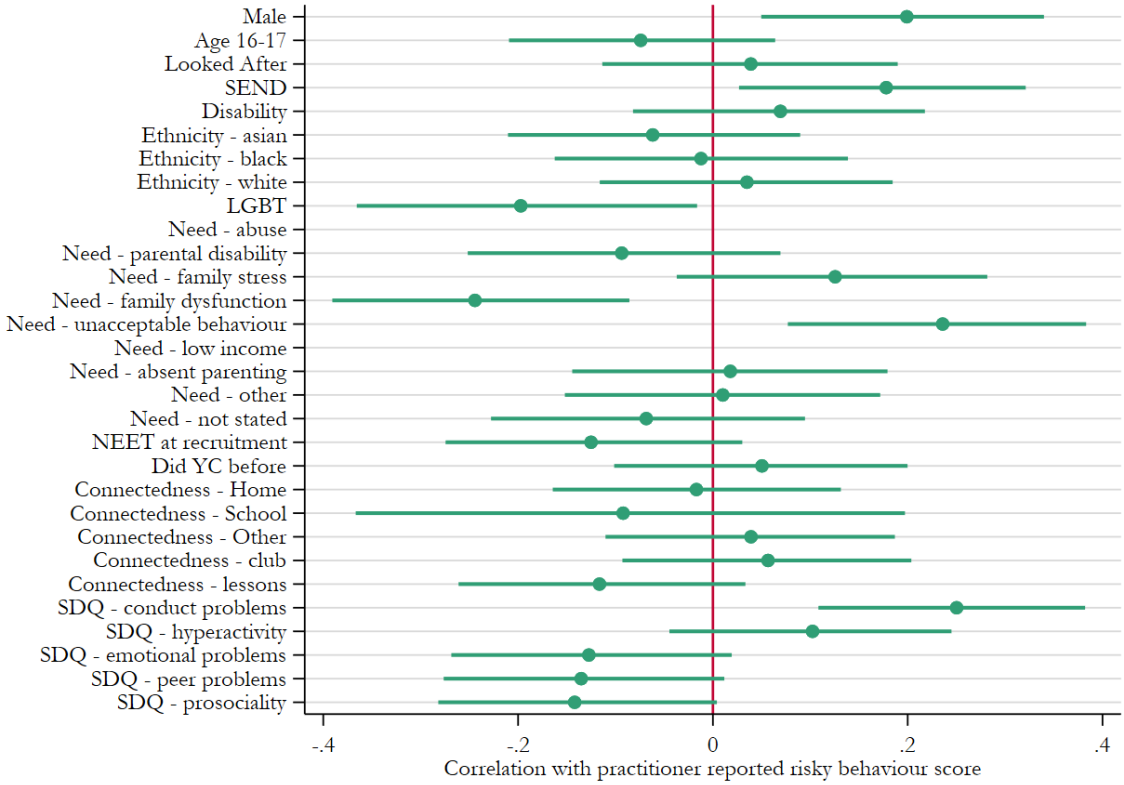


Figure 20. Correlation in Risky Behaviour Scores with Young Person Characteristics

Our baseline surveys of the young people and practitioners are designed to support the comparison of their risk assessments. As shown in Figure 21, the self-reported and practitioner-reported assessments of the same young person's risk are positively correlated (correlation coefficient = 0.4).

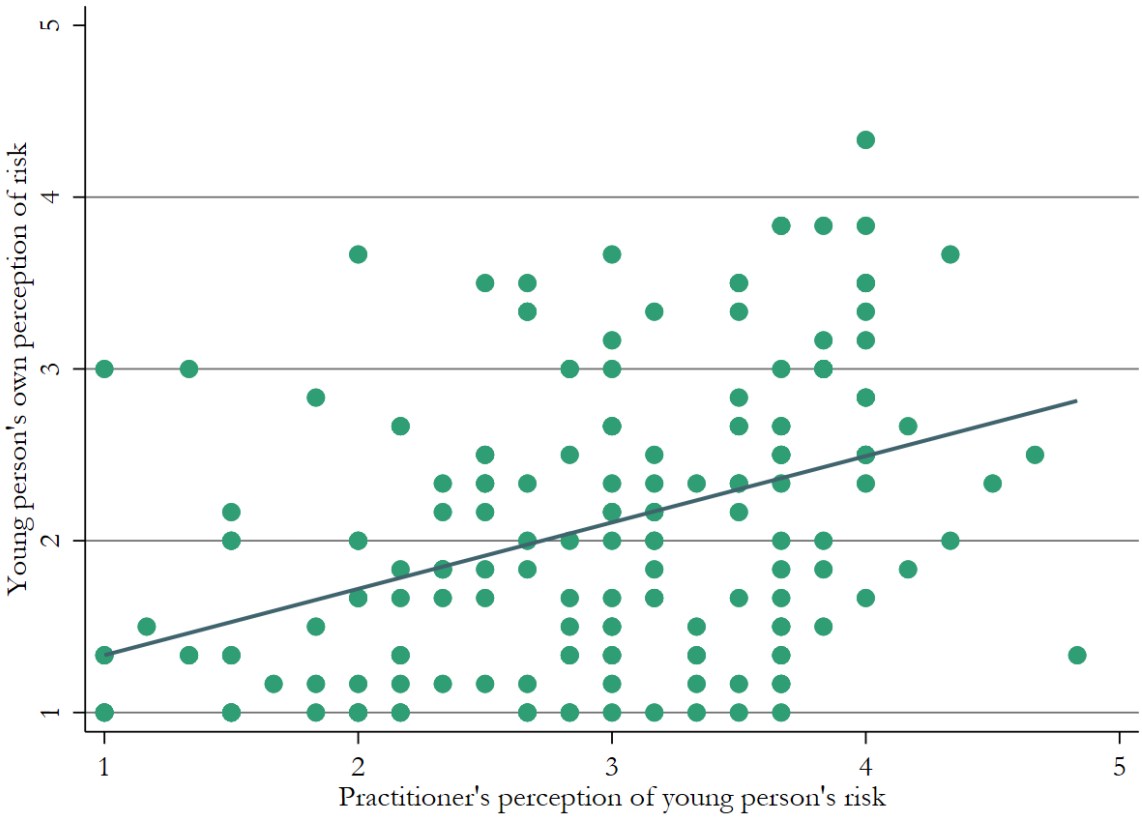
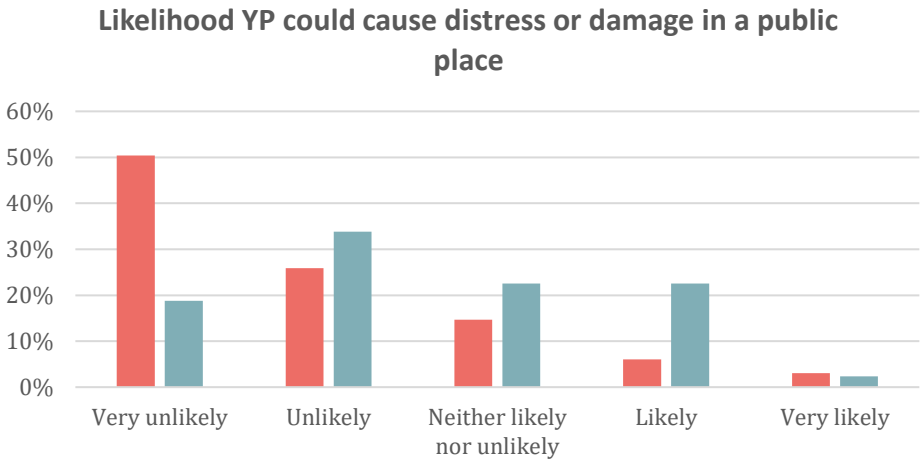


Figure 21. Scatter Plot (dots) and Fitted Line (straight line) of the Relationship Between Total Risk Scores as Reported by the Young Person and by Their Practitioner

Across most items, we find practitioners reported a systematically higher likelihood that young people would engage in risky behaviours than the young people reported. We provide a few illustrative examples in Figure 22.



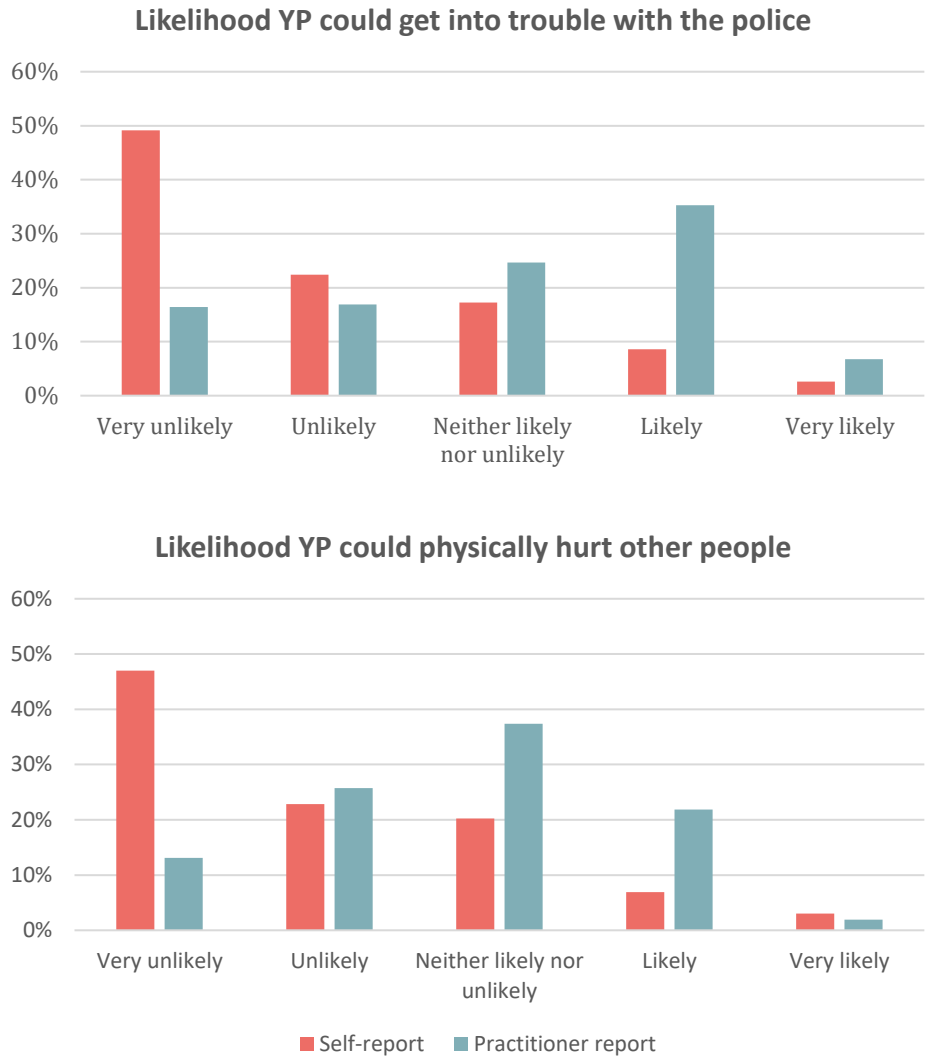


Figure 22. Young Person's and Practitioner's Risk Assessments[6]

The overall differences in reports – between the practitioner and the young person – are shown in Figure 23 for all six dimensions of the risk assessed. It is clear that young people tended to report lower risks than practitioners, but exact agreement happened frequently, and there are fewer cases where the young person reported higher risk than that perceived by the practitioner.

[6] In the figure, 'YP' stands for 'young people'.

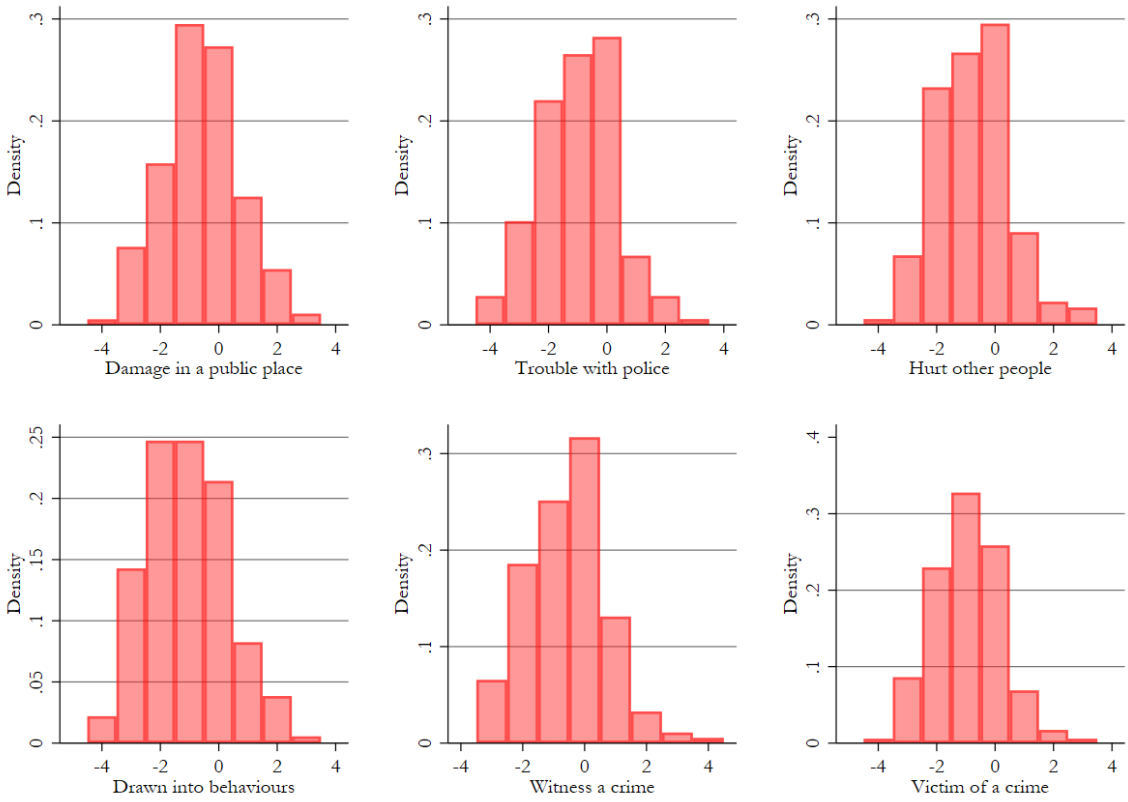


Figure 23. Difference in Risk Assessments Between Practitioners and Young People

Quality of the endline survey data

The endline data is far too limited in the number of data points to assess its quality. As described earlier, despite 300 young people in the pilot at baseline, only 50 endline questionnaires have so far been completed. Additionally, the survey has been sent to 17 young people for them to complete alone, and nine more data collection sessions have been scheduled for subsequent weeks.

Figure 24 shows the completion rates by weeks since recruitment. Even accounting for the fact that the YC intervention takes 12 to 18 weeks to run from recruitment, there remains a large shortfall of endline surveys being completed relative to what is expected given the recruitment dates and what is required for the successful completion of the pilot. Among the young people who were recruited 20 to 30 weeks ago, the completion rate is 28.5%. This is substantially lower than the completion rate among the young people who were recruited more than 30 weeks ago, which is 68%. The low completion rate is primarily due to a lack of response or a delay in response from the practitioners to requests about arranging an endline data collection session – as can be seen from the Figure, only for week 22 since recruitment has there been a 100% completion rate. On the other hand, for weeks 12–17, the delayed response rate is 100%. Out of all the young people recruited, eight young people have refused to participate in the endline survey, and one young person has been in care and remains unavailable for data collection.

It is important to note that getting the completion rate up to its current level among the young people who were recruited more than 20 weeks ago is extremely time-intensive on the research team, as it requires repeated follow-up contacts with practitioners and SPOCs. To actively improve the survey completion rate, several steps have already been taken. First, the SPOCs for each LA have been requested to encourage their practitioners to schedule sessions for the young people they support with peer researchers. Second, to

simplify the arrangement of the data collection meeting, we have introduced a new booking platform called Calendly, which enables practitioners to directly book/reschedule a meeting between the young person and one of our researchers to complete the endline survey without the need for constant email correspondence between the practitioner and evaluation team. So far, the new booking system appears to have increased the frequency of data collection meetings booked in a given week.

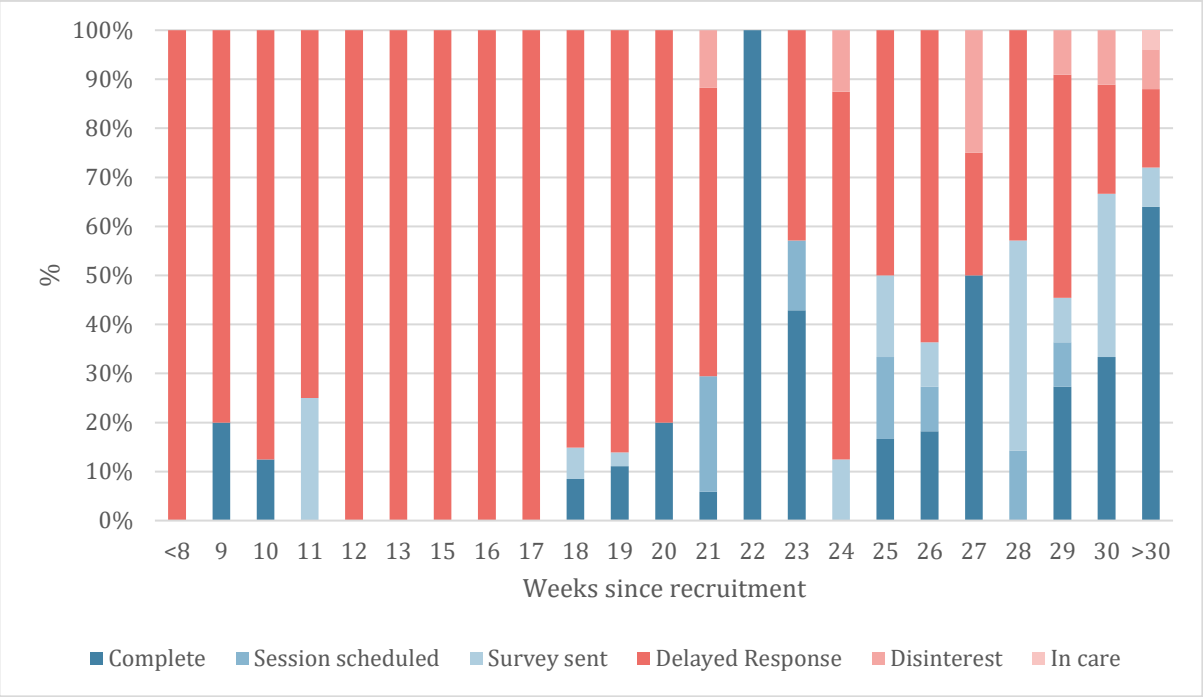


Figure 24. Completion Rate of Endline Surveys, by the Number of Weeks Since Recruitment

Likely sample size required for main stage analysis

Tables 9 and 10 report the likely sample size per arm required for the analysis of continuous and discrete outcomes, respectively. For continuous outcomes, we present the power calculations, assuming one baseline covariate is controlled in the model. For each set of power calculations, we make assumptions about the proportion of the individual outcome variance explained by the covariates (in the continuous outcomes case), the outcome's intra-cluster correlation, the number of young people per cluster, or the number of clusters. We cluster at the team level.

In the efficacy trial, possible outcomes of interest would include, in order of preference:

- An indicator for offending based on the PNC data, focusing specifically on the event of arrest to capture serious offences.
- The (continuous) total score on the SDQ and/or the (continuous) total score on sub-domains of the SDQ.

The use of PNC data to assess the effects of YC on offending behaviours will necessarily carry delays in the delivery of the findings beyond the initially planned timescale for the efficacy trial. That is because there is a six-month lag for the delivery of that data, and allowing time for the effects to build up after treatment also requires more time after the end of the delivery period. There is also a risk that the information needed to allow for the linkage is not provided for all participants. LA's have been particularly slow in sharing the

young people's UPNs and workbooks, an issue that needs to be addressed in preparing for an eventual efficacy trial.

Table 9: Power Calculations, Continuous Outcomes

Total sample size per arm and number of individuals per cluster to detect MDE between 0. and 0.4 on a continuous outcome

Source: McConnell and Vera Hernández (2015) calculator

				Total Sample Size per Arm To Detect Minimum Effect Size Of:												Number of Individuals Per Cluster To Detect Minimum Effect Size Of:											
Proportion of individual level variance explained by covariate	Proportion of cluster level variance explained by covariate	Intra-Cluster Correlation (ICC)	Number of clusters	0.20	0.21	0.22	0.23	0.24	0.25	0.26	0.27	0.28	0.29	0.30	0.40	0.20	0.21	0.22	0.23	0.24	0.25	0.26	0.27	0.28	0.29	0.30	0.40
0	0	0.05	30	1,195	907	724	598	506	436	381	337	301	271	245	116	40	30	24	20	17	15	13	11	10	9	8	4
0	0	0.05	40	770	638	541	467	408	361	322	290	263	239	219	109	19	16	14	12	10	9	8	7	7	6	5	3
0	0	0.05	50	635	542	470	413	366	327	295	268	244	224	206	106	13	11	9	8	7	7	6	5	5	4	4	2
0	0	0.05	60	568	492	432	383	342	308	279	254	233	214	198	103	9	8	7	6	6	5	5	4	4	4	3	2
0	0	0.1	30					4,260	1,755	1,089	781	604	489	408	138	-	34	-	48	-	85	-	385	142	58	36	26	20	16	14	5
0	0	0.1	40		3,773	1,780	1,147	836	652	530	444	380	331	291	121	#####	94	45	29	21	16	13	11	9	8	7	3
0	0	0.1	50	1,810	1,195	881	691	564	473	405	353	311	277	249	113	36	24	18	14	11	9	8	7	6	6	5	2
0	0	0.1	60	1,073	821	659	546	464	400	350	310	277	250	227	108	18	14	11	9	8	7	6	5	5	4	4	2
0	0	0.15	30										4,846	1,579	175	-	11	-	12	-	14	-	16	-	19	-	25	-	34	-	55	-	162	162	53	6
0	0	0.15	40						6,483	1,898	1,094	760	577	462	137	-	17	-	21	-	29	-	46	-	123	162	47	27	19	14	12	3
0	0	0.15	50			39,538	2,811	1,427	943	697	548	449	378	325	122	-	34	-	69	-	791	56	29	19	14	11	9	8	6	2
0	0	0.15	60	146,548	3,236	1,598	1,044	767	601	490	411	352	307	271	113	####	54	27	17	13	10	8	7	6	5	5	2
0.15	0.15	0.05	30	773	623	517	439	379	332	294	263	237	215	196	96	26	21	17	15	13	11	10	9	8	7	7	3
0.15	0.15	0.05	40	568	482	416	363	321	286	258	233	212	194	178	91	14	12	10	9	8	7	6	6	5	5	4	2
0.15	0.15	0.05	50	490	424	372	329	294	265	240	218	200	184	169	88	10	8	7	7	6	5	5	4	4	4	3	2
0.15	0.15	0.05	60	449	393	348	310	278	252	229	209	192	177	164	87	7	7	6	5	5	4	4	3	3	3	3	1
0.15	0.15	0.1	30			5,271	1,813	1,076	755	577	463	384	327	283	109	-	69	-	213	176	60	36	25	19	15	13	11	9	4
0.15	0.15	0.1	40	2,131	1,247	869	659	527	436	369	318	279	247	221	98	53	31	22	16	13	11	9	8	7	6	6	2
0.15	0.15	0.1	50	960	726	579	477	404	347	304	268	239	215	195	92	19	15	12	10	8	7	6	5	5	4	4	2
0.15	0.15	0.1	60	702	568	474	403	349	306	271	243	219	199	181	89	12	9	8	7	6	5	5	4	4	3	3	1
0.15	0.15	0.15	30								3,059	1,257	781	561	129	-	13	-	16	-	19	-	24	-	34	-	60	-	268	102	42	26	19	4
0.15	0.15	0.15	40				7,412	1,856	1,042	715	539	430	355	301	107	-	26	-	40	-	99	185	46	26	18	13	11	9	8	3
0.15	0.15	0.15	50		3,558	1,532	960	691	535	433	361	308	268	235	97	-	273	71	31	19	14	11	9	7	6	5	5	2
0.15	0.15	0.15	60	1,897	1,133	797	608	487	404	342	296	259	230	206	91	32	19	13	10	8	7	6	5	4	4	3	2
0.3	0.15	0.05	30	636	513	426	362	313	274	242	217	195	177	161	79	21	17	14	12	10	9	8	7	7	6	5	3
0.3	0.15	0.05	40	468	397	342	299	264	236	212	192	175	160	147	75	12	10	9	7	7	6	5	5	4	4	4	2
0.3	0.15	0.05	50	404	349	306	271	242	218	197	180	164	151	139	73	8	7	6	5	5	4	4	4	3	3	3	1
0.3	0.15	0.05	60	370	324	286	255	229	207	189	172	158	146	135	71	6	5	5	4	4	3	3	3	3	2	2	1
0.3	0.15	0.1	30			4,341	1,493	886	622	475	381	316	269	233	90	-	56	-	176	145	50	30	21	16	13	11	9	8	3
0.3	0.15	0.1	40	1,755	1,027	715	543	434	359	304	262	230	203	182	81	44	26	18	14	11	9	8	7	6	5	5	2
0.3	0.15	0.1	50	790	598	477	393	332	286	250	221	197	177	161	76	16	12	10	8	7	6	5	4	4	4	3	2
0.3	0.15	0.1	60	578	468	390	332	287	252	224	200	180	164	149	73	10	8	7	6	5	4	4	3	3	3	2	1
0.3	0.15	0.15	30								2,520	1,035	643	462	106	-	11	-	13	-	16	-	20	-	28	-	49	-	220	84	35	21	15	4
0.3	0.15	0.15	40				6,104	1,528	858	589	444	354	292	248	88	-	21	-	33	-	82	153	38	21	15	11	9	7	6	2
0.3	0.15	0.15	50		2,930	1,262	791	569	440	356	297	254	220	194	80	-	225	59	25	16	11	9	7	6	5	4	4	2
0.3	0.15	0.15	60	1,562	933	656	500	401	332	282	244	214	189	169	75	26	16	11	8	7	6	5	4	4	3	3	1

Table 10: Power Calculations, Binary Outcomes

Minimum number of clusters per arm to detect impacts on binary outcome

Source: McConnell and Vera Hernández (2015) calculator

Number of people per cluster	ICC	Probability of outcome in control group	Minimum number of clusters per arm required to detect impact size of: 5%	10%	15%	20%	21%	22%	23%	24%	25%	26%	27%	28%	29%	30%
10	0.05	0.3	2,154	545	245	139	127	115	106	97	90	83	77	72	67	63
20	0.05	0.3	1,448	367	165	94	85	78	71	65	60	56	52	48	45	42
10	0.1	0.3	2,822	714	321	182	166	151	139	128	118	109	101	94	88	82
20	0.1	0.3	2,154	545	245	139	127	115	106	97	90	83	77	72	67	63
10	0.15	0.3	3,490	884	397	226	205	187	172	158	146	135	125	117	109	102
20	0.15	0.3	2,859	724	325	185	168	153	141	129	119	111	103	96	89	84
10	0.05	0.4	1,376	346	154	87	79	72	66	61	56	52	48	44	41	39
20	0.05	0.4	925	233	104	59	53	48	44	41	37	35	32	30	28	26
10	0.1	0.4	1,803	453	202	114	104	94	86	79	73	68	63	58	54	51
20	0.1	0.4	1,376	346	154	87	79	72	66	61	56	52	48	44	41	39
10	0.15	0.4	2,230	561	250	141	128	117	107	98	90	84	77	72	67	63
20	0.15	0.4	1,827	459	205	116	105	96	87	80	74	68	63	59	55	51
10	0.05	0.5	909	226	100	56	50	46	42	38	35	33	30	28	26	24
20	0.05	0.5	611	152	67	37	34	31	28	26	24	22	20	19	17	16
10	0.1	0.5	1,192	297	131	73	66	60	55	50	46	43	39	37	34	32
20	0.1	0.5	909	226	100	56	50	46	42	38	35	33	30	28	26	24
10	0.15	0.5	1,474	367	162	90	82	74	68	62	57	53	49	45	42	39
20	0.15	0.5	1,207	301	133	74	67	61	56	51	47	43	40	37	34	32

Below, we justify our best estimate of the parameters needed for power calculations in both cases.

Parameter	Best estimate	Justification
Case 1: Binary outcome (offending)		
Likelihood of the outcome in the control group at endline	40%	Estimate from LA SPOCs of the proportion of study participants having a PNC record at baseline: 60% (n = 2) The likelihood of any active risky behaviour at endline: 37% The proportion of study participants supported by Youth Justice Services: 29%
Intra-cluster correlation (ICC)	0.05–0.10	The ICC of the risky behaviour scale in the baseline survey: 0.10 (all items), 0.08 (first three items), and 0.05 (last three items)
Number of individuals per cluster	20	At the time of writing, based on LA surveys about plans for efficacy, we estimate a maximum of 22.5 participants on average in the efficacy trial. We discount this number by 10% to account for delivery issues.
Case 2: Continuous outcome (SDQ continuous score)		
ICC	0.10–0.15	We estimate the ICC for SDQ scores in the baseline survey data to be 0.13 (total score), 0.05 (peer), 0.07 (emotion), 00.13 (conduct), and 00.18 (hyper)
Number of clusters per arm	50	At the time of writing, based on LA surveys about plans for efficacy, we estimate 112 teams to potentially participate in the pilot (116 if 18-year-olds are included). We discount this number by 10% to account for delivery issues
The proportion of individual-level and cluster-level variance explained by covariate(s), if any	15% and 15%	The adjusted R-squared of regression of the endline SDQ on the baseline SDQ is 31%. The adjusted R-squared of regression of the endline SDQ on the residual of the regression of the baseline SDQ on team fixed effects is 12%

Under these assumptions, we summarise the likely sample size required to detect effect sizes between 10% and 30% of the probability of offending in the control group and effect sizes between 0.2 and 0.3 of a standard deviation of the SDQ score in the control group in the Figures below. We later describe the sample sizes we expect to be able to achieve in an efficacy trial, given the current information provided by LAs.

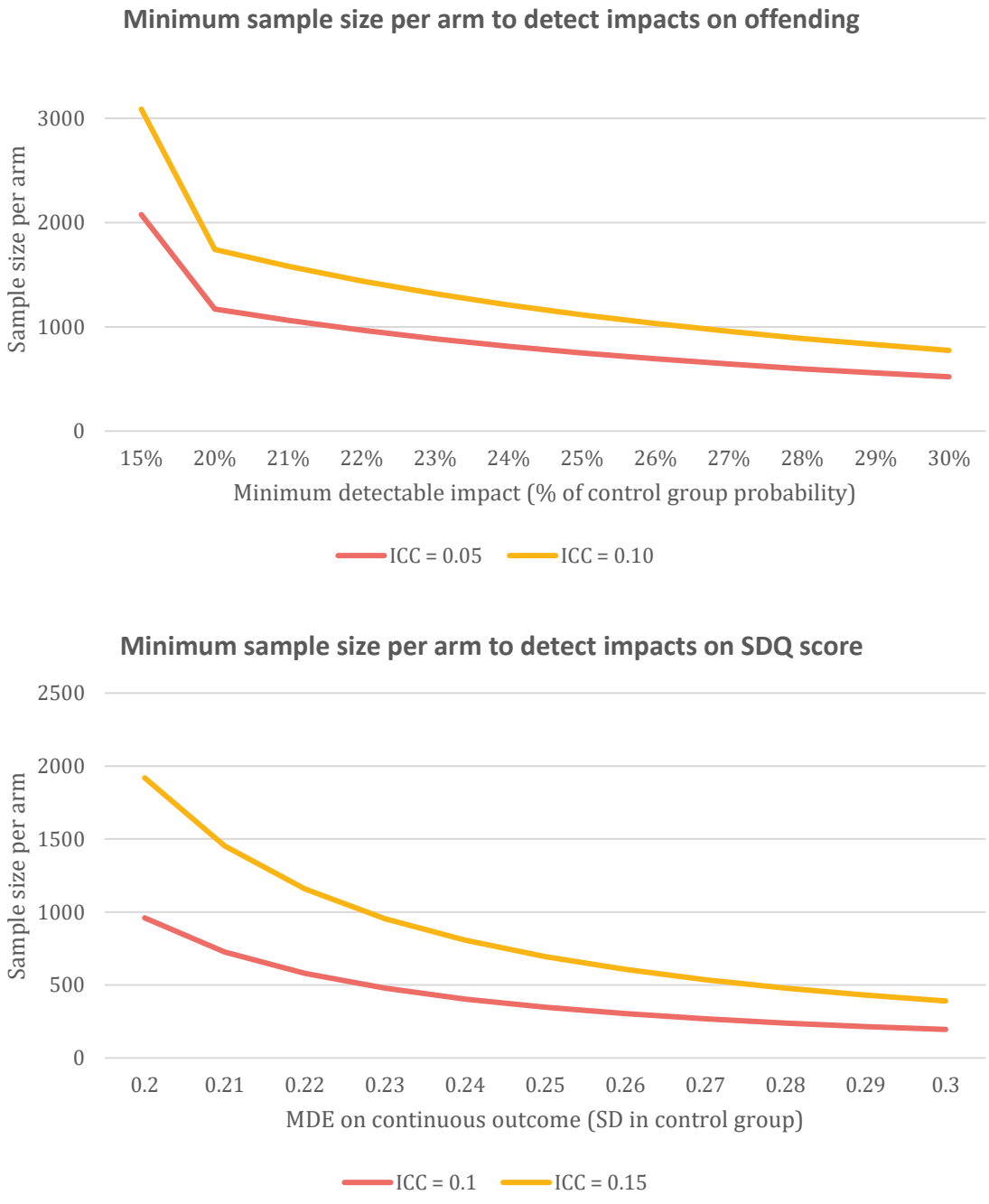


Figure 25. Summary of Power Calculations

The pilot study identified important difficulties related to implementing the randomisation protocol and the processes of data collection and sharing. It will be essential to reflect on those in assessing the potential for an efficacy trial and to consider ways of reducing their prevalence and impact. Specifically:

- It is fundamental that LAs commit to rigorous adherence to the randomisation and data collection and sharing protocols to guarantee participation in an efficacy trial.
- To ensure that such commitment is based on full and clear information of what is required, close and clear communication with LAs will be required in preparation for the trial.
- The data collection processes, particularly in relation to the session data and endline surveys, will need to be revised to substantially reduce missing data.

Evidence of promise

Qualitative findings on the perceived impact of YC

The qualitative interviews revealed two types of perceived impacts of YC – impacts on young people and impacts on practitioners. We bring findings from discussions with the practitioners, implementers, and young people to bear on these two categories of impacts.

Perceived impact on young people

The young people's perceptions of the impact of YC could be grouped into three main themes described below:

Theme 1: increased engagement in education, employment, or training

A change in attitude towards education led to an increase in school attendance for some of the young people (e.g. *'I used to not go to class a lot and kept on getting excluded ... [now] I go to all my classes').* Practitioners facilitated this change in attitude through techniques like managing catastrophising and having conversations about future careers. Most of the young people talked about specific career ambitions for the future, which was supported to varying extents by YC sessions. Support from the practitioners included encouraging the young people to overcome setbacks to their goals, looking into relevant jobs, supporting them in writing CVs, or arranging specific activities to develop relevant skills. There was an indication that the young people would continue working on their education- or employment-related goals on their own.

Theme 2: changes in 'risky' behaviour

Reducing risky and health-harming behaviours was an explicit goal for one young person, who reported that they had managed to completely stop engaging in these behaviours. Another young person decided to change peer groups as a result of being in the programme:

> *[Working with practitioner] really opened my eyes about who you surround yourself with makes an image of who you are ... I was chilling with people who were obviously missing school, misbehaving, had involvement with drugs, weapons, stuff like that, and the group I'm chilling with now are all people who are trying to be things.*

Theme 3: improvements in mental health, well-being, and confidence

The young people indicated general improvement in mental health: feeling happier and being more positive *(e.g. 'more positive thinking than negative thinking'*). There was also a reduction in worry in general or in relation to not anticipating conflict with other peers. For some, they felt more confident, assertive, and mature after compared to before they had started working with their practitioner. For others, they felt more open and willing to talk to others about things that they were dealing with.

Practitioners described a range of positive impacts of the intervention on the young people with whom they worked. They reported seeing improvements in their mental health *('by accessing positive activities'*), family and relationships, and confidence and self-esteem (*'through being able to identify additional needs around*

communication and putting things in place'). They indicated increases in the young people's safety by reducing exploitation concerns and helping to integrate the young people into the community. Some young people were more engaged in activities relating to employment. This was described by a small number of practitioners who felt that the young person would not *'come back'*, indicating a reduced risk of reoffending.

Practitioners described factors that could have affected the change for the young person, including acute crises, family factors, and levels of crime and violence in the local area. They explained that such factors had a direct influence on the young people's progress with or ratings of their goals. Practitioners also described the challenge of maintaining the young people's trust when working with the family. However, they suggested that unaddressed multiple needs within the family, such as mental health difficulties or substance misuse, could limit – or even worsen – outcomes for the young people:

> *I think you need to be really careful of the work that you're doing if you're allowing a young person to become more psychologically minded and they are in a home with a parent who's experiencing mental health difficulties or is quite dysregulated.*

Regarding levels of crime and violence in the local area, practitioners recognised the ongoing risk of exploitation and direct or indirect victimisation that the young people faced:

> *I think it's important to recognise that although when we work with the young people, we're helping them to work towards a specific goal: that we'll help them manage their behaviour or regulate their emotions. Actually, they still live within the context that they were in when they were referred.*

Similarly to practitioners, allocators described positive impacts on the young people of YC that they had observed. There was also some mention that those with more experience of victimisation rather than perpetration had better outcomes from the programme. One of the secondary analyses in the full evaluation could examine the extent to which the effectiveness of the programme is moderated by baseline levels of experience of victimisation versus perpetration, as measured by the Checkpoint. Similarly, qualitative data could particularly examine the perspective of practitioners regarding whom they perceive as engaging more readily with and benefitting more from YC. Triangulation of the quantitative data from the young people and the qualitative data from the practitioners will be of particular interest, given the different reports. For example, there may be social desirability biases in which young people more readily express experiences of perpetration than victimisation to practitioners and others due to reputational pressures.

Perceived impact on staff

Implementers thought that the upskilling of and investment in practitioners was cited as a key area of impact of the YC programme for staff: *'I think it's great that the model is about investing in them and teaching them additional clinical skills'*. This was described as the gap that the programme was addressing within LAs.

Practitioners described that being involved in YC was described by practitioners to have impacted their personal and professional selves. While they acknowledged its challenges (e.g. *'I'm exhausted' and 'It's been hard work'*), they also reported that it *'reignited some of [their] passion as a worker as well'*. The work had *'reiterated to [them] the importance of gaining a young person's trust and building that relationship before a deeper therapeutic work can happen'*, and practitioners indicated that they would incorporate the tools and strategies into their practice.

Allocators described how staff had developed as a result of the YC training (e.g. *'In their practice definitely and in their confidence. Their language now, CBT has opened up a whole new language of words that we're hearing: talking about Socratic questioning in team meetings and stuff'*).

Qualitative findings on the perceived impact of BAU

The young people's perceptions of the impact of the control intervention could be grouped into three main themes described below:

Theme 1: progress towards school and/or work opportunities

The young people indicated that they made less progress towards getting back into school because it was either too early in the process or because of a waiting list. They still expressed hope in continuing their studies, though, and even shared career ambitions. A small number of the young people described having made significant progress in their employability owing to the help of the practitioner and other specialists at the service.

Being engaged in work opportunities seemed to give the young people a sense of purpose: *'Making sure there's a path for me and not just getting left on the roads doing something, getting up to mischief with my friends like they always do'.*

Theme 2: change in 'risky' behaviours or attitudes

To note: we refer to 'risky', although we do not intend this to locate the responsibility of the behaviours within the individual young person.

The young people indicated that they had not been involved in 'risky' behaviours and desired *'[not] to go near any trouble'.* For some, this was represented by a better understanding of different issues as a result of their sessions, such as the *'rights and wrongs'* in a relationship. For others, this was represented by not spending time with friends who might typically engage in *'mischief'*. However, the young people sometimes felt that they already knew much of the information that they had been given.

Perceptions of factors affecting change in the BAU condition

The young people reported different factors that may have affected the impact of the intervention, including external factors (e.g. previous experiences of working with professionals and the local environment) and internal factors (e.g., communication needs and the young person's mood at the session). For example, *'If there's a negative, it's just about me on that day; do you know what I mean? I couldn't be bothered to come or do anything'.* One young person whose family had been supported by many professionals in the past felt *'all the support is the same'* in that they *'try to help me*' but *'don't do a good job'*, indicating a mistrust of the wider system.

The young people also reported the impact of discriminatory or stigmatising practices: '*I get stopped and searched too much for no reason ... it was very embarrassing' a*nd *'So, if I go there and police recognise me, they will just misunderstand and probably take me for it as well ... there's a lot of surveillance around me'*. The young people indicated that such practices had an impact on their behaviour (i.e. hypervigilance of their own behaviour) or on their ability to see change in their lives.

Preliminary quantitative findings

Delays in recruitment and low responding rates meant that, at the time of writing, only 50 endline surveys had been completed by the young people, with a split of 40 to 10 from the treated and control teams, respectively, and 43 endline surveys had been completed by practitioners, with a corresponding split of 36 to 7. We are unable to conduct a preliminary analysis of the programme's impacts on outcomes (which was not an aim of the pilot trial anyway).

Readiness for trial

We consider readiness for trial along two dimensions: factors specific to LAs (see Table 11) and factors that cross-cut the operations in all LAs (see Table 13).

Readiness of LAs

Table 11 compiles a readiness-for-trial score for each LA we worked with during the pilot, with each row corresponding to a different LA. This progression score is based on 15 components, described in Table 12. These are based on the progression criteria A, B, and C described earlier in this document related to whether YC teams have been trained or control teams designated, the ability to meet their own recruitment targets for the number of young people in the trial, missing data, evidence of randomisation having taken place, and other criteria. Relative to progression criteria A to C, one item was added to identify cases where pilot randomisation was not possible.

Each LA was then assigned an overall risk score (a lower score indicating a higher readiness for trial). Potential scores range from 0 (no warning flags) to 15 (warning flags identified). Table 11 shows the progression scores by LA, as well as scores on each of the criteria. We colour-coded the LAs into various bands to indicate their readiness for trial.

Ten LAs have a high readiness (low risk) for trial (shown in shades of green for scores of six or less). A further 15 LAs have low readiness (high risk) for trial (shown in shades of red for scores of eight or higher). The remaining six LAs have intermediate readiness for trial (shown in yellow for a score of seven).

We can see how this readiness translates into the usefulness of an efficacy trial by examining the number of young people each LA expects to be able to recruit into the efficacy trial. Summing these numbers by progression score, we can establish the likely sample sizes in the efficacy trial if LAs of a given progression score are included. This information is shown in Figure 26: this shows the cumulative number of young people we can expect to recruit into the efficacy trial as we increase the progression scores of LAs in the full trial.

Table 11: LA Progression Rating

Data source: Local Authority Workbooks, Consent forms, Surveys and Session Forms

Tier	A - Delivery is taking place as expected							B - Data is being logged as it should						C - Data can be accessed by evaluators	Other	TOTAL RATINGS			EFFICACY PLANS	
	Team training concerns[a]	Control team delivering YC[b]	Unknown teams involved[c]	Recruitment in only one arm[d]	Missed target[e]	Missed target by >60%[f]	Recruiting outside eligibility reqs (low risk)[g]	Consenting YP missing from WB[i]	Consenting YP missing baseline[j]	Consenting YP missing practitioner baseline[k]	Consenting YP missing session form[l]	Workbook missingness >30%[m]	Key identifier missingness >30%[n]	WBs not sent timely[o]	Pilot randomisation not possible[p]	Total rating (max 15)	A rating (max 7)	B rating (max 6)	Estimated no. teams in efficacy trial (incl. 18 yo)	Estimated no. young people in efficacy trial
1	0	1	0	0	0	0	1	0	0	0	1	0	0	0	0	3	2	1	7	192
2	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	4	0	4	3	160
1	0	0	0	1	1	0	1	0	1	0	0	0	0	0	0	4	3	1	1	64
2	0	0	0	1	1	1	0	0	0	0	1	0	1	0	0	5	3	2	0	0
2	0	0	0	1	1	1	0	0	1	0	1	0	1	0	0	6	3	3	3	64
1	0	1	0	0	1	0	0	0	1	1	1	0	1	0	0	6	2	4	15	192
2	1	0	0	0	1	0	1	0	1	1	1	0	0	0	0	6	3	3	5	96
2	0	1	0	0	0	0	0	1	1	1	1	0	1	0	0	6	1	5	5	96
2	0	0	1	0	1	0	0	1	0	1	1	0	1	0	0	6	2	4	2	96
2	0	0	0	1	1	0	1	0	1	1	0	0	1	0	0	6	3	3	6	96
2	0	0	0	0	0	0	1	1	1	1	1	1	1	0	0	7	1	6	3	80
1	0	0	0	0	1	0	0	1	1	1	1	1	0	1	0	7	1	5	2	128
1	1	0	0	0	1	0	1	1	1	1	1	0	0	0	0	7	3	4	2	176
1	0	0	0	1	1	1	0	0	1	1	1	0	1	0	0	7	3	4	2	64
2	0	0	0	1	1	0	0	1	0	1	0	1	1	0	1	7	2	4	10	64
1	1	0	0	0	1	0	1	1	1	1	1	0	0	0	0	7	3	4	3	160
2	0	0	0	0	1	1	0	1	1	1	1	1	1	0	0	8	2	6	3	80
1	0	0	0	0	0	0	1	1	1	1	1	1	1	1	0	8	1	6	3	128
2	0	0	0	1	1	0	1	1	0	0	1	0	1	1	1	8	3	3	0	0
2	0	0	0	1	1	1	0	1	0	0	1	1	1	1	0	8	3	4	2	32
2	0	1	0	0	1	0	1	1	0	1	1	1	1	0	0	8	3	5	2	64
2	0	0	0	0	1	1	0	1	1	1	1	1	1	0	0	8	2	6	0	0
2	0	0	0	1	1	0	0	1	1	1	1	1	1	1	0	9	2	6	16	80
1	0	0	0	1	1	1	0	1	0	1	1	1	1	1	0	9	3	5	0	0
1	0	0	0	0	1	1	0	1	1	1	1	1	1	1	0	9	2	6	7	160
2	0	0	0	1	1	0	0	1	1	1	1	1	1	0	1	9	2	6	2	48
1	0	0	0	0	1	0	1	1	1	1	1	1	1	0	1	9	2	6	4	80
1	1	0	0	0	1	0	1	1	1	1	1	1	1	0	0	9	3	6	0	0
1	0	1	0	0	1	0	1	1	1	1	1	1	1	0	0	9	3	6	4	160
1	1	0	1	1	1	1	0	1	1	1	1	0	0	1	0	10	5	4	2	0
1	0	1	0	0	1	1	1	1	1	1	1	1	1	0	0	10	4	6	3	80

Table 12: LA Progression Rating Criteria

Data source: Local Authority Workbooks, Consent forms, Surveys and Session Forms

Notes: Below is a description of the data that was used to score each criterion and of the rule used to do so.

Category	Progression criteria	Dataset	Definition
a	A.1, A.2	Workbook (pract)	treatment group have been trained
b	A.3	Master dataset	trained in YP consent form or if a session form states a session as being related to YC
c	A.1, A.1, A.3	Workbook (pract)	Set to equal 1 if any teams unknown to us are included in the workbook
d	A.4	Master dataset	or control teams
e	A.4	Master dataset	Equal to 1 if total YP with full consent is less than the total pilot target for that LA
f	A.4	Master dataset	Equal to 1 if total YP with full consent is less than 40% of the total pilot target for that LA
g	A.4	Master dataset	Equal to 1 if LA recruited any YP listed as "low risk"
i	B.3	Master dataset	Restricted to full consent and set equal to 1 if any YP in LA is missing from workbook
j	B.1	Master dataset	Restricted to full consent and set equal to 1 if any YP in LA is missing a YP baseline questionnaire
k	B.1	Master dataset	questionnaire
l	B.2	Master dataset	Restricted to full consent and set equal to 1 if any YP in LA is missing all session forms
m	B.3	YP workbook	Set to equal 1 if missingness of workbook data > 30%
n	B.3	YP workbook	Set to equal 1 if missingness of key identifiers (ULN or UPN & DoB) > 30%
o	C.3	Workbook log	Equal to 1 if a) an LA has only sent 1 workbook or b) and LA sent either workbook very late
p	n/a	Pilot plans	Equal to 1 if randomisation was not possible for pilot study

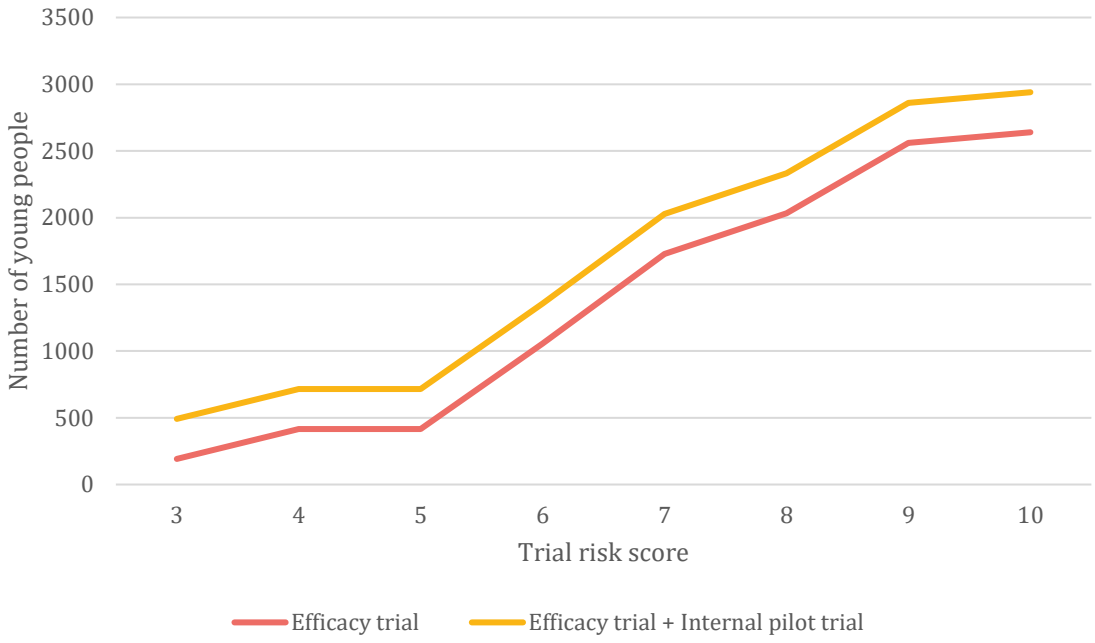


Figure 26. Cumulative Expected Number of Study Participants, by LA Efficacy Trial Risk Rating

It is useful to contrast these projections with the power calculations provided earlier in Tables 9 and 10 for continuous and binary outcomes, respectively.

Assuming a sample size of 1,500 for the efficacy trial (an estimate based on current LA projections of the number of young people they will be able to recruit) evenly split between treatment and control, our power calculations suggest all those combinations of parameters that require 750 individuals *per treatment arm* can be reached. For continuous outcomes, this is quite promising, but for binary outcomes the power

requirements are far more stringent, and only estimates at the top end of the minimum detectable effect are likely to be detected.

Risk register

Table 13 shows a complete register of risks for the transition to any efficacy trial: the likelihood of the risk, mitigation strategies that the pilot learnings suggest, and our confidence in these mitigation strategies being implementable. Risks are broken down into categories of design, delivery and implementation, and data collection in panels A, B, and C, respectively – the three key dimensions, all of which need to be successful for any efficacy trial to be worthwhile.

In terms of design (see Table 13A), many of the risks are classified as low/medium, and we are quite confident that most of them can be mitigated in the run-up to an efficacy trial. A key concern remains in relation to other programmes running in tandem with YC, which would reduce capacity within LAs to deliver YC and conduct an efficacy trial.

In terms of delivery and implementation (see Table 13B), a key issue that has been highlighted by the qualitative evidence is the continued buy-in of control teams – their participation and management of young people and data flows are critical. Something that will be especially relevant over the longer timeframe of the efficacy trial is the potential turnover of youth practitioners. However, we expect the train-the-trainer model to be quite robust in allowing most practitioners in treated teams to remain able to deliver YC.

In terms of data collection (see Table 13C), the widest range of potential risks is identified – the most critical being that key variables required for linkage to administrative data are missing, such as the NPD-PNC. Given the efficacy trial is already likely underpowered to detect binary outcomes – such as offending behaviour – this is a serious concern. The same applies to the high levels of incomplete or missing data related to session forms (especially from control teams) and at endline (for both young people and practitioners). Even if all other risks are addressed, the efficacy trial should not be started without the data collection risks being mitigated. Table 13C includes detailed plans for increasing the quality of the different types of data collection.

Table 13A: Efficacy Trial Risk Register - Design

Description of risk	Likelihood of risk	Impact of risk on trial success	Mitigation(s)	Confidence in mitigation impact
Design				
LAs do not provide enough teams to sufficiently power the efficacy trial	Low	High	Ask LAs to confirm list of teams to randomise and to have list signed-off by LA DCS before randomisation is performed. Trial will not start if list of signed-off teams does not meet required numbers	High
LAs randomise the wrong teams	Medium	Medium	Co-produce with project team clear communication strategy with LAs for the whole project, including: - Clear communication about teams to randomise for efficacy trial - 1to1s with LAs after randomisation plans confirmed to ensure full understanding of LAs - Regular check-ins by project and evaluation teams with LA SPOC about adherence to randomisation	High
LAs allocate young people into teams following a non-random process	Low	Medium	Collect historical administrative anonymous data on allocation of young people to teams within services involved in study in a set of LAs, in order to check whether characteristics of young people Collect high quality baseline information from LA workbooks and baseline surveys	Medium
LAs recruit numbers of participants lower than expected	Medium	High	LAs to be provided real-time information about their recruitment numbers	High
			VRU to build regular checks on recruitment numbers, with funding implications when targets are not met	Medium
			Provide particular support to LAs with higher (riskier) ratings but potentially large number of participants to ensure adherence to randomisation and data protocols	Medium
Recruitment larger in treated teams than in control teams	Medium	High	Build better engagement of control teams into the evaluation	High
Other programmes running at the same time (e.g. Turnaround), reducing LA capacity to deliver Your Choice as part of YEF evaluation of Your Choice	Medium	High	VRU to build regular checks on recruitment numbers, with funding implications when targets are not met	Low
Evaluation team stretched due to multiple LA troubleshotting and high admin requirements, alongside continuous data quality checks and efforts to increase endline completion rates	High	High	YEF to provide additional funding for a project manager hired and supervised by IFS evaluation team and to work across evaluation and project team	High

Table 13B: Efficacy Trial Risk Register - Delivery and Implementation

Description of risk	Likelihood of risk	Impact of risk on trial success	Mitigation(s)	Confidence in mitigation impact
Delivery and implementation				
Low buy-in of LAs staff into Your Choice	Medium	Medium	Appropriate communication and engagement strategy with DSCs and operational leads/service managers to ensure strong leadership buy-in Targeted communication strategy for practitioners about the programme and evaluation (e.g. webinars about the study so far, webinars and drop-ins with guidance for practitioners), with special attention to improving the buy-in of control practitioners	Medium
Capacity of practitioners and clinical leads constrained due to high intensity of Your Choice	Medium	Medium	Increase motivation and buy-in of practitioners and clinical leads by sharing more information about the study and improving communication strategy to make them feel more part of the study	Medium
High practitioner turnover, leading to need of retraining and delivery below expectations	High	Medium	Training of trainer enables training of new stuff to be done relatively quickly LAs encouraged to attend network groups to find cross-LA solutions Increase regular communication between evaluation team and LAs in order to support LAs find solutions quickly to capacity issues creating a risk to the trial	Medium

Table 13C: Efficacy Trial Risk Register - Data Collection

Description of risk	Likelihood of risk	Impact of risk on trial success	Mitigation(s)	Confidence in mitigation impact
Data collection				
Workbooks not fully completed for young people in study	Low	Medium	Make DPA between LA and evaluatior a requirement of participation in the efficacy trial so that evaluator can communicate the list of young people recruited into the study in real-time Have a DPA between LIIA data lead and IFS so that LIIA data lead can access evaluation data and provide more targeted support to LAs in completing workbooks Improve process to share workbooks through London Data Store from July 2023	High
Key variables (DOB, UPN) for admin data linked not provided by LAs	High	High	Have a DPA between LIIA data lead and IFS so that LIIA data lead can access evaluation data and provide more targeted support to LAs in completing workbooks	High
Delays in accessing administrative data for participants	Medium	High	Start PNC and NPD data applications at the start of efficacy trial to link data on pilot participants and set up an arrangement for linking batches of new efficacy participants every 6 months	Medium
High rate of non-consent among eligible young people (and their parents)	Medium	High	Focus groups with study participants to understand barriers to recruitment and improve recruitment materials Learning group of practitioners to share successful practices and develop evaluation toolkit for other practitioners Review of recruitment materials with young people advisory groups and peer researchers	Medium
Survey data of poor quality	Low	High	Ensure adequate team of peer researchers is appropriately funded to support young people with data collection	High
Low endline data completion rate	High	Medium	Explore possibility of increasing incentives for completing endline surveys with YEF and/or VRU additional funding Consult with VRU and Evaluation young people advisory groups as well as LA reference group, to improve endline data collection success Create mobile-optimised interface for practitioners and SPOCs, through which they will be able to: - Visualise, for each study participant in their LA, completed and missing data - Book endline data sessions with peer researchers Make primary outcome of trial based on PNC	Medium
Practitioner surveys not completed	Medium	Medium	Create mobile-optimised interface for practitioners and SPOCs, through which automatic reminders for completing missing surveys will be sent to practitioners and SPOCs	High
Session forms not duly completed	High	Medium	Create mobile-optimised interface to collect baseline survey data and session forms, which will: - Provide a real-time tracker of completed and missing data - Reduce time to complete each form by avoiding the need to re-enter information about the young person and practitioner on each form - Enable practitioners and SPOCs to visualise a log of session forms completed and to extract session form data for their own records - Allow SPOCs or data leads to complete information not completed by practitioner based on case notes	Medium

Cost information

Following the YEF's guidance and in conjunction with the co-project team, we developed a template and completion guidance for LAs to report information about the cost of implementing YC. The `typical cohort' was defined as three young people supported by a team of six practitioners (five practitioners and one team leader) through the duration of the programme (12 weeks). Full compliance among these three young people is assumed.

The template was shared with one LA for feedback and completion. Following positive feedback from this LA on the template, six other LAs were requested to complete it. At the time of writing, we only have data back for the first LA, which we summarise below. Table 14 provides a full breakdown of costs and underlying assumptions about the wages of staff involved in implementation.

The total cost of delivering YC to this typical cohort of three young people is just under £29,500, with one-quarter of these costs being set-up costs and three-quarters being recurring costs. This comes down to a cost per young person of £9,775, with £7,240 of recurring costs per young person. This value represents the total cost, not net of the cost of providing alternative BAU services.

The set-up costs include staff costs associated with the training: being trained and, subsequently, training the team of practitioners and its leader. Recurring costs include the time spent by practitioners and their team leader, clinical lead/trainer, and administrative staff (operational lead and team co-ordinator), as well as material and equipment (travel costs, engagement/behavioural activation activities, and step-down costs). Figure 27 breaks down all recurring costs into these categories.

Table 14: Intervention Costs

Cost of implemtation of Your Choice in a team of 5 practitioners supporting 3 young people over 12 weeks

Source: Cost survey from one of the LAs

Cost items	Upfront or recurring?		Frequency	Total	Assumptions
Staff					
Operational Lead/Service Manager					
Familiarisation/Getting staff buy-in	Recurring	£281	Weekly	£3,367	7 hours per week
Attendance of operational leads network group	Recurring	£80	Monthly	£240	2 hours per month
Data and governance activities	Recurring	£80	Weekly	£962	2 hours per week
Additional administrative cost linked to delivery	Recurring	£80	Weekly	£962	2 hours per week
Team co-ordinator					
Additional administrative cost linked to delivery	Recurring	£53	Weekly	£630	2 hours per week
Trainer (could be Clinical Lead)					
Attending LIIA training	Set-up	£1,368	Once	£1,368	28 hours
Training practitioner and team leader	Set-up	£1,368	Once	£1,368	28 hours
Practitioner					
Training	Set-up	£3,935	Once	£3,935	28 hours per practitioner
Delivery of sessions (including travel time)	Recurring	£590	Weekly	£7,084	7 hours per child per week
Preparation ahead of sessions	Recurring	£253	Weekly	£3,036	3 hours per child per week
Attendance of clinical supervision meetings	Recurring	£126	Monthly	£379	1.5 hours per child per month
Attendance of coach network groups	Recurring	£281	Monthly	£843	2 hours per month per practitioner
Overview of cases and supervision of practitioners	Recurring	£281	Monthly	£843	2 hours per month per practitioner
Team leader					
Training	Set-up	£935	Once	£935	28 hours
Attendance to coach network group	Recurring	£67	Monthly	£200	2 hours per month
Overview of cases and supervision of practitioners	Recurring	£334	Monthly	£1,002	2 hours per month per practitioner
Clinical lead					
Provision of clinical supervision	Recurring	£220	Monthly	£659	Average of 1.5 hrs per month per child
Attendance of clinical leads network groups	Recurring	£98	Monthly	£293	2 hours per month
Programme					
None	-	£0		£0	
Buildings & facilities					
None	-	£0		£0	
Materials & equipment					
Travel costs	Recurring	£15	Weekly	£180	3 visits per child per week
Behavioural activation funds	Recurring	£1,015	Once per child	£1,015	£338.45 on average per child
Step-down costs	Recurring	£24	Once per child	£24	Done only for 50% children, avg cost £40
Incentives					
None	-	-	-	£0	
Other costs					
None	-	-	-	£0	
Total cost					
Set-up	-	£3,619	-	£7,606	
Recurring	-	£0	-	£21,721	
Total	-	£3,619	-	£29,327	
Cost per participant					
Number of participants	-	-	-	3	
Set-up costs per participant	-	£17	-	£2,535.31	
Recuring cost per participant	-	£0	-	£7,240.49	
Total cost per participant	-	£17	-	£9,775.79	

Notes: Assumed hourly wages are: Operational lead: £40.08; Trainer: £48.84; Clinical lead: £48.84; Practitioner: £28.11; Unit leader: £33.41; Unit coordinator: £26.26. Assumed variable parameters are: Number of practitioners: 5; Unit leader: 1; Unit coordinator: 1; Number of children: 3; Number of weeks: 12; Number of months: 2.

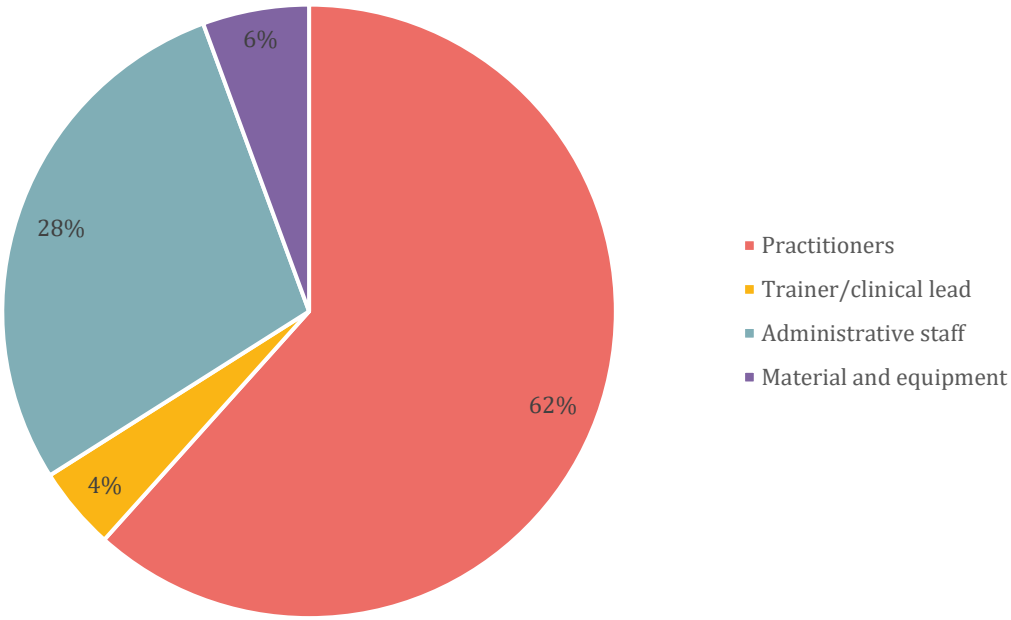


Figure 27. Breakdown of Recurring Costs of Delivering YC

Conclusion

A summary discussion of the findings of the pilot study in relation to each of the research questions can be found in Figure 1 earlier in the document.

Evaluator judgement of evaluation feasibility

See the discussion under the next item.

Interpretation

Overall, the evidence remains mixed for the readiness to move to an efficacy trial. We have highlighted both positive and negative aspects, and the summary of the readiness of LAs and the risk registry provides an overview of the issues to be balanced against each other.

Given the lack of existing evidence in the literature related to such interventions – both in the nature of the YC intervention's targeted population and in that most related evidence originates from other countries – we still regard there to be very high value in proceeding to an efficacy trial. Qualitative evidence found support for the logic model. Moreover, analysis of the baseline data offers good support that some of the key measures collected are of high value.

However, this needs to be balanced against three key factors. First, that effective mitigation strategies can be found to address serious concerns over adherence to randomisation protocols. Second, that there is good evidence of the trial's ability to generate sufficiently sized samples (young people who are recruited, give consent, and have their data collected) to be powered to detect longer-term impacts on key outcomes. Third, that more complete high-quality data is collected for pilot participants, confirming the readiness of LAs to adhere to the data collection protocols and, upon analysis by the evaluation team, also confirming the promising impacts of the intervention that were established with the incomplete data so far. Without these three conditions in place, we cannot advise progression to an efficacy trial. However, the experience of the pilot provides insights into how to adapt strategies to collect data and mitigate risks that, if implemented, can support a successful efficacy trial.

Limitations and mitigation steps

We now summarise the limitations to the analysis that were identified throughout the report, together with mitigation strategies that have either been implemented during the pilot or are planned for the efficacy trial.

Assignment of young people to teams We do not directly observe how the young people are assigned to teams, a procedure that is directly implemented by LAs and does not follow random assignment. Fairness and practical concerns raised by LAs led to the decision to keep the existing assignment process based on team capacity at the time the young person is referred to the LA services and allow young people returning after a short interruption to continue with the same team they had before. This assignment rule is independent to the potential benefits that the young person may have from participating in YC, so we consider that the assignment is 'as good as random' if this rule is strictly followed. However, qualitative evidence showed that, on rare occasions, other considerations influenced the assignment of the young people to teams, including the young person's potential benefit from YC (see discussion in 'Feasibility and acceptability of evaluation design'). Such practice subverts the design and has the potential to bias estimates of the impact of YC.

We developed various ways of checking on the assignment of young people to teams and ensuring that it creates comparable treatment and control groups. Some of these procedures were applied during the pilot

period, and others were planned for the efficacy trial, including checking the balance between treatment and control groups on a rich set of observed variables and discussing concerns with LAs if systematic differences emerge, assessing whether the flow of young people into treated and control teams has changed with the introduction of YC, using qualitative data to check the processes in detail, and running frequent information sessions with LAs to reinforce the importance of adhering to this (and other) feature(s) of the design.

Engagement of control teams It was challenging to engage control teams in the pilot. LAs initially did not realise that, as part of the study, control teams were required to recruit participants and participate in the data collection efforts. This misunderstanding delayed the recruitment of participants for the control arm and created an uneven sample of young people allocated to the two treatment arms and for whom data was available. This initial misunderstanding contributed to the low number of young people in the control group and the higher prevalence of missing data in that group.

Once this pattern became obvious to us, information sessions with each LA were intensified to specifically clarify the essential role of control teams. This improved recruitment to those teams, as well as data collection.

Young people's endline survey: The initial pilot protocol determined that the endline young person survey would be administered 12 weeks after recruitment by external peer researchers in a special session arranged by the young person's lead practitioner. It soon became clear that this procedure was impractical and resulted in delays in collecting this data, heterogeneity in the time of survey completion, and a sever missing data problem. These features can bias estimates of the impact of treatment by introducing selection error (selective data completion) and measurement error (variation in the time of survey completion) in the outcome.

To deal with these issues, we developed and implemented a simpler data collection procedure during the pilot period (see discussion under the heading 'Changes to the pilot trial methods or measurements after the pilot trial commenced, with reasons'). Under the new procedure, the endline survey is administered in a regular session with the practitioner (but not with a peer researcher) during week 20 after recruitment, which more realistically describes the end of the programme. The youth practitioner is there to provide the link for the questionnaire; they were instructed not to interfere with the completion of the survey except to read out questions when participants experienced difficulties in doing so themselves. This proved to be an efficient and reliable way of collecting endline data.

Missing data More generally, missing data was common on all blocks of information that were planned for the quantitative analysis, including the LA workbook data, young people baseline survey, session records, and practitioners' survey. To the extent that missing data may not be random, this again would compromise the reliability of any estimates of the effect of YC.

We have reinforced information sessions to highlight the importance of LAs collaborating with the data collection exercise and to clarify the procedures. We have also simplified the technology used for data collection, having developed an app that automatically fills all fields for which information already exists and which has a simpler interface. Plans for the efficacy trial will demand that LAs follow the data collection and sharing procedures much more rigorously, with sizeable funding consequences for those failing to collaborate on this effort.

Contamination of the control group Qualitative analysis revealed evidence of contamination, with the young people assigned to the control arm having occasional sessions with trained youth practitioners. In a full evaluation, this practice would dilute estimates of the effects of YC.

To minimise the risk of this happening going forward, we ran repeated information sessions with LAs, reminding them of the importance of adhering to the allocation of young people to the treated and control arms.

Adherence to the randomisation of teams In several instances, LAs did not follow the randomisation of teams. This was mostly due to LAs putting forward inadequate teams (e.g. because they did not deal with the target population or had no capacity) given initial misunderstandings about which teams could participate in the programme. The internal nature of the pilot implies that data on non-randomly allocated teams will be excluded from the final evaluation exercise (to be carried out once the efficacy trial is implemented).

To minimise the risk of randomisation not being strictly followed during the efficacy phase, we ran numerous information sessions with LAs, clarifying the eligibility criteria and the need for LAs to carefully select teams that have the availability to deliver YC.

Future research and publications

The recommendations for strengthening the current design were described earlier. The outcome measures have been validated to be of good quality. Given the more stringent demands of the power calculations for binary outcomes and the risks of missing data preventing linkage to the NPD-PNC data, keeping an offending outcome (e.g. whether arrested, as measured by the PNC data, over a period after recruitment), as the main outcome will require careful consideration of strategies to increase the sample size during the efficacy trial. We recommend that the trial period be extended to allow for a larger build-up of cases.

Given the preliminary support offered to the logic model, the same core research questions remain for future study.

Given the opportunity to complete data collection from the pilot, from all those we have baseline data for, we will consider writing up the findings for an academic audience. This would likely be a mixed-methods paper that highlights the learnings for an academic audience of the evaluation of such an intervention in the context of LA youth services. This would establish the short-run impacts of the intervention. Given the reliability of the data and the possibility to validate it with data from the MCS, there remains scope to project findings on short-run measures – say on the SDQ – as surrogate indices on projected impacts on offending later in life. This would enable a potential cost–benefit analysis of YC to be proposed (subject to multiple assumptions) that would help place it into a wider context of potential interventions targeted to similar vulnerable groups of young people.

References

Barnao, M. (2022). “The good lives model: A strength-based approach to rehabilitating offenders.” *In*: Garofalo, C., Sijtsema, J.J. (eds) *Clinical Forensic Psychology*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-80882-2_27

Brooks, R., Lambert, C., Coulthard, L., Pennington, L., & Kolehmainen, N. (2021). “Social participation to support good mental health in neurodisability.” *Child Care Health Dev.* 47: 675– 684. https://doi.org/10.1111/cch.12876

Butler A.C., Chapman J.E., Forman E.M., & Beck A.T. (2006). “The empirical status of cognitive-behavioral therapy: A review of meta-analyses.” *Clin Psychol Rev.* 26*(1)*: 17–31. doi: 10.1016/j.cpr.2005.07.003

Case, S, & Browning, A (2021). “Child first justice: The research evidence-base [Full report]." Loughborough University Report. https://hdl.handle.net/2134/14152040.v1

Crenna-Jennings, W., & Hutchinson, J. (2020). “Access to child and adolescent mental health services in 2019.” The Education Policy Institute. https://epi.org.uk/wp-content/uploads/2020/01/Access-to-CAMHS-in-2019_EPI.pdf.

Erikson, E. (1968). *Youth: Identity and crisis*. New York, NY: Norton. http://dx.doi.org/10.1126/science.161.3838.257

Farrell, A.D., Meyer, A.L., & White, K.S. (2001). “Evaluation of responding in peaceful and positive ways (RIPP): A school-based prevention program for reducing violence among urban adolescents.” *Journal of Clinical Child Psychology,* 30*(4)*: 451–463. https://doi.org/10.1207/S15374424JCCP3004_02

Fonagy, P., Butler, S., Cottrell, D., Scott, S., Pilling, S., Eisler, I., Fuggle, P., Kraam, A., Byford, S., Wason, J., Smith, J.A., Anokhina, A., Ellison, R., Simes, E., Ganguli, P., Allison, E., & Goodyer, I.M. (2020). “Multisystemic therapy versus management as usual in the treatment of adolescent antisocial behaviour (START): 5-year follow-up of a pragmatic, randomised, controlled, superiority trial.” *The Lancet. Psychiatry*, *7(5)*: 420–430. https://doi.org/10.1016/S2215-0366(20)30131-0Foshee, V.A., Reyes, L.M., Agnew-Brune, C.B., Simon, T.R., Vagi, K.J., Lee, R.D., Suchindran, C. (2014). “The Effects of the evidence-based *safe dates* dating abuse prevention program on other youth violence outcomes.” *Prev Sci,* 15: 907–916. https://doi.org/10.1007/s11121-014-0472-4

Gaffney, H., Farrington, D.P., & White, H. (2021) “Cognitive behavioural therapy: Toolkit technical report.” YEF. Haggerty, K.P., Skinner, M.L., MacKenzie, E.P., Catalano, R.F. (2007). “A Randomized trial of parents who care: Effects on key outcomes at 24-month follow-up.” *Prev Sci*, 8: 249–260. https://doi.org/10.1007/s11121-007-0077-2

Hawkins, J.D., Oesterle, S., Brown, E.C., Monahan, K.C., Abbott, R.D., Arthur, M.W., & Catalano, R.F. (2012). “Sustained decreases in risk exposure and youth problem behaviors after installation of the Communities That Care prevention system in a randomized trial.” *Archives of pediatrics & adolescent medicine*, 166*(2)*: 141–148. http://doi.org/10.1001/archpediatrics.2011.183

Heller, S.B., Anuj, K.S., Guryan, J., Ludwig, J., Mullainathan, S., & Pollack, H.A. (2017). “Thinking, fast and slow? Some field experiments to reduce crime and dropout in Chicago,” *The Quarterly Journal of Economics*, 132*(1)*: 1–54. https://doi.org/10.1093/qje/qjw033

Hoffmann, T.C., Glasziou, P.P., Boutron, I., Milne, R., Perera, R., Moher, D., Barbour, V., Macdonald, H., Johnston, M., Lamb, S.E., Dixon-Woods, M., McCulloch, P., Wyatt, J.C., Chan, A.W., Michie, S. (2014).

"Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide." *BMJ* 348

Koehler, J.A., Lösel, F., Akoensi, T.D., & Humphreys, D.K. (2013). "A systematic review and meta-analysis on the effects of young offender treatment programs in Europe." *Journal of Experimental Criminology* 9, 19–43. https://doi.org/10.1007/s11292-012- 9159-7

NHS England, (2023). "Increasing diversity in research participation: A good practice guide for engaging with underrepresented groups." [online] Available from: https://www.england.nhs.uk/aac/wp-content/uploads/sites/50/2023/02/B1905-increasing-diversity-in-research-participation.pdf

Quitangon, G. (2019). "Vicarious trauma in clinicians: Fostering resilience and preventing burnout." *Psychiatric Times* 36*(7)*: 18–19

Riise, E.N., Wergeland, G.J.H., Njardvik, U., & Öst, L-G. (2021). "Cognitive behavior therapy for externalizing disorders in children and adolescents in routine clinical care: A systematic review and meta-analysis." *Clinical Psychology Review*, 83. https://doi.org/10.1016/j.cpr.2020.101954

Simon, T.R., Ikeda, R.M., Smith, E.P., Reese, L.E., Rabiner, D. L., Miller, S., Winn, D.M., Dodge, K.A., Asher, S.R., Horne, A.M., Orpinas, P., Martin, R., Quinn, W.H., Tolan, P.H., Gorman-Smith, D., Henry, D.B., Gay, F. N., Schoeny, M., & Farrell, A.D. (2009). "The ecological effects of universal and selective violence prevention programs for middle school students: A randomized trial." *Journal of Consulting and Clinical Psychology,* 77*(3)*: 526–542. https://doi.org/10.1037/a0014395

Spoth, R.L., Redmond C., & Shin C. (2000). "Reducing adolescents' aggressive and hostile behaviors: Randomized trial effects of a brief family intervention 4 years past baseline." *Arch Pediatr Adolesc Med.*, 154*(12)*: 1248–1257. doi:10.1001/archpedi.154.12.1248.

Steinberg, L. (2008). "A Social neuroscience perspective on adolescent risk-taking." *Dev Rev,* 28*(1)*: 78–106. doi: 10.1016/j.dr.2007.08.002

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). "Trauma-informed mental healthcare in the UK: What is it and how can we further its development?" *Mental Health Review Journal* 21*(3)*: 174–192.

Thomson, A., Dow, M.G., Kenardy, J.A., Johnston, D.W., Newman, M.G., & Taylor, C.B. (2007). "Prognostic indices with brief and standard CBT for panic disorder: II. Moderators of outcome," *Psychological Medicine*, 37*(10)*: 1503–1509

Wenzel, A. (2021). "The therapeutic relationship." In A. Wenzel (ed.), *Handbook of cognitive behavioral therapy: Overview and approaches*. American Psychological Association. https://doi.org/10.1037/0000

Vivolo-Kantor, A.M., Niolon, P.H., Estefan, L.F., Le, V.D., Tracy, A.J., Latzman, N.E., Little, T.D., Lang, K.M., DeGue, S., Tharp, A.T. (2021). "Middle school effects of the *Dating Matters*® comprehensive teen dating violence prevention model on physical violence, bullying, and cyberbullying: A cluster-randomized controlled trial." *Prev Sci*, 22: 151–161. https://doi.org/10.1007/s11121-019-01071-9

Appendices

Annex A: Full pilot trial protocol

Annex B: Information sheets

Annex C: Consent forms

Annex D: Privacy notice

Annex E: Questionnaires and session forms

PILOT TRIAL PROTOCOL

Your Choice: Randomised Controlled Trial of a CBT Informed Violence Reduction Programme

Institute for Fiscal Studies and Anna Freud Centre

Principal investigator: Professor Imran Rasul

YOUTH ENDOWMENT FUND

Pilot trial protocol: Your Choice: Randomised Controlled Trial of a CBT Informed Violence Reduction Programme

Evaluating institution: Institute for Fiscal Studies and Anna Freud Centre

Principal investigator: Professor Imran Rasul

Project title[1]	Your Choice: Randomised Controlled Trial of a CBT Informed Violence Reduction Programme
Developer (Institution)	London Violence Reduction Unit (VRU)
Evaluator (Institution)	Institute for Fiscal Studies and Anna Freud Centre
Principal investigator(s)	Professor Imran Rasul
Evaluation plan author(s)	Imran Rasul, Julian Edbrooke-Childs, Laura van der Erve, Sarah Cattan
Evaluation setting	32 Local authorities in London
Target group	11–17-year-olds living in London at medium or high risk of serious violence
Number of participants	32 London boroughs, 200-400 young people

[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).

Protocol version history

Version	Date	Reason for revision
1.0 [*original*]	27/06/2022	
1.1	14/7/2022	More specificity added to the success/ progression criteria and success/ progression criteria shared with the project team (consistent with original version and no change to design).
1.2	26/9/2022	1) More detail added to progression criteria C 'Data can be accessed by evaluators'. They now include: • IG infrastructure for LAs sharing data with evaluators is created and sent to LAs for review and to be signed • Data sharing agreement approved by IGFL and signed copies received from LAs 2) YEF principles for consideration when deciding whether to progress to an efficacy study were added (see p.5)
1.3	27/12/2022	More details to the endline data collection procedure, which was not fully fleshed out in previous version given limitations of our knowledge on context.

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

This project is piloting the roll out of Your Choice, a large-scale project from London VRU and the Association of London Directors of Children's Services, developed in partnership with the Children and Adolescent Mental Health Service (CAMHS), which is proposing to train clinical practitioners in the Your Choice programme. Using a train-the-trainer model to support local roll out of the training, they will train youth workers (e.g. social workers, youth justice workers, teachers) in a range of CBT tools and techniques and will work intensively with young people aged 11-17, across London boroughs. Young people aged between 11-17, at medium to high risk of harm, who are discussed at multi agency panels will be eligible for the programme, with the aim of reaching children at risk of serious violence who typically are less likely to access CAMHS in clinical settings (e.g. young people from black and minoritized ethnic groups). Once assessed they will work intensively (three contacts per week with their Your Choice coach), towards goals that hold meaning and value to them to support positive behavioural activation. During sessions, which are likely to be held within community settings, whilst working towards their goals young people will be introduced to CBT tools and techniques through experiential learning to support skills development. The project will provide qualitative and quantitative evaluations of the intervention, where the latter will use a randomized control trial methodology. Although YEF only requires data collection on intervention costs, the evidence gathered by this evaluation will identify the costs and benefits (in terms of increases in school engagement, reductions in delinquency and reductions in emotional and behavioural difficulties) of delivering a CBT informed approach to young people at risk of violence. This will provide evidence to determine whether this project should be continued and rolled out in the rest of the country.

The logic model is attached.

Research questions and/or objectives

Objectives of the pilot trial:

1. To examine how the Your Choice intervention is implemented, fidelity of delivery, and what helps and hinders implementation;
2. To assess the adherence of Local Authorities and youth practitioners to randomisation.
3. To pilot study outcomes and evaluation methods, assess the parameters for conducting an efficacy evaluation and to assess whether operational progression

criteria have been met and if so to develop a full protocol for an appropriately powered efficacy study.

Success criteria and/or targets

The pilot is designed to establish whether Local Authorities have sufficient demand for Your Choice across youth service teams for a full-scale efficacy trial to be conducted. The pilot will also serve as a testing ground to understand whether Local Authorities can adhere to the randomization protocol, as we gradually expand the roll out of Your Choice during the pilot across teams. The pilot also serves as a test of whether primary data can be collected on young people (and from youth practitioners) who receive Your Choice, as well as those that receive business as usual (the control group). The pilot phase is also being used to explore how we can practically link these data to secondary administrative data sources collected by Local Authorities on young persons' pathways through Youth Services. If sufficient samples are generated in the pilot and randomization protocols are adhered to, then we hope to use the primary data collection to provide preliminary evidence on the short run efficacy of Your Choice on some outcome measures. If the pilot remains underpowered, it will still provide invaluable evidence on the ability of LAs and project team to engage in an RCT design, and the evidence generated can help inform updated power calculations for the efficacy trial. Establishing that LAs can adhere to the randomization protocols, and that the research design is valid are fundamental to the purpose of the pilot (even if underpowered to detect short run impacts).

In detail, the success criteria are:

A - Delivery is taking place as expected

- Teams assigned to receiving Your Choice are getting trained
- Teams not assigned to receiving Your Choice are not getting trained
- No other teams except treated and HO teams are delivering Your Choice
- Young people are being recruited and eligibility criteria are respected when recruiting young people in the study
- Delivery of work with young people is taking place

B - Data is being logged as it should

- Questionnaires are completed by young people and practitioners, when they are supposed to be completed
- Information about sessions is being shared through session forms
- LAs are filling out their Study Workbook in line with instructions

C - Data can be accessed by evaluators

- IG infrastructure for LAs sharing data with evaluators is created and sent to LAs for review and to be signed
- Data sharing agreement approved by IGFL and signed copies received from LAs
- LAs are complying with the requirement to share updated versions of their spreadsheet with evaluator every month

D - Verification of the design through data analysis

- Do young people in the treated and control teams have similar characteristics on average? Does this hold within services within LAs, as initially intended, or more broadly?
- Are young people in the control teams are actually receiving BAU and not Your Choice?
- Are young people in Your Choice actually receiving Your Choice?
- Are untrained practitioners using Your Choice practices?

If this set of criteria for success are not met during the pilot, then we would recommend stopping the study and not moving to a full efficacy trial.

The following principles are also considered by YEF when deciding whether to progress to an efficacy study:

- Project Implementation: Can the project be implemented as intended
- Evaluation recruitment: can enough numbers of young people been recruited (intervention & control)?
- Grantee, YEF, evaluator relationship: has the working relationship developed that could support moving to a larger and more complex study?
- Measurement & Findings: Can we collect data & information in the way that we need to?
- Change - Do we believe that this is likely to lead to change?
- Supplementary funding - Do we believe that we can bring in supplementary funding?

Methods

Pilot trial design

Randomisation

The randomization relates to the assignment of teams of youth practitioners to be trained to deliver Your Choice. Local Authorities have provided us with a list of all their services which may come into contact with our study participants, and the team structure within these services. They will be asked to provide a list of all the teams that they are happy to receive Your Choice training. The evaluators will then randomise which teams get trained in the first round of training (rather than later on in the trial) out of those teams put forward for training.

LAs participating in the pilot will be required to sign a Memorandum of Understanding specifying the requirements attached to their participation, including their willingness for their teams to partake in the randomisation, their readiness to share data about participants' background information and compliance with the study, their willingness to facilitate survey data collection, and the readiness to administer Your Choice during the duration of the pilot. Initial discussions between VRU, LIIA and LAs indicate that the number of LAs meeting those requirements could be lower than 32. LAs that are willing to be part of the randomisation but not ready to implement the randomisation, nor to collect data on the children receiving Your Choice, could not join the efficacy trial – because they will not be able to demonstrate being able to adhere to the randomization protocols or data collection requirements. LAs that are seeking the training but not willing to be part of the randomisation would not be part of the efficacy trial. They would also not be included in the IPE evaluation (see below).

Under the assumption that the assignment of young people to services and teams within services continues to be made independently of the fact that some teams have been trained in Your Choice, then this design randomises individuals into treatment and control groups. Children are assigned to teams within services based on which team has availability at the time the child is referred to the service. If this team is Your Choice trained, the young person will be in the treatment group, and when this is a team that is not (yet) trained, the young person will be in the control group.

While our understanding from the co-design period is that the assignment of children to teams within each service is largely done according to which team has availability at the point of referral, we have not been able to acquire more information about the assignment of children to teams during the co-design period to verify that this is absolutely the case. This will be an important point to verify during the pilot through further conversations with the project team and individual LAs. During the pilot, we will acquire detailed information about

the assignment process, the children's characteristics upon which allocation decisions are taken, as well as the characteristics of teams. We will compare children assigned to different teams based on the background characteristics collected and their responses to the SDQ and crime and violence questionnaires at baseline. Specifically, we will check balance on the following characteristics in the pilot trial:

- Using the data collected from the LA: age, gender, ethnicity, disability, in Education/Training/Employment, length of involvement with LA, most relevant primary need for involvement in teams involved in trial, nature of involvement in other council service,
- Using the baseline young person questionnaire: SDQ, crime and violence measure
- Using the baseline practitioner questionnaire (about the young person): practitioner's assessment of young person's involvement in crime.

In assessing whether imbalances are problematic for the validity of the design, we will pay particular attention to imbalances on characteristics that are most predictive of the outcomes the program intends to shift (based on the literature and correlations between background characteristics and baseline SDQ and crime and violence measure).

If there are small deviations from random assignment of children and young people into treated and control, we will consider using two strategies to correct for them: (i) explicitly control for pre-assignment characteristics of children (and maybe those of teams), and (ii) across LA variation in treated teams.

Importantly, our design also leaves open the possibility of excluding all children whose assignment was based on considerations of how much they would benefit from interactions with a specific team – hence effectively focusing only on those children who are randomly assigned. Through the qualitative work and the quantitative analysis of imbalances on baseline variables specified above, we will aim to get an understanding of the reasons where and why non-random allocation is most likely to take place in order to make an informed decision about children to be excluded from the sample, if any.

Note that these children will be excluded from the evaluation, but not the data collection. Having information on non-randomly selected children can also help later place the evaluation results in context – and if sample sizes permit, we can aim to see whether the evaluation results support the idea that these children – based on observables – are likely to gain more from the intervention than others.

Participants

Participants will be young people aged 11-17 referred to children's services and at high or medium risk of serious violence. All participants (and their parents if aged 11-15) will be asked to consent to be part of the evaluation before receiving the Your Choice programme.

Sample size

In the pilot study we will randomise one team to be trained in each of the local authorities who put forward at least two teams for training during the pilot. We will additionally include the local authorities who already randomised the training of teams during the Home Office funding training. This likely gives us 31 treatment teams (and a slightly larger number of control teams). Based on the results of the survey, we expect treated teams to enrol at least 4 new children in Your Choice each month. During the pilot we will enrol new participants for two months, which will mean a recruitment of over 200 children in the treatment group (and at least as many in the control group). From the information provided to us so far on the flow of young people through children's services, this should be feasible in the time frame of the pilot, and will allow for exploration of key parameters needed to confirm sample size calculation for the efficacy study.

Methods and data collection

Outcomes

We will have the following two primary outcomes:

- *Emotional and behavioural difficulties and pro-sociality* assessed using the Strengths and Difficulties Questionnaires (SDQ);
- *Offending, as measured in the Policy National Computer (PNC),* teams.

We will have several secondary outcomes:

- *Engagement and exposure to crime and violence,* as measured by a scale co-produced by the evaluation and project teams administered to both the young person and their lead practitioner
- *Social connectedness*, measured by a subscale of the the Student Resilience Survey
- *Mental Well-Being*, measured by The Short Warwick–Edinburgh Mental Well-being Scale (SWEMWBS)
- *Self-efficacy*, measured by the New General Self-Efficacy Scale

- *Self-regulation,* measured by the Trait Emotional Intelligence Questionnaire – Adolescent Short Form (teique-asf) – self-regulation subscale

As we have multiple primary and secondary outcomes, we will adjust inference for multiple hypothesis testing.

Our choice of outcomes is based on the Theory of Change. Both primary outcomes are supported by the theory of change and there is a clear rationale for including both in the pilot research. This is due to the importance of detecting impact on offending (including violence) if possible, as it is the ultimate aim of Your Choice. However, given that PNC only measures crime that have led to an arrest, impacts may be harder to detect. Power calculations indicate that we would need a much bigger sample to pick up relatively small impacts on offending (at least based on the literature, as shown in the annexed power calculations), even in the efficacy study. This makes only relying on a PNC-based measure of offending as primary outcome too risky. Therefore, another intermediate outcome has been selected, based on the theory of change. If needed, the choice of primary outcome will be refined during the pilot based on the qualitative and quantitative data that is being collected and the learning about the theory of change.

Data sources

1) Surveys of young people and surveys of practitioners about the young people

With the exception of the PNC-based offending measure, we will collect data on all outcomes using baseline and endline surveys completed by each young person and their practitioner in the evaluation sample.

The baseline surveys will be administered after a young person has consented to participate and prior to their practitioner delivering support to them. The young person baseline survey will include the SDQ, the self-reported measure of crime and violence developed by the project and evaluation teams, as well as the measure of social connectedness. The practitioner baseline survey about the young person will include an assessment of the youth's likelihood to engage in crime and violence based on the same questions asked to the young person.

The young people and practitioner endline surveys will take place 14-20 weeks later (so within 2 weeks of finishing Your Choice for those assigned to treatment, given that Your Choice should not take longer than 18 weeks to complete). The young people endline will include the SDQ (with follow up questions), the self-report measure of crime and violence, the social connectedness, mental wellbeing, self-efficacy, and self-regulation scales. The endline survey

will also ask a question about the young person's main activity (education, employment, training), and it will also include questions about the young person's experiences working with the practitioner over the past 3-4 months. Specifically, we will ask young people to report the extent to which their practitioners used different CBT techniques during their work with the youth. The endline survey will also include free text questions to examine intended and unintended outcomes, not captured through the standardised tests.

The endline practitioner survey will also ask the practitioner to report the extent to which they have used CBT techniques with the youth. The point of asking both the practitioner and the young people about the use of CBT techniques during their work together is to capture the extent to which a) treated practitioners actually make use of the training they receive and b) control practitioners also use these techniques (hence measuring cross-contamination).

The baseline practitioner surveys will be sent to practitioners via email. Practitioners trained in Your Choice will deliver Your Choice to all eligible young people assigned to them. They will therefore not be blind to the treatment status of the young person. The baseline young people survey will be completed in the session when the young person consents to participate, on a tablet provided by the practitioner. The practitioner will pass the tablet to the young person, who will fill in the survey. They will be on hand in case the young person has any questions, but will not see the questions and answers, which will be sent directly to the evaluation team. Where the young person is old enough and so desires, the practitioner can be asked to leave the room while the young person fills in the survey.

To administer the endline young people survey, we will recruit peer researchers to meet with the young people and support them with the completion of the questionnaire. These meetings will be either in person (in a Local Authority building) or online and will be arranged with the practitioner. The practitioner will be asked to be present at the beginning of the meeting in order to introduce the peer researcher to the young person and ensure that the young person feels more comfortable. This approach will minimize the burden of survey data collection on youth practitioners while minimizing any bias the presence of the youth practitioner may have on the young person's answers.

In the rare cases the youth practitioner advises against such a meeting (either because it would be unsafe for the peer researcher or because it would not be in the interest of the young person's wellbeing), we will ask the practitioner to have another practitioner support the young person to complete the questionnaire and, when this is not possible, to support the young person themselves (as in the case of the baseline questionnaire).

Finally, if the young person drops out of the intervention (but not out of the study) before it

is time to complete the endline questionnaire, we will contact them using their phone number or email address to organise a meeting with a peer researcher, either in-person or online, in order for them to complete the questionnaire. Should they not want to complete it during such a meeting, we will send them the questionnaire online for them to complete it on their own time.

While our preferred option will be for young people to complete their online questionnaire during meetings with peer researchers (and organized by their youth practitioner), our revisions to the initial approach are aimed to offer more flexibility than initially planned in order to minimize attrition, in addition to enabling us to collect endline data even on individuals who drop out of the programme. . During the pilot stage, we also prefer allowing different ways to collect data in order to learn whether flexibility should be allowed during the efficacy trial or not. A note will be made as to how each questionnaire is filled out (and which peer researcher supports the young person), in order to explore the extent to which there may be systematic differences in responses driven by the procedure employed to complete the questionnaire.

2) Data from Local Authorities

With the project team, we have created a spreadsheet for LAs to complete that will provide the following information:

- Background information on all young people participating in the study, held and easily accessible by the LAs: name, date of birth, gender, ethnicity, UPN/ULN where available, details about involvement with the LA
- Log of all practitioners who have under gone the Your Choice training
- Log of all clinical supervision sessions taking place during the study
- Log of all sessions scheduled between youth practitioners and young people participating in the study, including date, length, engagement of young people and content covered. We are considering developing an online form for practitioners to fill out this information themselves, on the go everytime they finish a session with the young person., as this will increase the quality of information collected.

3) Data from government data sources

Using name, date of birth and UPN/ULM when available, we will apply for PNC and NPD data (ILR and LEO data later on) to match individuals and measure their offending and school engagement and attainment both before and after the treatment.

Approach to implementation and process evaluation data

There are four components of the implementation and process evaluation data:

1. Endline quantitative survey data on therapeutic alliance as a core intervention process and follow up free text questions (described above)
2. Implementation monitoring data (described above)
3. Implementation survey (described below)
4. Interview and focus group data (described below)

An implementation survey will be collected from professionals working in sites implementing Your Choice, depending on the capacity of site alongside other evaluation activities during the pilot. The implementation survey will examine:

- Readiness for change
- Views and experiences on the journey of implementation
- Implementation plans
- Progress toward (and deviation from) implementation plans
- Acceptability of Your Choice (including recruitment rate and subsequent engagement)

The priority for the pilot phase is to examine the acceptability of Your Choice and the evaluation and to understand the processes of early implementation. Interviews will be co-facilitated with our appointed peer researcher. This will involve semi-structured interviews with 3-5 young people receiving Your Choice and 3-5 young people receiving usual practice. We will conduct interviews/ focus groups with professionals involved in the delivery of Your Choice, recruiting up to 5-7 youth workers, 3-5 implementers/trainers, and 3-5 referrers. Interview schedules for each group will be co-produced with the core implementation team and peer researcher, and our initial topic guides outlined below have been designed to capture YEF recommendations about important types of information from feasibility studies, relevant to Your Choice. We will also examine any available implementation data routinely collected by Local Authorities (e.g., to examine recruitment and retention rates).

During the pilot phase, we will work with our appointed peer researcher to conduct specific activities with the Research Young Person's Advisory Group (YPAG) to build knowledge of Your Choice, which may include joining meetings with the implementation team and shadowing implementation activities (such as training) where appropriate. Adverts to join the

YPAG will be disseminate to a range of networks (e.g., Anna Freud Centre, VRU YPAG) in addition to any local LA expert by experience groups. Any groups we feel do not have a voice in the YPAG will be identified in the early meetings and we will conduct ongoing recruitment to represent these voices. These activities are essential to enable the YPAG to meaningfully work alongside the research team in interpreting the findings from the pilot and using this learning to inform the ongoing planning for the full trial. It will also enable us to understand the views of young people on the early stages of implementation and programme, including their views on the encouragement design (what would and would not work), the intensity of the treatment, the best ways of collecting data in questionnaires, and their attitudes towards consenting their various data to be linked.

Interview and consultation topics guides will include:

- Views and experience of Your Choice
    - To what extent does the programme fit with and add to the landscape of existing practice?
    - Do youth practitioners view Your Choice as needed and why?
- How the programme is implemented
    - To what extent does this fit, or not fit, the theory of change and TIDieR?
    - How, if at all, could the programme be tailored to meet the context and population needs?
        - Interviews and focus groups with professionals will ask about equity for marginalised groups, including Black and minoritized ethnic groups, LGBTQ+ groups, neuro-diverse groups, and special educational needs.
        - Interviews with young people will ask about the extent to which Your Choice or usual practice met their individual needs and was personalised to and inclusive of them. We find this a more suitable way into such questions; for example, an intervention may not meet an individual's needs but they might not connect it to a particularly part of their identity.
        - In the quantitative analysis, if sample sizes allow, we will try to explore the differential returns to the intervention from targeting different racial groups or other minority groups such as SEN children.
    - How well are the different components being delivered?
- Barriers and facilitators to implementation
    - What helps and hinders recruiting young people to the programme and then engaging them?
    - Which components of the intervention are more, and less, readily delivered?
    - What would be needed to make components of the intervention more readily delivered?

- Impact of Your Choice have on young people
    - Is there evidence to support anticipated outcomes in the logic model?
- Acceptability of the research
    - An overview of the full trial, drawing on the infographic; for example, for the Research Advisory Group we say:
        - Half of the young people will get Your Choice. The other half will get existing help – this means the youth workers will work with them in the same way as they do at the moment. This will look different in different areas, as the project is across London.
        - Young people will get Your Choice or existing help randomly (by chance or the toss of the coin). This is important so that we can tell if Your Choice works.
        - Let's say young people feel better after Your Choice. We wouldn't know if they would have felt better anyway, even if they didn't get Your Choice, without having a group to compare to.
        - We do this at random so we can make sure young people getting Your Choice or existing help are as similar as possible. If we don't do this, young people who get Your Choice and existing help could be very different, for example young people with higher levels of difficulties are given Your Choice. If we find young people feel better after Your Choice, we wouldn't know if this was because of Your Choice or because young people had higher levels of difficulties to begin with.
        -
    - How would you feel if you received Your Choice or not by chance or the toss of a coin?
    - What do trainers, youth workers, and young people think about the information sheet, consent form, and measures? How could these be improved and/or made easier to complete?
    - What would help in recruiting young people to the full trial and retaining them?

Methods overview

Research methods	Data collection methods	Participants/ data sources (type, number)	Data analysis methods	Research questions addressed
IPE	Survey	1 per borough for all LAs which take part in the randomisation (likely to be 31)	Descriptive statistics	#3
IPE	Interview	3-5 young people (intervention), 3-5 young people (control)	Thematic analysis	#3
IPE	Interview/ focus group	5-7 youth workers (intervention), 3-5 implementers/trainers, and 3-5 referrers	Thematic analysis	#3

Note. IPE = implementation and process evaluation.

Data analysis

Our quantitative analysis will focus on two parameters: the Intention to Treat (ITT) which measures the impact of being offered treatment, and the Treatment on the Treated (TOT) which measures the impact of receiving the treatment. These parameters can differ due to non-compliance. For example, we may expect some young people to not participate in the Your Choice program, despite being referred to youth services and allocated to a Your Choice trained team of case workers. Moreover, dosage may also differ among those who get some treatment, as youth may drop out or disengage with youth practitioner teams during the delivery of Your Choice.

Assuming the pilot is sufficiently powered, our main measure of effectiveness will be based on the ITT, which we will estimate by regressing the outcomes on an indicator whether the youth is in the treatment group (i.e. was assigned to a team trained in Your Choice) and LA fixed effects. To increase power and adjust for regression to the mean we will, where possible,

control for pre-intervention outcomes such as the assessment score from the referral panel and prior referrals.

We will recover the TOT using instrumental variables, using the randomisation as an instrument for participation in the programme, and controlling for the same pre-intervention outcomes as for the ITT. We will also examine whether certain correlates of attrition (such as the timing of treatment – term-time vs school holidays) can be used as additional instrumental variation.

Qualitative data (i.e., transcripts, free-text responses) will be analysed using the NVivo qualitative data analysis software. We will use the framework analysis approach to manage the data, categorising transcripts according to which component of the logic model they address. We will then use thematic analysis to analyse the data organised in the framework to explore themes across participants' experiences and perspectives. At least two members of staff (including the peer researcher) will be involved and there will be regular coding review meetings throughout the stages of the analysis. Such approaches are commonly used in applied policy evaluations. Different reliability processes are available for qualitative data than quantitative data, and the research team will adhere to quality standards for establishing the trustworthiness of the data (i.e., credibility, transferability, dependability, and confirmability).

We are also using the pilot phase to explore obtaining access to secondary administrative data sources that follow a young person's pathway through engagement with Youth Services. We are still establishing whether this will be feasible, and how any matching to primary data collection can be reliably conducted, in accordance with ethics guidelines and with ethics approval.

Outputs

The outputs of the pilot trial will be:

1. A full report on the design, conduct, analysis and interpretation of progression to an efficacy trial.
2. If an efficacy trial is warranted a revised protocol for the design of that trial.

Cost data reporting and collecting

We will report cost of implementation in the final report following YEF guidance. That is:

- We will use a bottom-up approach and break costs down into: prerequisites, set-up costs, and recurring costs.
- We will report average cost for a typical single cohort receiving the intervention for one round of delivery and average costs per participant for one round of delivery, assuming full compliance. The exact definition of a typical single cohort remains to be determined, based on LA's experience in the pilot trial. We will engage with the project team and with the LAs to ensure we pick the most meaningful definition of a typical single cohort.

Initial discussions with the project team indicates that there may be a non-negligible amount of heterogeneity in the cost of implementation across LAs, depending on their size, internal organisation and efficiency. To report cost at the end of the pilot, we will build a template for LAs to report costs of items and to ask a sample of LAs to fill out such template. We will pick 3-4 LAs to be in this sample. We will build this template in collaboration with the project team, so as to ensure that all costs involved are appropriately itemised.

We expect most costs to fall within the following two categories:

- Staff cost: cost of practitioners, supervisors, and managers involved in the implementation of Your Choice
- Engagement initiatives: as part of Your Choice, practitioners can support young people by, say, paying for additional forms of support (e.g. tutoring costs, music lesson, training, etc) that would allow the young person to achieve their goals.

Ethics and registration

- We have submitted a high-risk ethics application to the UCL Research Ethics Committee, and expect to hear back by early May.

Data protection

Data storage

Data will be stored on the network of the Institute for Fiscal Studies (IFS) in a secure folder with access restricted to named researchers.

The IFS information security management system is ISO27001 compliant and the IFS has an Information Classification and Handling Policy which sets out a comprehensive set of guidelines for handling all types of data and information (including highly confidential information). AFC have similar Information Governance policies, and all information will be held on the secure AFC servers, with only approved researchers having access. All project team members will follow strict procedures in this policy and adhere to the IFS/AFC Information Security Policy when using or collecting data. All project team members will have received appropriate GDPR training.

Data deletion

We will keep the data for a minimum period of 10 years after the delivery of the final report, in line with UCL guidelines. This period of data retention is required for us to deliver a full analysis of the long-term effects of the interventions studied in this project and to go through the publication process of this work in peer-reviewed journals. Data in fully anonymised form will be made available on journal websites once the papers that result from this study have been accepted for publication.

We will only store digital records of the data, which will be held securely on the network as outlined above.

Data sharing

As part of the consent process, we will ask potential participants permission to link their survey answers to their National Pupil Database (NPD) records, their Police National Computer (PNC) records, their earnings records (HMRC) and benefits records (DWP). To operate such linkage, we will need to share the data with the Department for Education, MoJ, HMRC, and DWP. Specifically, we will do the following:

- Send these departments the names and DOB of study participants, alongside the survey questions we want them to match to linked data (e.g. treatment condition, background variables)

- The departments will match these individuals in the relevant datasets using names and DOB and prepare datasets with the outcomes of interest for our sample

- They will provide these datasets on the SRS or other Safe data platforms, after having removed the names and DOB of the individuals

- This (de-identified) data will only ever be used within the secure environment at the ONS SRS by approved researchers (for DfE and MoJ data) or equivalents (for HMRC/DWP) data.

Legal basis for processing

The lawful basis for processing is: Legitimate Interests (Article 6(1)(f)). A legitimate interest Assessment has been carried out.

Personnel

Our project is a partnership between the Institute for Fiscal Studies (IFS) and Anna Freud Centre (AFC). Professor Rasul will act as PI, taking overall responsibility for the project. The IFS team will lead the quantitative evaluation. The AFC team will lead the qualitative process evaluation.

Rasul will lead engagements with YEF and be responsible for ensuring the close integration of quantitative and qualitative work streams. Cattan and the project manager will lead in liaising with the delivery partner. All members will be engaged in the design of the evaluation and survey instruments. Costa-Dias will lead on methodological aspects and trial design. Cattan will lead on data collection and administrative data acquisition. Under supervision from all other team members, the Research Economist will clean and analyse data and provide frequent updates to the team. Rasul will take the lead on the write up and dissemination of results, with input from all team members.

Edbrooke-Childs will act as Process Evaluation Lead. He will lead engagement with YEF alongside Rasul. Edbrooke-Childs and Stapley will lead on the methodological design. Jacob will work closely with the project manager on operational oversight, planning, and risk/issue log monitoring. Jacob will supervise the Researcher and Peer Researcher who will lead on data collection, with specialist input from Stapley throughout. All team members will analyse the data, with Edbrooke-Childs, Stapley, and Jacob leading the reporting and dissemination. Deighton will provide ongoing critical appraisal with a view of the overall process evaluation.

The team will be supported by a 0.8 FTE project manager who will liaise across sites and evaluation teams to ensure all aspects of the project run smoothly. He/she will manage the day-to-day working relationship with partner, especially as they relate to research design and data collection operations; monitor implementation of intervention; supervise data collection, manage team of surveyors, and ensure quality control of research.

Relevant experience of team members

Prof. Rasul (Professor of Economics, UCL; Research Director, IFS) has two decades of research experience in designing and implementing multi-site randomized control trials to evaluate policy interventions, including projects combining quantitative and qualitative research streams. His has studied the causes and consequences of engagement in criminal activity, utilizing administrative records (e.g. PNC), conducted cost benefit analysis based on impact evaluations, and is a member of the Academic Advisory Group, Ministry of Justice Data First project.

Prof. Costa-Dias (Professor, University of Bristol; Deputy Research Director, IFS) is an expert in micro-econometrics evaluation methods. She has developed empirical methods for policy evaluation (e.g anticipation effects, spillover effects), studied impacts of multiple reforms on those treated and their families (e.g. New Deal for Young People, Housing Benefit), conducted evaluation feasibility studies (e.g. Universal Credit), is currently studying the long-shadow of mental health problems during adolescence using Danish data.

Dr. Cattan (Associate Director and Head of Education and Skills sector, IFS) has worked on several experimental and quasi-experimental evaluations of interventions to promote children's cognitive and emotional development (e.g. Sure Start, Head Start). She has extensive experience working with English administrative data and psychometric analysis, and disseminating her findings to policy-makers.

Laura van der Erve (Senior Research Economist, IFS) has extensive experience working with English administrative data and disseminating her findings to policy-makers. She has worked on a range of projects commissioned by the Department for Education and the Social Mobility Commission which have utilised linked administrative data.

Prof. Edbrooke-Childs (Professor of Evidence-Based Child and Adolescent Mental Health, UCL; Head of Evaluation, AFC; Deputy Director, Evidence Based Practice Unit, AFC and UCL) research focuses on empowering young people to actively manage their mental health and mental health care. He has extensive experience of leading qualitative research; e.g., PI of Evaluation, Health and Justice Specialised Commissioning Workstream (NHS England & NHS Improvement); lead qualitative researcher and Co-I, Mental Health Policy Research Unit funded by the Department of Health and Social Care.

Dr Stapley (Senior Qualitative Research Fellow, AFC and UCL) has led large-scale qualitative research studies nested in high-profile national research programmes, was the qualitative lead for the HeadStart programme involving extensive qualitative longitudinal study of over 80 adolescents' experiences for five years.

Dr Jacob (Research Lead Child Outcomes Research Consortium, AFC) has managed large-scale qualitative research (e.g. Community F:CAMHS, SECURE STAIRS), was Co-PI on a project involving interviews and focus groups with young people and professionals across eight countries, worked on the project "Child- and Parent-reported Outcomes and Experience from Child and Young People's Mental Health Services 2011–2015", which informed the rollout of Children and Young People's Improving Access to Psychological Therapies.

Prof. Deighton (Professor, UCL; Director of EBPU) is an expert in mental health and wellbeing in

childhood and adolescence. She has led various programmes of research (e.g. 7-year evaluation of HeadStart, DfE Mental Health Research Programme), has extensive experience of working with policy makers, and is the Co-I for the NIHR Children and Families Policy Research Unit.

Collaboration between IFS and AFC

The teams will work closely to maximise complementarities in expertise, expanding on the successful collaboration between Cattan and Deighton on the evaluation of HeadStart and the NIHR Children and Families Policy Research Unit. Regular meetings will keep the teams co-engaged in developing the research design, data collection strategy, interpreting and contextualising the evaluation results, and drawing policy lessons.

IFS has experience working on the causes and consequences of vulnerabilities among children and youth, especially in the context of education systems and labour markets; AFC brings expertise on the needs and trajectories of youth at risk or with prior involvement in crime and the youth justice system. On methods, IFS has designed and evaluated complex, multi-site randomised controlled trials; AFC has conducted mixed methods studies that included collection and analysis of qualitative data for process and implementation evaluations. IFS brings expertise in psychometric analysis and econometric analysis of survey and administrative data; AFC brings knowledge of measurement tools of antisocial and mental health problems. IFS has experience performing economic policy evaluation. AFC has institutional knowledge of CAMHS and services accessed by the target population.

Both organisations are unique in their focus on generating high-quality academic research to improve policy-making. They will use their experience speaking to policy-makers about research and activate their wide networks to enhance the impact of the study.

Risks

We have identified the following risks:

1) **Violations of the randomization of youth practitioner teams into Your Choice training (MEDIUM)**. We will need to ensure the randomized initial and later staggered timing of teams of youth practitioner being trained in Your Choice is adhered to. This requires that at the start of the pilot, LA's provide a list of at least two teams they would like to be trained and that, following our randomization, they will ensure that the selected team is trained and is kept together as far as possible (except in the obvious circumstance of members of the team permanently leaving youth services).
2) **Matching of young people to teams within service sections. (LOW)**. Our understanding is that referral panels designate the services young people should

receive but not the specific teams within each service section that should deliver the service. We require the assignment of teams to young people to be entirely independent of the Your Choice training status of the team – so that effectively the assignment of young people to teams within service sections follows the same procedures as those in place before Your Choice. Any targeting of young people to teams based on whether they have been trained in Your Choice would undo the randomization protocol and violate the requirements of the trial. Our understanding is that referral panels do not always know the Your Choice treatment status of teams. We have always made it very clear to local authorities in their Grant Agreements that any assignment of young people to teams should ignore the treatment status of teams.

3) **Insufficient data provision**. **(MEDIUM)**. Right at the start of the programme, we will require that Directors of Children's Services (or their teams) draw up the lists of youth services and teams delivering them, and indicate which they would like to be trained in Your Choice. We will also require real time data on each referral panel, the cases they assess and their recommendations. Referral panels meet at least once monthly in each LA, and there can be more than one panel per LA. From each sitting panel, we will need information on the panel composition, the young people being considered, their assessment scores (and other information utilized by the panel), and the decisions over services to be received by each young person. That information defines which young people enter our evaluation sample. The grant agreement clearly lines out for each local authority the data they need to collect, and emphasizes this is a condition for the receipt of YEF funding for this intervention.
4) **Not all LA's engaging with the evaluation exercise. (LOW)**. We hope to be able to mitigate these concerns by continuing to build a close working partnership with the VRU and LA's and by transmitting to them the importance of adhering to the randomization protocols (many of which require them to continue operating in the exact same way as they did prior to Your Choice) and to the consistent delivery of the programme within the diversity of the populations that LA's work with. We hope these risks are being mitigated by the close working relationship between the evaluation team, the VRU and the LAs. In the communication between the VRU and LAs, the requirements of the evaluation have been clearly spelled out, the required randomization protocols have also been explained, and a key deliverable indicated by the VRU is that LAs engage with the evaluation.
5) **Low recruitment (LOW).** The projected numbers provided by the VRU of 100 young people being identified as medium/high risk across London boroughs each month suggests the trial will be of the scale required by the power calculations. There is a risk that even when young people are identified, they might not consent to being involved

in the evaluation – further reducing sample size. To mitigate these concerns, we are making the information sheet and consent form as clear and approachable as possible for the participants, including creating a video explaining the study. There is an additional risk of lack of engagement of young people with the high-intensity schedule of meetings proposed under Your Choice. This is a risk the encouragement-to-all aspect of the design specifically addresses and we will closely monitor its effectiveness.

6) **Cross contamination between treated and control participants**. **(MEDIUM)**. This applies to both treated teams of case workers interacting with non-treated teams, and treated young people interacting with controls. With such spillovers, the benefits of the treatment could spillover onto controls, confounding measuring the impact of the intervention. We have discussed this concern throughout with the project team. We will ask both the control and treatment young people and practitioners about the techniques used during the sessions to measure the extent of cross-contamination.
7) **Contamination is between the Your Choice intervention and the NHS intervention London Vanguard (LOW).** The two programmes will overlap in time and will target similar populations, although London Vanguard has a wider reach by not being restricted to young people, and is planned to operate across multiple sites which may or not include LA premises. Given the dimension of the two programmes in terms of number of participants, and their concurrent focus on the population at risk of violent crime, there is a risk that some young people will be assigned to both programmes, or that some young people in the control group for Your Choice will participate in London Vanguard, and perhaps receive similar treatment to that delivered by Your Choice through London Vanguard. However, it is at this stage clear that not all young people assigned Your Choice will participate in London Vanguard. That is both due to capacity constraints and to the fact that London Vanguard will operate only in 3 out of the 5 Integrated Care Systems in London. While we cannot impede young people from participating in London Vanguard, we can control for it. We will require that information on treatment status by London Vanguard is provided to us, so that we know who is having the opportunity to receive the set of services provided by that programme. This will allow us to gauge the frequency of overlapping treatments. If in practice London Vanguard treats a significant proportion of the Your Choice population, we will be able to use information on participation in that programme to assess the additional impact of participating in Your Choice. In this case, and to better understand our results, we will aim to further our understanding of the services provided by London Vanguard. In particular, we will aim to keep a close contact with those designing the London Vanguard evaluation, including with Professor Peter Fonagy, to continue exchanging information on the scope of both programmes.

Timeline

Phase		Description of activities during phase	Target date
• Study and project mobilisation/set up. • Stage 1 of pilot (Home office pilot) (1st January 2022 – 31st March 2022)			
		• Evaluator completes theory of change/logic model, in partnership with project team • Evaluator finalises intervention description, in partnership with project team	28th February 2022
		Evaluator completes DRAFT information sheets and privacy notices for whole evaluation, including archive, for YEF review	11th March
		• Evaluator completes final information sheets and privacy notices for whole evaluation, including archive, incorporating YEF review feedback	25th March 2022
		Evaluator completes DRAFT pilot trial protocol for peer review	4th April
		Evaluator obtains ethical approval and provides confirmation to YEF	4th May 2022
		• Evaluator incorporates feedback from peer review and submits final pilot trial protocol	18th May
• Project delivery & stage 2 of pilot (YEF pilot): 1st April 2022 – 31st August 2022		Data collection begins	15th June 2022
	5	Completion of baseline data collection as specified in pilot trial protocol (rolling recruitment ends)	15th July 2022

	6	Completion of all data collection as specified in pilot trial protocol (includes both quantitative pilot trial data and implementation and process data)	15th December 2022
• Data analysis and report write up	7	Evaluator completes DRAFT interim evaluation report (basis of decision to progress to efficacy study) and submits for review	15th February 2022
	8	Evaluator incorporates feedback and completes final, peer reviewed interim evaluation report	15th March 2023
	9	Evaluator completes support for YEF publication process	15th April 2023

Your Choice:

Intervention Description

Item	*Description*
1. BRIEF NAME	Your Choice
2. WHY	Young people who get involved in violence (those most at risk) are those in most of need of therapeutic support, but most unlikely to receive it. We need to shift how we offer support to young people, by shifting the offer, so they can access it within their community, within a broader context of support and behavioural change. This can be delivered best through a holistic, community model delivered through all relevant partners.
3. a) WHAT (Your Choice)	Upskilling practitioners • 5 days of training for youth workers (delivered in a cascading model) • Monthly clinical supervision • Regular peer supervision • Handbook and resources to support delivering sessions Upskilling children and young people • 3 x weekly meeting with youth practitioner for 12 weeks • Build authentic and trusting relationship – safe space where young people can grow • Accessible clinical intervention, including emotional literacy, emotion regulation, understanding cognitive processes, and strategies for managing intense feelings (Brain Gym) • Solution focused • Goal setting (using Goal Based Outcome Tool) and practical support with activities to achieve these goals • Understanding and formulating young people's needs • Coach to guide self-understanding
3. b) WHAT (usual care)	Young people with medium or high risk. Description to be developed from evidence and learning from the pilot.
4. WHO PROVIDED	Youth practitioners: youth workers, social workers, youth justice

	worker, gang workers, etc
5. HOW	Individual or work with the family (e.g., psychoeducation for parents/carers
Item	***Description***
6. WHERE	Range of locations, accessible to the young person, so they are engaged in the places they want to be engaged; mainly community settings such as youth centre, cafes, gyms, etc
7. WHEN and HOW MUCH	3 x a week for 12 weeks (calls, meetings, going to the gym, working with parent/carer for psychoeducation); 45-60 mins (poss. longer)
8.TAILORING	To facilitate sustainability and meet local needs, it is important that Local Authorities own Your Choice; it will build on existing services and delivery for this cohort of young people, which will vary between different Local Authorities
9. MODIFICATIONS	To be determined based on the pilot
11. HOW WELL	To test fidelity monitoring during the pilot

Hoffmann T C, Glasziou P P, Boutron I, Milne R, Perera R, Moher D et al. Better reporting of interventions: template for intervention description and replication (TIDieR) checklist and guide BMJ 2014; 348 :g1687 doi:10.1136/bmj.g1687

Annex A – Power calculations (pilot)

The table below shows the number of teams required in each arm to detect various effect sizes for different combinations of baseline prevalence and ICC. This is based on a cluster size (number of CYP per team) of 8, based on 4 children per team per month, and a 2 months pilot. The cells highlighted in green show the effect sizes we can detect with 31 treated teams (the likely number of treated teams we can use in the pilot).

Table 1. Outcome: Probability of externalising disorder (based on SDQ)

ICC	Prevalence of externalizing problems in both arms at baseline	*MDE Size*				
		20%	30%	40%	50%	60%
0.05	50%	66	29	16	10	7
0.05	60%	46	20	11	7	5
0.1	50%	83	36	20	13	8
0.1	60%	58	26	14	9	6

Table 2. Outcome: Probability of committing at least one offence

ICC	Percentage of young people in the control arm who commit at least one offence	*MDE Size*				
		10%	20%	30%	40%	50%
0.05	20%	1019	244	104	56	34
0.05	30%	600	145	62	34	21
0.05	40%	390	95	41	23	14
0.1	20%	1283	308	131	70	43
0.1	30%	755	183	78	42	26
0.1	40%	491	120	52	28	18

Annex B – Power calculations (efficacy trial)

The table below shows the number of teams required in each arm to detect various effect sizes for different combinations of baseline prevalence and ICC. This is based on a cluster size (number of CYP per team) of 45, based on 3 children per team per month, and a 15 months efficacy. The cells highlighted in green show the effect sizes we can detect with 62 treated teams. The assumption of 62 treated teams relies on 31 treated teams in the pilot, all LAs going ahead to the efficacy, and all LAs having the capacity and resources to have an additional team trained and delivering Your Choice during the efficacy trial. It will need to be determined during the pilot whether this number of treated teams and number of children enrolled each month is indeed feasible.

Table 1. Outcome: Probability of externalising disorder (based on SDQ)

ICC	Prevalence of externalizing problems in both arms at baseline	*MDE Size*				
		20%	30%	40%	50%	60%
0.05	50%	28	12	7	4	3
0.05	60%	19	9	5	3	2
0.1	50%	47	20	11	7	5
0.1	60%	32	15	8	5	4

Table 2. Outcome: Probability of committing at least one offence

ICC	Percentage of young people in the control arm who commit at least one offence	*MDE Size*				
		10%	20%	30%	40%	50%
0.05	20%	429	103	44	23	14
0.05	30%	253	61	26	14	9
0.05	40%	164	40	17	9	6
0.1	20%	725	174	74	40	24
0.1	30%	427	103	44	24	15
0.1	40%	277	68	29	16	10

Table 3. Outcome: School engagement index

ICC	School engagement of control arm - Mean = 0, SD = 1	MDE Size (in SD of the control group)					
		0.03	0.05	0.07	0.1	0.15	0.2
0.05	N teams in each arm	1240	447	228	112	50	28
0.05	N kids per arm	55800	20115	10260	5040	2250	1260
0.1	N teams in each arm	2093	754	384	188	84	47
0.1	N kids per arm	94185	33930	17280	8460	3780	2115

YOUTH ENDOWMENT FUND

Impetus

Home Office

youthendowmentfund.org.uk

hello@youthendowmentfund.org.uk

@YouthEndowFund

The Youth Endowment Fund Charitable Trust

Registered Charity Number: 1185413

THE LONDON YOUNG PEOPLE STUDY

Information Sheet for Young People

My name is Imran Rasul.

I am a Researcher and Professor.

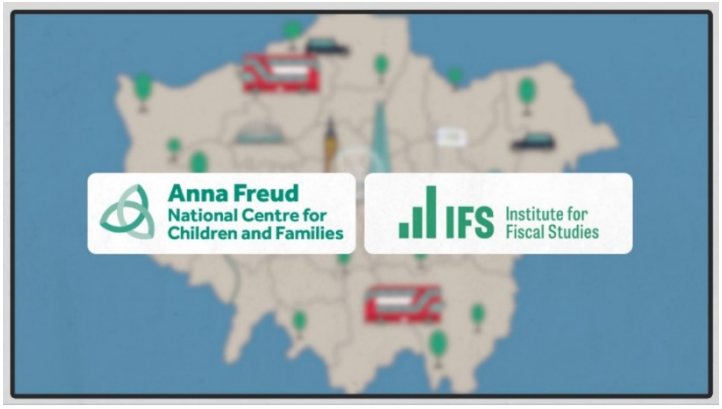
I want to understand **how we can best support young people to keep safe and healthy.**

We would like you to help us.

This sheet is **to help you decide whether you would like to take part.** Before you decide take time to read this information.

If anything is unclear, **please speak with your parent or carer,** the professional who has given you this information sheet, or email me at: LondonStudy@ifs.org.uk

Who are we?



We are based at the **Institute for Fiscal Studies** and the **Anna Freud Centre.**

I was born and raised in London, I want to try hard to find ways that help young people in London be safe and healthy.

All my team care about this project and believe it can help young people's lives.

In their work, they have seen how young people from certain groups are much less likely to be listened to. Meeting different groups will help how young people are supported by professionals and make sure support meets their needs.

IFS Institute for Fiscal Studies

Anna Freud National Centre for Children and Families

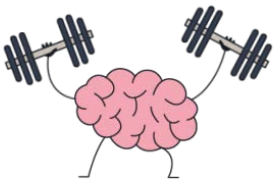
Section 1: What is this study about and how does it work?

When young people work with youth practitioners (for example, youth workers, social workers or specialist workers), the goal is always to **support them to keep them safe and healthy.**

There are **different ways** of supporting young people.

In this study, we would like to test whether a new way of working with young people is **better, worse, or the same** as the usual way of working with them.

This new way of working will teach the young person new skills in the brain gym. The brain gym helps people with their thoughts and feelings which can change how they behave and help them to achieve their goals.



The young person may meet with the youth practitioner more often than usual – up to 3 times a week for 12 weeks.

Why are you being invited to take part?

- You are between **11-17 years old** and
- You are **working with a team of practitioners from your borough**

Do you have to take part? If you take part, can you change your mind?

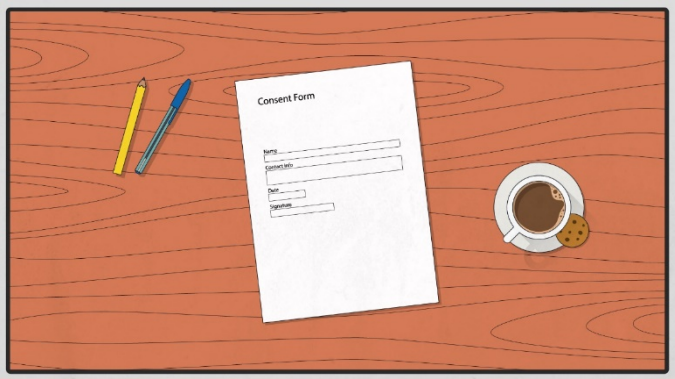
- **It is up to you** (and your parent/carer if you are age 11-15) to decide whether to take part. If you don't want to, your borough's youth practitioners **will still support you.**
- **You can change your mind and stop taking part at any time without telling us why.** Make sure that you (or your parent/guardian) notify the practitioner you are working with or contact me.

What will happen if you decide to take part?

- Your borough has given you a practitioner or a team of practitioners to work with you. Some of them have been trained in this new way of working already and some will be trained later on. This practitioner has given you this information sheet and told you about the study.

The steps below tell you what happens if you decide to take part:

1 We will ask you to **sign a consent form** and give us **your name and contact information** (if you are 11-15, your parent/carer signs one too)



10 mins

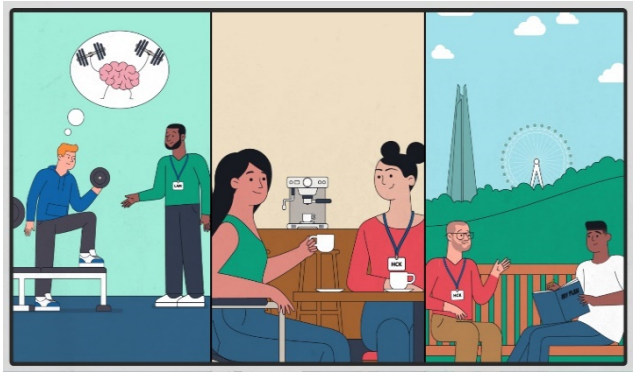
2 You fill out a **confidential questionnaire about your feelings and behaviours**.
If you do, you will receive a **£10 voucher.**

15 mins

3 You will work with your practitioner in one of two ways.

Either….
Your practitioner will work with you in the usual way

Or…
Your practitioner will work with you following the new approach



12 weeks

4 About **four months after**, we will ask you to fill out another **confidential questionnaire about your feelings and behaviours**.
If you do, you will receive a **£15 voucher.**

30 mins

5 If you would like, you can also talk to a researcher about how you found working with your practitioner**.**

If you do, you will receive an additional **£10 voucher**.

30 mins

What will happen if you talk to a researcher about your experience?

- It will be a one-to-one discussion for about 30 minutes.
- It can be online using Microsoft Teams or in person – **it is your choice.**
- If you choose to take part, we will record the discussion so we don't miss what you say. We will make sure we follow COVID-19 rules.

- *The Transcription Service* will write up what you say - we will make sure they keep your data safe. **We will replace your name with a number and the recording will be deleted.**

Why should I take part in the study?

- To thank you for completing the questionnaires, you'll receive **Love2Shop vouchers.**
- If you speak with a researcher you will receive another **Love2Shop voucher**.
- By taking part, **you will help us understand what makes a difference for young people.** You may also find it rewarding to have your story heard as **this will help other young people to be supported by local authorities in the future.**
- If you are going through a tough time, please talk to your practitioner about whether this is the right time for you to be taking part in this study.
- Do remember that **you do not have to talk about anything that makes you feel upset or uncomfortable.**
- Please do contact me if you would like to talk or need a break at any time during the study. If you do not feel able to ask your practitioner or the researchers for help, we encourage you to contact external support services such as:
    - *The Samaritans* (Tel. **116 123**, www.samaritans.org)
    - *Childline* (Tel. **0800 1111**, www.childline.org.uk)

Section 2: Your information and how it will be used

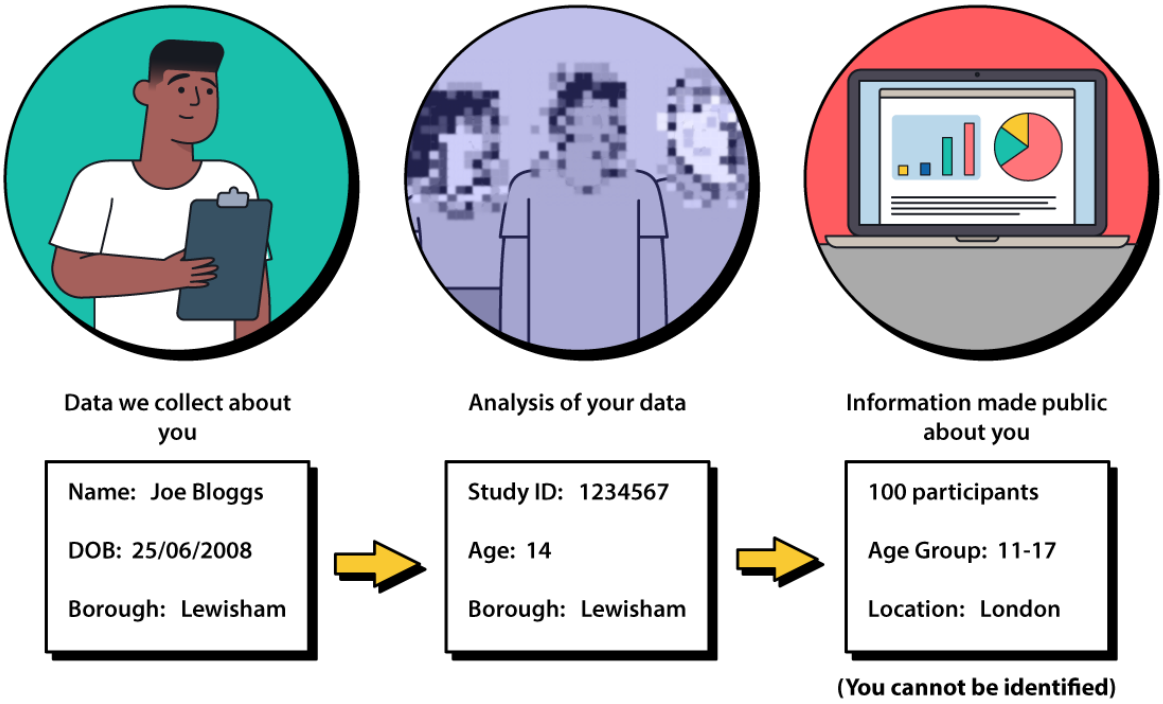
Note: The next section relates to how your information will be used in the study. We would strongly suggest that you go through this with your youth practitioner, and do not hesitate to ask any questions.

What information will we collect during the study?

- Your name and contact information in the consent form
- Your borough will also tell us things like your **date of birth, gender, ethnicity, your sexual orientation, whether you have any special educational needs, whether you have a disability, whether you are looked after by the local authority,** whether you are in **education, employment or training**, **why and how you are supported by your borough**
- We will ask you to complete **two questionnaires about your feelings and behaviours** – once at the start and once at the end of the study
- We will ask your practitioner to tell us a bit about your meetings with them, like:
    - if and when you had the meetings
    - what sort of work you did together
- We will also ask your practitioner to share your progress in keeping safe.

What will we do with the information that we collect?

- We will use this information to find out whether the young people who worked with their practitioner following the new approach do **better, worse or the same,** compared to the young people who work in the usual way.
    - To help with this, researchers will want to see your progress in the long term and will use information available with the **Department for Education** and the **Ministry of Justice**. **More information about this can be found inthe sections below and in the privacy notice.**
- We will write about the results, **and reports will be free online.** In these reports, we will use the things that you have said but **we will never use your name or any other information that might identify you.** No one will know that it is you who has said them.



- If you take part, your conversations will be audio-recorded so that the researchers can remember everything that was said.

How will we keep your information safe?

- **No information collected as part of this study can be used by the police (or other law enforcement bodies), by the Home Office for immigration enforcement purposes or by anyone else for any purpose other than seeing how well the London Young People Study has worked.**

- Most of your information is stored by the Institute for Fiscal Studies for the purposes of this project. They will be able to identify you in this information. The Institute for Fiscal Studies has strong measures in place to ensure that only the research team can see your information. Please read more below about requesting to delete this information if you want to.
- The only time someone **other than someone in the research team** will see your name alongside the information you give us in your questionnaire is if we need to share information with your practitioner, **to keep you or someone else safe.**
- If you talk to a researcher about your experience, the recording and write-up (transcript) of the discussion will be stored by the Anna Freud Centre. The recording will be deleted

once it has been written up. The Anna Freud Centre has strong measures in place to protect your data and the transcript will be kept for no longer than 9 months.

- After the study ends, some of your information will also be stored in an archive. Your identity is protected by replacing your name and other information with a number.
- There are strong measures in place to protect the information in this archive. This means **you cannot be identified without your information being illegally linked back to your name and address**.
- You can find out more about how we will use your information and who it is shared with in the **privacy notice** accompanying this information sheet.

What if I want my information to be deleted?

- If you want us to remove your information, you can contact us and ask us to delete them.
- **Your survey responses, which contain your personal information, will be kept by the IFS on an ongoing basis and can be deleted at any time**.
- However, it won't be possible to delete the information which will be stored in the archive because it will not be possible to identify you. Therefore, if you wish for your data to be deleted, you need to do this **before 30th December 2022, when the study ends.**

Section 3: Other information – ethics, questions and complaints

- All research is looked at by an independent group of people, called a "Research Ethics Committee (REC)", to protect your interests and safety.
- **This research has been reviewed and approved by University College London Research Ethics Committee (reference number: 5113.013).**
- If you would like to see a summary of what we will have learned from the study, **please let us know and we will send this to you**, or check our website (https://ifs.org.uk/london-study)
- Please contact us if you have any **questions, problems or complaints** at: LondonStudy@ifs.org.uk
- If you want to take your complaint further, you can contact the Chair of the ethics committee at ethics@ucl.ac.uk

THE LONDON YOUNG PEOPLE STUDY

Information Sheet for Parents of Young People Age 11-15

My name is Imran Rasul.

I am a Researcher and Professor.

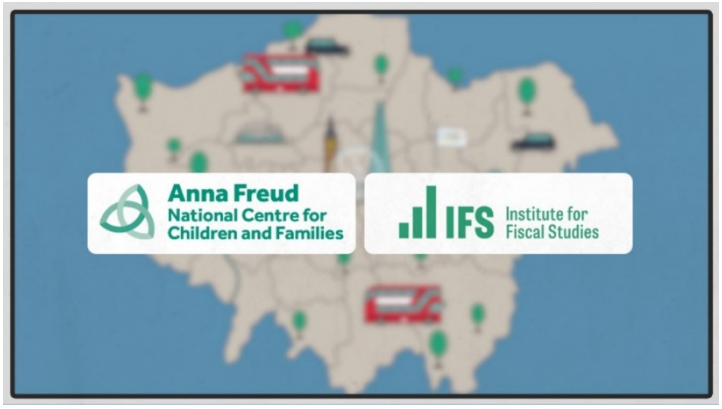
I want to understand **how we can best support young people to keep safe and healthy.**

We would like you to help us.

This sheet is **to help you decide whether you would like your child to take part.** Before you decide take time to read this information.

If anything is unclear, please speak with the professional who has given you this information sheet, or email me at: LondonStudy@ifs.org.uk

Who are we?



We are based at the **Institute for Fiscal Studies** and the **Anna Freud Centre.**

I was born and raised in London, I want to try hard to find ways that help young people in London be safe and healthy.

All my team care about this project and believe it can help young people's lives.

In their work, they have seen how young people from certain groups are much less likely to be listened to. Meeting different groups will help how young people are supported by professionals and make sure support meets their needs.

IFS Institute for Fiscal Studies

Anna Freud National Centre for Children and Families

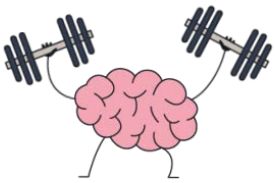
Section 1: What is this study about and how does it work?

When young people work with youth practitioners (for example, youth workers, social workers or specialist workers), the goal is always to **support them to keep them safe and healthy.**

There are **different ways** of supporting young people.

In this study we would like to test whether a new way of working with young people is **better, worse, or the same** as the usual way of working with them.

This new way of working will teach the young person new skills in the brain gym. The brain gym helps people with their thoughts and feelings which can change how they behave and help them to achieve their goals.



The young person may meet with the youth practitioner more often than usual – up to 3 times a week for 12 weeks.

Why is your child being invited to take part?

- They are between **11-17 years old** and
- They are **working with a team of practitioners from your borough**

Does your child have to take part? Can you/they change your/their mind?

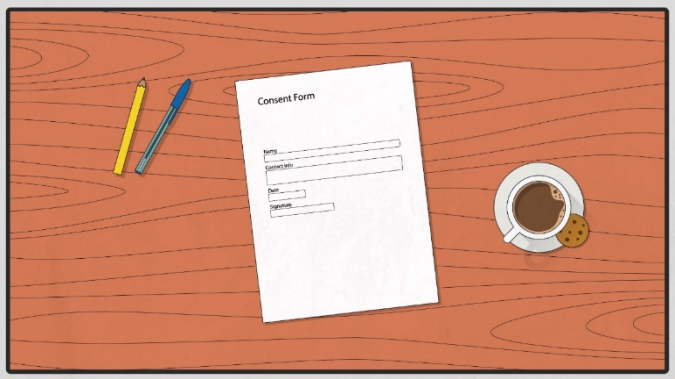
- **It is up to you** and your child to decide whether to take part. If you don't want to, your borough's youth practitioners **will still support your child.**
- **You and/or your child can change your/their mind and stop taking part at any time without telling us why.** Make sure that you or your child notify the practitioner you are working with or contact me.

What will happen if your child decides to take part?

Your borough has given your child a practitioner or a team of practitioners to work with you. Some of them have been trained in this new way of working already and some will be trained later on. This practitioner has given you this information sheet and told you about the study.

The steps below tell you what happens if your child takes part:

1 We will ask your child to **sign a consent form** and give us **their name and contact information** (for children age 11-15, their parent/carer signs one too)



10 mins

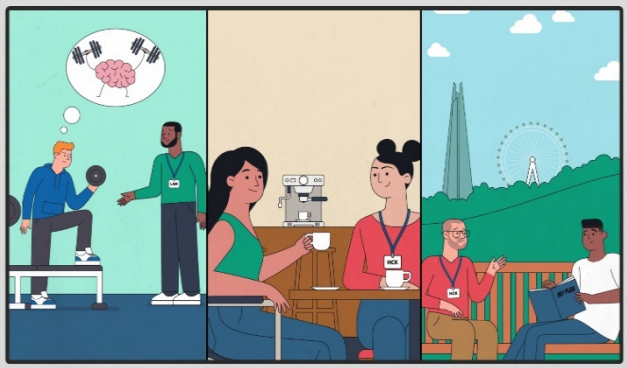
2 Your child fills out a **confidential questionnaire about their feelings and behaviours**. If they do, they will receive a **£10 voucher.**

15 mins

3 Your child will work with their practitioner in one of two ways.

Either…. Their practitioner will work with them in the usual way

Or… Their practitioner will work with them following the new approach



12 weeks

4 About **four months after**, we will ask your child to fill out another **confidential questionnaire about their feelings and behaviours**. If they do, they will receive a **£15 voucher.**

30 mins

5 If your child would like, they can also talk to a researcher about how they found working with their practitioner**.**

If they do, they will receive an additional **£10 voucher**.

30 mins

What will happen if your child talks to a researcher about their experience?

- It will be a one-to-one discussion for about 30 minutes.
- It can be online using Microsoft Teams or in person – **it is their choice.**
- If your child chooses to take part, we will record the discussion so we don't miss what they say. We will make sure we follow COVID-19 rules.

- *The Transcription Service* will write up what they say - we will make sure they keep your child's data safe. **We will replace their name with a number and the recording will be deleted.**

Why should your child take part in the study?

- To thank them for completing the questionnaires, they'll receive **Love2Shop vouchers.**
- If they speak with a researcher, they will receive another **Love2Shop voucher**.
- By taking part, **they will help us understand what makes a difference for young people.** They may also find it rewarding to have their story heard as **this will help other young people to be supported by local authorities in the future.**
- If they are going through a tough time, please talk to their practitioner about whether this is the right time for them to be taking part in this study.
- Do remember that **they do not have to talk about anything that makes them feel upset or uncomfortable.**
- Please do contact me if you or your child would like to talk or they need a break at any time during the study. If you or they do not feel able to ask their practitioner or the researchers for help, we encourage you/your child to contact external support services such as:

  - *The Samaritans* (Tel. **116 123**, www.samaritans.org)
  - *Childline* (Tel. **0800 1111**, www.childline.org.uk)

Section 2: Your information and how it will be used

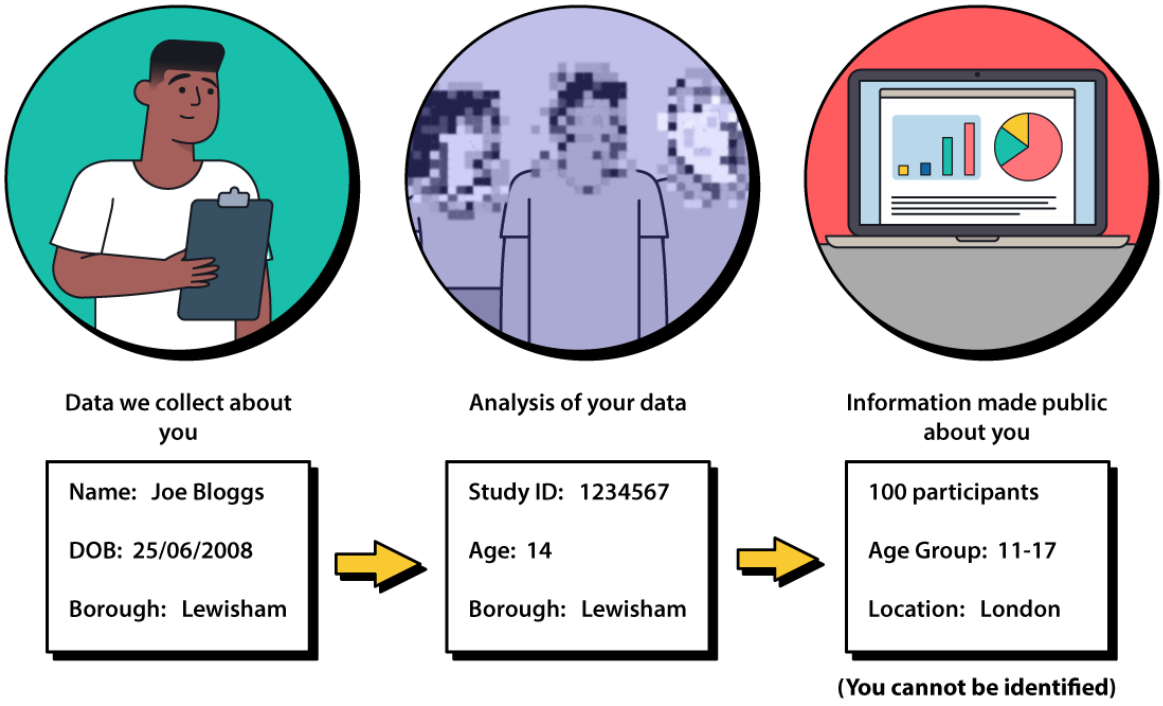
Note: The next section relates to how your and your child's information will be used in the study. We would strongly suggest that you go through this with your child's youth practitioner, and do not hesitate to ask any questions.

What information will we collect during the study?

- Your and your child's name and contact information in the consent forms
- Your borough will also tell us things like your child's **date of birth, gender, ethnicity, their sexual orientation, whether they have any special educational needs, whether they have a disability, whether they are looked after by the local authority,** whether they are in **education, employment or training**, **why and how your borough is supporting your child**
- We will ask your child to complete **two questionnaires about their feelings and behaviours** – once at the start and once at the end of the study
- We will ask your child's practitioner to tell us a bit about their meetings with your child, like:
    - if and when they had the meetings
    - what sort of work they did together
- We will also ask your child's practitioner to share your child's progress in keeping safe.

What will we do with the information that we collect?

- We will use this information to find out whether the young people who worked with their practitioner following the new approach do **better, worse or the same,** compared to the young people who work in the usual way.
    - To help with this, researchers will want to see your child's progress in the long term and will use information available with the **Department for Education** and the **Ministry of Justice**. **More information on this can be foundin the sections below and in the privacy notice.**
- We will write about the results, **and reports will be free online.** In these reports, we will use the things that your child has said but **we will never use your child's name or any other information that might identify them.** No one will know that it is your child who has said them.



- If your child takes part, their conversations will be audio-recorded so that the researchers can remember everything that was said.

How will we keep your and your child's information safe?

- **<u>No information collected as part of this study can be used by the police (or other law enforcement bodies), by the Home Office for immigration enforcement purposes or by anyone else for any purpose other than conducting the London Young People Study.</u>**

- Most of your child's information is stored by the Institute for Fiscal Studies for the purposes of this project. They will be able to identify them in this information. The Institute for Fiscal Studies has strong measures in place to ensure that only the research team can see your information. Please read more below about requesting to delete this information if you want to.
- The only time someone **other than someone in the research team** will see your name alongside the information you give us in your questionnaire is if we need to share information with your practitioner, **to keep you or someone else safe.**
- If you talk to a researcher about your experience, the recording and write-up (transcript) of the discussion will be stored by the Anna Freud Centre. The recording will be deleted

once it has been written up. The Anna Freud Centre has strong measures in place to protect their data and the transcript will be kept for no longer than 9 months.

- After the study ends, some of your child's information will also be stored in an archive. Your child's identity is protected by replacing their name and other information with a number.
- There are strong measures in place to protect the information in this archive. This means **your child cannot be identified without their information being illegally linked back to their name and address**.

You can find out more about how we will use your child's information and who it is shared with in the **privacy notice** accompanying this information sheet.

What if I want my and my child's information to be deleted?

- If you want us to remove your and/or your child's information, you can contact us and ask us to delete them.
- **Your child's questionnaire responses, which contain their personal information, will be kept by the IFS on an ongoing basis and can be deleted at any time**.
- However, it won't be possible to delete the information which will be stored in the archive because it will not be possible to identify your child. Therefore, if you wish for your child's data to be deleted, you need to do this **before 30th December 2022, when the study ends.**

Section 3: Other information – ethics, questions and complaints

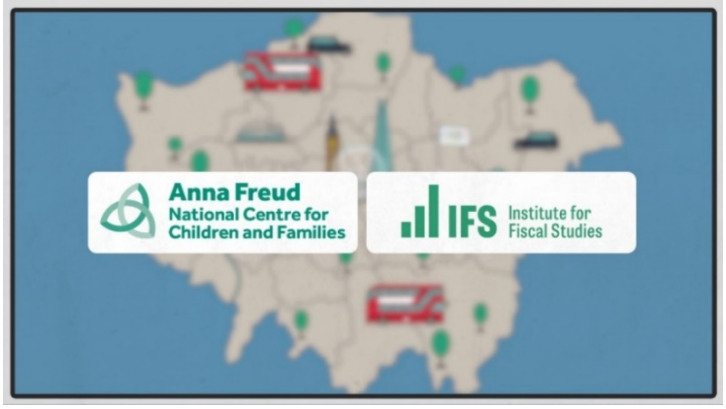
- All research is looked at by an independent group of people, called a "Research Ethics Committee (REC)", to protect your interests and safety.
- **This research has been reviewed and approved by University College London Research Ethics Committee (reference number: 5113.013).**
- If you would like to see a summary of what we will have learned from the study, **please let us know and we will send this to you**, or check our website (https://ifs.org.uk/london-study).
- Please contact us if you have any **questions, problems or complaints** at: LondonStudy@ifs.org.uk
- If you want to take your complaint further, you can contact the Chair of the ethics committee at ethics@ucl.ac.uk

THE LONDON YOUNG PEOPLE STUDY

Information Sheet for Practitioners

The London Young People Study (LYPS) wants to understand **how we can best support young people to keep safe and healthy.** This sheet is **to help you understand how your data will be used in order to help us do this.** If anything is unclear please email us at: LondonStudy@ifs.org.uk

Who are we?



We are a group of researchers based at the **Institute for Fiscal Studies** and the **Anna Freud Centre.** In our work, we have seen how young people from certain groups are much less likely to be listened to. Meeting different groups will help how young people are supported by professionals and make sure support meets their needs.

Section 1: What is this study about and how does it work?

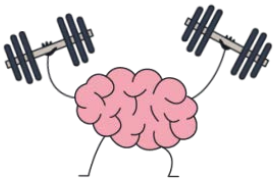
When you meet with a young person, the goal is always to **support them to keep them safe and healthy.** You probably already have different ways of doing this.

In this study, we would like to test whether a new way of working with young people is **better, worse, or the same** as the usual way of working with them.

In order to evaluate this, we have randomly assigned one team in your local authority to be trained in this new way of working. We will collect information on the young people

assigned to work with practitioners in these teams and compare them to data we are collecting on the young people assigned to one or more teams that did not get the training.

This new way of working will enable trained practitioners to teach the young person new skills in the brain gym. The brain gym helps people with their thoughts and feelings which can change how they behave and help them to achieve their goals.



Practitioners trained in this new way of working will aim to meet with the young person 3 times a week for 12 weeks.

Collecting information on the young people supported by untrained teams not only provides us with a suitable benchmark to compare this new way of working to but will also help us build a valuable set of information on "business as usual" provision across all London Boroughs.

Who is being invited to take part?

Each Local Authority has selected a number of teams to participate in the London Young People Study (with one of these teams being trained now and the other teams being trained in the future). Young people assigned to these teams are invited to take part in the LYPS if:

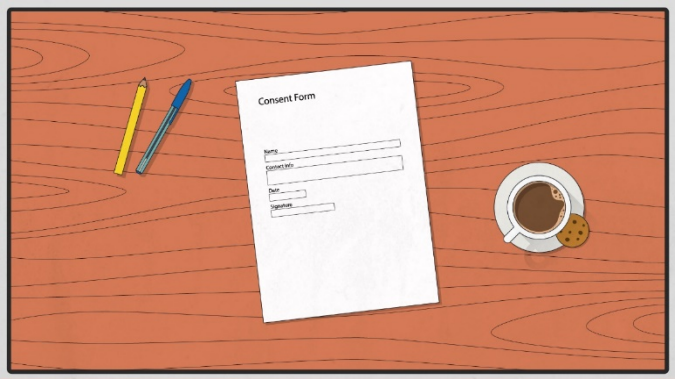
- They are between **11-17 years old** and
- They have been assessed medium to high risk, and this assessment has been confirmed by their practitioner's manager and validated by a multi-agency panel or equivalent in last 30 days

The young person can change their mind and stop taking part at any time without telling us why. To do this, the young person or their practitioner must email us to let us know (LondonStudy@ifs.org.uk).

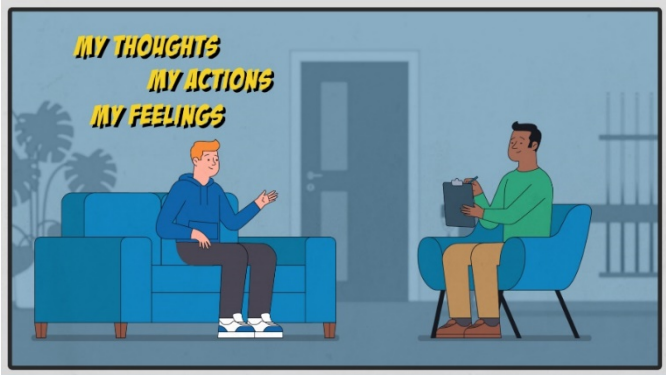
As the main trusted point of contact with young people, practitioners play a key role in the recruitment of young people. Recruitment follows several steps outlined on the next page.

Follow the following steps for each young person you recruit:

1 Collect a **signed consent form** with young person and practitioner details (if the young person is 11-15, collect parent/carer consent too)



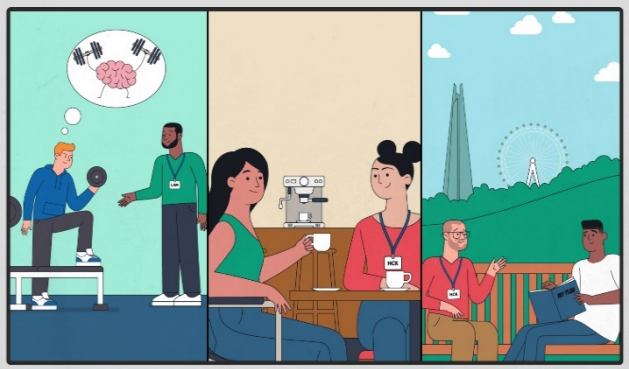
10 mins



2 Help the young person fill out a **confidential questionnaire** about their feeling and behaviours. AND complete the **practitioner questionnaire** about the young person.

15 mins

3 You will either work with the young person in the usual way or you will follow the new approach. During this time, you will complete a **session form every time** you meet with the young person.



12 weeks

4 About **four months after**, we will ask both the young person and practitioner to fill out another **confidential questionnaire about the young person**.

30 mins

Section 2: Your information and how it will be used

What information will you provide during the study?

The only information we collect on **you** is your name and contact information in the consent forms.

- We will ask you to complete **two questionnaires about the risky behaviours of each young person** you recruit (one at recruitment and one about 15-20 weeks later)
    - If you recruited a young person but are no longer their lead practitioner by the time of the endline questionnaire, we will ask the lead practitioner to complete it. We may ask for your help in getting in touch with this person.
- We will ask you to tell us a bit about your sessions with them, like:
    - if and when you had the meetings
    - what sort of work you did together
    - how engaged was the young person during the session.

What will we do with the information that we collect?

- We will use this information to find out whether the young people who worked with their practitioner following the new approach do **better, worse or the same,** compared to the young people who work in the usual way.
- We will also use the information provided by untrained, "business as usual", practitioners to learn about the **characteristics** of young people and the **services** they receive across all London Boroughs
- We will write about the results, **and reports will be free online.** In these reports, we will use the things that you, and the young person, have said but **we will never use your names or any other information that might identify you.** No one will know that it is you who said them.
- This information will never identify you and assess the work that individual practitioners do with young people.

How will we keep your information safe?

- **No information collected as part of this study can be used by the police (or other law enforcement bodies), by the Home Office for immigration enforcement purposes or by anyone else for any purpose other than seeing how well the London Young People Study has worked.**

- Your information will be stored by the Institute for Fiscal Studies for the purposes of this project. They will be able to identify you in this information. The Institute for Fiscal Studies has strong measures in place to ensure that only the research team can see your information.
- After the study ends, all data will be placed in a secure archive and all personal details of the practitioner and young person will be removed and replaced with a **number**.
- There are strong measures in place to protect the information in this archive. This means **you cannot be identified without your information being illegally linked back to your name**.

You can find out more about how we will use your information and who it is shared with in the **privacy notice** accompanying this information sheet.

Section 3: Other information – ethics, questions and complaints

- All research is looked at by an independent group of people, called a "Research Ethics Committee (REC)", to protect your interests and safety.
- **This research has been reviewed and approved by University College London Research Ethics Committee (reference number: 5113.013).**
- If you would like to see a summary of what we will have learned from the study, **please let us know and we will send this to you**, or check our website (https://ifs.org.uk/london-study)
- Please contact us if you have any **questions, problems or complaints** at: LondonStudy@ifs.org.uk
- If you want to take your complaint further, you can contact the Chair of the ethics committee at ethics@ucl.ac.uk

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR YOUNG PEOPLE AGE 16-17

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

1. I have read the Information Sheet for this study.	☐
2. I have had the opportunity to ask questions about the study and how my personal information will be used, and these questions have been answered. I understand what will be involved.	☐
3. I understand what working with the team supporting me may involve, and I am happy to work with them.	☐
4. I have enough information to decide whether to participate in the study.	☐
5. I understand that I am free to stop taking part at any point and can request to have my information removed from the YEF archive until 30th November 2022.	☐
6. I understand that all personal information will be kept private and stored securely.	☐
7. I understand that the researchers will link the information they collect on me to my records held by the Department for Education and Ministry of Justice (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my information collected as part of this study.	☐
8. I understand that I will never be identified in any publications or websites.	☐
9. I agree to taking part in the above study.	☐

If you would like to have a discussion (which will be recorded) with a researcher about your experience working with your practitioner, please tick this box: ☐

Please enter your contact details so that we can send you vouchers when you complete questionnaires

First name	Signature
Last name	
Email address	Telephone number
First line of address	Postcode

To be completed by practitioner:

Practitioner's first name	
Practitioner's last name	
Practitioner's email address	
Practitioner's phone number	
Practitioner's service name	
Practitioner's team name	
Have you ever trained in Your Choice? ☐ Yes ☐ No	
Please confirm your Local Authority	

Thank you for agreeing to participate in this study!

We are committed to keeping your information safe.

If you have any questions, please contact us at:
LondonStudy@ifs.org.uk

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR YOUNG PEOPLE AGE 11-15

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

1. I have read the Information Sheet for this study.	☐
2. I have had the opportunity to ask questions about the study and how my personal information will be used, and these questions have been answered. I understand what will be involved.	☐
3. I understand what working with the team supporting me may involve, and I am happy to work with them.	☐
4. I have enough information to decide whether to participate in the study.	☐
5. I understand that I am free to stop taking part at any point and can request to have my information removed from the YEF archive until 30th November 2022.	☐
6. I understand that all personal information will be kept private and stored securely.	☐
7. I understand that the researchers will link the information they collect on me to my records held by the Department for Education and Ministry of Justice (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my information collected as part of this study.	☐
8. I understand that I will never be identified in any publications or websites.	☐
9. I agree to taking part in the above study.	☐

If you would like to have a discussion (which will be recorded) with a researcher about your experience working with your practitioner, please tick this box: ☐

Please enter your contact details so that we can send you vouchers when you complete questionnaires

First name	Signature
Last name	
Email address (if known)	

To be completed by practitioner:

Practitioner's first name	
Practitioner's last name	
Practitioner's email address	
Practitioner's phone number	
Practitioner's service name	
Practitioner's team name	
Have you ever trained in Your Choice? ☐ Yes ☐ No	
Please confirm your Local Authority	

Thank you for agreeing to participate in this study!

We are committed to keeping your information safe.

If you have any questions, please contact us at:
LondonStudy@ifs.org.uk

THE LONDON YOUNG PEOPLE STUDY

CONSENT FORM FOR PARENTS AND CARERS

Hello!

We are thrilled that you are interested in taking part in the London Young People Study!

Please complete this form after you have read the Information Sheet and discussed it with your practitioner.

Please read each sentence and tick the box if you agree:

1. I have read the Information Sheet for this study.	☐
2. I have had the opportunity to ask questions about the study and how my child's personal information will be used, and these questions have been answered. I understand what will be involved.	☐
3. I understand what working with the team supporting my child may involve, and I am happy for my child to work with them.	☐
4. I have enough information to decide whether my child should participate in the study.	☐
5. I understand that my child is free to stop taking part at any point and can request to have their information removed from the YEF archive until 30th November 2022.	☐
6. I understand that all personal information will be kept private and stored securely.	☐
7. I understand that the researchers will link the information they collect on my child to records held by the Department for Education and Ministry of Justice on my child (if any) but neither the Department for Education nor the Ministry of Justice will be able to see my child's information collected as part of this study.	☐
8. I understand that my child will never be identified in any publications or websites.	☐
9. I agree for my child to take part in the above study.	☐

If you are happy for a researcher to contact you to schedule a discussion (which will be recorded) with your child about their experience working with practitioners, please tick this box: ☐

Please enter your child's name so that we can send them their voucher when they complete questionnaires:

Child's first name	**Child's last name**
Child's email address	**Child's telephone number**
Child's first line of address	**Child's postcode**

Please enter your name and contact details:

Parent/carer's first name	Parent/carer's signature
Parent/carer's last name	
Parent/carer's email address (if different from above)	

Thank you for agreeing to your child participating in the study.

We are committed to keeping your information safe.

If you have any questions, please contact us at:
LondonStudy@ifs.org.uk

THE LONDON YOUNG PEOPLE STUDY

PRIVACY NOTICE FOR YOUNG PEOPLE

What is a privacy notice?

A privacy notice is an important document which tells you how we use and look after information that we have got about you (or a child in your care).

Who are we?

There are three key organisations involved in the processing and storing of your information. These are the Institute for Fiscal Studies (IFS), the Anna Freud National Centre for Children and Families (AFC) and the Youth Endowment Fund (YEF). Our contact details can be found a the end of this privacy notice.

Who is responsible for looking after the information you have about me?

"Data controller" is a legal phrase, which tells you who makes the decisions about how your information will be used and looked after. During the study, the Institute for Fiscal Studies (IFS) and the Anna Freud Centre (AFC) are what's known as "joint data controllers". This means that IFS and AFC are jointly responsible, for processing and looking after your information whilst the data are being collected and analysed by the team.

When the study is finished in the second half of 2024, your information will be handed over to Youth Endowment Fund (YEF), who have funded the study. This means that YEF will then become another "data controller" along with the Institute for Fiscal Studies who will keep a copy of your personal data for a minimum of ten years. AFC will no longer be a data controller. YEF will store your information in a safe and secure place called the YEF archive. You can find out more about this here (https://youthendowmentfund.org.uk/evaluation-data-archive/), where you can find a copy of their privacy statement.

What information do we collect about you?

The information that we collect, use, store and will share with YEF at the end of the study will include personal information about you. Some of this information will be given to us by you and some of this will be given to us by your youth practitioner.

The information that we will ask you to tell us will include;

- Your name and contact details
- Your parents name and contact details (if you are 15 or below when you sign up to the study)
- Information about your thoughts, feelings and behaviour that you share with us as part of the questionnaires

- The responses that you share with the researchers
- The names and details of your youth practitioners.
- The audio recording of your one-to-one discussion with a researcher about your experience in the study if you if you took part in this

The team in your Borough that you are working with will also share some of the information that they have about you, which will include;

- Your date of birth
- Your gender
- Your sexual orientation
- Whether you are looked after by the local authority
- Whether you have any special educational needs
- Whether you have a disability
- Information about your race or ethnicity
- Whether you are in education, training or employment
- Why you have come to work with your youth practitioner
- The names and other details about other youth practitioners who are supporting you
- When and where you met with your youth practitioners

We will also get some information about you from the Department for Education and the Ministry of Justice which will include:

- Your educational record
- Your crime record (if any)

How do we use your information?

We will use the information you give us to help us to find out how well the new way of working (explained in the explainer video) supports young people to stay safe and healthy. This includes how well it has worked in the short term (in the next year) and the long term (in the next few years). By putting your information together with the information about all of the other young people that have taken part in the London Young People study, we will be able to look for patterns that will tell us whether the new way of working is helpful for young people. We will give presentations and write reports about this but this will never include your name or any other personal information about you. The reports will appear on the IFS, AFC and YEF websites.

Who will we share your personal information with?

Your personal data will be collected and processed by the research teams at IFS and AFC.

We will share your information with these organisations:

IFS Institute for Fiscal Studies

Anna Freud National Centre for Children and Families

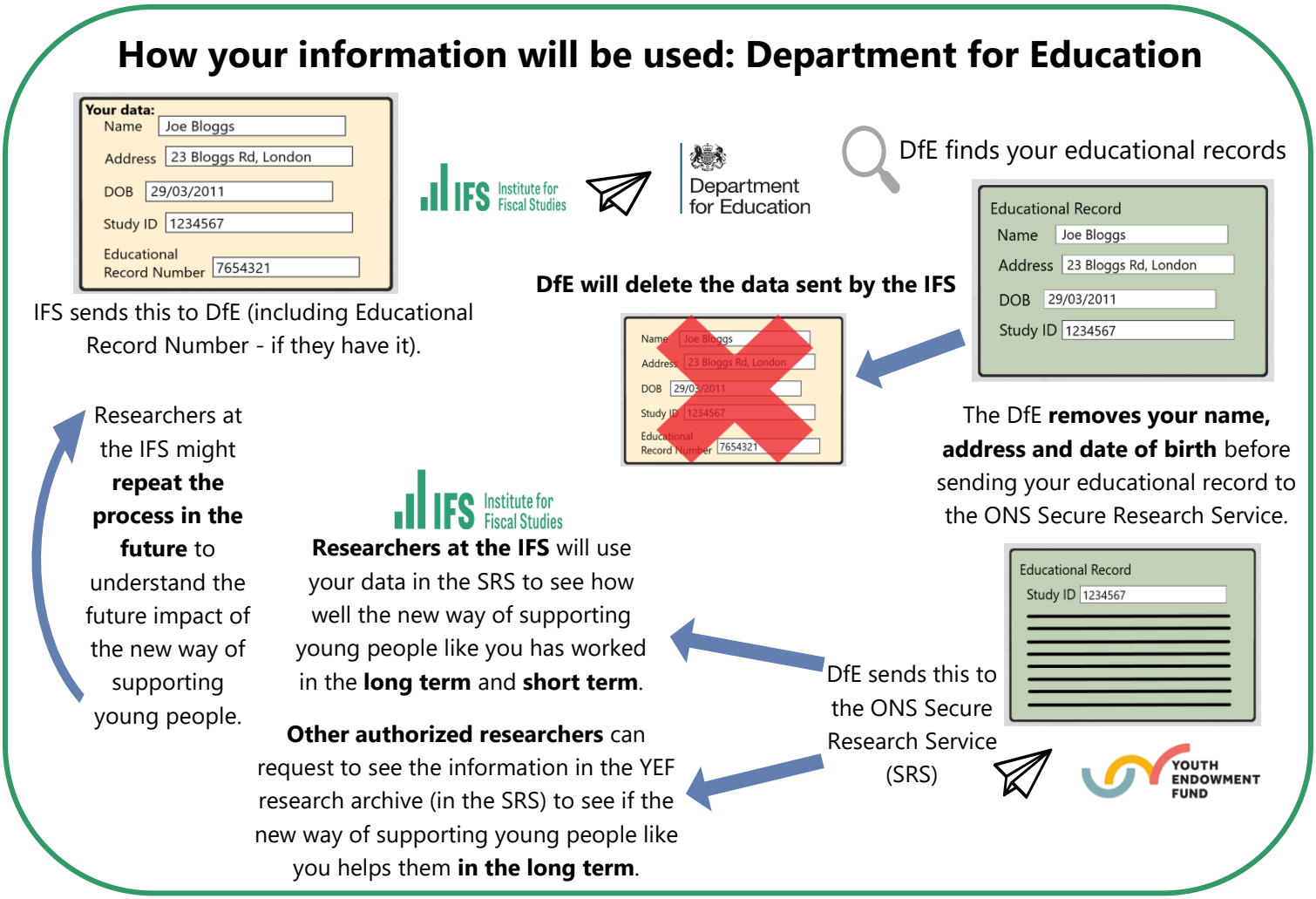
- Department of Education
- Youth Endowment Fund
- Ministry of Justice
- The team you work with in your Borough
- The Transcription Service

Department of Education and the Youth Endowment Fund

When we have finished collecting data on everyone taking part in the study, we will send your name, address and date of birth to the Department for Education (DfE) and ask them to find your information in their databases. We will not send them your questionnaire answers but we will send them a number in place of your name (study code) so we can find your answers again when they send us their information. If your Local Authority has given it to us, we will also send DfE your educational record number to help them find the right person.

DfE will send your educational records, any social care records, your study code and their own meaningless code to the Office for National Statistics' Secure Research Service where it will be analysed by the research team at IFS. When the study has ended and the research team has completed their analysis, the data used by the research team will be moved to the YEF archive for other approved researchers to use. At this point, the YEF will become another data controller of your data. The YEF archive is part of the ONS Secure Research Service. The Secure Research Service is what is known as a "Trusted Research Environment" which is designed to allow approved researchers to use data safely and securely in their work. All the data in the Secure Research Service is "pseudonymised". This is a term used in data protection that means that you cannot be identified in the data unless the study code given to you is linked back to your name and address. Because the Secure Research Service is an extremely controlled environment, it would be technically almost impossible and also illegal for anyone to do this.

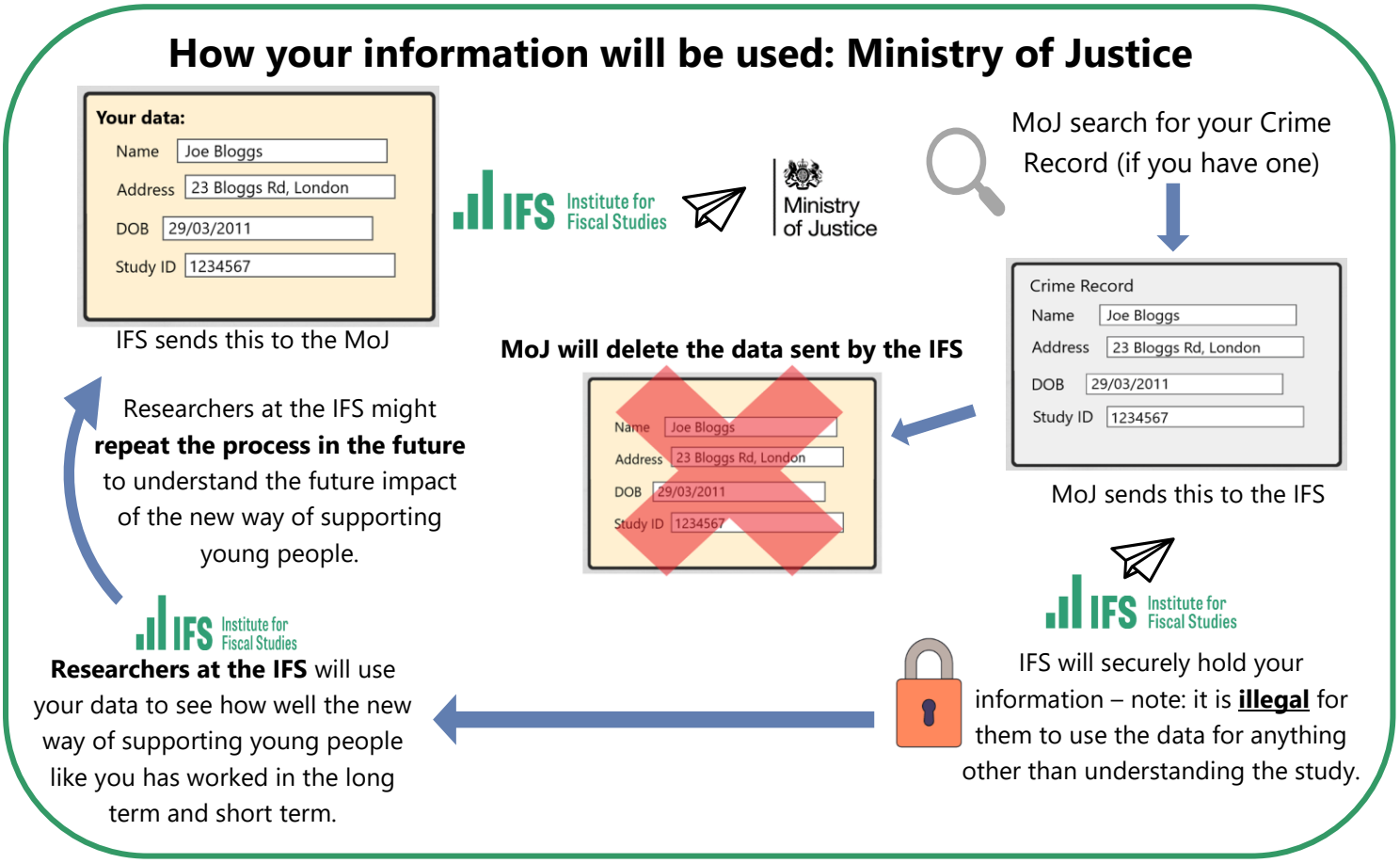
The picture below explains how this process works:



Ministry of Justice

When we have finished collecting data, we will send your name, address and date of birth to the Ministry of Justice (MoJ) and ask them to find your information in their databases. We will not send them your questionnaire answers but we will send them a number in place of your name (study code) so we can find your answers again when they send us their information. MoJ will send your study code and your crime records (if you have any) back to the research team at IFS. IFS will store your crime data separately from your name and address to keep your data as secure as possible. IFS will only ever use your data for finding out how well the different services are doing at keeping you safe and healthy. Under data protection law it is illegal for IFS to use this data for any other purpose.

This picture explains how this process works:



The team you work with in your Borough

If you agree to take part in the study, we will ask you (and your parent if you are 11-15) and your practitioner to complete a series of online forms. This includes your consent form (and your parent, if you are 11-15), your baseline and endline questionnaire, as well as a questionnaire to your practitioner at the beginning and end of your work with them. In order to ensure that all our records are accurate we will share information on which forms you or your parents have completed with the team you are working with in your Borough so that if any forms are missing, the team can ensure that everything we need from you has been completed. We will not share any of the content of your and your practitioner's questionnaire with your Borough.

The Transcription Service

As part of the study we are inviting you to talk to a researcher about your experience in the study. If you choose to do this, your audio recordings will be shared with a company called *The Transcription Service* for the purposes of writing up your spoken answers into words. We will make sure that they keep your data safe in line with UK data protection law. When the recording has been written up, we will replace your name with a number and the recording will be deleted.

What does the law say about using and storing my information?

The law says that each data controller must have a "lawful basis" for processing and storing your information in the way that we have described.

IFS and AFC's legal basis for processing information and in this study is *Legitimate Interest*. Our legitimate interest is research into the best way to support young people.

By maintaining the YEF archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest and this gives the YEF a lawful basis to use personal information.

Certain bits of information about you are known as "Special Category Data" and require more legal protection. This includes things like your ethnicity, wellbeing This kind of information needs an extra condition for processing. The condition that applies to your data in this study is Article 9 (2) (j) Archiving, research and statistics.

Your crime records (if you have any), also require more legal protection. We process your crime record data under Article 10 and the condition for processing that applies in this study is Research.

How long do we keep your information for?

The information from audio recordings (if you agree to meet with one of the researchers to talk about your experiences in the study) will be kept for no longer than 9 months. As soon as the audio recordings have been written up in text your personal information will be deleted and it will not be possible to identify you.

The information stored by IFS which includes the information that you share in your questionnaires and any crime records from MoJ will be stored for as long as necessary to understand what all of the information, collected together, tells us about the different ways of working with young people. The project will start in April 2022. Your information will then be stored for a minimum of 10 years. This is to allow us time to look at the longer-term effects. After 10 years, we will carry out a review to see if there is still useful work that can be done using your data. At any point that we no longer need your data for this research project, we will delete it.

The coded data (pseudonymised) data that would make it really difficult to identify you by name) that is stored in the ONS Secure Research Service for analysis by IFS researchers will be stored securely for a minimum of 10 years or until the DfE ask us to delete it (whichever is sooner).

The coded data that is stored in the YEF archives at the ONS Secure Research Service will be stored indefinitely to allow for long term follow up. However, YEF will review this every

five years to decide whether the information could still be helpful in future research. If it is not, then the information will be deleted.

Your rights

You have the right to:

• ask for access to the personal information that we hold about you;

• ask us to correct any personal information that we hold about you which is incorrect, incomplete or inaccurate.

In certain circumstances, you also have the right to:

• ask us to erase the personal information where there is no good reason for us continuing to hold it – please read the information below about the time limits for requesting deletion of your personal information;

• object to us using the personal information for public interest purposes;

• ask us to restrict or suspend the use of the personal information, for example, if you want us to establish its accuracy or our reasons for using it.

Time limits for deleting your data

Your survey responses, which contain your personal information, will be kept by the IFS on an ongoing basis and can be deleted any time. However, once your name and other identifying information has been deleted from your survey answers and has gone to the ONS Secure Research Service for analysis by IFS researchers or into the YEF archive for use by other researchers it won't be possible to delete your information from those archives because we won't be able to identify you. If you wish your data to be deleted before it is sent to the YEF archive for analysis by other researchers, you need to do this before 30th June 2023, when the study ends.

If you wish to exercise your rights, please contact us on LondonStudy@ifs.org.uk.

Who can I speak to if I have any questions?

You can contact both the Institute for Fiscal Studies (IFS) and the Anna Freud Centre (AFC) by emailing LondonStudy@ifs.org.uk;

Other contact details

You can find information and other contact details of each of the data controllers on their webpages:

Institute for Fiscal Studies: www.ifs.org.uk

Anna Freud Centre: https://www.annafreud.org/

Youth Endowment Fund: https://youthendowmentfund.org.uk/

Who can I speak to if I want to make a complaint?

If you want to make a complaint about our use of personal data, please contact the Data Protection Officer at dataprotectionofficer@ifs.org.uk.

You can also make a complaint to the Information Commissioner's Office (ICO) (The UK's data protection regulator) via;

- their website https://ico.org.uk
- by phone 03031231113
- or by writing to Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

THE LONDON YOUNG PEOPLE STUDY

PRIVACY NOTICE FOR PRACTITIONERS INVOLVED IN THE STUDY

1. Introduction

At the Institute for Fiscal Studies (IFS) and the Anna Freud National Centre for Children and Families (AFC), we respect your privacy and we are committed to protecting your personal data.

Please read this Privacy Notice carefully – it describes why and how we collect and use personal data and provides information about your rights.

2. About us

The research team is composed of researchers based at IFS and AFC. The Principal Investigator of the study is Imran Rasul, Research Director at the Institute for Fiscal Studies and Professor of Economics at University College London.

IFS and AFC are the entities that jointly determine how and why your personal data is processed.

This means that during the study IFS and ARC are the 'joint controllers' of your personal data for the purposes of data protection law.

Our contact details are:

Address:	Institute for Fiscal Studies, 7 Ridgmount Street, WC1E 7AE
Phone number:	020 7291 4800
Email address:	LondonStudy@ifs.org.uk
Website:	www.ifs.org.uk

Address:	Anna Freud Centre, 4-8 Rodney Street, London N1 9JH
Phone number:	020 7794 2313
Email address:	LondonStudy@ifs.org.uk
Website:	www.annafreud.org

3. Personal data that we collect about you

Personal data, or personal information, means any information about an individual from which that person can be identified. It does not include data where it is not possible to identify an individual (anonymous data).

The only personal data about you we will collect, use, store and transfer is your name and contact details.

4. How we use your information

We will use your name and contact details to link your session logs and assessments of the young person's behaviours to the Your Choice training records we will receive from Local Authorities. This will allow us to ascertain who the young person has worked with and when and whether this practitioner received Your Choice training.

We will also use your email address to remind you when it is time for you and for the young people involved in the study you work with to complete questionnaires. We will contact you to arrange a meeting with a researcher and the young people you work with so that the researcher can help the young person complete the endline young people questionnaire at the end of their time in the study.

Finally, we may use your contact details only in case we require any clarification on your survey answers.

5. Who we share your personal data with

Your personal data will be collected and processed by the research teams at IFS and AFC.

After the study is finished, we will delete all personal information relating to practitioners.

6. Data Processors

We will not use any third-party processors of your personal data.

7. Lawful basis for processing

Data Protection Legislation requires that we meet certain conditions before we are allowed to use your data in the manner described in this notice, including having a "lawful basis" for the processing. The basis for processing in this study is *Legitimate Interest - Article 6(1)(f)*. That is, the processing of your personal data is necessary for the purposes of the legitimate interests pursued by us, except where such interests are overridden by your interests or by fundamental rights and freedoms which require protection of personal data. Our legitimate interest is research into the best way to support young people. There is a wider public benefit in supporting young people in the most effective way.

8. Data retention

Data protection laws permit personal information to be kept for longer periods of time where it is necessary for research and archiving in the public interest, and for statistical purposes.

The project will start in April 2022. Your information will then be stored for a minimum of 10 years. This is to allow us time to look at the longer-term effects. After 10 years, we will carry out a review to see if there is still useful work that can be done using your data. At any point that we no longer need your data for this research project, we will delete it.

9. Your rights

Under data protection law, these are your general rights:

- **Your right of access** - You have the right to ask us for copies of your personal information.
- **Your right to rectification** - You have the right to ask us to rectify personal information you think is inaccurate. You also have the right to ask us to complete information you think is incomplete.
- **Your right to erasure** - You have the right to ask us to erase your personal information in certain circumstances.
- **Your right to restriction of processing** - You have the right to ask us to restrict the processing of your personal information in certain circumstances.
- **Your right to object to processing** - You have the right to object to the processing of your personal information in certain circumstances.
- **Your right to data portability** - You have the right to ask that we transfer the personal information you gave us to another organisation, or to you, in certain circumstances.

However, since your data will be processed for scientific or historical research purposes that further a general public interest, various exceptions from these rights apply. In particular, the right to access, the right to rectification, the right to restrict processing, and the right to object do not apply, provided the appropriate safeguards are in place. The right to erasure is not absolute, and does not apply if it would seriously impair processing necessary for scientific research. However, if you wish for your data to be deleted, we will do so. If you wish to submit this request or talk to us about exercising any other right, please contact us at LondonStudy@ifs.org.uk or contact the IFS data protection officer at dataprotectionofficer@ifs.org.uk

More information about individual rights can be found on the Information Commissioner's Office (ICO)'s website (https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/individual-rights/), and information about the rights exemptions that apply under the context of research can be found there as well (https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/exemptions).

10. Contacting us

You can contact IFS by telephoning +44 (0)20 7291 4800 or by writing to: Institute for Fiscal Studies, 7 Ridgmount Street, London WC1E 7AE.

Please note that IFS has appointed a Data Protection Officer. If you have any questions about this Privacy Notice, including any requests to exercise your legal rights, please contact our Data Protection Officer at dataprotectionofficer@ifs.org.uk.

11. Complaints

If you wish to complain about our use of personal data, please send an email with the details of your complaint to the IFS Data Protection Office (dataprotectionofficer@ifs.org.uk) so that we can look into the issue and respond to you.

You also have the right to lodge a complaint with the Information Commissioner's Office (ICO) (the UK data protection regulator). For further information on your rights and how to complain to the ICO, please refer to the ICO website (https://ico.org.uk).

The ICO's address is the following:
Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

Helpline number: 0303 123 1113

Date: 07.07.2022

THE LONDON YOUNG PEOPLE STUDY

BASELINE YOUNG PEOPLE QUESTIONNAIRE

Thank you for being part of the London Young People Study!

In this questionnaire, we are going to ask you some questions about how you've been feeling lately and how you're thinking about yourself in different situations.

There are no right or wrong answers, but please try to answer the questions as truthfully as possible. This information will really help us understand how to empower young people to keep as safe as possible.

This questionnaire might take about 15 minutes to complete. If you complete it, we will email you a **£10 Love2Shop voucher** shortly after you finish it.

Your answers to this questionnaire are **confidential** and we are committed to keeping your information safe. The only time that your answers might be shared with your practitioner is if your answers suggest that you, or someone else, is at risk of harm. We will let you know which questions we refer to when we get to them.

To start this questionnaire, please enter your first and last name:

First name	
Last name	

Date: 07.07.2022

1. Currently, what is your main activity? Please tick all that applies.

- ☐ I go to school/college
- ☐ I work for pay
- ☐ I am following a training programme
- ☐ None of the above

In the next set of questions, we would like to ask you how you have been feeling lately. This is called the Strengths and Difficulties Questionnaire. Remember, there is no right or wrong answer. We will not share your answers to these questions with anyone.

Date: 07.07.2022

2. Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True.

It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft!

Please give your answers on the basis of how things have been for you over the last six months.

	Not true	Somewhat true	Certainly true
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐

	Not true	Somewhat true	Certainly true
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

3. Thank you for answering these questions. This is great! Just a few more questions to go through.

In this set of questions, we would like you to ask how likely you think different situations will happen in the next month.

Your responses are confidential - we will not tell anyone (e.g. your youth worker, the police) what you tell us.

The only exception is if there is a risk of significant harm to you or other people. For questions marked with ** if you answer likely or very likely then we will let your practitioner know so that they can work with you towards a plan to keep you safe.

If you have questions about this, please pause to talk to your practitioner.

In the next month, how likely do you think you are to engage in behaviour that…	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… could cause distress or damage in a public place? (e.g. graffiti or other damage to public property, being drunk in a public place, transport fare dodging)	☐	☐	☐	☐	☐
… would get you into trouble with the police? (e.g. theft, fire setting, selling illegal substances or property, drink or drug driving, taking a car without consent, carrying an item that could cause serious physical harm to others)	☐	☐	☐	☐	☐
… could physically hurt other people? ** (e.g. serious physical fights, using an item that could cause serious physical harm to others)	☐	☐	☐	☐	☐

In the next month, how likely do you think it is that…	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… that other people in your life will try and involve you in any of the above behaviours? **	☐	☐	☐	☐	☐

In the next month, how likely do you think it is that you will …	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… witness a violent crime?	☐	☐	☐	☐	☐
… be a victim of a violent crime? **	☐	☐	☐	☐	☐

3. Thank you so much for sharing your thoughts with us.

We're in the final stretch now!

We would like to finish this questionnaire by asking you about the people in your life who may support you at home, at school, or elsewhere.

At home, there is an adult who….	None of the time	Rarely	Some of the time	Often	All of the time
… is interested in my school work	☐	☐	☐	☐	☐
… believe that I will be a success	☐	☐	☐	☐	☐
… wants me to do my best	☐	☐	☐	☐	☐
… listens to me when I have something to say	☐	☐	☐	☐	☐

(The next block about support at school or in college will only be asked to those young people who respond their main current activity is attending school in question 1A)

At school or college, there is an adult who…	None of the time	Rarely	Some of the time	Often	All of the time
… really cares about me	☐	☐	☐	☐	☐
… tells me when I do a good job	☐	☐	☐	☐	☐
… listens to me when I have something to say	☐	☐	☐	☐	☐
… believes that I will be a success	☐	☐	☐	☐	☐

In other places, there is an adult who….	None of the time	Rarely	Some of the time	Often	All of the time
… really cares about me	☐	☐	☐	☐	☐
… tells me when I do a good job	☐	☐	☐	☐	☐
… believes that I will be a success	☐	☐	☐	☐	☐
… I trust	☐	☐	☐	☐	☐

Date: 07.07.2022

Away from school, ….	None of the time	Rarely	Some of the time	Often	All of the time
… I am a member of a club, sports team, church group, or other group	☐	☐	☐	☐	☐
… I take lessons in music, art, sports or have a hobby	☐	☐	☐	☐	☐

Fantastic! You've made it through to the end of the questionnaire!

We will be sending your £10 Love2Shop voucher very soon using the email address you have provided on your consent form.

If you haven't provided an email address, we will send your voucher to your practitioner so that they can share it with you.

Thank you so much for your time contributing to the London Young People Study!

Date: 07.07.2022

THE LONDON YOUNG PEOPLE STUDY

BASELINE PRACTITIONER QUESTIONNAIRE ABOUT THE YOUNG PERSON

We are asking you to complete this short questionnaire because you or another practitioner in your team has recently recruited a young person into the study.

In this short questionnaire, we would like to ask you for **your assessment of this young person's likelihood to engage in behaviours or situations that could cause harm to themselves or to others**.

In a few months' time, we will ask you similar questions about the young person. This information will help us understand what are the most effective ways of working with young people to keep them safe and healthy.

The questionnaire has 7 questions and should take you **no more than 5 minutes** to complete. Please answer these questions as truthfully as possible.

All the information you share in this questionnaire will be kept entirely **confidential** and only used for the purpose of this research.

Young person's first name _____

Young person's last name _____

Practitioner's first name _____

Practitioner's last name _____

Practitioner's service _____

Practitioner's team _____

Have you ever trained in Your Choice?

☐ Yes

☐ No

Date: 07.07.2022

1. What is the young person's current risk rating?

Low ☐	Medium ☐	High ☐	Very high ☐

2. Based on your best intelligence to date, …

How likely do you think the young person currently engages in behaviour that…	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… could cause distress or damage in a public place? (e.g. graffiti or other damage to public property, being drunk in a public place, transport fare dodging)	☐	☐	☐	☐	☐
… would get them into trouble with the police? (e.g. theft, fire setting, selling illegal substances or property, drink or drug driving, taking a car without consent, carrying an item that could cause serious physical harm to others)	☐	☐	☐	☐	☐
… could physically hurt other people? (e.g. serious physical fights, using an item that could cause serious physical harm to others)	☐	☐	☐	☐	☐

How likely do you think it is that currently …	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… other people in the young person' life currently try and involve them in any of the above behaviours?	☐	☐	☐	☐	☐

In the next month, how likely do you think it is that the young person will …	Very unlikely	Unlikely	Neither likely nor unlikely	Likely	Very likely
… witness a violent crime?	☐	☐	☐	☐	☐
… be a victim of a violent crime?	☐	☐	☐	☐	☐

Date:29.07.2022

THE LONDON YOUNG PEOPLE STUDY

ENDLINE YOUNG PEOPLE QUESTIONNAIRE

FOR REFERENCE ONLY – DATA TO BE COLLECTED BY IFS RESEARCHER

Please contact LondonStudy@IFS.org.uk to arrange.

Thank you so much for agreeing to take part in this study. Your participation is invaluable to us and will help us understand how best to support young people in London.

There are no right or wrong answers, but please try to answer the questions as truthfully as possible. This information will really help us understand how to empower young people to keep as safe as possible.

This questionnaire might take about 30 minutes to complete. If you complete it, we will email you a **£15 Love2Shop voucher** shortly after you finish it.

Your answers to this questionnaire are **confidential** and we are committed to keeping your information safe. The only time that your answers might be shared with your practitioner is if your answers suggest that you, or someone else, is at risk of harm. We will let you know which questions we refer to when we get to them.

To start this questionnaire, please enter your first and last name:

First name	
Last name	

Section 1 - About you and what you've been up to

1A. Currently, what is your main activity? Please tick all that applies

1. I go to school/college
2. I work for pay
3. I am following a training program
4. None of the above

1B. We would like to hear about your experience working with your worker(s) over the past 3-4 months. What are the things that you particularly liked about it?

(Free text box)

1C. Thinking about the worker you've spent most time with over the past 3-4 months, how often did they do the following things?

	Never	Rarely	Sometimes	Often	Always
My practitioner spent time getting to know and understand me.					
My practitioner tried to help me to better understand things that are important to me.					
My practitioner encouraged me to work towards goals that are important to me.					
My practitioner taught me new skills or behaviours.					
My practitioner helped me to see things differently.					
My practitioner helped me to find new ways of coping with difficult feelings.					
My practitioner helped me to find new ways of coping with difficult situations.					

Section 2 – Your feelings and emotions

In the next set of questions, we would like to ask you how you have been feeling lately. This is called the Strengths and Difficulties Questionnaire. Remember, there is no right or wrong answer. We will not share your answers to these questions with anyone.

○ *Click here when you are ready to continue*

Date:29.07.2022

2A. Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you in the last month.

	Not true	Somewhat true	Certainly true
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I'm doing. My attention is good			

Do you have any other comments or concerns?

(Free text box)

Since you entered this study, are your problems:

1 Much worse	2 A bit worse	3 About the same	4 A bit better	5 Much better

Since then, has working with your practitioner been helpful in other ways, e.g. providing information or making the problems more bearable?

1 Not at all	2 Only a little	3 Quite a lot	4 A great deal

Over the last month, have you had difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

1 No	2 Yes - minor difficulties	3 Yes - definite difficulties	4 Yes - severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

Do the difficulties upset or distress you?

1 Not at all	2 Only a little	3 Quite a lot	4 A great deal

Do the difficulties interfere with your everyday life in the following areas/

	1 Not at all	2 Only a little	3 Quite a lot	4 A great deal
Home life				
Friendships				
Classroom learning				
Leisure activities				

Do your difficulties make it harder for those around you (family, friends, teachers etc.)?

1 Not at all	2 Only a little	3 Quite a lot	4 A great deal

2B. Thank you for answering these questions. This is great! Just a few more questions to go through. In this set of questions, we would like you to ask **how likely you think different situations will happen in the next month.**

Your responses are confidential – we will not tell anyone (e.g. your youth worker, the police) what you tell us.

The only exception is if there is a risk of significant harm to you or other people. For questions marked with ** if you answer likely or very likely then we will let your practitioner know so that they can work with you towards a plan to keep you safe.

If you have questions about this, please pause to talk to your practitioner.

○ *Click here when you are ready to continue.*

In the next month, how likely do you think you are to engage in behaviour that…	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… could cause distress or damage in a public place? (e.g. graffiti or other damage to public property, being drunk in a public place, transport fare dodging)					
… would get you into trouble with the police? (e.g. theft, fire setting, selling illegal substances or property, drink or drug driving, taking a car without consent, carrying an item that could cause serious physical harm to others)					
… could physically hurt other people? ** (e.g. serious physical fights, using an item that could cause serious physical harm to others)					

In the next month, how likely do you think it is that…	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… that other people in your life will try and involve you in any of the above behaviours? **					

In the next month, how likely do you think it is that you will …	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… witness a violent crime?					
… be a victim of a violent crime? **					

Section 3 - Your social life

Thank you so much for sharing your thoughts with us. We're in the final stretch now!

We would like to finish this questionnaire by asking you about the people in your life who may support you at home, at school, or elsewhere.

Please read every statement carefully and indicate the answer that fits you best.

At home, there is an adult who….	None of the time	Rarely	Some of the time	Often	All of the time
… is interested in my school work					
… believe that I will be a success					
… wants me to do my best					
… listens to me when I have something to say					

(The next block about support at school or in college will only be asked to those young people who respond their main current activity is attending school in question 1A)

At school or college, there is an adult who…	None of the time	Rarely	Some of the time	Often	All of the time
… really cares about me					
… tells me when I do a good job					
… listens to me when I have something to say					
… believes that I will be a success					

In other places, there is an adult who….	None of the time	Rarely	Some of the time	Often	All of the time
… really cares about me					
… tells me when I do a good job					
… believes that I will be a success					
… I trust					

Away from school, ….	None of the time	Rarely	Some of the time	Often	All of the time
… I am a member of a club, sports team, church group, or other group					
… I take lessons in music, art, sports or have a hobby					

Section 4 - Your feelings and thoughts recently

4A. Below are some statements about feelings and thoughts. Thinking about the last month, please tell us how much you agree or disagree with each sentence below.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I find it hard to control my feelings					
I change my mind often					
I'm able to deal with stress					
I can control my anger when I want to					
Sometimes I get involved in things later I wish I could get out of					
I try to control my thoughts and not worry too much about things					

4B. Please tick the box that best describes your experience over the last month.

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

4C. For this question, please indicate how much you agree or disagree with each of the eight statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I will be able to achieve most of the goals that I have set for myself.					
When facing difficult tasks, I am certain that I will accomplish them.					
In general, I think that I can obtain outcomes that are important to me.					
I believe I can succeed at almost any endeavor to which I set my mind.					
I will be able to successfully overcome many challenges.					
I am confident that I can perform effectively on many different tasks.					
Compared to other people, I can do most tasks very well.					
Even when things are tough, I can perform quite well.					

Fantastic! You've made it through to the end of the questionnaire!

We will be sending your £15 Love2Shop voucher very soon using the email address you have provided on your consent form.

If you haven't provided an email address, we will send your voucher to your practitioner so that they can share it with you.

Thank you so much for your time contributing to the London Young People Study!

Default Question Block

THE LONDON YOUNG PEOPLE STUDY

Researcher Form

Please complete this form about any session scheduled or held between you and a young person involved in the London Young People Study.

Young person's first name

${e://Field/RecipientFirstName}

Young person's last name

${e://Field/RecipientLastName}

Researcher's first name

Researcher's last name

Day the session was scheduled for / took place

Months the session was scheduled for / took place

Did ${q://QID1/ChoiceTextEntryValue/1} attend the session?

No

Yes

Did ${q://QID1/ChoiceTextEntryValue/1}'s main practitioner attend the session?

Yes

No

If no, who else was present?

If session did not take place

Did ${q://QID1/ChoiceTextEntryValue/1} notify you they would not attend the session?

Yes

No

If known, please briefly describe the reason why ${q://QID1/ChoiceTextEntryValue/1} did not attend the session.

Please use this box if you would like to share any other details about the session that did not take place (e.g. significant events, next steps, etc.).

If session did take place

Where did the session take place?

How would you rate ${q://QID1/ChoiceTextEntryValue/1}'s engagement?

Not engaged at all

Somewhat disengaged

Neither engaged not disengaged

Somewhat engaged

Very engaged

How long did the whole session take? (Including introductions and goodbyes)

If held in person, where was the practitioner?

In the room, listening

In the room, not listening

Outside the room

Other (please state)

Were any safeguarding concerns raised during the session? Please give details including whether the practitioner was informed.

Please use this box if you would like to share any other details about the session that took place (e.g. significant events, next steps, etc.).

Date: 07.07.2022

THE LONDON YOUNG PEOPLE STUDY

ENDLINE PRACTITIONER QUESTIONNAIRE ABOUT THE YOUNG PERSON

We are asking you to complete this short questionnaire because you or another practitioner in your team has recently recruited a young person into the study 3 - 4 months ago.

In this short questionnaire, we would like to ask you about your work with the young person during this time and for **your assessment of this young person's likelihood to engage in behaviours or situations that could cause harm to themselves or to others**.

The questionnaire includes 8 questions and should take you **no more than 10 minutes** to complete. Please answer these questions as truthfully as possible.

All the information you share in this questionnaire will be kept entirely **confidential** and only used for the purpose of this research.

Young person's first name _____

Young person's last name _____

Practitioner's first name _____

Practitioner's last name _____

Practitioner's service _____

Practitioner's team _____

Date: 07.07.2022

1. What is the young person's current risk rating?

Low	Medium	High	Very high

2. Based on your best intelligence to date, …

How likely do you think the young person currently engages in behaviour that…	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… could cause distress or damage in a public place? (e.g. graffiti or other damage to public property, being drunk in a public place, transport fare dodging)					
… would get them into trouble with the police? (e.g. theft, fire setting, selling illegal substances or property, drink or drug driving, taking a car without consent, carrying an item that could cause serious physical harm to others)					
… could physically hurt other people? (e.g. serious physical fights, using an item that could cause serious physical harm to others)					

How likely do you think it is that currently …	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… other people in the young person' life currently try and involve them in any of the above behaviours?					

In the next month, how likely do you think it is that the young person will …	**Very unlikely**	**Unlikely**	**Neither likely nor unlikely**	**Likely**	**Very likely**
… witness a violent crime?					
… be a victim of a violent crime?					

3. Thinking about the sessions you had with the young person over the past 3 - 4 months, how often did you do the following things?

	Never	Rarely	Sometimes	Often	Always
I spent time getting to know and understand the young person.					
I tried to help the young person to better understand things that are important to them.					
I encouraged the young person to work towards goals that are important to them.					
I taught the young person new skills or behaviours.					
I helped the young person to see things differently.					
I helped the young person to find new ways of coping with difficult feelings.					
I helped the young person to find new ways of coping with difficult situations.					

Date: 24.06.2022

THE LONDON YOUNG PEOPLE STUDY

SESSION FORM

Please complete this form about any session scheduled or held between you and a young person involved in the London Young People Study.

Young person's first name _____

Young person's last name _____

Practitioner's first name _____

Practitioner's last name _____

Practitioner's service _____

Practitioner's team _____

Day the session was scheduled for / took place _____

Month the session was scheduled for / took place _____

Did the young person attend the session? Yes ☐ No ☐

Is the young person currently receiving *Your Choice*? Yes ☐ No ☐

Date: 24.06.2022

PAGE TO BE ANSWERED ONLY IF THE SESSION DID NOT TAKE PLACE

Did the young person notify you they would not attend the session? Yes ☐ No ☐

If known, please briefly describe the reason why the young person did not attend the session.

Please use this box if you would like to share any other details about the session that did not take place (e.g. significant events, next steps, etc.)

Date: 24.06.2022

PAGE TO BE ANSWERED ONLY IF A SESSION TOOK PLACE

Where did the session take place? ***(If the session was delivered in more than one location please use the location of the main part of the session)***

How would you rate the young person's engagement during the session?

Not engaged at all ☐	Somewhat disengaged ☐	Neither engaged nor disengaged ☐	Somewhat engaged ☐	Very engaged ☐

Date: 24.06.2022

SECTION TO BE ANSWERED ONLY IF A SESSION TOOK PLACE AND YOUNG PERSON IS CURRENTLY RECEIVING YOUR CHOICE

Was the session related to the *Your Choice* programme? Yes ☐ No ☐

- ***[If `no' to previous answer]*** **Was the session related to an entirely new intervention or programme that cannot be incorporated into the *Your Choice* plan?**
  Yes ☐ No ☐ Don't know ☐
- ***[If `yes' to previous answer]*** **What new intervention or programme was the session related to?**

Please choose as many options as apply from the list below to describe the content of the session

- ☐ Relationship building
- ☐ Exploring values
- ☐ Identifying hook
- ☐ Exploring Your Choice goals
- ☐ Your Choice goal setting
- ☐ Working towards Your Choice goals
- ☐ Introduced CBT tools and techniques
- ☐ Pulling together what works for me (My Manual)
- ☐ Focus on presenting crisis situation
- ☐ Contact with Parent/Carer
- ☐ Planning for next steps (i.e. after Your Choice)
- ☐ Other

- ***[If `Other' to previous answer]*** **Please provide a brief description of the content of the session**

Was the session observed by a clinical supervisor? Yes ☐ No ☐

Have you discussed this case in clinical supervision in the last 30 days? Yes ☐ No ☐

Please use this box if you would like to share any other details about the session (e.g. significant events, next steps, etc.)

Date: 24.06.2022

SECTION TO BE ANSWERED ONLY IF A SESSION TOOK PLACE AND YOUNG PERSON IS NOT CURRENTLY RECEIVING YOUR CHOICE

Please choose as many options as apply from the list below to describe the content of the session

- ☐ Relationship building
- ☐ Assessment / report preparation
- ☐ Contact with parent/ carer
- ☐ Working towards care plan/ intervention plan
- ☐ Constructive / leisure activity
- ☐ Group work
- ☐ Signposting
- ☐ Other

➢ *[If `Other' to previous answer]* **Please provide a brief description of the content of the session**

Was the session observed by a clinical supervisor? Yes ☐ No ☐

Have you discussed this case in clinical supervision in the last 30 days? Yes ☐ No ☐

Please use this box if you would like to share any other details about the session (e.g. significant events, next steps, etc.)
