Trauma Informed Care

Toolkit technical report

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Abstract/Plain Language summary

Trauma-informed care or practice is defined as any attempt by an organisation/system to address the symptoms and/or effects of trauma into their policies and practices to actively prevent re-traumatisation. In responding to the outcome of trauma such as negative behaviours, in a way that acknowledges trauma and its impact, a system such as a school or child welfare services could help prevent later crime and violence. Trauma-informed practice can also be implemented in the criminal justice system and mental health services.

The objective of this technical report is to review the evidence on the effect of trauma-informed care/practice on children's involvement in crime and violence.

This report is based on two reviews. Maynard et al. (2019) examined the effectiveness of trauma-informed practice in schools on outcomes such as trauma symptoms, mental health, academic performance, behaviour, and socioemotional functioning, but no meta-analysis was performed for any of these outcomes. Bunting et al. (2019) reported the results of a rapid evidence review of trauma-informed practice in child welfare systems on a range of outcomes, including child behaviour problems and post traumatic symptoms. A broader evidence review (Bunting et al., 2019) and a review of implementation of trauma-informed care (Bryson et al., 2017) are also included.

A trauma-informed practice approach implements trauma-informed policies and practices across three domains (Bunting et al., 2019; Maynard et al., 2019). These domains are labelled as follows: (1) workforce training and development; (2) trauma-focused services; and (3) organisational change.

Trauma-informed practice can be implemented in a range of contexts and settings, and thus involves a wide variety of personnel. For example, a trauma-informed care approach could be implemented in education systems (e.g., schools; Maynard et al., 2019), healthcare systems (e.g., hospitals, general practice, emergency departments), criminal justice settings (e.g., prison and penal systems, parole and probation services, police forces, juvenile

residential centres and youth offending teams), and other social welfare-focussed systems (e.g., child welfare agencies, child advocacy agencies, social services, foster care services).

Neither of the included reviews includes a meta-analysis. Maynard et al. (2019) is an empty review, i.e., the authors found no eligible studies for inclusion. Bunting et al. (2019) include 21 evaluations of 17 community-based child welfare initiatives that implemented trauma-informed care with social workers, family welfare staff and or other professionals. These studies include a small number of effectiveness studies, but it was difficult to disentangle the effects of trauma-informed care from the broader projects within which they are set.

There is thus a need to grow the evidence base with more rigorous evaluations to assess the effects of trauma-informed care and practice.

Objective and approach

The objective of this technical report is to review the evidence on the effect of trauma-informed care/practice on children's involvement in crime and violence.

The rationale for trauma-informed practice is the growing body of evidence that Adverse Childhood Experiences (ACE), such as physical, sexual and emotional abuse, are linked to later behavioural problems including offending[1] [2]. More specifically, there is a clear 'graded' relationships, with the more ACEs a child has been exposed to then the greater the likelihood of negative outcomes in behaviour, school performance, offending and so on (Felitti et al., 1998; Anda et al., 2006; Bellis et al. 2015; and Hughes et al., 2017).

Trauma-informed practice can occur in a variety of contexts, including but not limited to schools, healthcare, social services, and criminal justice settings. Trauma-informed practice is defined as any attempt by an organisation/system to address the symptoms and/or effects of trauma into their policies and practices to actively prevent re-traumatisation. As such, this is a different approach to specific trauma-focused interventions such as trauma-focused cognitive behavioural therapy which support recovery from trauma (Fondren et al., 2020; Olaghere et al., 2021).

The objective of this technical report is to review the evidence of the effect of trauma-informed practice on children's involvement in crime and violence. This technical report is based on one systematic reviews of trauma-informed care in schools (i.e., Maynard et al., 2019) and a rapid evidence review of trauma-informed care in child welfare systems (i.e., Bunting et al., 2019).

The following inclusion and exclusion criteria were used to inform selection of systematic reviews.

[1] https://www.gov.scot/publications/understanding-childhood-adversity-resilience-crime/
[2] https://phw.nhs.wales/files/aces/the-prisoner-ace-survey/

Inclusion criteria

To be included in this report, a review must include systematic search processes and report on the effects of trauma-informed practice or trauma-informed care on children and young people. Given the lack of research in this area, a variety of contexts (e.g., schools, healthcare, justice settings) were eligible for inclusion. Furthermore, we did not restrict our inclusion criteria to only reviews that computed a meta-analysis. We purposively kept our inclusion criteria broad to reviews of trauma-informed care/practice on children and young people given the paucity of research in this area.

Therefore, 'empty reviews' or those that did not find any eligible studies were considered to inform our technical report (e.g., Maynard et al., 2019) and we also included reviews that did not focus on effectiveness. For example, the review by Bryson et al. (2017) is used to inform the implementation section of the present report. A broader evidence review that used systematic search methods also informs the current report (Bunting et al., 2019a).

Exclusion criteria

Reviews were excluded for the following reasons:

- The review included only evaluations of trauma-specific interventions for children and/or young people who have experienced trauma, or are at-risk for exposure to trauma (e.g., Fondren et al., 2020; Olaghere et al., 2021).
- The review explicitly excluded studies that focused on outcomes related to children and young people's involvement in crime violence. For example, Berger (2019) conducted a systematic review of multi-levelled approaches of trauma-informed care in schools, but specify that they excluded studies that reported effects on school violence, behaviour management, community violence, school bullying, and internalising and externalising behaviours (p. 653).

Overall, it was difficult to find reviews that focussed on the impact of trauma-informed care and practice on children and young people's involvement in crime and violence. More research, and a new review, is needed in this area.

Outcomes

Neither of the effectiveness reviews that inform the current technical report conducted a meta-analysis.

Maynard et al. (2019) examined the effectiveness of trauma-informed practice in schools on outcomes such as trauma symptoms, mental health, academic performance, behaviour, and socioemotional functioning, but no meta-analysis was performed for any of these outcomes. Bunting et al. (2019) reported the results of a rapid evidence review of trauma-informed practice in child welfare systems on a range of outcomes, including child behaviour problems and post traumatic symptoms.

Description of interventions

There is often confusion about what constitutes trauma-informed practice/care, and this approach is not clearly defined (Maynard et al., 2019). In contrast to the better-known trauma-focused interventions, for example trauma-focused cognitive behavioural therapy or Eye Movement Desensitization and Reprocessing (EMDR) for the treatment of post-traumatic stress disorder, there is no clear operational definition of what trauma-informed practice involves. Furthermore, this approach is often labelled in different ways, for example, trauma-informed practice, trauma-informed care, or a trauma-informed system (Hanson & Lang, 2016; Maynard et al., 2019). A review of the components of trauma-informed care within outpatient and counselling health settings for young people concluded that 'most studies did not define trauma-informed care, those that did generally relied on the SAMHSA (2014) definition' (Bendall et al., 2020: 9).

Maynard et al. (2019) utilise a definition set by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014; a US governmental agency), to define trauma-informed practice as one that incorporates key trauma principles into the organisational culture of an intervention, agency, or system. A trauma-informed approach is therefore best described as a framework to guide systems, rather than a specific set of interventions (Maynard et al., 2019).

There are four key assumptions and six key principles that underly a trauma-informed care approach (Lang et al., 2015; Maynard et al., 2019). These are outlined below:

Assumptions

It is assumed that a trauma-informed approach:

- Realises the impact of trauma
- Recognises the signs and symptoms of trauma
- Responds by integrating knowledge and research on trauma into policies, procedures and practices
- Prevents re-traumatisation

Principles

The principles that are encompassed in a trauma-informed practice approach are:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

Examples of these principles in practices are not provided, but one can assume that safety refers to ensuring that the system is a psychologically safe place for all individuals and peer supports refers to, not only top-down training and support, but also developing the skills and abilities of peers to help one another (e.g., students helping other students, or social workers helping colleagues). Trustworthiness and transparency in a trauma-informed system may refer to a system or organisation being open and communicative about their policies and practices and ensuring trust amongst all members of the organisation. One can imply that collaboration, mutuality, and empowerment refer to a trauma-informed system ensuring that all members of an organisation work together and feel empowered to use their voice. Finally, a trauma-informed system should address relevant cultural, historical and gender issues that may be important. For example, a trauma-informed system would be amiss to not address

the impact of trauma due to colonisation, institutional racism and patriarchal societal structures.

A trauma-informed practice approach implements trauma-informed policies and practices across three domains (Bunting et al., 2019; Maynard et al., 2019). These domains are labelled as: (1) workforce training and development; (2) trauma-focused services; and (3) organisational change.

Bunting et al. (2019) outline that in child welfare systems, workforce development may involve training of all staff on the impact of trauma, strategies to reduce staff traumatic stress and assessments of staff members' knowledge on trauma and its impacts (Bunting et al., 2019). Information about the duration of this training is not provided, but Bunting et al. (2019) outline that post-training follow up lasted from between six weeks and two years. In schools, workforce development includes training teachers and school staff to effectively respond to, and address, the behaviour of students exhibiting trauma symptoms as well as making suitable referrals to targeted services (Maynard et al., 2019).

The trauma-informed services domain refers to the inclusion of a child's trauma history in their case notes or file, increasing the availability of evidence-based trauma-focused interventions and practices and using screening tools to assess a child's trauma history and symptoms (Bunting et al., 2019). It also includes increasing the availability of trauma specific treatment services and the development of trauma-focused support services, such as training or mentoring for children and young people. Maynard et al. (2019) highlights how a trauma-informed school may screen students directly for trauma symptoms or collaborate with external agencies to undertake screening in the community or the school.

The organisational change domain refers to the collaboration, coordination, and information sharing between organisations to create a trauma-informed system. In a school, this may mean modifying disciplinary procedures so that children's negative behaviours are viewed through a trauma-informed lens. This can also include developing policies that specify how communication between the school, external agencies/services and caregivers which is trauma-aware (Maynard et al., 2019). Organisational change and collaboration can occur

both internally, between different branches or departments within the system, or externally, between the system and other agencies or services. Another important element is the implementation of procedures to reduce the risk of re-traumatising service users, using a safe physical environment, and using written policies that include and support trauma-informed practice principles (Bunting et al., 2019).

Across the UK, different approaches are being adopted for trauma-informed care in the justice system, though these are not necessarily or entirely focused on CYP (Durr, 2020). In England, a trauma informed integrated mental health service is being developed in prisons, and in Scotland and Wales new strategies seek to tackle the problem at source by reducing ACEs – in Bridgeport, South Wales – an ACE Support Hub is being piloted (Bunting et al., 2019a).

Targeted or Universal

Trauma-informed practice/care is an example of a universal approach to the prevention and reduction of children and young people's involvement in crime and violence. The core component of this approach is that trauma-informed practices and policies are implemented at an organisational level. In this way, the approach aims to target children and young people, but the agents of intervention are the professionals and other adults (e.g., families or caregivers) and not the individual children.

Bunting et al. (2019) describe the implementation of trauma-informed practice in the USA as typically being either state-wide implementation or organisation-wide. The former refers to trauma-informed practice approaches that involved multiple agencies (e.g., child welfare agencies, foster care and adoption services), whilst the latter involves individual organisations or agencies implementing trauma-informed practice and care. For example, a Child Advocacy Centre or fostering agencies may implement trauma-informed practice for the benefit of their service users and staff (Bunting et al., 2019).

In schools, trauma-informed practice is similarly a universal approach, where trauma-informed policies and practices are embedded into staff training and interactions with students.

If a system were to implement trauma-informed polices and practices, these may include using specific targeted trauma-interventions, such as CBT for individuals who have been exposed to trauma, but in its entirety, trauma-informed practice is a universal approach.

Implementation setting and personnel

Trauma-informed practice can be implemented in a range of contexts and settings, and thus involves a wide variety of personnel. For example, a trauma-informed care approach could be implemented in education systems (e.g., schools; Maynard et al., 2019), healthcare systems (e.g., hospitals, general practice, emergency departments), criminal justice settings (e.g., prisons, parole and probation services, police forces, juvenile residential centres and youth offending teams), and other social welfare-focussed systems (e.g., child welfare agencies, child advocacy agencies, social services, foster care services). As such the personnel involved in a trauma-informed practice approach could be teachers, school administrative staff, psychologists, police officers, prison governors, doctors, nurses, social workers, or anyone working within the organisation implementing the approach.

Trauma-informed care in CJS

Bunting et al. (2019a) provide a brief overview of trauma-informed care in different systems, including criminal justice settings.

Bunting et al. (2019a) identified three evaluations of trauma-informed care in juvenile justice settings (Elwyn et al., 2015; Elwyn et al., 2017; Marrow et al., 2012). There was little agreement in how best to implement the domains of trauma-informed care in juvenile justice settings. However, some suggestions included:

- Using existing assessment tools to identify the systems' existing strengths and the system-specific needs. For example, trauma triggers may include loud and overwhelming noise, and some YOIs may already have the facilities to provide trauma-informed care (e.g., a quiet place) but are not using them in this way. Such

modifications to the physical environment are an important part of trauma-informed care.

- A YOI may find it useful to develop dynamic individualised care plans and focus on developing individuals' coping skills, but also revise the institutions' disciplinary methods to prevent re-traumatisation (e.g., solitary confinement or physical restraints). There also needs to be accountability and transparency between all members of the organisation, so between staff and residents of a YOI but also organisational leaders and managers.
- Communication and information sharing between multiple systems is essential for a trauma-informed care in juvenile systems. For example, information sharing about the trauma triggers and responses of an individuals to trauma, between a YOI, youth probation and parole officers and mental health professionals will improve outcomes for the young person.

Theory of change (presumed causal mechanisms)

Trauma-informed practice emerged from extensive research on adverse childhood experiences (ACEs) and as previously outlined, the evidence-based link between experiencing traumatic events in childhood and later involvement in crime and violence. Maynard et al. (2019) outline the extensive research on the impact of trauma on a young persons' development in a wide array of domains. Trauma can impact social, emotional, physical, neurological, and behavioural development, and as such, is related to outcomes such as delinquency, substance abuse, behaviour problems in schools, academic performance, emotional regulation difficulties, and mental health (Maynard et al., 2019).

The presumed causal mechanism in trauma-informed practice is that, in responding to the outcome of trauma such as negative behaviours, in a way that acknowledges trauma and its impact, a system can help to reduce this negative behaviour and prevent later crime and violence (Maynard et al., 2019).

The standard responses can re-traumatise a young person and lead to further behavioural issues. For example, if a child or young person has experienced physical abuse in the home and is then subjected to physical restraints in a YOI, re-traumatisation may occur. Thus, a cycle is created and the behavioural response to trauma is never addressed and may get progressively worse.

Therefore, implementing trauma-informed care in criminal justice settings could improve behaviour, and improve outcomes in many ways. Addressing a young person's previously experienced trauma using assessment tools and making appropriate referrals for treatment services will not only improve their behaviour in the criminal justice setting, but also in the community upon reintegration. Moreover, a trauma-informed care approach in a criminal justice setting (e.g., YOI) may lead to improved behaviour whilst a resident at the YOI and allow the individual to engage with other rehabilitative services thus reducing the risk of reoffending.

However, more research is needed to better evaluate these possible pathways.

Evidence base

Descriptive overview

Maynard et al. (2019) found no evaluations of trauma-informed practice that met their inclusion criteria, and so published an 'empty review'.

Bunting et al. (2019) identified 75 papers that met their inclusion criteria, of which 21 were evaluations of 17 community-based child welfare initiatives that implemented trauma-informed care with social workers, family welfare staff and or other professionals. All of these evaluations were implemented in the United States of America. The initiatives were either state-wide implementation of trauma-informed practice (*n* = 8) or organisation-wide implementation of trauma-informed practice (*n* = 9).

Assessment of the strength of evidence

We have confidence that, at the time of writing, the reviews by Maynard et al. (2019) and Bunting et al. (2019) are the best available evidence on the effectiveness of trauma-informed

practice. Neither review conducted a meta-analysis and so no impact estimate could be estimated.

Impact

Summary impact measure

Neither of the reviews that inform the current technical report conducted a meta-analysis and so, a summary impact measure cannot be computed.

There is a wealth of research advocating for the implementation of trauma-informed practice in a variety of settings but very little effort to rigorously evaluate the impact of this approach. Maynard et al. (2019) found no evaluations of trauma-informed practice in schools that met their inclusion criteria in their systematic searches of the literature. The authors note that they did find a plethora of studies that discuss the possible merit of trauma-informed practice in education systems.

Bunting et al. (2019.; p. 8) summarised the results of seventeen evaluations of trauma-informed care in child welfare services, most of which suggest that this approach could be effective in reducing post-traumatic symptoms and behaviour problems. Whilst the authors observe that a stronger evidence base is emerging, with some studies attempting to measure effectiveness, that there are problems in trying to disentangle the effects of trauma-informed care from the overall projects within which they take place. Moreover, the majority of evaluations used non-experimental methods and were based on very different measures and outcomes. Hence, no meta-analysis was performed Therefore, as outlined in our technical guide, the evidence rating for trauma-informed care is 1.

Implementation and Cost analysis

We found three process evaluations of trauma-informed care in schools in England: the Leicestershire Virtual School's Attachment Aware Schools Programme (Fancourt and Sebba, 2018), the Attachment Aware Schools Programme in Bath and Somerset (Dingwall and Sebba, 2018a), and the same programme in Stoke-on-Trent (2018b). In addition, we have one

process evaluation of the use of the Trauma Recovery Model as a part of Enhanced Case Management by three YOTs in Wales (Cordis Bright, 2017). We also draw on a realist review of trauma-informed care in youth inpatient psychiatric and residential treatment settings which reports on findings of 13 studies (Bryson et al., 2017). Annex 1 summarises the findings from reach of the process evaluations.

Important facilitators for successful implementation are: (i) senior leadership commitment to the approach; (ii) a whole school approach classroom aligning organisational structure and overall environment of school with trauma informed principles, so trauma-informed care is not restricted to what happens in the classroom; (iii) a culture of support across the school so there are range of safe spaces (such as 'drop in' places or formal Pupil Support offices – these spaces were mentioned by children as a positive feature of the programme) and different adults (teachers, teaching assistants, and dinner ladies) can be a trusted adult by a child; (iv) staff need adequate training and support to be confident of having sufficient understanding of both attachment theory and emotion coaching; (v) ensuring the voices of CYP and their families are heard; and (vi) data sharing helped monitor progress and cooperation in dealing with specific cases. In the case of YOTs adopting a trauma-informed approach, there was a good understanding of the approach, which was supported by training, and this was seen to have led to organizational improvements in case management.

Barriers which are mentioned are: (i) having a sufficient number of staff who have enough time to devote to the approach (especially for online learning which was found to be very time consuming); (ii) staff turnover; and (ii) absence of continuing support outside of the training. In YOTs there were few referrals so the eligibility criteria had to be broadened.

We are not aware of any studies of cost effectiveness, or other measures of costs, of trauma-informed care. In the case of the pilot of trauma-informed care in YOTs, some staff felt it was a different approach, but not necessarily a more expensive one, however one YOT and partner agencies withdrew because of additional demands on resources.

Findings from UK/Ireland

All of the studies included by Bunting et al. (2019) were conducted in the USA and Maynard et al. (2019) also found no effectiveness evaluations conducted in the UK or Ireland. The process evaluation section draws on available studies.

What do we need to know? What don't we know?

Despite the increasing interest in trauma-informed practice to reduce/prevent children and young peoples' involvement in crime and violence, there is currently only limited evidence of its effectiveness. We do not yet know if trauma-informed practice is an effective approach to address children and young people's involvement in crime and violence, and more high-quality research is needed.

In the first instance, this means more rigorous evaluations of trauma-informed practice. Both quantitative outcomes and qualitative outcomes should be included in such evaluations so that we can better understand how effective trauma-informed practice is, and also what might explain these effects. As trauma-informed practice can be implemented in a variety of settings, multiple evaluations are needed to understand how this approach may work in schools, healthcare, criminal justice, and social services.

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Annex 1 Overview of Process Evaluations

(Prepared by Sabina Singh)

Author & Title	**Intervention**	**Success**	**Issues/ Challenges**	**Young People's views**
Fancourt & Sebba 2018 The Leicestershire Virtual School's Attachment Aware Schools Programme: Evaluation Report	Leicestershire Virtual School offered a choice or combination of attachment awareness and emotion coaching to school staff to tackle anxieties and insecurities of pupils related to issues of trauma, attachment and emotional well-being. Emotion coaching and enabled school staff to	Quality of training The overall quality of training was crucial to the success of the program. The attendees specifically appreciated if teachers gave insights from their personal experience. Better understanding of both attachment theory and emotion coaching instilled confidence in school staff to identify and understand pupil	Challenge of treating pupils equitably. Difficulty in application/practice of attachment theory to specific pupils. Regular guidance and support beyond the virtual school to discuss issues staff may be experiencing with students.	Highlighting the kind of support that was available to pupils, a year 9 pupil shared; *Usually, people go to Pupil Support, if they've got a problem, if it's like at home or with their friends, but you could go to a form tutor as well.* Another year 7 pupil commented:

	understand behavioural difficulties of pupil that resulted from underlying unaddressed feelings. The school staff would use empathy and acknowledge feelings of people and help them to tackle their own problems. The programme thus ensured that the school staff was aware and understood attachment theory, and had knowledge about the implications of trauma on brain, learning and	with attachment disorders or trauma. Whole school level changes in organisational structure and overall environment of school including academic and pastoral group arrangements, and not merely confining to the classrooms. Commitment of senior leadership and head teachers during the trainings. 'Culture of support' in the schools whereby students could approach a variety of spaces and people such as teaching assistants, teachers, and form teachers.		*They (teaching assistants, form teachers, and the teachers) talk to you really and try and calm you down.*

	behaviour of children and young people.			
Dingwall & Sebba 2018a Evaluation of The Attachment Aware Schools Programme Final Report (Bath and Somerset)	The Bath and North East Somerset Attachment Aware Schools Programme required enrolment of two staff members from each school to the program with at least one senior member to lead whole school change with attachment aware practices embedded at all the levels.	Support and commitment of senior leadership team as they supported staff at all levels such as teaching assistants and school meals supervisory assistants (SMSAs). Appropriately staffed safe spaces in the schools such as 'drop in' places in the schools and relationships of trust between pupil and a significant adult. Increased awareness, knowledge and changes in attitudes and practices of staff	Online learning required a lot of writing and more contact between participating schools was needed. Movement of leaders and staff that underwent training and from one school to another affected the progress of the programme. Time and buy-in were also constraints in participation to the programme.	One of the young persons shared the availability of SMSAs in the school and the kind of support they offer to children and young people as: *The dinner ladies. … If you're upset or if you're hurt, they look after you.* Another student shared the emotional support

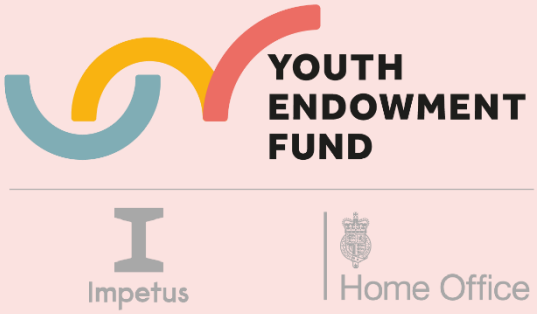
	Attachment Aware Programme Trainings were provided in the form of four core units of e-learning with each unit requiring about 16 to 20 hours of work.	at all levels led to a nurturing school environment. The staff gained more confidence in understanding needs of children and young people.		offered by the teaching staff as: *Because they* [teachers] *like talk with them, like they talk about their feelings and what might happen and things that you might get upset about.* Another student shared how she liked being in certain spaces in the school such as a specific room: *I do think it is mainly Miss … and just the kids in our, like not, it's not*

				our but in that room, it just makes me feel like I want to be there.
Dingwall & Sebba 2018b Evaluation of The Attachment Aware Schools Programme Final Report (Stoke)	The Stoke-on-Trent local authority together with Kate Cairns Associates ran an Attachment Aware Schools Programme in 2016-17. The school had to commit to the school becoming attachment aware, including designating an 'Attachment Lead Teacher' at senior level to coordinate activities and	Buy-in the from the school leadership team. Having sufficient staff in place to ensure adequate implementation and sustainability of the programme. Create safe spaces in school.	Adopting whole school approach means a wider range of staff (e.g. dinner ladies) should bet trained and attend case meetings. No opportunities provided for cross-school learning.	*they now know more about how to help and not just the basics so they know more of the like severe ways of ... I wouldn't say severe, I would say more comfortable ways of talking to you.* (Pupil, post Programme interview) *They look after us. They make you settled in*

	training on attachment, trauma and nurturing strategies. Schools involved in the Programme received an Attachment Awareness whole school staff development day followed by a two hour session with staff on Emotion Coaching.			*school. They make you ... they say, like, 'There's nothing to worry about'. They comfort you. They just make things better, basically.* (Pupil, postProgramme interview) *The pod ….yeah it's like a reading area or a stress out area,* (Pupil, post-Progamme interview) *they've got a designated school welfare office now …called Oasis so it's a safe haven for them to go and they've all been*

				made aware that the school welfare officer is there for them if they need (English Teacher, post-Programme interview)
Cordis Bright 2017 Enhanced Case Management encompassing the Trauma Recovery Model	The trauma recovery model is a seven stage adaptation of the case management process. The study concerns trailing the approach in 4 YOTs in Wales with a target of 36 young people (reduced to 27 as one YOT dropped out);	(1) Good awareness of ECM/TRM amongst YOT staff; (2) training beneficial, though not all received it; (3) Case formulation meeting helped adherence to the approach improving insights to the case and appropriate referrrals; (4) participation by other agencies started strong but trailed off; (5) clinical supervision of cases mostly viewed positively (but not always); (5) ECM led to	(1) 1 of the 4 YOTs in the trial withdrew because of capacity & resource issues; (2) delays in implementation; (3) lower number of referrals than expected (so eligibility criteria changed to meet numbers): after one year 8 actually involved compared to target of 8, reached 21 just over a year later; (4) engagement of other agencies not sustained (too time consuming for the agencies)	None in the report

		change in practice in YOTs at organizational level		



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